Bury Health and Wellbeing Board

Title of the Report	Better Care Fund (BCF) Improved Better Care Fund (IBCF) 23/25 and Adult Social Care Discharge Funding.
Date	19th September 2023
Contact Officer	Shirley Allen
HWB Lead(s) in this area	Will Blandamer Executive Director Health and Adult Care and Place Based lead Adrian Crook – Director Adult Social Care Lynne Ridsdale, Chief Executive

Executive Summary			
Is this report for?	Information	Discussion	Decision Y
Why is this report being brought to the Board?	To seek Health and Wellbeing Board retrospective sign off for the Bury submission to the Better Care Fund 2023/2025		
Please detail which, if any, of the Joint Health and Wellbeing Strategy priorities the report relates to. (See attached Strategy) www.theburydirectory.co.uk/healthandwellbeingboard	The Better Care Fund primarily focuses upon: • Living Well with a Long-Term Condition • Reducing Length of Stay in hospitals • Improving and supporting Hospital Discharges • Prevention & Early Intervention		
Please detail which, if any, of the Joint Strategic Needs Assessment priorities the report relates to. (See attached JSNA) http://jsna.theburydirectory.co.uk/kb5/bury/jsna/home.page	• Living Well with a Long-Term Condition • Reducing Length of Stay in hospitals • Improving and supporting Hospital Discharges • Prevention & Early Intervention • Falls		

Key Actions for the Health and Wellbeing Board to address – what action is needed from the Board and its members? Please state recommendations for action.	(1) Note the content of the report. (2) Agree the retrospective submission to BCF 2023/2025 as per the attached Planning Template and the Narrative Plan
What requirement is there for internal or external communication around this area?	None
Assurance and tracking process – Has the report been considered at any other committee meeting of the Council/meeting of the CCG Board/other stakeholders....please provide details.	The planning template has been collaboratively populated by relevant colleagues from within Bury Council and NHS GM Bury ICB. The final planning template has been signed off for progression by the Executive Director for Health and Adult Care, Director of Adult Social Care, s.151 officer at Bury Council, and the joint Chief Finance Officer.

Introduction / Background

1. **Introduction and background**

1.1. The final Better Care Fund (BCF) 2023/2025 Policy Framework and Planning Guidance can be found at: BCF https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025 This policy framework confirms the conditions and funding for the Better Care Fund (BCF) for 2023 to 2025.

1.2. Since 2015, the BCF has been crucial in supporting 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 2 core objectives, to:

- enable people to stay well, safe, and independent at home for longer
- provide people with the right care, at the right place, at the right time

1.3. The BCF achieves this by requiring Integrated Care Boards (ICBs) and local government to agree a joint plan of how the funding will be spent to meet the core objectives. Indeed, 94% of local areas agreed that joint working had improved because of the BCF following a survey in 2022.

1.4. The plan is owned by the Health and Wellbeing Board (HWB) and governed by an agreement under section 75 of the NHS Act (2006). This continues to provide an important framework in bringing local NHS services and local government together to tackle pressures faced across the health and social care system and drive better outcomes for people.

1.5. The BCF programme underpins key priorities in the NHS Long Term Plan by joining up services in the community and the government's plan for recovering urgent and emergency care (UEC) services, as well as supporting the delivery of Next steps to put People at the Heart of Care. The BCF facilitates the smooth transition of people out of hospital, reduces the chances of re-admission, and supports people to avoid long term residential care. The BCF is also a vehicle for wider joining up of services across health and local government, such as support for unpaid carers, housing support and public health.

1.6. The delivery of the BCF will support 2 key priorities for the health and care system that align with the 2 existing BCF objectives:

- improving overall quality of life for people, and reducing pressure on urgent and emergency care, the acute sector, and social care services through investing in preventative services
- tackling delayed discharges from hospital and bringing about sustained improvements in discharge outcomes and wider system flow - these are set out in the 'BCF objectives and priorities for 2023 to 2025' section below

1.7. At the same time, NHS England and the LGA published the Planning Requirements for the BCF. These can be found at: BCF planning requirements,

1.8. The framework and guidance establish the key conditions and requirements of the Better Care Fund in 2023/2025.

1.9. The requirement in 2023/2025 was for a fully completed Better Care Fund planning template to be submitted accompanied by a narrative plan detailing how activities will achieve the BCF national objectives and priorities. This planning template was, for the first time since 2015, to be for a period of 2 years to allow for better financial planning and to offer more certainty for services delivering the objectives. All previous plans had to be submitted annually. The only exception to this was that local areas were also asked to submit a detailed plan, for one year only, identifying all of the available bed capacity to support discharges from the hospitals. This was to be accompanied by an estimate of how many beds will be actually needed to support discharge.

1.10. Adult Social Care Discharge Funding was allocated for the first time in 2022/2023 and has now been incorporated into the main BCF allocation and has to be used to support the main BCF objectives and priorities and must be used to support safe and timely discharge from hospital to home or an appropriate community setting. The Additional Discharge Funding is to enable local areas to build additional adult social care (ASC) and community-based reablement capacity to reduce delayed discharges and improve outcomes for patients. This funding is intended to provide increased investment in social care and community capacity to support discharge and free up beds. Local

areas should use the funding in ways that support the principles of 'Discharge to Assess': to enable timely discharge from hospital with appropriate short-term support, where needed, pending assessment of long-term care needs.

1.11. The BCF allocation for Bury also includes the Disabled Facilities Grant (DFG). Housing adaptations, including those delivered through the DFG, support the BCF objectives by helping towards the costs of making changes to people's homes to enable them to stay well, safe and independent at home for longer. The DFG capital grant must be spent in accordance with the approved joint BCF plan, developed in keeping with this policy framework and the planning requirements. In line with national condition 2 (implementing BCF policy objective 1: enabling people to stay well, safe and independent at home for longer).

1.12 The Improved Better Care Fund (IBCF) has also been incorporated into the main BCF planning requirements and is to be used to fund

- meeting adult social care needs
- reducing pressures on the NHS, including seasonal winter pressures
- supporting more people to be discharged from hospital when they are ready
- ensuring that the social care provider market is supported.

2. **BCF 2023/2025 Vision and Objectives**

2.1. 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 over 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:

2.2 The objectives, priorities and performance targets and what data we have to collect to report on are defined very clearly in the guidance: https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025.

The objectives of the BCF are what we, as a system in Bury have to focus all of our activities to achieve, they are the vision for BCF as a national programme

2.3 **Objective 1: to enable people to stay well, safe and independent at home for longer**

The priorities for health and social care are to improve quality of life and reduce pressure on urgent emergency hospital care, other acute care in the hospitals and adult social care services. This has to be achieved by everybody in the health and care system working together. including: collaborative working with the voluntary, housing and independent provider sectors and by investment in a range of preventative, community health and housing services and by supporting unpaid carers

2.4 **Objective 2: to provide people with the right care, at the right place, at the right time.**

The priorities for health and social care are to tackle immediate pressures in delayed discharges and demand for hospital attendances and admissions, bringing about sustained improvements in outcomes for people discharged from hospital, and wider system flow. This will be achieved by embedding strong joint working between the NHS, local government and the voluntary, housing and independent provider sectors

2.5 As well as the above, we must also:

- Complete and submit a jointly agreed plan between local health and social care commissioners, signed off by the Health and Wellbeing Board
- maintain the NHS's contribution to adult social care (in line with the uplift to the NHS minimum contribution to the BCF), and investment in NHS commissioned out of hospital services

2.6 **BCF metrics for 2023 to 2025**

2.7 There are a number of performance targets that we have to achieve in year. They are reported annually in the end of year evaluation and if we do not achieve them, we have to provide a reason why.

2.8 While there is a new metric this year: **Falls**, there are a number of new metrics planned that we have marked new in the information below, however, no further details have been provided about the type of data we will need to capture. The information below shows which metrics we will have to report on in which financial year.

Provide people with the right care, at the right place, at the right time In 2023 to 2024:

- discharge to usual places of residence
- new: discharge metric ahead of winter 2023

In 2024 to 2025:
- discharge to usual places of residence
- new: discharge metric ahead of winter 2023
- proportion of people discharged who are still at home after 91 days

Enabling people to stay well, safe and independent for longer

In 2023 to 2024:
- admissions to residential and care homes
- unplanned admissions for ambulatory sensitive chronic conditions
- the proportion of older people who were still at home 91 days after discharge from hospital into reablement or rehabilitation services
- new: emergency hospital admissions due to falls in people over 65

In 2024 to 2025:
- admissions to residential and care homes

- unplanned admissions for ambulatory sensitive chronic conditions
- emergency hospital admissions due to falls in people over 65
- new: outcomes following short-term support to maximise independence

2.9 The metric and the target we will be expected to achieve, or over achieve against are shown in the table below.

Metric	Description	23/24 Qtr. 1 target	23/24 Qtr. 2 target	23/24 Qtr. 3 target	23/24 Qtr. 4 target
Avoidable Admissions	Required to reduce the number of unplanned hospitalisations to be at or below the figures shown in each quarter	291.2	237.9	276.9	267.4
Falls	Required to reduce the number of emergency hospital admissions due to falls in people aged 65 or older over the year to at , or below the figure in quarter 4.				626
Discharge to normal place of residence	To measure the % of people, who are discharged to their normal place of residence, wherever 'home' is for them. Aiming to be at or above the figures shown in each quarter	91.5%	91.5%	91.5%	91.5%
Residential Admissions	Aim is to reduce the number of people aged 65 and older having to move into 24 hour care to meet their long term support needs, aiming to be at or below the figure shown in quarter 4 by the end of the year.				605
Reablement	Requirement to measure the % of people aged 65 and over who remain in their own home 91 days after discharge from hospital into reablement or rehabilitation services and at the end of the year this should be not less than 87.5%				87.5%

2.10 **Intermediate care capacity and demand plans**

2.11 Intermediate care (rehabilitation and reablement) services are provided to individuals, usually older people, after leaving hospital or when they are at risk of being sent to hospital. Intermediate care helps people to avoid going into hospital or residential care unnecessarily, helps them to be as independent as possible after a stay in hospital, and can be provided in different places (for example community hospital, residential home or in people's own homes). The types of services are:

- Short-term domiciliary care to support someone to remain at home following a deterioration, fall, or following a spell in hospital.

- Reablement and rehabilitation provided to people in their own homes either to recover function and avoid admission to hospital/residential care (step-up), or to enable a return to home, following a spell in hospital (step-down)

- Reablement and rehabilitation provided in a bedded setting, either to recover function and avoid admission to hospital/residential care (step-up), or to facilitate an eventual return home following a spell in hospital (step down).

- Urgent Community Response (crisis response) to prevent hospital admissions.

- Low level support provided to a person to help them return home following a stay in hospital, or to help someone stay at home in a crisis. This could include voluntary organisations that provide social and practical support to people or other neighbourhood support that is less intensive than reablement or intermediate care

2.12 There is a continued focus on intermediate care as being a key service in achieving the BCF objectives and priorities.

2.13 As in 2022 to 2023, local areas are required to agree and submit a plan showing expected demand for intermediate care services showing:

- services to support this recovery (including rehabilitation and reablement)
- expected capacity in the HWB area to meet this demand

The intermediate care capacity and demand plans should cover all intermediate care services (and other short-term care) across the local system

2.14 **Reporting and checkpoints**

2.15 It is expected that performance on spend and the outputs aligned to the main BCF programme will be reported on a quarterly basis.

2.16 During the 2-year cycle, there will be a quarterly reporting process where areas will be required to set out progress on delivering their plans. This process has not yet been clearly defined so we cannot include the detail relating to this at this moment in time.

2.17 There is already a set of reporting requirements in place, Adult Social Care Discharge fund has to be reported on every 2 weeks, The hospital demand and the capacity to cover this demand has to be reported on a monthly basis and the ICB Discharge Funding also has to be reported on a monthly basis. We are expecting the main BCF quarterly report to be an addition to this monitoring requirement and this will put considerable pressure on a very small reporting team.

3. BCF 2023/2025 Planning Template

3.1. The national Planning Template sets out in detail the Bury Better Care Fund proposals for 2023/2025. The submitted planning template is included in the appendix for further information.

3.2 The table below details what the total allocation for BCF for 2023/2025 is made up of, how much has been given to Bury as income, and how much has been allocated to services.

Funding Source	Income 23/24 £m	Income 24/25 £m	Expenditure 23/24 £m	Expenditure 24/25 £m
Disabled Facilities Grant	2,076,611	2,076,611	2,076,611	2,076,611

Minimum NHS Contribution	16,583,256	17,521,869	16,583,256	17,521,438
IBCF	7,628, 448	7,628, 448	7,628, 448	7,628, 448
Additional ICB Contribution	2,828,222	2,988,299	2,828,222	2,988,300
LA Discharge Funding	1,069,497	1,782,000	1,069,497	1,782,000
ICB Discharge Funding	971,000	1,025,959	968,494	1,489,983
Totals	**31,157,034**	**33,023,186**	**31,154,528**	**33,486,680**

4. **Impact of BCF funding**

4.1. The impact of the BCF funding is sizeable and contributes to the continued support of the most vulnerable people in Bury.

4.2. The table below shows the services that are being funded by BCF. The full detailed plan showing the source of funding and the outcomes expected to be achieved can be found in the planning template in the appendix.

4.3. BCF funds the following crucial services:

Scheme Name	Description of scheme	Cost 23/24 £	Cost 24/25 £
Crisis Response	Multi-Disciplinary Team of health and social care staff to prevent avoidable admissions	2,080,729	2,198,500
Integrated Intermediate Care	Short term adult rehabilitation and reablement support bed based service	1,945,951	2,056,092
Reablement Service	Short term adult rehabilitation and reablement support home based service	3,588,650	3,791,368
Staying Well Service	Support service for older people to prevent admissions to hospital and to enable people to live well, at home for longer.	418,704	442,402
Meeting Care Act Requirements	Care Act Implementation related duties including providing advice and support	702,699	742,472
Programme Management	Care Act Implementation related duties including support to co-ordinate BCF and wider transformation programmes	141,061	149,045
Intermediate Tier	A single Bury wide integrated health and social care team focused on outcomes of individuals and their carer. Promotes independence, provides care, therapies and rehabilitation (MDT staff)	1,668,397	1,762,829
Rapid Response Service	A rapid community response team providing short term, intensive, holistic support for people at risk of hospitalisation	576,192	608,805

Integrated Neighbourhood Teams	MDT case management supporting adults particularly at risk of admissions or readmission into hospital or permanent admission into nursing or residential care as well as high intensity users of various services	2,848,782	2,886,460
Home Care or Domiciliary Care	Protection of Adult Social Care Services to enable continued whole system flow- home care packages to enable people to remain in their own homes for longer	6,865,415	6,926,781
24 hour care placements	Protection of Adult Social Care Services to enable continued whole system flow- residential placements	1,084,040	1,145,396
24 hour care placements	Protection of Adult Social Care Services to enable continued whole system flow- nursing placements	1,084,040	1,145,396
24 hour care placements	Protection of Adult Social Care Services to enable continued whole system flow- supported living services to enable people to remain in the community	1,084,040	1,145,396
Assistive Technologies and Equipment	Carelink 24 hr telephone link and technology to provide a home safety and personal safety security system that enables people to remain at home for longer	66,276	70,027
Disabled Facilities Grant	Meeting the costs of adapting homes to enable people to stay independent in their own homes	2,076,611	2,076,611
Nursing Discharge to Assess Beds	To provide 8 D2A beds at Heathlands for up to 4 weeks to enable planning and assessment of long term care needs and to support hospital discharges	407,497	678,973
Step Down Dementia Nursing Beds	To provide 8 beds at Heathlands for up to 6 weeks to support those people in hospital with the most complex dementia needs, to have their long term needs assessed in a non-hospital setting	662,000	1,103,027
Primary Care Support	To provide additional Primary Care appointments in the locality	497,494	528,300
Primary Care Support	GP in reach to the Intermediate Tier to provide additional GP support for reablement and rehabilitation services	48,000	50,717
Home from Hospital	To fund a service led by the voluntary sector which supports people after they are discharged home from hospital to prevent readmissions to hospital	100,000	104,603
Bury Hospice	To fund additional support to the hospice to support discharges from hospital	99,000	104,603
Additional IMC beds	To purchase 13 additional Bed-based intermediate care beds in the community with rehabilitation (to support	102,000	571,698

	discharge)		
Care of vulnerable adults at Fairfield General Hospital (RAID)	Provide monitoring, treatment and support. Monitoring effects of medication, risk assessments and mental health risk assessments	708,868	746,847
Discharge Liaison Team	Plan discharge of patients with complex needs	740,202	782,097
Falls Prevention	Person based preventative support to adults at risk of falls	216,994	229,276
Palliative Care	Palliative Care Service Expansion	156,637	165,503
Bury Local Care Organisation	Infrastructure to enable integration. Joint commissioning.	1,204,239	1,272,399

5. **Links to the Bury Locality Plan**

5.1. The Better Care Fund proposals should not be read in isolation but should be seen as a constituent part of the Bury Locality Plan and ''Let's Do It' 2030 Bury Strategy which sets out the entirety of the local approach to Health and Social Care transformation.

6. **Deadlines for Submission**

6.1 The guidance for the Better Care fund planning requirements was issued to lead officers in May 2023 with a submission deadline of **30 June 2023**. As a result of this short timescale for development and submission, the deadline fell between Health and Wellbeing Board planned meetings. The planning template has been collaboratively populated by relevant colleagues from within Bury Council and GM Bury ICB

6.2 The final planning template has been signed off for progression by the Executive Director for Health and Adult Care, Director of Adult Social Care, s.151 officer at Bury Council, and the joint Chief Finance Officer.

6.3 This report seeks retrospective ratification of the attached planning template and narrative plan from Health and Wellbeing Board.

6.4 Please note that initial feedback from the national Better Care fund team is that the submission from Bury was a strong submission and the narrative plan was of a high standard.

Recommendations for action

- That the Health and Wellbeing Board note the content of the report.
- That the Bury Health and Wellbeing Board retrospectively approve the attached Better Care Fund 2023/2025 Planning Template and ratify the decision to submit to the national Better Care Fund team for assessment.
- That the Bury Health and Wellbeing Board retrospectively approve the attached Better Care Fund Narrative plan for 23/25 and ratify the decision to submit to the national Better Care Fund team for assessment.

Financial and legal implications (if any)

- These proposals relate to the use of financial resources
- These proposals have been developed in partnership with the Bury Council s.151 Officer and the Bury Joint Director of Finance.

Equality/Diversity Implications. Please attach the completed Equality and Analysis Form if required.

- None

CONTACT DETAILS:

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Date: 19 September 2023

Appendices

Bury BCF narrative template 2023-25.doc

Bury-BCF 2023-25 Planning Template.xls

Bury 2023-25_ICB_Dischar

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