Better Care Fund (BCF)

Report to Telford & Wrekin Health and Wellbeing Board March 2022

Michael Bennett, Service Delivery Manager, Prevention and Enablement, Telford & Wrekin Council
&
Tracey Jones, Deputy Director of Partnerships, Shropshire, Telford and Wrekin Clinical Commissioning Group

The BCF aims to (as a partnership):

- Locally transform the health and social care system
- Work towards a fully integrated intermediate care service to prevent admissions to an acute hospital
- Support residents to live in the way they choose
- Reduce dependency on services
- Integrate with the wider TWIPP and STP programmes

a co-operative council

Telford & Wrekin COUNCIL

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

Better Care Fund inter-relationships

- BCF programmes are integral to delivery of specific Place and system work programmes. Specific and shared priorities of the system can be clearly through:
- BCF Board and Programme
- TWIPP plan supporting integration, community resilience, prevention and tackling health inequalities at Place while supporting system priorities
- Alignment to Urgent Care priorities
- Alignment to Local Care Programme priorities
- BCF identified as an Enabler / Associated Programme within the STW ICS UEC Plan 21/22
- High impact Changes Action Plan reviewed through the system Discharge Alliance and Urgent Care governance
- Tackling health inequalities through the updated Health Inequalities Plan learning from the impact of Covid-19 Review

Better Care Fund national conditions

- Minimum level of funding agreed, agreed by HWB Boards (jointly agreed)
- Specific proportion of investment to Adult Social Care
- Specific proportion of BCF invested in commissioned NHS out of hospital services
- Clear plan for DToC High Impact Change Metrics
- Maintain progress on previous national conditions
  - Seven day services across health and social care
  - Improved data sharing
  - Joint approach to assessments and care planning
- Nationally agreed metrics
  - Avoidable admissions (new in 2021/22)
  - 14+ and 21+ day Length of Stay (new in 2021/22)
  - Discharge to normal Place of Residence
  - Maintained at home 91 days post Re-ablement
  - Permanent admissions to care homes
- Submitted in November 2021 for 2021/22

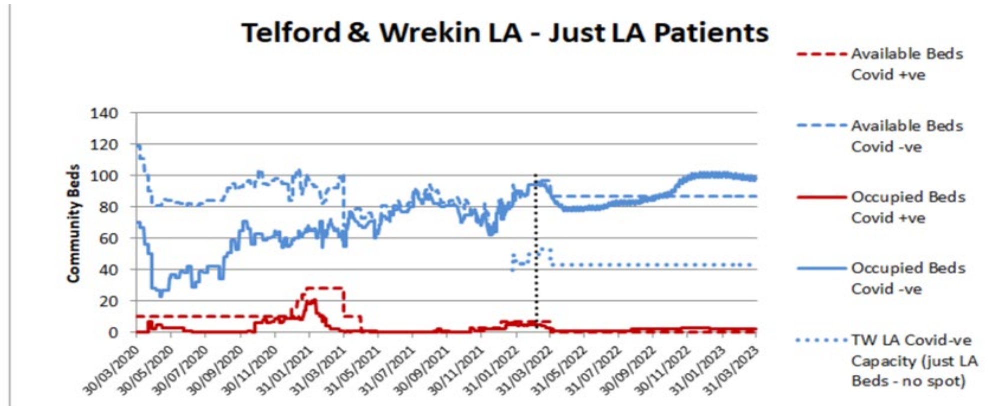
BCF metrics and current performance

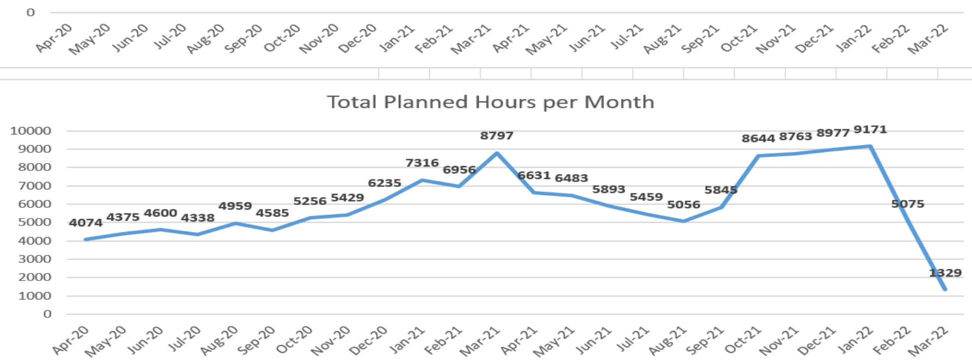
BCF Performance Dashboard March 2022

<table>
<tr><th>Key metrics</th><th>Performance/ position</th><th>Comments</th></tr>
<tr><td>Avoidable admissions (new metric)</td><td>
<table>
<tr><th></th><th>19-20 Actual</th><th>20-21 Actual</th><th>21-22 Plan</th></tr>
<tr><td>Unplanned hospitalisation for chronic ambulatory care sensitive conditions
(NHS Outcome Framework indicator 2.3i)</td><td>Available from NHS Digital (link below) at local authority level.
Please use as guideline only</td><td>549.5</td><td>548.0</td></tr>
</table>
</td><td>549.5 reported in the November data reporting</td></tr>
<tr><td>Length of Stay 14+ and 21+ day</td><td>
<table>
<tr><th></th><th></th><th>21-22 Q3 Plan</th><th>21-22 Q4 Plan</th></tr>
<tr><td rowspan="2">Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for:
i) 14 days or more
ii) 21 days or more
As a percentage of all inpatients
(SUS data - available on the Better Care Exchange)</td><td>Proportion of inpatients resident for 14 days or more</td><td>8.6%</td><td>9.2%</td></tr>
<tr><td>Proportion of inpatients resident for 21 days or more</td><td>3.8%</td><td>4.0%</td></tr>
</table>
</td><td>9.3% for 14 days LOS/ 4.2% for 21 days year to date
11.6% for 14 day LOS/ 5.6% for 21 days in November
10.6% for 14 day LOS/ 5.4% for 21 days in January
Q4 saw increased DTOC in annual reporting and was factored into annual target setting.</td></tr>
<tr><td>Discharge to Normal Place of Residence</td><td>
<table>
<tr><th></th><th>21-22 Plan</th></tr>
<tr><td>Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence
(SUS data - available on the Better Care Exchange)</td><td>92.4%</td></tr>
</table>
</td><td>92.3% year to date
92.0% in November
93.4% in January (latest data)
Q4 saw increased DTOC in annual reporting and was factored into annual target setting.</td></tr>
<tr><td>Permanent admissions to care homes</td><td>
<table>
<tr><th>Previous Performance</th><th>2017-18</th><th>2018-19</th><th>2019-20</th><th>2020-21</th><th>2021-22</th></tr>
<tr><td>Telford & Wrekin</td><td>307.3</td><td>548.9</td><td>472.7</td><td>390.7</td><td>653.0</td></tr>
<tr><td>National</td><td>585.6</td><td>579.4</td><td>584.0</td><td>498.2</td><td></td></tr>
</table>
</td><td>Target of 492/ 100,000 population (160 people).
Outturn for 2020/21 was 391/100,000. (127 people)
Current projections shows increased trajectory- moving away from the previous similar trajectory to last year.
Some increase in EMI related long term care placements
Further reviews being undertaken of data</td></tr>
<tr><td>At Home 91 days after Reablement</td><td>
<table>
<tr><th>Previous Performance</th><th>2017-18</th><th>2018-19</th><th>2019-20</th><th>2020-21</th><th>2021-22</th></tr>
<tr><td>Telford & Wrekin</td><td>61.7%</td><td>65.4%</td><td>71.4%</td><td>76.4%</td><td>81.2%</td></tr>
<tr><td>National</td><td>82.9%</td><td>82.4%</td><td>82.0%</td><td>79.1%</td><td></td></tr>
</table>
</td><td>T&W target is 76%%
Monthly tracking in place. Dropped slightly from 82.7% last month.
Metric based on October –December reviews through Q4</td></tr>
</table>

Managing demand

	2016	2017	2018	2019	2020	2021	2022
TOTAL	1161	1311	1527	1728	2200	2650	383
AVERAGE	97	109	127	144	183	221	192
		13%	16%	17%	27%	20%	-13%





- Fact Finding Assessments (referrals for complex discharge) overall 120% increase over 5 years.
- Jan- Feb 2022 shows -13% reduction (-55) less than last year
- Bed utilisation continues to increase due to increase demand and impact of covid 19 on capacity
- Domiciliary care demand continues to increase through supporting Home First and higher care needs
- Admission avoidance referrals have increased and been maintained at c55 / week

Pooled budget value

Summary Statement	Budget based on Period 12					
	2016/17 Annual Budget £	2017/18 Annual Budget £	2018/19 Annual Budget £	2019/20 Annual Budget £	2020/21 Annual Budget £	Annual Budget £
Intermediate Care	6,004,400	5,524,049	6,423,928	7,394,811	7,552,187	7,641,250
Community Resilience	1,283,321	1,056,221	1,107,414	972,012	996,311	1,016,237
Telford Neighbourhood Care	3,485,636	3,959,686	4,003,876	4,279,510	4,386,498	4,514,965
Other Care	3,432,564	7,640,491	9,694,094	11,734,627	11,445,021	11,437,007
Grand Total:	**14,205,922**	**18,180,447**	**21,229,312**	**24,380,960**	**24,380,017**	**24,609,459**

- BCF is formed from six budgets;
  - BCF minimum requirements from the NHS
  - Disabled Facilities Grant
  - Additional contributions from CCG and Council
  - iBCF directly to the Council
  - Winter Pressures directly to the Council

- Increased Pooled Budget values due to:
  - Increased DFG funding
  - iBCF introduced in 2017/18 and increased
  - Winter pressures monies introduced in 2019/20
  - Nationally identified CCG inflation uplifts in 2019/20 and 2020/21
- Budget for 2022/ 23 to be confirmed

BCF programme priorities for 2021/22 and updates

Priority	Update
Maximise potential for admission avoidance including Hospital at Home / Virtual Ward and HSCRRT	HSRCCT staff in place. Average of 55 referrals / week this year Falls Pathway developed with WMAS Working closely with SPA and SATH to increase referrals. Development of Virtual ward includes alignments to HSCRRT Working closely with SCC to support their Team Business case for admission avoidance agreed. Twice monthly reporting of referrals. Developing more reporting metrics for admission avoidance
Community Teams further integrated - TICAT, IDT, HSCRRT, Frailty Team, Care Home MDT into a single function	IDT Hub has TWC, SCHT and SCC integrated within the new location. ASC aligned across admission avoidance and hospital discharge IDT pathway being reviewed as part of the System Discharge Alliance work programme TICAT staff within Care Home MDT Desktop review against Admission Avoidance guidance
Develop specific approaches with PCNs including MDTs supporting risk stratification/ active case management	MDT in place with GP practice Linking with PCN Programme lead to further develop Proactive Prevention part of the Local Care Programme
Development towards a Single Referral Point	Work programme in place SPA within CCC in place to support admission avoidance
Maximise ILC and wider Prevention models and alternatives to formal care/ services	4826 hits in Virtual House to date. Ave 286 visits/ month. Regular communication to promote ILC and preventative support options Weekly programme continues to expand including ALD, Mental Health, Sensory Impairment Drop-Ins with Sign Language Gradual increase in Walk-Ins alongside OT, Sensory, Pathway Zero, Locality and Enablement assessments Directing prevention and early help to the ILC across TICAT reviews, Hub appointments Developed video for ADASS to showcase Virtual House and part of Digital Innovation Challenge Fund by ADASS and Microsoft.
Develop the Older People strategy	Task Group in place taking planning forward Seeking to develop Virtual ward for EMI/ Dementia as part of the work programme
Review options for delivery of bed based Enablement services	Options Appraisal updated and further meeting being planned For further review and discussion in TWIPP and Local Care Programme
Review alternatives and options for building capacity to meet demands eg OTs reducing LOS in Enablement beds OT working as one NHS and Council team	NHS and Council OTs agreed to review gaps and duplications and link into existing ICS AHP Council and Faculty meetings. Audit of therapy and nursing staff across Enablement beds completed Winter scheme of therapists showing reducing time for therapy optimised
Domiciliary care development and expansion to further promote Home First	Pathway profile remains essentially unchanged. Overall increase in demand met through commissioning Agency capacity at additional cost. Supreme Bridging funding agreed until March 2022. Pathway Zero processes in place with SaTH linked to ILC and WIP TICAT review FFAs as part of IDT functioning to ensure correct pathway Discretionary Enablement Grant in place but with limited take -up Working group reviewing technology or Virtual calls instead of formal care.

Key themes affecting delivery of programmes

- Impact of Covid 19 on
  - Workforce
  - Provision
  - Capacity
  - Performance
  - Planning and innovations to maximise use of resources
  - Individual experience
- Planning and working in unison as System partners
- Supporting key priorities eg admission avoidance staffing
- Development of the Independent Living Centre and Virtual House
- More focus on strengths based approaches

BCF programme for 2022/23 initial considerations

- Maximise potential for admission avoidance including Hospital at Home / Virtual wards
- Enhance integrated working of Community Teams – integrating TICAT, IDT, HSCRRT, Frailty Team, Care Home MDT, Virtual wards into a single function to maximise discharge
- Develop Community MDTs with SCHT and PCNs including supporting risk stratification/ active case management supporting anticipatory care
- Maximise Proactive Prevention approaches to reduce/ delay use of statutory services
- Develop the Older People strategy
- Integrate HICMs to urgent care delivery ie Hospital Improvement/ Flow workstream
- Develop options for delivery of a sustainable Intermediate care function (including beds, Enablement interventions; key outcomes)
- Re-commission domiciliary care provision to maximise resources and meet increased demand