BRIEFING	**TO:**	Health and Wellbeing Board
	DATE:	24th November 2021
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	TITLE:	Better Care Fund Plan (2021/22)

Background

1.1 The purpose of this report is to provide the Health and Wellbeing Board with an overview of the Better Care Fund (BCF) Planning Template (Appendix 1) and Narrative Plan (Appendix 2) 2021-22 for information and opportunity to provide feedback.

The BCF planning template is in line with the 2021-22:

- BCF Policy Framework,
- BCF Planning Requirements, and
- BCF Metrics Guidance 2021-22.

The BCF narrative plan is an optional template for local areas to use to submit narrative which complement the agreed spending plans and ambitions for BCF national metrics. This is a national template and editing is restricted with limited capacity to provide additional narrative or to amend the layout of the document. This report provides further details around the key priorities for 2021-22 and the key changes since the last BCF plan.

The BCF will continue to provide a mechanism for personalised, integrated care, with health, social care, housing, and other public services working together to provide joined up care. The BCF supports services to work even more closely together so that people can live healthy, fulfilled, independent and longer lives, so that they continue to remain independent at home or to return to independence after an episode in hospital.

The BCF is a joint plan which uses pooled budget arrangements to support integration, governed by an agreement under Section 75 of the NHS Act (2006).

The BCF planning and reporting has incorporated the utilisation of the IBCF and Disabled Facilities Grants. The narrative plan includes: the local approach with regards to engagement with key stakeholders, key priorities, governance arrangements, supporting discharge and improving outcomes for those discharged from hospital, use of DFG through providing adaptations and priorities for addressing health inequalities.

The narrative plan covers our approach to:

- joint priorities for 2021-22 including supporting discharge from hospital and improving outcomes;
- integrating care around the person, including prevention and self-care, and promoting choice and independence;
- supporting people to remain independent at home, including strengths-based approaches and person-centred care;
- integrating services including joint commissioning arrangements, alignment with primary care services (including Primary Care Networks), alignment of services and the approach to partnership with the voluntary and community sector;
- integration with wider services including Housing, the use of DFG funding to support the

	housing needs of people with disabilities or care needs, including arrangements for strategic planning for the use of adaptations and technologies to support independent living; and • system level alignment, including how the BCF plan and other plans align to the wider integration landscape e.g., ICS/ ICB plans and joint governance arrangements.
Key Issues	
2.1	**Key Priorities for 2021-22** In the refreshed Rotherham Place Reset Plan the following were identified as priority areas for the Urgent and Community Transformation Group (aligned to BCF and Ageing Well funding streams): ***Workstream 1: Prevention and Urgent Response*** 1. Front Door (priority 1). 2. Urgent Response Standards (priority 2). 3. Prevention and anticipatory care in localities: long term conditions and unplanned care (priority 3). ***Workstream 2: Integrating a sustainable Discharge to Assess Model*** (priority 4) to support patient flow from hospital. ***Workstream 3: Enhanced Health in Care Homes*** (priority 5) These priorities include key actions such as: further development of our local Clinical Assessment Service (CAS) working with 111 and 999 to ensure urgent services are effectively managed through the Directory of Services (DOS) to reduce unnecessary conveyances to hospital and avoidable admissions. To pilot an integrated community hub for the triage of complex urgent and intermediate care and reablement, including the co-location of social care reablement staff within Woodside. ***Intermediate Care and Reablement Pathway*** After the implementation of the Integrated Intermediate Care and Reablement pathway, work has now been completed in the development of integrated service specs with KPIs / outcomes across the system. The aim is also to develop further and embed the urgent 2 hour and reablement 2 day urgent standard and mandatory reporting. ***Hospital Discharges*** Although there has been an Integrated Discharge Team in place for a number of years, due to Covid, the guidance has changed to a same day discharge and the aim is to review processes to remove any barriers, developing a business case for a sustainable model with the right workforce to meet demand. ***Enhanced Health Care in Care Homes / High Impact Change Model*** There are a number of key actions across the Enhanced Health in Care Homes and High Impact Change Model which include: Integrating MDTs, review of referral routes and signposting for residents and families, review of physical and mental health care homes team, development of the Rotherham Health Record for Care Homes which provides a care home view of existing information for health and social care practitioners. There is a jointly commissioned Home Care service detailed through the Section 75 and part funded within the BCF. However, a key priority is to align our commissioning of Care Homes across Health and Social Care (joint contracting/ specifications).
2.2	**Key Changes - since the previous BCF Plan**

There are a number of key changes since the previous BCF plan, namely:

- Further integration of community services including enhanced MDT working.
- Training of reablement staff to deliver therapy plans.
- Jointly commissioned home care provision including night visiting services.
- Increase in providers on the framework to support demand.
- Remote monitoring pilot in care homes established.
- ECHO e-learning platform in place for End-of-Life Care and other health related topics.
- New model for Intermediate Care (bed base reconfigured).
- Increased the spend on the COT provision in year to support the demand profile.
- Increased resources across Reablement and Rapid Response to support community services (hospital avoidance/ effective discharge).
- Funded brokerage to provide support over the weekend to facilitate hospital discharges.

2.3 Income and Expenditure

The total BCF for 2021-22 is £45.486m, an increase of £2.796m from 2020-21. This is due to underspends in 2020-21 on the improved BCF and Disabled Facilities Grant, mainly due to covid-19 and these underspends have been carried forward into this years' BCF.

Spending Plans continue to be allocated to the 6 themes and managed within 2 separate pooled funds, with the CCG and RMBC managing one pool fund each. This is in line with previous years and can be summarised in the table below:

BCF Budget 2021/22	2021/22 INVESTMENT			2021/22 SPLIT BY POOL	
BCF Investment	RCCG SHARE	RMBC SHARE	Total	Pool 1 RMBC Hosted	Pool 2 RCCG Hosted
	£000	£000	£000	£000	£000
THEME 1 - Mental Health Services	1,209		1,209		1,209
THEME 2 - Rehabilitation & Reablement	11,253	6,716	17,969	17,969	
THEME 3 - Supporting Social Care	3,624		3,624		3,624
THEME 4 - Care Mgt & Integrated Care Planning	5,111		5,111		5,111
THEME 5 - Supporting Carers	601	50	651		651
THEME 6 - Infrastructure	241		241		241
Risk Pool	500		500		500
Improved Better Care Fund		15,666	15,666	15,666	
Other Health/Grants Funding	500	15	515	515	
TOTAL	**23,039**	**22,447**	**45,486**	**34,150**	**11,336**

2.4 National Conditions

Rotherham is fully meeting the 4 national conditions set within the Government's BCF Policy Framework as follows:

(i) A jointly agreed plan between local health and social care commissioners, signed off by the Health and Wellbeing Board.
(ii) NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution.
(iii) Invest in NHS-commissioned out-of-hospital services.
(iv) A plan for improving outcomes for people being discharged from hospital.

2.5 National Metrics

	The BCF Policy Framework for 2021-22 sets national metrics which includes ambitions on how the spending will improve performance. The framework retains two existing metrics from previous years which are: (i) Effectiveness of reablement (proportion of older people still at home 91 days after hospital discharge). (ii) Older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population. The previous measure on non-elective admissions will be replaced with a measure of avoidable admissions (unplanned hospitalisation for chronic ambulatory care sensitive conditions). This reflects better the focus of joint health and social care work to support people to live independently in their own home and prevent avoidable stays in hospital. The previous measure relating to delayed transfers of care (DTOC) has been replaced with two measures. One relating to acute hospital lengths of stay over 14 and over 21 days and one relating to patients discharged from acute care back to their usual place of residence. Please note the trajectory on length of stay has been refined since the original papers. The guidance requires that ambitions should reflect a joint local government, CCG and provider agreement, and a co-ordinated approach to discharge. The original trajectory was based on a late September position and sought to achieve the NHS England ambition of 12% or less of patients in hospital over 21 days. The increased pressure seen during October and the early part of November in the system has however led us to a position of holding Q3 performance of 15% of patients in hospital over 21 days. Following feedback from Rotherham FT colleagues the 15% felt more reflective of the joint agreement requested in the guidance.
Key Actions and Relevant Timelines	
3.1	The BCF planning and narrative templates for 2021-22 will go through various stages of the approval process as follows: • Optional draft BCF planning submission to BCM – 19th October 2021. • Review and feedback to areas from BCMs - 2nd November 2021. • BCF Operational Group – 11th November 2021. • BCF Executive Group – 12th and 17th November 2021. • BCF planning submission from local HWB areas - 16th November 2021. • Health and Wellbeing Board – 24th November 2021. • Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation from 16 November to 7th December 2021. • Regionally moderated assurance outcomes sent to BCF team - 7th December 2021. • Cross-regional calibration - 9th December 2021. • Approval letters issued giving formal permission to spend (CCG minimum) - 11th January 2022. • All section 75 agreements to be signed and in place - 31st January 2022.
Implications for Health Inequalities	
4.1	There is a recognition at SYB and Place that Health Inequalities (HI) is integral to everything. Rotherham is working across Place and ICS partners to share knowledge and develop our capabilities in understanding Health Inequalities and Population Health Management (PHM). Work has commenced to develop a Rotherham Office of Data Analytics (RODA) as a Place wide capability in analysing and interpreting PHM and HI data, supporting the Place wide HI and Prevention Group work programme. RODA will generate insight into areas such as the inclusive restoration of services and population segmentation. Rotherham is actively engaged in the SYB PHM work programme to develop insight into SYB communities and share best practice.

	The Prevention and Health Inequality Group provides a multi-agency approach and formulates and leads on actions on tackling health inequalities by looking at the whole population and individual person. It focuses on helping people to get the best start in life, reduce harm from smoking, alcohol, obesity, improving cardio-respiratory health, mental health/well-being and early diagnosis and survival of cancer. BCF funded schemes that aim to tackle health inequalities includes the Social Prescribing programme which provides interventions on tobacco, weight, alcohol, physical activity, obesity reduction, smoking cessation, and diabetes prevention programmes. Breathing Space is also delivering respiratory services within the Right Care pathway. There are projects underway, focused on Frailty and Anticipatory Care including the use of external support to agree a capacity/ demand modelling tool for community services (including urgent response 2 hour and 2 day reablement).
Recommendations	
5.1	**That the Health and Wellbeing Board note the content of the:** **(I) Documentation which was submitted to NHS England (NHSE) on 16th November 2021.**