<table>
<tr><td>Name of meeting:</td><td colspan="2">Executive Management Team meeting
Public ✓ | Confidential ✓</td><td>Date:</td><td>26th May 2022</td><td>Paper:</td><td></td></tr>
<tr><td>Report title:</td><td colspan="6">BCF Year end report 2021/22 – 3 LLR (City, County and Rutland) draft BCF year end template for review in preparation for submission on 27th May to NHS England</td></tr>
<tr><td>Presented by:</td><td colspan="6">Rachna Vyas, Executive Director, Integration & Transformation, LLR CCG's</td></tr>
<tr><td>Report author:</td><td colspan="6">Mark Pierce – Head of Population Health Management
Mayur Patel – Senior Integration and Transformation Manager</td></tr>
<tr><td>Executive lead:</td><td colspan="6">Rachna Vyas, Executive Director, Integration & Transformation, LLR CCG's</td></tr>
<tr><td rowspan="2">Action required:</td><td>Receive for information only:</td><td></td><td>Progress update:</td><td>✓</td></tr>
<tr><td>For assurance:</td><td>✓</td><td>For approval / decision:</td><td></td></tr>
<tr><td>Executive summary:</td><td colspan="6">BCF year-end reporting template for the financial year 2021-2022 was released on April 20th 2022 with a submission deadline of May 27th 2022.

These templates include the following components:

• National Conditions – A declaration if these have been achieved or not for each respective BCF
• Metrics – Using data and narrative to declare achievement against expected sets of targets
• Income & Expenditure – Local allocations, IBCF, voluntary contributions etc are incorporated in this section
• Year-end feedback – Narrative related to successes and challenges
• ASC fee rates – Reflect the fees paid by local authority

For LLR, there are three BCF year-end submissions – one for each of our places (City: Appendix A, Leicestershire: Appendix B, Rutland: Appendix C). These reports have been approved by the chair of the Health and Wellbeing Board in each place and reviewed by the local Integrated Care forum (ISOC in the city, IDG in County and Rutland) prior to coming to EMT

Key points: Successes
• All three places report that their BCF programmes have had a positive impact on Integrated working in their place, in the face of adversity including the challenges of the Omicron wave and those posed by recruitment and retention of workforce.
• Integrated Care Response Service (ICRS) in City, working in partnerhsip with other organisations, remains the national exemplar service supporting patients in crises with an ultimate aim to avoid hospital admission and remain home receiving the immediate care they need.
• Falls services in Rutland focused on upskilling staff, twinned with a Care home Falls pilot ensuring prevention and safeguarding for fallers in local care homes - aimed at reducing hospital admissions and other adverse outcomes that can arise from falls.</td></tr>
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	• Completion of the re-commissioning of domiciliary care contracts in November provided great opportunities to implement zonal, cost-effective local care as well as dramatically improved care-wait times, reducing the amount of people awaiting care from around 300 to 50 within a few weeks, positively impacting on 'flow' from system perfective. **Key points: Challenges** • The increasing clinical complexity of patients admitted to hospital has created significant challenges in attaining Length of stay and success of reablement targets in all three places. • The instability of the domiciliary care and residential care market as well as retaining workforce in these sectors has also been a challenge -especially in Leicestershire and Rutland. However, the partnerships in each place have collaborated well to mitigate the worst of the effects – including using the resources of additional CCG voluntary contributions to the BCF to support innovative new ways of working. • Interoperability of systems and thus sharing of patients record with bordering ICSs remains a challenge for Rutland.
Appendices:	• Appendix A – City template • Appendix B – Leicestershire template • Appendix C – Rutland template
Recommendations:	The Executive Management Team is asked to: • REVIEW and APPROVE the three BCF DRAFT year-end reports in preparation for submission on 27th May 2022 • NOTE the system and local challenges and the achievements by each place for feeding into future improvement programmes • NOTE that some amendments may be made to these drafts between 23rd May to 27th May.
Report history and prior review:	• Paper presented on 25th/10/21 to RECEIVE AND ENDORSE the approach, including the engagement & governance of the 3 BCF plans • Paper presented on 8th/11/21 to REVIEW AND APPROVE the 3 BCF plans for submission on 16th November 2021

Aligned to Strategic Objectives		
Leicester City CCG	**West Leicestershire CCG**	**East Leicestershire and Rutland CCG**
✓	✓	✓

Implications	
a) Conflicts of interest:	N/A

b) Alignment to Board Assurance Framework	N/A
c) Resource and financial implications	Better Care Fund CCG Minimum Contribution and allocated uplift completely spent in all three places. Additional CCG Voluntary contributions totalling £28,403,008 approved by EMT in March 2022
d) Quality and patient safety implications	N/A
e) Patient and public involvement	N/A
f) Equality analysis and due regard	N/A

Briefing paper – Annual Report: Leicester, Leicestershire, and Rutland BCF 2021-22.

2021-22 marked another challenging yet a successful year for LLR's Better Care Fund (BCF) partnerships. The BCF allows the NHS to pool certain monies with the local authority to spend in ways that joins up care more effectively. The main focus of the 2021-22 year-end reporting requirements was on how well our system was able to respond to one of the national conditions related to 'improving outcomes for people being discharged from hospital.

While the challenges presented by the pandemic are less acute, there were ongoing challenges presented by the aftermath of the pandemic and the impact of the Omicron variant.

Each place based BCF has either achieved or come very close to achieving a stretching set of targets around hospital discharge, avoidable admissions, admissions to residential care in those over 65 years, and outcomes from reablement. All of these results have been the outcome of strong system partnership relationships twinned with effective integrated working in the face of very challenging circumstances related to COVID (Omicron) and a stretched domiciliary care and residential care market.

Year-end position Leicester City

Metric	Definition	For information - Your planned performance as reported in 2021-22 planning				Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)				1,197.7	On track to meet target	This performance reflects the strength of our pre-hospital suite of integrated offers - many BCF funded. Additional funding for carer support would be very helpful here as carers play a very	Forecast= 1013.3. (Locally calculated rate = 1002.5). This was a stretch target for us and we are very pleased with this position - achieved through partnership work (and several BCF-funded
Length of Stay	Proportion of inpatients resident for: i) 14 days or more ii) 21 days or more	14 days or more (Q3)	14 days or more (Q4)	21 days or more (Q3)	21 days or more (Q4)	Not on track to meet target	Challenges were in the clinical complexity of patients entering hospital and the difficult landscape for D2A and community provision of domiciliary care. Had it not been for BCF funding of	Actual YTD for 14+ = 10.2 Actual YTD 21+ = 4.9
		9.2%	9.2%	4.4%	4.4%			
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence				94.4%	Not on track to meet target	The clinical complexity and acuity and frailty of the patients entering the pathway has meant that more patients have not stayed at home compared to previous years. In light of these	Actual YTD - 92.9%. We are likely to miss this ambitious target by less than 2%. In light of the ongoign pressures related to pandemic era discharge, we feel this is a creditable achievement.
Res Admissions*	Rate of permanent admissions to residential care per 100,000 population (65+)				557	On track to meet target	No support needed in this area at the moment.	Achievement = 515 (Numerator= 231. Denominator = 44,865)
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				92.1%	Not on track to meet target	Challenge is in increased level of frailty of patients entering the pathway. Home First offer includes clinical assessment and monitoring but inevitably more such patients readmit or die or must be	Achievement = 88.2% (annual). Numerator = 150. Denominator = 170

Year-end position Leicestershire County

Metric	Definition	For information - Your planned performance as reported in 2021-22 planning				Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)				775.0	On track to meet target	With increasing admissions and attendances, there has been a system focus on the front-door and community support for those at high-risk of admission. Support to left-shift from	The target for this indicator is projected to have been exceeded by approx 5% to 735.1. Therefore, fewer non-planned admissions occured than predicted.
Length of Stay	Proportion of inpatients resident for: i) 14 days or more ii) 21 days or more	14 days or more (Q3)	14 days or more (Q4)	21 days or more (Q3)	21 days or more (Q4)	Not on track to meet target	Both targets have been missed by approx 1%. With data for 14+ days at 11.2% and 21+ days at 5.4%. This has been reflected on as a system acknowledging a focus on those with	The targets for Leicestershire for LOS were reflective of pre-pandemic data. This did not include the increase in demand for those that have delayed seeking care over the past 2 years. In
		10.0%	10.0%	4.6%	4.6%			
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence				93.1%	Not on track to meet target	Increased acuity and demand has led to increased use of D2A bedded solutions (incuding designated settings). This has required additional support from hospital teams to better describe need	This metric is slightly off target (0.8%) projected to be 92.3%. However, it was an ambitious target for post-pandemic recovery. It does however, represents an improvement on both previous years
Res Admissions*	Rate of permanent admissions to residential care per 100,000 population (65+)				519	Not on track to meet target	Currently data suggests that this is not on target and will miss this by approx 10% (574.7 per 100,000 population). As detailed above, additional use of residential care settings has led to	The achievements made as a system to improve the triage of patients within hospital settings have been embedding within this financial year. This is starting to see a reduction in the use of
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				85.1%	On track to meet target	There have been limitations to ASC staff having access to wards to contribute to identifying reablement potential. This has been restarted in year. Staff sickness recruitment and retention within HART	This metric will exceed the target by approx 4.3% to 89.4%. The focus on reablement in hospital and the community has improved performance against this metric within the financial

Year-end position Rutland

Metric	Definition	For information - Your planned performance as reported in 2021-22 planning				Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)				539.0	On track to meet target	No support needs to highlight. GP services have been very challenged to meet needs, which could have pushed numbers of avoidable admissions up. In practice however this has not been the case. Local action is being taken around GP sufficiency in the context of Rutland's Joint Health and Wellbeing Strategy. Potentially, the logistical challenges in reaching acute hospitals reduce the tendency of the population to present with conditions that can be treated via alternative means. This would also potentially increase demand on GP services, something which is not necessarily factored into local contracts.	Local data indicate a rate of 513 for 2021-22, which is lower than the target we set, in spite of this having been a very challenging year for the availability of GP support, with high local demand and disruptions to the service offer both in Rutland and, particularly, in neighbouring Stamford.
Length of Stay	Proportion of inpatients resident for: i) 14 days or more ii) 21 days or more	14 days or more (Q3)	14 days or more (Q4)	21 days or more (Q3)	21 days or more (Q4)	Not on track to meet target	We would appreciate access to Rutland long stay data broken down by Trust, to support accurate interpretation of patterns and the planning of relevant next steps. Based on available interim local data, we will have exceeded the heavily caveated targets for both 14 and 21 day stays. Stays appear to be on average somewhat higher in areas neighbouring Rutland but outside LLR (North Northants, Peterborough, Lincoln) than in Leicester and Leicestershire. As Rutland acute patients make significant use NWAFT (in Peterborough), this may account in part for the Rutland's rates being higher than those in the rest of LLR. In addition, ambulatory care sensitve admissions are very low on average for Rutland, which is likely to mean that those patients who do find themselves in hospital on average are more seriously ill, pushing up the percentage who become long stays.	The Rutland Integrated Discharge Team, our in-house Micare homecare service, and care providers have worked very hard to maintain the flow of patients from acute care back to the community, as set out in the Year End Feedback tab.
		11.0%	11.0%	6.9%	6.9%			
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence				90.8%	On track to meet target	The over-stretched state of the homecare market in Rutland (as elsewhere) over the winter, with the tail end of pandimic conditions affecting the workforce, required a small number of people to return into temporary residential care rather than straight home to ensure their wellbeing while freeing up hospital capacity. This reflects safe care decisions, and maintains flow, but impacts on this indicator.	Available data indicates that this target may be narrowly missed at 90.1%. It is not surprising that winter conditions, on top of a range of other pressures in the homecare sector (see Year End Feedback) meant a marginally less good performance in the final two quarters of the year.
Res Admissions*	Rate of permanent admissions to residential care per 100,000 population (65+)				364	On track to meet target	No challenges currently relating to this indicator. Care home capacity has increased with two significant care home openings over the last 2 years. At the same time, Adult Social Care has managed to keep admissions it is funding at a low level. We arguably have an imbalance of care capacity, with more capacity in care homes than required and ongoing challenges with homecare capacity.	We anticipated that there would be more care home admissions than usual this year, with people coming forward whose needs had increased during the lockdowns. In practice, the number permanently entering a care home and in scope for this indicator was just 27, or 258 per 100,000 over 65s.
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				90.0%	On track to meet target	No challenges requiring support. Important to ensure there is sufficient capacity for reablement given its role in maintaining independence and avoiding hospital readmission. This can be challenging where there is high demand for post-hospital care services that are not reablement based.	The custom has been to report on Q3 performance for this indicator (ie Oct-Dec). Q3 performance was 96% reablement success. The average across the whole year was only slightly lower at 94% of people receiving reablement still being at home 91 days after hospital discharge.

Notable successes in 2021/ 22

System

Developing system wide governance and systems leadership: Effective partnership working has been vital during 2021/22. Partners have built on existing strong relationships ensuring a joined-up approach to discharge, case management, “bridging” of domiciliary care offers and therapy needs. Strong governance and leadership supported the delivery of most aspects of patient and resident care. The BCF budgets supported the use of community assets, the resources of the voluntary sector, public health, NHS and social care resources to deliver support to Leicester, Leicestershire, and Rutland residents in all settings.

Leicester City

Integrated Crisis Response Service (ICRS): This service is jointly commissioned (via the BCF) and works to deliver an integrated Urgent Community Response service in partnership with other local UCR services. It is an enhanced social care service, provided by the Local Authority on behalf of the City BCF system and over the course of 2021/22, increasingly supporting the wider LLR system. ICRS was commended nationally following a visit from Amanda Pritchard (Chief Executive of NHS England) on 23rd November 2021. The service has delivered a core element of the city's step up / admission avoidance offer, focusing on responding to people in crisis to enable them to remain at home with timely, holistic support.

The service has been largely funded by BCF for a number of years and notable successes in driving the ambition for integration over 2021/22 have been:

- Using the Ageing Well accelerator programme to pilot night sitting support, progressing the submission of data via CSDS (in progress)
- End of life pilot across LLR

- Acute diversion via work in ED, to support flow, reduce ambulance waits and waits of beds
- Bridging support to neighbouring Local Authority citizens to support timely hospital discharge
- Falls - reduced EMAS/hospital attendance
- Participation in the Unscheduled Care Hub, to 'pull' people out of the EMAS stack and provide a timelier, home based response. with good outcomes for people

Rutland

Falls: In Ruland a BCF-resourced joint approach to training and upskilling of workforce focusing on falls has delivered additional benefits. In light of higher-than-average injuries from falls in Rutland, teams have worked proactively to target this area. This includes safeguarding for falls, and a falls prevention pilot within local care homes, which is aimed at reducing hospital admissions and avoiding the increased need for care that can follow a fall.

In the community, we have also continued to be proactive in using adaptations to maintain independence, improve safety in the home and promote wider wellbeing, working proactively to ensure adaptations are delivered in a timely way once a need is identified.

Alongside this, there has been a wider Leicester, Leicestershire, and Rutland pilot of a rapid response callout service for fallers, helping to avoid the 'long lies' waiting for an ambulance that can lead to lasting health deterioration even in patients who have not sustained significant injuries during their fall.

Leicestershire County

Completion of the re-commissioning of domiciliary care contracts: This process was completed in November 2021 with a new framework covering Leicestershire. The new framework allowed for zonal pricing to ensure care availability in traditionally more rural areas giving wider scope for timely and cost-effective delivery.

The new framework dramatically improved care-wait times, reducing the amount of people awaiting care from around 300 to 50 within a few weeks, which helped to restore confidence in the market and ensured reduce discharge.

Challenges in 2021/22

System

Maintaining workforce capacity: This is a system wide issue but is particularly acute in the domiciliary care market.
There has been a sense of constant firefighting across the year, often with multiple issues at play at any one time. The BCF funds dedicated roles who work actively with care providers, and this has been vital to sustaining services.

Pressures such as Covid outbreaks, staff sickness and staff isolation took their toll, as well as recruitment and retention challenges in a low paid, over-stretched sector within an increasingly competitive labour market.

The care market is not sustainably funded and, while some issues have abated as we emerge from the pandemic, remaining pressures are now being compounded by rising fuel prices which are having a marked impact on the viability of homecare delivery in rural areas.

Other workforce challenges included:

- The impact of the mandatory vaccination programme on staff retention
- Skilled roles & supply deficits, including Occupational Therapy, Qualified Social Work and nursing roles
- Provider failure, despite significant additional funding via IPC and other grants
- Lack of sustainable funding solutions enabling appropriate commissioning of services

Rutland

Problems with cross border Shared care Records: Rutland have been participating actively in the LLR Shared Care Record project to enable improved information sharing in support of swifter and more confident care decisions. As the LLR Care Record is currently only populated by LLR partners, this means that the full picture will not be available for many Rutland patients who access care from providers both in Rutland and from services in neighbouring counties until much further into the future, when local systems are potentially linked together into a more comprehensive inter-operable infrastructure.

Leicester City

Changes in Hospital Discharges: During 2021/22 the pace and demand for hospital discharges has been unprecedented as a result of the pandemic. This is coupled with the changed expectations for discharge arising from the Hospital Discharge Guidance.

As a result, our system focus has been on reducing length of stay, avoiding challenges with flow (and its impact on ambulance handovers and ED waits) and ensuring discharge as soon as safely possible.

In addition, the focus on not assessing or meeting on wards prior to discharge has led to greatly reduced contact with people prior to leaving hospital. This has impacted on our ability to focus on the empowerment of people who draw on our support, their families and carers, when planning for discharge.

To mitigate this, we have:

- Used a multi-agency approach to triage of HomeFirst forms to ensure a focus on pathways that return people to their own homes
- Implemented rapid post-discharge follow-up
- Maximised the use of BCF-funded services that focus on reablement / recovery and not making long term care arrangements at an inappropriate point in people's lives and without adequate participation from individuals and their families
- Adopted best practice in promoting strengths-based approaches relevant to the discharge context

Leicestershire County

Reverting to pre-pandemic regulations: The joined up regulatory response during the pandemic highlighted how well we had driven and progressed integration since 2017. However, changes in this financial year highlighted gaps and differences in regulation between Health and Social Care. For example, the removal of D2A funding combined with Adult Social Care reform has meant that there is increased pressure to ensure that the focus reverts to pre-pandemic processes and structures particularly for self-funders.

Some of these challenges were mitigated by additional contribution on top of the CCG Minimum Contribution for ASC resilience including the winter retention scheme and levelling up workforce costs to the national living wage tariff. Work in underway to look at long term suitability of removal of D2A fudning how the system will manage the challenges posed by the removal of this fuding.

Looking towards BCF 2022/23 and beyond..

The national planning guidance for 2022/23 is awaited and likley to be release by the end of June. The NHS England/Improvement team have also indicated that there will be an additional planning guidance will also be released later on this year, requiring ICSs to submit BCF plans from 2023 to 2025.

The BCF schemes and associated funding has been reviewed by a working group of the CCG and County Council colleagues for 2022/23 expenditure. It is anticipated that this process will be replicated for Rutland and Leicester City during the course of this year.

The Executive Management Team is asked to:

- REVIEW and APPROVE the three BCF DRAFT year-end reports in preparation for submission on 27th May 2022
- NOTE the system and local challenges and the achievements by each place for feeding into future improvement programmes
- NOTE that some amendments may be made to these drafts between 23rd May to 27th May.