

Better Care Fund (BCF) 2024-2025 update

Presentation to Telford & Wrekin Health and Wellbeing Board – November 2024

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Purpose of update

The presentation will cover the following areas:

- 1. Quarter 4 2023/ 24 return
- 2. 2024/25 Plan for formal approval
- 3. Quarter 1 2024/25 return
- 4. Quarter 2 2024/25 return
- 5. Summarise programme for 2024/25
- 6. Update on BCF schemes and how they support local programmes
- 7. Summarise finance and performance to date across 2024/25





Better Care Fund (BCF) approach to supporting local and system wide programmes

Key delivery mechanisms and principles:

- Integrated delivery by teams
- Engagement in Place-based, Local Care and Urgent Care programmes
- Strengths-based, person-centred approach across all access points
- Personalised approaches as a fundamental principle
- Understanding demand and capacity to meet needs
- Joint planning and commissioning
- Care market sustainability

BCF national priorities for 2023/25:

- Clear approach to integration across delivery and commissioning
- Enable people to stay well, safe and independent at home
- Providing the right care in the right place at the right time
- Supporting unpaid carers
- Support to housing including minor and major adaptations
- Improving health inequalities



Quarterly returns and 2024/25 submission summary

Quarter4/ Year End (May return)

- Meeting the national conditions
- Projections of achieving metrics; Income, Expenditure and Activity
- Demand and capacity activity to meet projections
- Year End feedback- impact of BCF, successes and challenges

24/25 BCF Plan Return (July return)

- Demand and capacity modelling
- Income, Expenditure, Activity and Metrics for 2024/25
- Update on the BCF programmes narrative for 2024/25
- Assurance of meeting the national conditions

Quarter 1 Return (September return)

Discharge Fund Spend and Activity

Quarter 2 Return (October return)

- Meeting the national conditions
- Projections of achieving metrics; Income, Expenditure and Activity
- Demand and capacity activity to meet projections



BCF workstream schemes

Resilient Communities

- OTs supporting carer moving and handling
- Carers support through Carers Contact Centre, Emergency Carers Support, Carer Respite and Admiral Nursing
- Volunteering
- Befriending
- Safeguarding
- Independent Advocacy

BCF Contribution £1.1m

Prevention at Place

- OTs mobility and independence and provide supporting aids and adaptations
- Adaptations and interventions through DFG
- Sensory Impairment assessments
- Assistive Technologies (aids, adaptations)
- Specialist Locality Team workers Family Connect
- · First Point of Contact
- Care Navigators within GP practices
- Stroke 6- and 12- month reviews
- Dementia Day service support
- Tenancy and community support
- SCHT Community teams
- SATH teams including post Stroke support

BCF Contribution £5.3m

Urgent Care

- Hospital Social work team (TICAT) supporting discharge planning
- Case management team (TICAT) supporting through Enablement
- Enablement therapists
- Personal Care for Pathway 1 discharges and admission avoidance
- Planned Overnight Care with AT support
- Block and spot Pathway 2 and 2 beds and admission avoidance
- GP Enablement care
- SCHT Community teams including Rapid Response, Community Respiratory Team, Specialist Community Team

BCF Contribution £13.03m



BCF programme supports...

Resilient Communities

- All Age Carers Strategy
- Dementia strategy
- ASC Strategy
- ASC and Health Improvement Delivery Plan
- ICB Forward Plan

Prevention at Place

- Ageing Well strategy
- Health and Well-Being Strategy
- Health Inequalities Plan
- Specialist and Supported Accommodation Strategy
- Disabled Facilities Grant

Urgent Care

- Tier 1 Urgent Care Priority Plan programme including:
- Alternatives to ED
- Frailty
- System Discharge Alliance
- Enablement pathway
- Care Transfer Hub

BCF impact – case illustrations

Mr A has dementia, presenting with confusion and memory issues with tasks through the day. He woke at 3am, dressed ready for the day. His daughter, providing 24-hour care, was exhausted and near the point of being unable to maintain her role. We provided an Orientation clock with a simple photo of the moon until 7am when it turned to a sun. This simple piece of 'kit' meant that he stayed settled in bed until the sun appeared. His daughter was also able to sleep and continue her caring role.

Mr B was assessed as the ILC. He had COPD and was no longer able to get up and down stairs. He was living and washing downstairs. He was assessed as needing a stair lift and a DFG application for a wet room to support his self-care. Since the stair lift has been in situ, Mr A has regained his independence: able to sleep upstairs with his wife; living up and downstairs and using his bathroom which was extremely important to him.

Mrs B was the sole carer for her husband and her needs were also considered. She has been registered with the Carers Centre to ensure she receives support as and when she is ready.





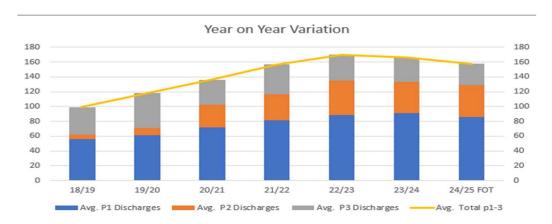
Protect, care and invest to create a better borough

Performance

Key metrics	Performance	position				Trends	Comments Month 6
Avoidable admissions	Indicator value Number of Admissions Population Indicator value	Actual 117.1 226 185,842	Actual 102.1 197 185,842	2023-24 Q3 Plan 110.2 - - 2024-25 Q3 Plan 125.9	Plan - 113.7	1	2023/4 total 442.5/ average just below target Q2 showed an avoidable admissions indicator value of 108.3 against target of 122.4
Falls admissions	Indicator value Count Population		2023-24 Plan 1,369.6 441 34,226	2023-24 estimated 417.0 120 34,226	2024-25 Plan 455.7	1	Q1 showed a falls indicator value of 41.4. Q2 to date is 11.4
Discharge to Normal Place of Residence	Quarter (%) Numerator Denominator Quarter (%) Numerator Denominator	Actual 94.6% 3,824 4,041	Actual 95.2% 3,944 4,145	2023-24 Q3 Actual 93.9% 3,633 3,869 2024-25 Q3 Plan 95.0% 3,939 4,148	94.0% 3,644 3,875	1	2024/25 target of 95.1% Current performance average 92.9% (national is 92.7) to date April to September 91.4 (national at 93.1)% Data shows increase in national averages Further review of impact of Rehabilitation and Recovery Unit transfers
Permanent admissions to care homes	Annual Rate Numerator Denominator	2022-23 Actual 482.2 159	2023-24 Plan 428.5 145	2023-24 estimated 481.7 163	2024-25 Plan 470.9 163	1	2023/24 target of 429/ 100,000 population (145 people). Actual is 609/100,000 (193 people) for 23/24 National was 560.8 Data entries are currently being reviewed



- On track on 75% of national metrics
- Discharging more people more quickly
- Reductions in number of No Criteria to Reside and length of stay
- Maintaining focus to increase Home First to 70%
- Care Transfer Hub commenced 2/10/24



Finance





- BCF budget for 2024/25
- BCF value identified over 2year duration
- Budget additional Discharge Fund monies to Council and from NHS
- Managing cost pressure due to Enablement Care bed and domiciliary care demand, increased needs and unit cost
- No current indications about 2025/26 finance of Policy Guidance.

	2024-25					
Running Balances	Income	Expenditure to date	Percentage spent	Balance		
DFG	£2,516,094	£1,288,971	51.23%	£1,227,123		
Minimum NHS Contribution	£15,331,492	£8,205,796	53.52%	£7,125,696		
iBCF	£7,823,562	£3,911,779	50.00%	£3,911,783		
Additional LA Contribution	£1,618,410	£804,485	49.71%	£813,925		
Additional NHS Contribution	£383,383	£154,027	40.18%	£229,356		
Local Authority Discharge Funding	£1,828,085	£914,042	50.00%	£914,043		
ICB Discharge Funding	£1,776,801	£888,400	50.00%	£888,401		
Total	£31,277,827	£16,167,500	51.69%	£15,110,327		

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2024-25				
	Minimum Required Spend	Expenditure to date	Balance		
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£4,356,775	£3,538,579	£818,196		
Adult Social Care services spend from the					
minimum ICB allocations	£7,737,449	£4,549,976	£3,187,473		

Progress

- Commissioned additional block beds to ensure capacity
- Reduced domiciliary care hours and overall beds utilisation
- Confirmed funding for additional therapists
- Developed Care Transfer Hub to maximise effective discharge processes
- Commissioned Extra Care beds to commence in November

Progress through Q3 and Q4

- Further support to Alternatives to ED and Frailty Tier 1 workstreams
- Further development of Care Transfer Hub to accelerate complex discharge
- Maintain and improve discharge performance through winter
- Model levels of beds and domiciliary care need for 25/26
- Commissioning planning for 25/26



Recommendations

- Support progress to date
- Formally approve BCF submissions





Any Questions?

