Better Care Fund 2024-25 Update Template

7. Narrative updates

Selected Health and Wellbeing Board: Leicestershire

Please set out answers to the questions below. No other narrative plans are required for 2024-25 BCF updates. Answers should be brief (no more than 250 words) and should address the questions and Key lines of enquiry clearly.

2024-25 capacity and demand plan

Please describe how you've taken analysis of 2023-24 capacity and demand actuals into account in setting your current assumptions.

For hospital demand, 23-24 actuals have been used for rehab and reablement. During this period HART capacity increased by 30%. The amount of capacity rejections has been added to the amount of current capacity to calculate the demand. The unmet demand has been financially modelled into Discharge Grant support. This means that by Q4 HART reablement teams should be expanded sufficiently to take the capacity rejections. This is for hospital discharges only. Line 11 of the hospital demand and capacity tab shows unmet demand being met by Jan 25.
Hospital demand has all been entered on the UHL lines only as data through the hub and from ASC doesn't split this between providers. It does split out of area discharges and this is entered into the 'other' lines on the hospital demand tab. For Leicestershire the assumption is made that OOA demand equates to approximately 30%.
Data on p2 demand for spot purchased is based on actuals from 23-24 as is the rehab and reablement in a bedded setting. For other short-term bedded pathway 2, the usage of the High Dependency beds has been included based on data captured in 23-24. The average stay is 28 days and there are 15 beds. For other short-term nursing, data taken from the 16 beds opened in 23-24 in LPT Charnwood ward has been used. Currently 10 beds at an average LOS of 20 days. This equates to approx. 16 patients per month.

Have there been any changes to commissioned intermediate care to address any gaps and issues identified in your C&D plan? What mitigations are in place to address any gaps in capacity?

For 23-24 the anticipated intake model was planned for hospital step-down only. However, due to work within ASC to identify unmet community demand and hospital demand for reablement services, this meant that the reablement service worked to increase capacity by an additional 30% across hospital and community. This led to an increase in step-up and step-down capacity rejections. For 24-25 additional investment to support being able to extend the service to include capacity rejections for hospital step-down only has taken place and forms part of the discharge grant returns. The demand modelling plan identified that this equates to an additional 59 starts per month on average. Additional investment in the discharge grant is approx. 800k.
The modelling also identified gaps in commissioning for P2 bed base for LLR. This has a shortfall of approx. 60 beds required per month. Additional investment in 23-24 has seen the start of Community Hospital nursing beds (short-term) and pilots for 2 intermediate care wards. This modelling will inform the options appraisal for overall P2 capacity required in the long-term. Investment in an interim post to undertake the development of an options appraisal is also included in the discharge grant. This will include a step-up model of intermediate bedded care. The gaps for step-up bedded care has been highlighted by the C&D plans. Previous C&D plans highlighted the need to join up urgent crisis and community response data across LLR. This has now been done and is reflected in line 22 of that tab.

What impacts do you anticipate as a result of these changes for:

i. Preventing admissions to hospital or long term residential care?

Step-up bedded care within a community hospital setting will help to avoid hospital admissions. This will also help to reduce front door demand and bring our admission avoidance metric output in line with our target which is currently being missed due to an increase in front-door demand.
The work to increase capacity in intermediate care beds will also reduce the need for further admissions to care homes. Our strengthened P1 offer has already seen a reduction of 35% from 2022 data, in the demand for residential care admissions from hospital during 23-24. This we predict will remain for 24-25. This will be further increased by a robust long-term step-up and step-down bed base from 2025 onwards. Currently the data shows us that approximately 60% of p1-3 discharges are into P1. The intermediate care target is to increase this to 80%. With the aim of decreasing the use of short-term residential beds for P2 to 20% by 2025. The community P1 offer to support people at home has increased capacity by 30% to hep people to remain at home. The Falls car service has also been re-commissioned to prevent unnecessary admissions from falls, supporting people to remain at home and preventing long lies that can end in an admission.

ii. Improving hospital discharges (preventing delays and ensuring people get the most appropriate support)?

These changes will mean capacity for an additional 59 discharges from hospital into our P1 reablement model. Not only does this represent better outcomes for the person (with 89% remaining at home 90 days post reablement) but it also means that there will be a speedier response to discharge times with HART referrals bypassing the panel for social care services.
For P2, the expanded p2 bed base will support all people leaving hospital on p2 regardless of need, and offer all an equitable 3 r model of care before being assessed for any long term care needs. Again, this will speed up discharges as there will be no need for a panel process to take place at point of discharge from the acute freeing up beds and reducing LOS. Timescales for awaiting a plan in the acute have reduced on all pathways for 2023-24 p1 has reduced by 4 days since 2022. For P2 this has reduced by 7 days and for P3 this has reduced by 14 days. These are targets we aim to improve on further in 24-25 and form part of the work of the Intermediate Care Steering group and it's 3 sub-groups.
Additional investment in the Housing Enablement Service has increased support to those leaving hospital with housing and community related needs. This increased capacity is as a result of discharge grant investment for the 2 years and will continue into 24-25. Up from 1239 service users supported in 22-23 to 1583 in 23-24

Please explain how assumptions for intermediate care demand and required capacity have been developed between local authority, trusts and ICB and reflected in BCF and NHS capacity and demand plans.

For hospital related data returns, discharge hub data has been used consistently across LLR partners for all returns. This identifies one version of the truth and provides a centralised data storage. Data is used from the hub consistently for all hospital related discharge reporting and includes discharges for out of area trusts for LLR residents. This has provided us data on the use of community hospital bed demand, wait times for plans and usage of pathways.
Data from UHL and LPT providers is cross-referenced with hub data on demand and capacity to ensure robustness of reporting.
Where data is not able to be split into each HWBB area, percentage distributions on demand are calculated using the percentages attributed to the 22-23 discharge grant formula. 59% Leics, 38, City, 3% Rutland. This is more reflective of demand distribution than the IBCF precept formula. Community data is shared from LPT to partners to add their local data to ensure there is consistency. This also applies to urgent community response data within the Unscheduled Care Hub.

Have expected demand for admissions avoidance and discharge support in NHS UEC demand, capacity and flow plans, and expected demand for long term social care (domiciliary and residential) in Market Sustainability and Improvement Plans, been taken into account in you BCF plan?

Yes

Please explain how shared data across NHS UEC Demand capacity and flow has been used to understand demand and capacity for different types of intermediate care.

UEC demand data has been primarily used to inform flow and capacity for bedded settings and associated needs. This has been used to understand LOS and needs for people depending on their overall ongoing health and care requirements. This has involved collating data for commissioning of High Dependency beds (15), identifying the number of nursing beds required in a community hospital setting (10) and the levels of unmet demand in P1 services and the impact on LOS. For P1 demand, additional investment has been identified utilising UEC data to reduce the need for panel for capacity rejections going straight into domiciliary care settings. Early discharge planning for intermediate care has also been established to reduce LOS and reduce time waiting for a plan for onward care. All pathways have reduced in this respect with an 11% increase in the amount of P1 plans for those leaving on pathway 1 and a reduction in LOS of 0.5 days.
For step-up, admissions data is shared across partners through the commissioning support unit. Metrics and targets are also agreed with partners and the commissioning support unit to agree consistency in approach.

Approach to using Additional Discharge Funding to improve

Briefly describe how you are using Additional Discharge Funding to reduce discharge delays and improve outcomes for people.

Within Adults and communities, the discharge grant is being used on the following team to improve discharges. Intake model (increased capacity in P1) for more people to return home, Care Tech Equipment – supporting people to retain independence on discharge, Brokerage – speed of offer of packages and residential care, Review Team speed of reviewing reducing LOS and improving flow, Flow Improvement Team / Hospital Discharge improving assessment for care working as part of an MDT with health, Carers support payments – supporting people to care for their loved ones at home when being discharged from hospital settings. Additional housing related support including MH and VCS services to support P0 discharges. Assertive In Reach, Community Support Workers in Hospital Team (MH) and Agency Social Workers (MH teams) to speed up mental health discharges. Within the ICB, funding has been aligned to High Dependency cohorts, typically they have long waits for care homes that can take the level of need. This commissioning supplies, beds, 1:1 care and case management. In addition there is additional primary care support to ensure flow out of the bed base. Additional beds for the bariatric cohort – this includes therapy and mental health support to reduce LOS in acute settings. Home care packages for reablement capacity rejections to ensure people can return home as quickly as possible, there is also support for P2 patients who require assessment in a residential care setting. This shares the cost of placement while a person is assessed and moved on to more longer term requirements.

Please describe any changes to your Additional discharge fund plans, as a result from

- **o Local learning from 23-24**
- **o the national evaluation of the 2022-23 Additional Discharge Funding (Rapid evaluation of the 2022 to 2023 discharge funds - GOV.UK (www.gov.uk)**

Changes to the discharge fund this year have been made to add investment to reablement services to meet currently unmet demand identified in 23-24. Additional funding for harder to place cohorts of patients has been aligned to bedded contracts and spot-purchasing to further decrease LOS. The evaluation has informed the need to help with NCTR and as such training has been included within the grant for staff across all partners to support discharge planning. Funding for framework beds in residential care settings has been removed from the plan due to under-utilisation in 23-24. Support to carers has been aligned to the MSIF funding stream along with funding for Bridge Street units to support mental health discharges. In 23-24 we continued the risk share (where partners share the cost of residential care D2A for the first 4 weeks). We have identified that this needs to continue for the first 2 quarters with a view to finding alternative ways of funding in the future.

Ensuring that BCF funding achieves impact

What is the approach locally to ensuring that BCF plans across all funding sources are used to maximise impact and value for money, with reference to BCF objectives and metrics?

The governance for the BCF will be changing during 24-25 to streamline reporting on delivery and commissioning. The previous structure split the two sets of funding activity which has been simplified to one reporting stream from a joined up commissioning, delivery, finance and performance group. This will enable a greater reporting structure to the Integration Executive who will be reporting into the HWBB on a quarterly basis on BCF objectives and metrics (as is currently the case). In addition an a more thorough annual report on delivery of BCF objectives will be required once a year. This looks at the investment outcomes and beneficiaries for a range of schemes that meet the objectives of the BCF, Joint Health and Wellbeing Strategy and other strategy priorities from End of Life, NHS 5 year plan, MSIF, and UEC recovery plans. Activity is aligned to metric performance to ensure targets and performance is challenged and any reinvestment aligned to support improvements. This reporting mechanism is supported by the wider LLR partnership with investment for Intermediate Care reporting to the LLR Community Care Partnership Board. This gives both local and system challenge to spend activity and outcome delivery across LLR and locally.

Linked KLOEs (For information)

Checklist Complete:	
Yes	Does the HWB show that analysis of demand and capacity secured during 2023-24 has been considered when calculating their capacity and demand assumptions?
Yes	Does the plan describe any changes to commissioned intermediate care to address gaps and issues? Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the capacity needed for additional services?
Yes	Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service?
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Yes	Does the plan set out how demand and capacity assumptions have been agreed between local authority, trusts and ICB and reflected these changes in UEC activity templates and BCF capacity and demand plans?
Yes	
Yes	Has the area described how shared data has been used to understand demand and capacity for different types of intermediate care?
Yes	Does this plan contribute to addressing local performance issues and gaps identified in the areas capacity and demand plan? Is the plan for spending the additional discharge grant in line with grant conditions?
Yes	Does the plan take into account learning from the impact of previous years of ADF funding and the national evaluation of 2022/23 funding?"
Yes	Does the BCF plan (covering all mandatory funding streams) provide reassurance that funding is being used in a way that supports the objectives of the Fund and contributes to making progress against the fund's metric?