BRIEFING	**TO:**	Health and Wellbeing Board
	DATE:	28th June 2023
	LEAD OFFICER	Steph Watt Joint Head of Adult Commissioning (Rotherham Place) E-mail: steph.watt@nhs.net
	TITLE:	Better Care Fund (BCF) Plan 2023-25

Background

1.1 The purpose of this report is to give the Health and Wellbeing Board an overview of the Better Care Fund Plan for 2023/25.

1.2 The BCF Planning Template and Narrative Plan including capacity and demand for intermediate care services is in line with the Better Care Fund Policy Framework 2023-25 and the Better Care Fund Planning Requirements 2023-25.

Key Issues

2.1 **BCF Policy Framework and Planning Requirements for 2023/25**

The Better Care Fund (BCF) Policy Framework sets out the Government's priorities for 2023-25, including improving discharge, reducing the pressure on Urgent and Emergency Care and social care, supporting intermediate care, unpaid carers and housing adaptations.

The vision for the BCF plan in 2023-25 is to support people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person. This vision is underpinned by the two core BCF objectives:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

BCF is a joint plan for 2023/25 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 NHS minimum contribution, IBCF, Disabled Facilities Grants and the Discharge funding.

2.2 **BCF Planning Template 2023/25**

The BCF planning template (Appendix 1) shows that the planning requirements which are set out in the BCF Policy Framework 2023-25 are fully met as follows:

(i) A jointly developed and agreed plan between the Council and South Yorkshire ICB (Rotherham Place) which has been signed off by the Health and Wellbeing Board.
(ii) Clear narrative for the integration of health, social care and housing
(iii) A strategic, joined up plan for Disabled Facilities Grant (DFG) spending
(iv) A demonstration of how the services commissioned will support people to remain independent for longer and to support them to remain in their own homes for longer
(v) How the additional funding to support discharge will be allocated for Adult Social Care and community based reablement capacity to reduce delayed discharges and improve outcomes.
(vi) A demonstration of how the services commissioned will support provision of the right care in the right place at the right time

(vii) A demonstration of how the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution

(viii) Confirmation that the components of the BCF pool that are earmarked for a purpose are being planned to be used for that purpose

(ix) The plan sets stretching targets which are clear and ambitious

2.3

Income and Expenditure

The total Better Care Fund (BCF) for 2023/24 is £50.681m, an increase of £1.425m from 2022/23. This increase is due to a combination of underspends in 2022/23 on the Improved BCF and Disabled Facilities Grants (DFG) carried forward, plus additional investment and the removal of non-recurrent funds from the previous year.

Spending Plans continue to be allocated to the 6 themes plus Improved Better Care Fund and Discharge grant funding and managed within 2 separate pooled funds, both the South Yorkshire ICB (Rotherham Place) and RMBC managing one pool fund each. This is in line with previous years and can be summarised in the table below:

Better Care Fund 2023/24 Budget	2023/24 INVESTMENT			2023/24 SPLIT BY POOL	
BCF Investment	**SYICB SHARE**	**RMBC SHARE**	**Total**	**Pool 1 RMBC Hosted**	**Pool 2 SYICB Hosted**
	£000	£000	£000	£000	£000
THEME 1 - Mental Health Services	1,464		1,464		1,464
THEME 2 - Rehabilitation & Reablement	12,188	6,759	18,947	18,947	
THEME 3 - Supporting Social Care	4,144		4,144		4,144
THEME 4 - Care Mgt & Integrated Care Planning	5,090		5,090		5,090
THEME 5 - Supporting Carers	791		791		791
THEME 6 - Infrastructure	242		242		242
Risk Pool	500		500		500
Improved Better Care Fund		15,948	15,948	15,948	
Discharge Funding	1,525	2,030	3,555	2,030	1,525
TOTAL BUDGET	25,944	24,737	50,681	36,925	13,756

The indicative budget for 2024/25 is £53.149m, this assumes that the budget for 2023/24 is fully spend. The underspend on the Disabled Facilities Grant and iBCF funding in 2022/23 as been profiled over the 2 financial years and are included in these budget figures. Any further underspend on the BCF in 2023/24 will be carried forward into 2024/25 subject to approval of the BCF Executive Group. Grant funding allocations for the IBCF and Disabled Facilities grant for 2024/25 will be announced in the next comprehensive spending review. It is therefore likely that the budget for 2024/25 will change and is only an estimate at this stage.

2.4

BCF National Metrics

The BCF Policy Framework for 2023-25 sets out BCF national metrics which includes stretching ambitions for improving outcomes against the national metrics from the fund. These include:

(i) **Indirectly standardised rate (ISR) of admissions per 100,000 population –** Areas of work linked to this plan to stabilise and support an improved Q3 include, anticipatory care development, growing the use of the virtual ward and increasing the volume of urgent community response activity. Consideration of alternative ambulance pathways such as the PUSH model may also support this.

(ii) **Emergency hospital admissions due to falls in people aged 65 years and over directly age standardised rate per 100,000 – new metric introduced for 2023/24 and 2024/25**. Indicator has seen small decreases over the last couple of years (based on local data). Trend currently expected to continue. Trajectory is provisional, further work required on standardisation.

(iii) **% of people discharged from acute hospital to normal place of residence** - Moving to a discharge to assess model expected to impact this indicator and development of a more integrated approach across health, social care and voluntary sector partners to support right care right time right place.

(iv) **Long-term support needs of older people (65 years and over) met by admissions to residential and nursing care homes, per 100,000 population** - The Council acknowledges that further work is required to achieve a stepped reduction in placements and BCF, Commissioning and Service joint working and quality plans will be monitored in year to support delivery of improvement.

(v) **% of older people (65 years and over) who were still at home 91 days later after discharge from hospital into reablement / rehabilitation services** - We recognise and will monitor the impact of both increased numbers offered and benefiting from service in cohort count, but also the challenge in maintaining effectiveness rate due to increased complexity of people accessing service.

2.5 **Capacity and Demand**

The BCF capacity and demand for Intermediate Care Services (including hospital discharge and avoidance) which has become a new requirement and is part of the BCF assurance process for 2023/25. This includes:

- The expected capacity and demand on intermediate care services (hospital discharges and community) during 2023/24
- Reablement, rehabilitation in a person's own home, intermediate care bed step up / step down, urgent community response and voluntary and community services.
- The demand for hospital discharges and community has been calculated using the referral rate from 2022/23.
- The capacity for hospital discharges and community has been calculated using the maximum caseload or number of admissions at any one given time based on agreed 85% bed occupancy rates and average length of stay.

2.6 **BCF Narrative Plan 2023/25**

An optional narrative plan has also been completed which complements the agreed spending plans and ambitions of BCF national metrics for local areas.

The BCF narrative template (Appendix 2) covers our joint approach to:

- Continue further integration of health and social care and how they will support further improvement of outcomes for people with care and support need.
- Primary, intermediate, community and social care services are being delivered to help people to remain at home including steps to personalise care and deliver asset-based approaches, implementing joined up approaches to population health management and proactive care
- Multi-disciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- Estimates of demand and capacity for intermediate care to support people in the community and support hospital discharges.
- Integrating care to support people to receive the right care in the right place at the right time

2.7	• Implementing the High Impact Change Model for managing transfer of care and any areas for improvement identified. • IBCF and ASC Discharge Fund will ensure that duties under the Care Act are being delivered • Supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers. • Strategic approach to using housing support, including DFG funding, that supports independence at home • Addressing health inequalities and equality for people with protected characteristics within health and social services. **Key Priorities for 2023-25** The workstreams of the Urgent and Community transformation group (aligned to BCF and Ageing Well funding streams and Rotherham's Prevention and Health Inequalities strategy) are as follows: **Workstream 1: Sustaining People at Home, Prevention and Avoidance** The aim of this work stream is to develop a multi-disciplinary approach which provides the right level of care, at the right time and in the right place to support more people to remain/return to living in their own home as independently as possible and for as long as possible. Projects include: 1. Development of a prevention and anticipatory care model in localities to support those with complex needs, long term conditions and unplanned exacerbations aligned to Ageing Well priorities 2. Embedding and growing Rotherham's virtual ward offer for those who would otherwise be in an acute bed, supported by remote monitoring technology 3. Embedding and developing our urgent community response, growing referral numbers and ensuring a minimum 2 hour response at least 70% of the time 4. Delivering the 4 hour accident and emergency response standard including development of Rotherham's SDEC offer and alternative pathways to admission 5. Reviewing the falls offer to inform development of an integrated health and social care falls pathway **Workstream 2: Integrating a Sustainable Discharge to Assess Model (Priority 4)** The aim of this work stream is to develop and implement an integrated Discharge to Assess model, across 7 days, building on the changes made during the pandemic in response to national discharge guidance. We will target specific barriers to effective discharge, including those highlighted in the 100 day challenges, and enhance integrated working across acute and community health, care and the voluntary and community sector. Planned activity includes: 1. Developing and implementing a service improvement plan in the acute hospital to support early discharge planning with patients, carers and health, care and VCS colleagues to reduce those with no right to reside and long lengths of stay and support more people home. 2. Implement a Discharge to Assess model by moving assessment from the acute setting to the community and to further develop an integrated care co-ordination referral and triage hub for admission avoidance and discharge. Members of the hub will work together to identify the right pathway and level of care according to individual needs, facilitate movement across pathways as needs change and maximise effective use of resource. 3. Developing and implementing a service improvement plan in the community bed base to support early discharge planning with patients, carers and health, care and VCS colleagues to reduce those with no right to reside, long lengths of stay and support more people home

4. Review the community bed base offer in the post pandemic, home first contex

Workstream 3: Digital Whole System Flow

This work stream aims to use technology to support patient care and improve efficiency. Activity includes:

1. Approval and roll out of an assistive care strategy to promote independence and wellbeing and reduce reliance on formal care
2. Procurement of remote monitoring to support the virtual ward. This is being progressed with Barnsley and Sheffield through a joint process co-ordinated by South Yorkshire ICB
3. Digitising record keeping in care homes, part of a wider South Yorkshire programme
4. Expanding the acute command centre to provide a whole system OPEL escalation overview and performance dashboards for operational and strategic decision making.
5. Refreshing our capacity and demand model for intermediate care and discharge

Key Changes since Previous BCF Plan

The key changes since the last BCF plan are as follows:

- Further integration of community health, social and voluntary sector services to support people at home. This includes the initial phase of establishing a co-located multi-disciplinary referral and triage hub to co-ordinate the right level of care for individuals and reduce avoidable admissions and facilitate discharge.
- Increase in health and social care services to support more people at home. This includes support for health rapid response services, reablement and home care as well as the equipment service to enable the needs of the individual to be met at home.
- Both changes detailed above has enabled Rotherham Place to rapidly roll out the 'PUSH' model with Yorkshire Ambulance service in response to industrial action. This was initially in response to low level falls which resulted in "long lies" and potential complications and is currently being expanded and embedded. Over 50 conveyances and potential admissions have been avoided in Quarter 1 through this pathway.
- Investment in the community bed base has supported a higher level of acuity / complexity for people who cannot be supported at home and facilitated system flow.
- Support for the VCS hospital after care service has facilitated more timely discharge from acute and community beds, reducing the reliance on formal services. As well as transport, settling in support and advice, the service now provides low level non personal enablement and a follow up safety netting service.
- Support for carers – a Carers Strategy Manager has taken up post. The role will focus on delivering the objectives of "The Borough that Cares" Strategy
- The publication of the Market Position Statement for the South Yorkshire Integrated Care System (ICS) in relation to housing with support for people with learning disabilities and / or autism
- Further roll out of ECHO e-learning platform to cover health related topics including End of Life Care, Dementia, Falls, Strokes, Diabetes.
- Increased the spend on the COT provision in year to support the demand profile and to reduce waiting times
- Continued funding for brokerage to provide support over the weekend to facilitate hospital discharges.
- Continued funding for a Public Health Specialist (and admin. support) for the programme management of the Prevention and Health Inequalities Strategy.
- Workforce investment has enabled innovative approaches to be taken including development of a hybrid health and social care support worker role to support more people at home.
- Utilising technology as an alternative to formal care including use of assistive technology and promotion of Single Handed or Proportionate Care, an ethos which asks if the person's needs can be met by one carer with use of equipment, adaptations and techniques.

Key Actions and Relevant Timelines

3.1 The BCF planning and narrative templates for 2023/25 will go through various stages of the approval process as follows:

Task	Timeline
BCF Operational Group	12th May 2023
BCF Executive Group	17th May 2023
Optional Draft Planning Submission (highly recommended)	19th May 2023
Feedback on Optional Draft Planning Submission	w/c 5th June 2023
Health and Wellbeing Board	28th June 2023
Final Planning Submission to NHS England	28th June 2023
Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation	28th June to 28th July 2023
Regionally moderated assurance outcomes sent to BCF team	28th July 2023
Cross-regional calibration	3rd August 2023
Approval letters issued giving formal permission to spend (NHS minimum)	3rd Sept 2023
Revised S75 Agreement and BCF Call Off Partnership Work Order 2023/25 to Health and Wellbeing Board	27th Sept 2023
All Section 75 Agreements to be signed and in place	31st October 2023

Implications for Health Inequalities

4.1 Addressing health inequalities is integral to the allocation of BCF resource and funded schemes. This includes contributing to achieving the strategic aims of developing healthy lifestyles and prevention pathways, supporting prevention and early diagnosis of chronic conditions and targeting variation.

BCF funded schemes which reduce health inequalities include social prescribing, Breathing Space and project support for the implementation of Population Health Management (PHM) priorities.

Recommendations

5.1 **That the Health and Wellbeing Board approves the:**

(i) Documentation for submission to NHS England (NHSE) on 28th June 2023.