Telford & Wrekin Co-operative Council

Protect, care and invest to create a better borough

Borough of Telford and Wrekin

Health and Wellbeing Board

Thursday 28 September 2023

Better Care Fund Update

Cabinet Member:	Cllr Paul Watling - Cabinet Member: Adult Social Care & Health Systems
Lead Director:	Simon Froud - Director: Adult Social Care
Service Area:	Adult Social Care
Report Author:	Michael Bennett – Service Delivery Manager: Hospital and Enablement and Lead for the Better Care Fund Gemma Smith – Director of Strategic Commissioning, Shropshire, Telford & Wrekin NHS
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Wards Affected:	All Wards
Key Decision:	Not Key Decision
Forward Plan:	Not Applicable
Report considered by:	Better Care Fund Board – 20/09/2023 Telford & Wrekin Integrated Place Partnership – 21/09/2023 Health & Wellbeing Board – 28/09/2023

1.0 Recommendations for decision/noting:

It is recommended that the Health & Wellbeing Board:

1.1 Note the Better Care Fund programme progress to date;

1.2 Support the delivery of the Better Care Fund programme for 2023/25; and

1.3 Receive an update on progress in early 2024.

2.0 Purpose of Report

2.1 The purpose of this report is to provide the Health & Wellbeing Board with an update on the Better Care Fund (BCF) programme, as well as highlighting the current pressures, challenges and mitigation.

2.2 The principal aim of the BCF programme locally is to transform the health and social care system, utilising the resources that supports the local system to successfully deliver the integration of health and social care in a way that supports person-centred, sustainability and better outcomes for people and carers.

3.0 Background

3.1 BCF is a national programme that is place based to Telford and Wrekin. It is jointly led by Telford & Wrekin Council and Shropshire, Telford & Wrekin Integrated Care System and as a partnership approach.

3.2 To monitor and drive the development of the BCF, a Programme Board is in place which reports directly into Telford & Wrekin Integrated Place Partnership (TWIPP)[1].

3.3 The BCF programme is a two year plan (2023-25) with the aim to further transform the health and social care system to support strengths-based, person-centred approaches to care, in a sustainable way, and provide better outcomes for people and carers. The BCF funded resources contribute to and support key programmes of work across:

- Place and neighbourhoods (led and coordinated through TWIPP), and
- System, in particular the
  - Local Care Transformation Programme, and
  - Urgent and Emergency Care Priority Transformation Programme

3.4 The BCF programme must meet the revised 4 National Conditions (see box to the right). The Telford & Wrekin BCF Narrative Plan demonstrates how the national conditions will be achieved (see Appendix A for a copy).

BCF National Conditions for 2023-2025:

- a jointly agreed plan between local health and social care commissioners, signed off by the HWB
- implementing BCF policy objective 1: enabling people to stay well, safe and independent at home for longer
- implementing BCF policy objective 2: providing the right care, at the right place, at the right time
- maintaining 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

(BCF Policy Framework 2023-25)

3.5 The Policy Guidance for 2023-25 also required a detailed profile of urgent care demand and capacity as part of the submission and regular reporting of the utilisation of specific allocated additional Discharge Fund monies.

[1] Information on TWIPP

3.6 The BCF Plan was submitted in June 2023 in line with national requirements. This included:

- A Planning Template including income and expenditure planning, metrics and planning requirements.
- A Narrative document setting put actions to meet the planning requirements including achievements during the last year and priorities for 2023-2025.
- Urgent and Community Care Demand and Capacity modelling.
- Review of the past year (12 months) – what was achieved both quantitatively and qualitatively.

3.7 The indication is that the BCF Plan for 2023-25 will be formally approved by the BCF National Team.

4.0 2022/2023 Highlights

The BCF programme schemes and workstreams during 2022/23 continued to develop and maintain integrated team working, approaches and planning through, and alongside the place-based work, Local Care Transformation and Urgent and Emergency Care Programmes. This section of the report highlights some of the successes in 2022/23.

4.1 **Preventative approaches** were further established including:

- Healthy Lifestyles Hubs, Social Prescribing, Care and Community Navigators to support and signpost,
- Accessible information and early help through Live Well Telford and the commissioned first point of contact, Wellbeing Independence Partnership, and
- Assessors for equipment.

4.2 The **Independent Living Centre** was further developed (watch the video on the right to find out more about what is on offer):

- access to assistive and digital technologies;
- Early Help appointments,
- OT assessments for aids and adaptations;
- a community hub for Voluntary Community Sector groups to meet, and
- assessments for identified discharges from hospital.

4.3 **Assistive technology / technology enabled care** was further developed. Working with a domiciliary care proving overnight care, a digital device allows the cared for to notify the care provider during the night when they require assistance such as personal care. Without the device

and associated service, the individuals would likely need residential care or full overnight care. This was shared as good practice nationally and was picked up by ITV News Centre - New device aiming to tackle social care crisis piloted in Telford and Wrekin | ITV News Central

4.4 The **Health and Social Care Rapid Response Team (HCSRRT) is fully established** an alternative to hospital, supporting at the right time, at the right place in the right way. The Virtual ward has also been establishing itself during 2023 and daily tracking of the performance trajectory is in place. A further development programme has also been established to maximise its impact on supporting early discharge from hospital.

4.5 A **Falls Prevention Pilot** was developed and delivered as a winter scheme to reduce harm from long-lying while waiting for an ambulance. The pilot utilised the local Non-Elective Patient Transport Service providing an alternative response to West Midlands Ambulance Service for non-injurious falls. A specialist independent sector provider delivered postural stability programmes within local communities to maximise opportunities for improved mobility and reduce risk of falls.

4.6 The **Integrated Discharge Team (IDT) has been further embedded in system working**:

- more closely aligned with the acute hospital flow processes;
- implementation of MADE events so they are now embedded as Business as Usual.
- Adult Social Care more closely aligned to wards so can they support early discharge planning through ward/board rounds and through Multi-Disciplinary Team meetings.

4.7 Other schemes included in BCF include:

- Meeting Care Act 2014 duties including Safeguarding, Deprivation of Liberty Safeguards, Care Act Advocacy and provision of Information and Advice;
- Supporting unpaid carers through tailored information, services and support to maintain and improve well-being;
- Disabled Facilities Grant (DFG) providing equipment and adaptations to maintain independence and wider housing support; and
- Improving health inequalities.

4.8 To support the monitoring of progress, monthly reports (including performance) are shared at the BCF Board and escalated as and when needed through Telford & Wrekin Integrated Place Partnership as well as through the Integrated Care Board.

5.0 The Plan for 2023/2025

5.1 The BCF Board supported and approved the BCF programme for 2023/25 which includes:

- Development and delivery of the Integrated Discharge Model and Discharge to Assess (D2A) approach;

- Support acceleration of delayed discharge High Impact Change Metrics (HICMs) through further integrated working.
- Support the maximisation of admission avoidance and Virtual Ward.
- Support proactive prevention care programmes to maximise independence at home.
- Enhance voluntary sector involvement in supporting independence and alternatives to statutory care.
- Align capacity to meet demand.
- Maintain and sustain provider market capacity.

5.2 Specific actions and approaches were set out within the Narrative Plan and enable and support people to stay well, safe and independent at home for longer. These align to the Shropshire, Telford & Wrekin Integrated Care Strategy and Joint Forward Plan, the Telford & Wrekin Health and Wellbeing Strategy and Telford & Wrekin Integrated Place Partnership Strategic Plan 2022-2025.

5.3 Approaches and interventions will build on work in the previous years and include:

- Promoting healthier lifestyles through a number of initiatives including Social Prescribing
- Offering a range of early help in terms of information, advice, advocacy and support, through Live Well Telford , Well-being Information Partnership
- Promoting and further developing the Independent Living Centre
- Promoting and further developing the Virtual House for aids and adaptations ss independent sector providers and with statutory services
- Further developing preventative services:
  - Housing related support for vulnerable groups including homeless and tenancy support
  - Falls prevention
  - Housing related support and older people within tenancies including Trusted Assessors for equipment and minor adaptations
  - Digital Hub for virtual calls for assessment or support
  - OT assessments for equipment and adaptions at home
  - Carer Moving and Handling assessments
- Supporting independent sector providers to offer local community based support
- Support the Local Care Transformation Programme in particular the:
  - Approaches and interventions to enable people to stay well at home for longer
  - Principles and approaches to Proactive Care (previously known as Anticipatory Care)
  - Strength-based, person-centred approaches
  - Admission Avoidance
  - Virtual Ward
- Support providing the right care in the right place at the right time and promoting Home First principles. This is closely aligned to Urgent Care Programme.

5.4 **Supporting Urgent Care**

- The Telford Integrated Community Assessment Team (TICAT) are the Adult Social Care social workers, aligned in an integrated way with NHS partners to support admission avoidance and discharge. This is through the Health and Social Care Rapid Response Team (HSCRRT) and within the Integrated Discharge Team (IDT) - supporting discharge planning and discharge from hospital and Intermediate Care case management.

- TICAT and wider BCF resources are supporting and contributing to a wide range of schemes of programmes seeking to improve flow and discharge processes including:
    - Improving Discharge Flow
    - Integrated Discharge model and development of Discharge to Assess
    - Development of 7 day services

- Alongside the ICS's Urgent Care Programme, the acute hospital a number of workstreams aligned to improving discharge flow and improving discharge planning. These are aligned with the nine Transfers of Care High Impact Change Metrics (HICMs) that are evidence-based to improve discharge processes and outcomes – please see table below.

High Impact Change Metric	**Schemes/ programmes/ actions to support improvements**
Change 1: Early Discharge Planning	Ward processes to improve discharge planning workstream Improving Discharge Flow workstream Integrated Discharge Model development Virtual ward development Length of stay harm reduction
Change 2: Monitoring and responding to system demand and capacity	STW Demand and Capacity Modelling group tracking Discharge monitoring tool
Change 3: Multi-disciplinary working	Ward processes to improve discharge planning Improving Discharge Flow Integrated Discharge model development Virtual ward development
Change 4: Home First	Integrated Discharge model development
Change 5: Flexible working patterns	Development of 7 day services Business case Discharge metrics over 7 days
Change 6: Trusted assessment	Development of Trusted Assessors to support discharge Develop Trusted Assessor approach to view domiciliary care utilisation
Change 7: Engagement and choice	Review of Choice policy
Change 8: Improved discharge to care homes	Care Home MDT development Rapid Response support to care homes
Change 9: Housing and related services	Homeless Protocol

5.5 **Joint Commissioning Arrangements**

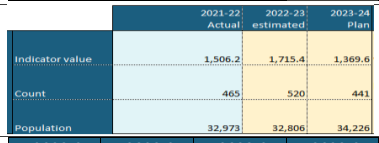
- Joint commissioning arrangements further supports integration.
- Focussing on the on the collective expertise and the NHS and Local Authority to support strategic planning and commissioning of services and building on the strengths of people and communities as a cornerstone of commissioning arrangements.

- Joint commissioning will seek jointly to design and invest in pathways which are person-centred and hold organisations jointly accountable for the overall experience of individuals and families. They will use the financial and workforce resources available across organisations to support local populations in the most effective means possible.
- Joint Commissioners will reflect and potentially identify areas of joint working in more detail during 2023-24 with the aim of aligning and/or integrating identified services in the way in which there can be (re-)commissioned via the BCF and deliver via place by year 2 (2024/25).

6.0 BCF Performance

Performance against BCF metrics and agreed programmes are monitored through a Dashboard within the monthly governance meetings.

The following images provide an outline of the performance to date:

Key metrics	Performance/ position	Trends	Comments
Avoidable admissions	2023-24 Q1 Plan: 103.3 | 2023-24 Q2 Plan: 106.8 | 2023-24 Q3 Plan: 110.2 | 2023-24 Q4 Plan: 113.7		Indicator value 75.2 for two months.
Falls admissions		**tbc**	Indicator value 13.1 for two months.
Discharge to Normal Place of Residence	2023-24 Q1 Plan | 2023-24 Q2 Plan | 2023-24 Q3 Plan | 2023-24 Q4 Plan 93.6% | 93.7% | 93.9% | 94.0% 3,610 | 3,621 | 3,633 | 3,644 3,858 | 3,863 | 3,869 | 3,875		Target of 93.7% May 2023 is 93%, National was 92.5% Current performance 93.2 (12 month rolling to May 23) National is 92.6
Permanent admissions to care homes	2021-22 Actual | 2022-23 Plan | 2022-23 estimated | 2023-24 Plan 447.4 | 429.0 | 438.1 | 428.5 142 | 142 | 145 | 145 31,739 | 33,097 | 33,097 | 33,838		Target of 429/ 100,000 population (142 people). Outturn for 2020/22 was 447/100,000 - better than national of last year. Some increase in EMI related long term care placements Review of data taking place currently
At Home 91 days after Reablement	2021-22 Actual | 2022-23 Plan | 2022-23 estimated | 2023-24 Plan 84.2% | 80.0% | 71.4% | 80.1% 186 | 180 | 142 | 181 221 | 225 | 199 | 226		T&W target is 80% Year end position was 71% Some drop off in performance from 79% within Q4 2021/22 reporting shows 84.2% - best ever performance Separate detailed report of Q4 tabled

BCF programmes 2023/24		
Development and delivery of the Integrated Discharge Model and D2A approach		•External consultancy supporting model and detailed plan development •Plan to have PDSAs through July-September •7 day working approach to be further developed
Support acceleration of delayed discharge HICMs through further integrated working		•Reviewing HICMs against urgent Care flow related programmes •Included within the Integrated Discharge Model phasing
Support the maximisation of admission avoidance and Virtual ward		•Funded resources to support admission avoidance •Virtual ward development as part of LCDP
Support Proactive Prevention Care programmes to maximise independence at home		•Current provisions includes Live Well Telford; Well-Being Information Partnership; Grant funding for Care Navigators, Day Centres and post Stroke reviews; •ILC offer expanded to support post discharge reviews, self help and Early help interventions including AT, Sensory assessments, Early Help Hubs, Trusted Assessors and OT assessments; •Tenancy support for vulnerable groups and older people currently being reviewed
Enhance voluntary sector involvement in supporting independence and alternatives to statutory care		•Reviewing current support to voluntary sector
Aligning capacity to meet demand		•Capacity gap identified
Maintained and sustain provider market capacity		•Market Position Statement in place with associated sustainability plan •Domiciliary care market increased by 50% since January 2023 •Limited bed capacity at nursing and EMI nursing designations. New providers developed locally and others in development •Independent sector within the SDA

	Completed or On Track		*In progress*		*Behind target timelines*		*Not yet commenced*

7.0 NHS England discharge visit

7.1 As part of the National Urgent and Emergency Care Recovery Plan, the Department for Health and Social Care (DHSC), NHS England (NHSE), the Department for Levelling Up, Housing and Communities (DLUHC), Local Government Association, and Association of Directors of Adult Social Services, have introduced an integrated approach to support performance improvement in local systems. This includes in-depth visits to identify challenges and potential solutions.

7.2 The Shropshire, Telford & Wrekin Integrated Care System have been supported with this approach. In August and September visits were held to review approaches to discharge and winter planning. Further action planning is now taking place to look at the feedback received from these visits.

8.0 Demand and Capacity modelling

8.1 The last census highlighted a significant growth in the over 65 population, increasing by over 35% from the previous census against an overall national increase of 20%.

8.2 Over the past 6 years of recording, demand for discharge into Intermediate Care has also increased significantly. The summary below shows year-on-year changes in referrals for complex discharge support. (2023 includes up to Month 8 -figures are January to December)

	2016	2017	2018	2019	2020	2021	2022	**2023**
TOTAL	1161	1311	1527	1728	2200	2650	2493	2003
AVERAGE	97	109	127	144	183	221	208	250

% increase/ decrease	13%	16%	14%	27%	20%	-6%	23%

8.3 The demand profile has also changed. Historically, July and August had less referrals that other months. Over the last four years, they have become some of the most demanding periods in terms of referrals for complex discharge.

8.4 Demand and capacity modelling for 2022/23 was undertaken for hospital discharges and community hospital discharges. In 2022/23, the modelling was based on predicted demand, with a reasonable degree of accuracy, and funded capacity was in place to meet the demand. Throughout the year specific actions were taken to ensure there was sufficient capacity.

8.5 For 2023/24, the Demand and Capacity modelling was completed as part of the BCF submission using a similar methodology to the previous year.

8.6 There is a gap identified within the available budget this year between predicted demand and currently funded capacity despite actions to reduce the capacity gap being identified.

8.7 There is ongoing discussion about approaches to reduce the financial gap to meet the projected demand.

9.0 Alternative Options

9.1 Please refer to the Narrative Plan (Appendix A)

10.0 Key Risks

10.1 Risks to the overall programme delivery were highlighted in the Narrative Plan and are considered within the monthly BCF Board.

10.2 Current risks identified include:

Risk	Mitigations taken	Residual risk level
Lack of confirmed funding to commission projected bed based and home based care to meet demand. This is a risk to the delivery of Intermediate Care discharges; hospital flow, market stability and capacity; impact on provider workforce and winter planning	• Urgent and Emergency Support Fund bid being completed • On-going discussion with NHS colleagues • Operational mitigating actions identified seeking to maximise resources and to reduce impact.	Risk remains as no confirmation of funding at time of reporting
Impact of Covid19 increased infections rates on service delivery, care capacity and	• Vaccination programme in place	Risk remains of increased Covid19

discharge from hospital into care settings and home.	• Infection Prevention Control support to care providers • System monitoring of infection rates	
Bed based market capacity of Nursing and EMI nursing designations of beds - impacting timely discharge from hospital and choice in relation to provision within the borough.	• Urgent Care programme supporting Home First • Sourcing specific designations of beds out of the borough. • Market management reviewing capacity and utilisation	Risk remains of increased utilisation of specific designations of beds out of the borough

11.0 Council Priorities

11.1 The BCF programme supports the council to achieve the following priorities specifically:

- Priority 1 – every child, young person and adult lived well in their community
- Priority 5 – a community-focussed, innovative council providing efficient, effective and quality services

12.0 Financial Implications

12.1 The BCF Plan 2023-2025 includes details of the planned BCF Pooled budget for the two years, the detail of which is shown in the table below against the relevant elements of the BCF programme.

12.2 The financial monitoring of this fund and consideration of any issues arising is undertaken by the BCF Board as per the required Section 75 agreement and is reported to the Council and the Integrated Care Board via their own financial management governance arrangements.

12.3 There continues to be discussion with all partners to address the key risks identified in section 10, in relation to demand and capacity within the system.

Summary Statement	Annual Budget 2023/24 (£)	Annual Budget 2024/25 (£)
Intermediate Care	**11,622,383**	**13,319,792**
Community Resilience	**1,061,701**	**1,082,347**
Telford Neighbourhood Care	**5,044,336**	**5,329,846**

Other Care	**11,579,393**	**11,629,191**
Grand Total	**29,307,813**	**31,361,176**

13.0 Legal and HR Implications

13.1 The Better Care Fund was established by the Government in June 2013 [in preparation for the Care Act 2014 coming into force] to provide funding to support the integration of health and social care to achieve National Conditions and Local Objectives and followed in the Health and Care Act 2022. A requirement of the Better Care Fund is for pooled funds to be established for this purpose. S.75 of the National Health Services Act 2006 [as amended] enables local authorities and NHS Bodies to enter into partnership arrangements to provide more streamlined services and to pool funds, subject to meeting the requirements of the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 [as amended]

13.2 There have been signed Section 75 Agreements in place between the Borough of Telford & Wrekin and NHS Telford & Wrekin Clinical Commissioning Group, now Shropshire, Telford and Wrekin Integrated Care System in respect of the Better Care Fund annually (updated and amended each year) which set out the accountability arrangements and flow of funding. Health and Wellbeing Boards are expected to oversee the strategic direction of the Better Care Fund and the delivery of better integrated care, as part of their statutory duty to encourage integrated working between commissioners [S.195 Health and Social Care Act 2012]. S.3 of the Care Act 2014 places a duty on local authorities to promote integration of care with health services while s.2 indicates a local authority duty to arrange services that prevents needs for care and support. Read in light of the s.22 prohibition on local authorities meeting health provision (save for incidental or expected services) the BCF is a pooled fund with contributions and priorities identified within the 2023 to 2025 Better Care Fund Policy framework referenced herein.

14.0 Ward Implications

14.1 All wards will be impacted on by these proposals.

15.0 Health, Social and Economic Implications

15.1 It is intended that this programme of work will contribute to improve health and wellbeing outcomes within the borough.

16.0 Equality and Diversity Implications

16.1 Joint Strategic Needs Assessment intelligence informs intentions to ensure resources are targeted appropriately to improve health and wellbeing and reduce inequalities.

16.2 The BCF Plan has a specific requirement to demonstrate its focus on reducing inequalities and disparities including protected characteristics within the local population and priorities under the Equalities Act.

16.3 An ICS Equality Impact Assessment has been carried out to identify the impacts related to the financial gap in funding projected demand for Intermediate Care beds and care.

17.0 Climate Change and Environmental Implications

17.1 This report has no direct climate change or environmental impact.

18.0 Background Papers

1 Health & Wellbeing Board – 11/02/2020
2 Health & Wellbeing Board – 24/03/2022

19.0 Appendices

A Better Care Fund Narrative Report 2023-2025

20.0 Report Sign Off

Signed off by	Date sent	Date signed off	Initials
Simon Froud	14/09/2023	21/09/2023	SF
Tracey Smart	13/09/2023	19/09/2023	TS
Oliver Nicolas	13/09/2023	19/09/2023	ON