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NHS

Better Care Fund 2021-22 Year-end Template

2. Cover

Version 2.0

Please Note:

- The BCF end of year reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. Narrative sections of the reports will not be published. However as with all information collected and stored by public bodies, all BCF information including any narrative is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information, including that provided on local authority fee rates, will be supplied to BCF partners to inform policy development.

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

		Checklist
Completed by:	Beverley Nicholson	Yes
E-mail:	Beverley.nicholson@reading.gov.uk	Yes
Contact number:	0118 937 3643	Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes	Yes
If no, please indicate when the report is expected to be signed off:		Yes

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

Job Title:	Executive Director of Adult Social Care	Yes
Name:	Seona Douglas	Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Income and Expenditure actual	Yes
6. Year-End Feedback	Yes
7. ASC fee rates	Yes

Better Care Fund 2021-22 Year-end Template

3. National Conditions

Selected Health and Wellbeing Board: Reading

Confirmation of Nation Conditions			Checklist
National Condition	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in 2021-22:	Complete:
1) A Plan has been agreed for the Health and Wellbeing Board area that includes all mandatory funding and this is included in a pooled fund governed under section 75 of the NHS Act 2006? (This should include engagement with district councils on use of Disabled Facilities Grant in two	Yes		Yes
2) Planned contribution to social care from the CCG minimum contribution is agreed in line with the BCF policy?	Yes		Yes
3) Agreement to invest in NHS commissioned out of hospital services?	Yes		Yes
4) Plan for improving outcomes for people being discharged from hospital	Yes		Yes

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4. Metrics

Selected Health and Wellbeing Board: Reading

National data may like be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Challenges and Support Achievement: Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievement: Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information – Your planned performance as reported in 2021-22 planning				Assessment of progress against the metric plan for	Challenges and any Support Needs	Achievements	Checklist Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)				635.0	Not on track to meet target	We were 6% above the target this year, due to a challenging winter alongside a difficult COVID environment (for both our health and social care staff and the people of	Whilst we just missed this target, with a final position of 675 admissions per 100k population, we have still had a performance improvement of 8% compared to the average (732) across	Yes
Length of Stay	Proportion of inpatients resident for: i) 14 days or more ii) 21 days or more	**14 days or**	**14 days or**	**21 days or**	**21 days or**	On track to meet target	There have been complex cases, assessed as needing high packages of care at the point of discharge, which in some cases delayed discharge due to capacity. Once	Performance improved against the 21day Length of Stay (LoS) at the end of Q4 (Jan to Mar), and as a result we have a positive position of 5.2% against our quarterly stretch target of	Yes
		8.5%	9.6%	4.5%	5.5%				
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence				91.0%	On track to meet target	Capacity in the reablement care market was challenged due to supporting intermediate care and rapid response services at times, as well as supporting end of life care	We exceeded the stretch target of 91% in every quarter with an overall year end position of 92%. The short term team worked effectively, together with our Voluntary Care Sector	Yes
Res Admissions*	Rate of permanent admissions to residential care per 100,000 population (65+)				439	Not on track to meet target	Due to the acuity of service users, needing long term extra care, and the intake of people that, without the HDS D2A funding, would have otherwise been self-funders, this has been a	Service users have been placed where there is a clear need for long term care based on acuity levels. We have worked hard to reduce the number of Service Users in temporary	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				87.0%	Not on track to meet target	Due to the requirement against this metric to include anyone who passed away with the 91 day period, we have consistently missed this target. Had those people not been included in the	The average length of stay with the reablement services across the year was 3.3 weeks, providing a good flow and releasing capacity for hospital discharges on pathway 1, requiring	Yes

* In the absense of 2021-22 population estimates (due to the devolution of North Northamptonshire and West Northamptonshire), the denominator for the Residential Admissions metric is based on 2020-21 estimates

Section 4 Metrics – expanded text:

	Challenges and any Support Needs	Achievements
Avoidable admissions	We were 6% above the target this year, due to a challenging winter alongside a difficult COVID environment (for both our health and social care staff and the people of Reading Borough) and a "stretch" target. However, when comparing our performance this year, with a rate of 675.5 per 100k to 19/20 (the last non-COVID year), with a rate of 709, our performance is the equivalent of a 5% reduction in admissions this year. Our performance is similar to that across the Berkshire West systems and 10% better than the last set of national data that we have available. Our projection was higher than the target, with a rate of 704.8 or 1,130 attendances but we were asked to set stretch targets in excess of the projections. We will continue to develop our projections, with engagement from our system partners, to better inform our ability to set achievable targets.	Whilst we just missed this target, with a final position of 675 admissions per 100k population, we have still had a performance improvement of 8% compared to the average (732) across 2018/19 and 2019/20. We had indicated in our BCF Plan that the admissions recorded for 2020/21 were skewed due to the pandemic and did not give a realistic picture. Key projects are continuing in our locality to support admission avoidance, such as our Multi-Disciplinary Teams (MDTs) at PCN level, which have been operating, focussed on long term conditions, using Connected Care (Our shared care record) for case finding. The MDT reviews are in place to support people in receiving the right level of care and staying well to remain out of hospital. The assessment of impact on hospital admissions and GP attendances will be measured in June 2022. The Nepalese Diabetic project enabled people from this ethnic group, who were more prone to diabetes, to be better informed and able to manage their conditions well. The Ageing Well project has been operating across Berkshire West, and has supported admission avoidance through the rapid referrals system (2hr and 2 day response) there are increasing numbers of people being referred in and ongoing work to support this service to embed. The Council's Reablement team have provided additional capacity to support rapid referrals and people at end of life.
Length of Stay	There have been complex cases, assessed as needing high packages of care at the point of discharge, which in some cases delayed discharge due to capacity. Once discharged and assessed, these packages have then been reduced by the Occupational Therapists, using a strengths-based approach. Our system partners BHFT started a project with the Rapid Community Discharge working group to review "double handed" care packages with a view to reducing these wherever possible prior to discharge. There have also been cases where home environments were not suitable for discharge, and the interim short-term discharge to assess facility supported cases such as this and enabled discharge from a hospital bed where possible, whilst works were underway to adapt and make safe the home environment.	Performance improved against the 21day Length of Stay (LoS) at the end of Q4 (Jan to Mar), and as a result we have a positive position of 5.2% against our quarterly stretch target of no more than 5.5%. We are pleased that we have been able to meet the overall annual target of no more than 4.7%, especially given the complexity and acuity of cases, and particularly those requiring support in a care home setting. Timely hospital discharge has also been impacted by Covid outbreaks in care homes, thereby limiting capacity. Our hospital discharge team continue to work with our care providers to meet specific and complex needs for people who have had a lengthy hospital stay, and ensuring there is a therapy led service to address the likely deconditioning due to a longer length of stay. Our overall performance for 21 days for the year, compared to the Berkshire West average was 5% better, and compared to the National average, was 25% better. Whilst we just missed the quarterly targets for 14 day length of stay, we exceeded performance at Berkshire West and National levels. Our hospital discharge short-term team engaged additional short-term capacity in both staff and discharge beds during the winter pressures period, to enable timely discharge and avoid unnecessary stays in hospital.

Discharge to normal place of residence	Capacity in the reablement care market was challenged due to supporting intermediate care and rapid response services at times, as well as supporting end of life care when additional capacity, over and above the contracted Berkshire West wide service commissioned through BHFT, was required. We have a review of our Community Reablement Team service within the borough and are engaging with our system partners to ensure effective collaborative working arrangements are in place that meet the needs of our local population.	We exceeded the stretch target of 91% in every quarter with an overall year end position of 92%. The short-term team worked effectively, together with our Voluntary Care Sector partners, who offered a "settling in service" to follow up with patients being discharged, particularly those who lived alone, to enable them to go home on discharge, with support where needed.
Res Admissions*	Due to the acuity of service users, needing long term extra care, and the intake of people that, without the HDS D2A funding, would have otherwise been self-funders, this has been a challenging target to meet. Our final position was 507, which was 13% above the target. It has been necessary to utilise residential care where domiciliary care at home has not been available, due to continued challenges in recruiting Care Staff, and this has contributed to a higher than planned level of admissions. We had reduced the target from 571 in the previous year, based on actual admission numbers in the preceding two years, and recognise that the intake in 2020/21 was skewed due to the pandemic and that our stretch target was too much of a stretch. We will need to revisit these targets to ensure a realistic measure for 2022/23.	Service users have been placed where there is a clear need for long term care based on acuity levels. We have worked hard to reduce the number of Service Users in temporary placements and ensure long term needs are assessed in a timely manner. Additional OT and SW locum staff were funded through the BCF to clear the backlog of assessments.
Reablement	Due to the requirement against this metric to include anyone who passed away with the 91 day period, we have consistently missed this target. Had those people not been included in the statistics our performance would have exceeded the target in relation to the actual reablement capacity of those referred into the service.	The average length of stay with the reablement services across the year was 3.3 weeks, providing a good flow and releasing capacity for hospital discharges on pathway 1, requiring additional support. Feedback from Service Users indicated a 100% satisfaction rate with the reablement services provided by the Council.

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5. Income and Expenditure actual

Selected Health and Wellbeing Board: Reading

Income

	2021-22	
Disabled Facilities Grant	£1,197,341	
Improved Better Care Fund	£2,613,472	
CCG Minimum Fund	£11,150,631	
Minimum Sub Total		£14,961,444

	Planned	Actual		
CCG Additional Funding	£0	Do you wish to change your additional actual CCG funding?	No	
LA Additional Funding	£771,000	Do you wish to change your additional actual LA funding?	No	
Additional Sub Total	£771,000			£771,000

	Planned 21-22	Actual 21-22
Total BCF Pooled Fund	£15,732,444	£15,732,444

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2021-22	Not applicable.

Expenditure

	2021-22
Plan	£15,732,444

Do you wish to change your actual BCF expenditure?	Yes

Actual	£15,673,044

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2021-22	Underspend of £59,400 due to vacancies in the project management team. Consideration being given to what resources are required (e.g. Project Manager or PHM Analyst). Additional locum resource was funded through the 'Projects' allocation for Social Workers and

Checklist Complete:
Yes
Yes
Yes
Yes
Yes
Yes

Difference between Planned and Actual expenditure – Expanded text:

Underspend of £59,400 due to vacancies in the project management team.

Consideration being given to what resources are required (e.g. Project Manager or PHM Analyst).

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6. Year-End Feedback

The purpose of this survey is to provide an opportunity for local areas to consider and give feedback on the impact of the BCF. Covid-19 had a significant impact on services and schemes delivered on the ground which may have changed the context. However, national BCF partners would value and appreciate local area feedback to understand views and reflections of the progress and challenges faced during 2021-22
There is a total of 5 questions. These are set out below.

Selected Health and Wellbeing Board: Reading

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate to what extent you agree with the following statements and then detail any further supporting information in the

Statement:	Response:	Comments: Please detail any further supporting information for each	Checklist Complete:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Strongly Agree	Our BCF has enabled continuation of schemes that support both health and social care services that are crucial to the wellbeing of our local residents, including our hospital discharge and reablement teams, as well as the Berkshire West commissioned intermediate care services, providing rapid	Yes
2. Our BCF schemes were implemented as planned in 2021-22	Disagree	There were some underspends against the BCF for 2022/23, and the Local Authority and Berkshire West CCG are in negotiations as to whether these would be carried forward into 2022/23 and to what they will be allocated. Our Executive Director of Adult Social Care is keen to develop a mental	Yes
3. The delivery of our BCF plan in 2021-22 had a positive impact on the integration of health and social care in our locality	Strongly Agree	The membership of our Integration Board encompasses Acute hospital, GPs, Community care providers and voluntary sector who work together in order to identify priorities. Whilst the BCF has continued to support key schemes such as Street Triage, Hospital Discharge and Reablement, the key	Yes

Part 2: Successes and Challenges

Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and two Enablers which you have experienced a relatively greater degree of challenge in progressing.
Please provide a brief description alongside.

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2021-22	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes	
Success 1	8. Pooled or aligned resources	87% of Rapid response services were delivered to patients in their own home, as part of the BW CCG commissioned services through our system partners BHFT, avoiding hospital admission within 2 hours with feedback provided to the referrer following assessment. 92% of those patients were seen for up to 2 weeks following a rapid response referral. Our Disabled Facilities Grant has been used effectively in supporting people to remain well at home, avoiding falls and hospital admissions. A	Yes
Success 2	3. Integrated electronic records and sharing across the system with service users	There are three Multi Disciplinary Team (MDT) Clusters established within PCNs in Reading and there is a theme for each meeting that will address high areas of need based on population health management data, gathered through the shared care records system, Connected Care. Cases are submitted for MDT review where there is a high risk of poor health outcomes, in consultation with the tient. Summary Case Studies (see Summary Case Studies below):	Yes

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2021-22	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges	
Challenge 1	5. Integrated workforce: joint approach to training and upskilling of workforce	Due to the short-term nature of funding it has not been possible to work with system partners to develop a joint approach to the workforce across health and social care services. Both health and social care are often competing for the same pool of staff, which is not conducive to an integrated approach. There has been some shared learning opportunities through the short-term discharge to assess service that was set up to meet the winter pressures for hospital discharges; the team worked	Yes
Challenge 2	4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production	It has been a challenge during the pandemic to create co-production opportunities to work together with people in our community to find out what they want to achieve and the best way to do this by building on their own strengths, as well the strengths of their family, friends and the local community. Creating a co-produced forum that enables people to achieve their goals, reach their potential and reduce reliance upon traditional services, through service user engagement and	Yes

Footnotes:

Question 4 and 5 are should be assigned to one of the following [SCIE Logic Model Enablers] categories:

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

Other

Section 6 Year End Feedback – expanded text:

Statement:	Response:	Comments: Please detail any further supporting information for each response
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Strongly Agree	Our BCF has enabled continuation of schemes that support both health and social care services that are crucial to the wellbeing of our local residents, including our hospital discharge and reablement teams, as well as the Berkshire West commissioned intermediate care services, providing rapid response and urgent care to support hospital avoidance.
2. Our BCF schemes were implemented as planned in 2021-22	Disagree	There were some underspends against the BCF for 2022/23, and the Local Authority and Berkshire West CCG are in negotiations as to whether these would be carried forward into 2022/23 and to what they will be allocated. Our Executive Director of Adult Social Care is keen to develop a mental health rehabilitation service, supported partially through the BCF underspend funds.
3. The delivery of our BCF plan in 2021-22 had a positive impact on the integration of health and social care in our locality	Strongly Agree	The membership of our Integration Board encompasses Acute hospital, GPs, Community care providers and voluntary sector who work together in order to identify priorities. Whilst the BCF has continued to support key schemes such as Street Triage, Hospital Discharge and Reablement, the key priorities for the integration board for 2021/22 were: 1. The development of Multi-Disciplinary Teams (MDTs) at PCN level to support reviews of patients who were frequent attenders at A&E or GPs, and these MDTs were mainly focussed on conditions for case finding. We have used our Connected Care system (shared care record) to enable effective case-finding and have worked with our primary care providers to ensure they are given the appropriate data to support the MDT Reviews. The MDTs have been successful and this project will continue into 2022/23. 2. Discharge to Assess future model - we were able to do a partial trial of the proposed future model, with a short-term therapy led service, following additional funding provided by the CCG during the Winter pressures period. This was really successful but unfortunately long-term funding could not be found to continue this service. We have taken the learning from this and will look at providing a more therapy led service for our existing D2A service to move people through more quicky and ensure they have timely reviews of their longer-term needs.

4. Outline two key successes observed toward driving the enablers for integration	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes
Success 1	8. Pooled or aligned resources	87% of Rapid response services were delivered to patients in their own home, as part of the BW CCG commissioned services through our system partners BHFT, avoiding hospital admission within 2 hours with feedback provided to the referrer following assessment. 92% of those patients were seen for up to 2 weeks following a rapid response referral. Our Disabled Facilities Grant has been used effectively in supporting people to remain well at home, avoiding falls and hospital admissions. A case study provided: "At the point of referral this client was living in one room using a commode and was frustrated and distressed. They had experienced a hip fracture and were attempting to climb stairs at great risk due to a desire to get upstairs. We were able to install a stair lift and adapt her upstairs bathroom. We were also able to install a ramp to accommodate access in and out of her home (they were unable to manage any stairs). This enabled access to the garden, the only form of exercise available to them. We prioritised the case due to the risk of falls & hospitalisation". We achieved the 21 day Length of Stay (LoS) target as at the of Q4 (Jan to Mar), with a positive position of 5.2% against our quarterly stretch target of no more than 5.5%, through working with our system partners at RBFT. We are pleased that we have been able to meet the overall annual target of no more than 4.7%, especially given the complexity and acuity of cases, and particularly those requiring 1:1 support in a care home setting. Additional resources were recruited to meet the demands of timely assessments following hospital discharge and to 'right size' care packages at the earliest opportunity. The challenge of Covid outbreaks in care homes, thereby limiting capacity, also impacted the service. Our hospital discharge team continued to work with our care providers to meet specific and complex needs for people who have had a lengthy hospital stay, and ensuring there is a therapy led service to address the likely deconditioning due to a longer length of stay.
Success 2	3. Integrated electronic records and sharing across the system with service users	There are three Multi-Disciplinary Team (MDT) Clusters established within PCNs in Reading and there is a theme for each meeting that will address high areas of need based on population health management data, gathered through the shared care records system, Connected Care. Cases are submitted for MDT review where there is a high risk of poor health outcomes, in consultation with the patient. Summary Case Studies (see Summary Case Studies below): Patient A - Referred by Occupational Therapist from Intermediate Care service, regarding falls, self-neglect and pressure sores which are being treated by a District Nurse. GP has referred to social prescriber for extra support and befriending. Patient has agreed to increase their care package and get a pressure cushion in place. Befriending are visiting weekly and social care are to do another assessment to increase the care.

		Review to take place to make sure care package is in place and all needs have been meet. Patient B – A patient with BMI>60, uncontrolled diabetic, self-neglect and a hoarder. Sleeps on a mattress on floor. Fall risk as place cluttered. Social Prescriber heavily involved also older people's mental health, and social care (Housing). New property found for patient, and visited with support worker, but refused to move in so now adaptations being made to current property. Fire Service arranged to make an assessment and update SCAS and Police. CMHT to take patient back to Complex Needs Panel to support anxiety. Regular outcome reports are submitted monthly to the Reading Locality Manager, with updates to the Reading Integration Board (RIB).

5. Outline two key challenges observed toward driving the enablers for integration	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges
Challenge 1	5. Integrated workforce: joint approach to training and upskilling of workforce	Due to the short-term nature of funding it has not been possible to work with system partners to develop a joint approach to the workforce across health and social care services. Both health and social care are often competing for the same pool of staff, which is not conducive to an integrated approach. There has been some shared learning opportunities through the short-term discharge to assess service that was set up to meet the winter pressures for hospital discharges; the team worked collaboratively with health and care partners with successful outcomes. As long-term funding was not continuing for discharge to assess, it was not possible to maintain that service, which was disbanded in April. Learning from this service has been taken into the existing baseline discharge to assess services for Reading.
Challenge 2	4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production	It has been a challenge during the pandemic to create co-production opportunities to work together with people in our community to find out what they want to achieve and the best way to do this by building on their own strengths, as well the strengths of their family, friends and the local community. Creating a co-produced forum that enables people to achieve their goals, reach their potential and reduce reliance upon traditional services, through service user engagement and education will be a focus of our 2022/23 programme of work.

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7. ASC fee rates

Selected Health and Wellbeing Board: Reading

The iBCF fee rate collection gives us better and more timely insight into the fee rates paid to external care providers, which is a key part of social care reform.
Given the introduction of the Market Sustainability and Fair Cost of Care Fund in 2022-23, we are exploring where best to collect this data in future, but have chosen to collect 2021-22 data through the iBCF for consistency with previous years.

These questions cover average fees paid by your local authority (gross of client contributions/user charges) to external care providers for your local authority's eligible clients. The averages will likely need to be calculated from records of payments paid to social care providers and the number of client weeks they relate to, unless you already have suitable management information.

We are interested ONLY in the average fees actually received by external care providers for your local authority's eligible supported clients (gross of client contributions/user charges), reflecting what your local authority is able to afford.

In 2020-21, areas were asked to provide actual average rates (excluding whole market support such as the Infection Control Fund but otherwise, including additional funding to cover cost pressures related to management of the COVID-19 pandemic), as well as a 'counterfactual' rate that would have been paid had the pandemic not occurred. This counterfactual calculation was intended to provide data on the long term costs of providing care to inform policymaking. In 2021-22, areas are only asked to provide the actual rate paid to providers (not the counterfactual), subject to than the exclusions set out below.

Specifically the averages SHOULD therefore:
- EXCLUDE/BE NET OF any amounts that you usually include in reported fee rates but are not paid to care providers e.g. your local authority's own staff costs in managing the commissioning of places.
- EXCLUDE/BE NET OF any amounts that are paid from sources other than eligible local authority funding and client contributions/user charges, i.e. you should EXCLUDE third party top-ups, NHS Funded Nursing Care and full cost paying clients.
- EXCLUDE/BE NET OF whole-market COVID-19 support such as Infection Control Fund payments.
- INCLUDE/BE GROSS OF client contributions /user charges.
- INCLUDE fees paid under spot and block contracts, fees paid under a dynamic purchasing system, payments for travel time in home care, any allowances for external provider staff training, fees directly commissioned by your local authority and fees commissioned by your local authority as part of a Managed Personal Budget.

If you only have average fees at a more detailed breakdown level than the three service types of home care, 65+ residential and 65+ nursing requested below (e.g. you have the more detailed categories of 65+ residential without dementia, 65+ residential with dementia) **please calculate for each of the three service types an average weighted by the proportion of clients that receive each detailed category:** 1. Take the number of clients receiving the service for each detailed category.
2. Divide the number of clients receiving the service for each detailed category (e.g. age 65+ residential without dementia, age 65+ residential with dementia) by the total number of clients receiving the relevant service (e.g. age 65+ residential).
3. Multiply the resultant proportions from Step 2 by the corresponding fee paid for each detailed category.
4. For each service type, sum the resultant detailed category figures from Step 3.

	For information - your 2020-21 fee as reported in 2020-21 end of year reporting *	Average 2020/21 fee. If you have newer/better data than End of year 2020/21, enter it below and explain why it differs in the comments. Otherwise enter the end of year 2020-21 value	What was your actual average fee rate per actual user for 2021/22?	Implied Uplift: Actual 2021/22 rates compared to 2020/21 rates	Checklist Complete:
1. Please provide the average amount that you paid to external providers for home care, calculated on a consistent basis. (£ per contact hour, following the exclusions as in the instructions above)	£18.52	£18.52	£19.00	2.6%	Yes
2. Please provide the average amount that you paid for external provider care homes without nursing for clients aged 65+, calculated on a consistent basis. (£ per client per week, following the exclusions as in the instructions above)	£862.35	£862.35	£850.30	-1.4%	Yes
3. Please provide the average amount that you paid for external provider care homes with nursing for clients aged 65+, calculated on a consistent basis. (£ per client per week, following the exclusions in the instructions above)	£936.72	£936.72	£872.47	-6.9%	Yes
4. Please provide additional commentary if your 2020-21 fee is different from that reported in your 2020-21 end of year report. **Please do not use more than 250 characters.**					Yes

Footnotes:

* ".." in the column C lookup means that no 2020-21 fee was reported by your council in the 2020-21 EoY report

** For column F, please calculate your fee rate as the expenditure during the year divided by the number of actual client weeks during the year. This will pick up any support that you have provided in terms of occupancy guarantees. (Occupancy guarantees should result in a higher rate per actual user.)

*** Both North Northamptonshire & West Northamptonshire will pull the same last year figures as reported by the former Northamptonshire County Council.