IASC/23/03
Health & Wellbeing Board
20 July 2023

# BETTER CARE FUND - UPDATE

Report of the Head of Integrated Adult Social Care Commissioning (Interim)

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Please note that the following recommendations are subject to consideration and determination by the Committee before taking effect.

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## 1) Recommendation:

1.1 The Board notes the out-turn of the BCF in 2022/23
1.2 The Board endorses the plans for 2023/25
1.3 The Board receives a 'BCF masterclass' at a future meeting.

## 2) Background / Introduction

The Better Care Fund (BCF) is the mandatory policy to facilitate integration between Health and Social Care, providing a framework for joint planning and commissioning. The BCF brings together ring-fenced budgets from NHS allocations, ring-fenced BCF grants from Government, the Disabled Facilities Grant and voluntary contributions from local government budgets, including the Adult Social Care Discharge Fund. The Health and Wellbeing Board has oversight of the BCF and is accountable for its delivery.

This report:

1. Provides an update on the outturn of the BCF for 2022/23 for the Board to note
2. Requests that the Board endorses the planning for 2023/25.

## 3) Outturn 2022/23

## 3.1 Governance

Following the approval of the Devon BCF Annual Plan in January, the s.75 (NHS Act 2006) agreement was signed by Devon County Council and the Integrated Care Board.

The conditions relating to the Adult Social Care Discharge Fund announced in the autumn of 2022 included a requirement to submit fortnightly returns to government on spending against the fund. These were provided and the fund (£6.7m) was spent in full.

## 3.2 Metric Targets

3.2.1 **Avoidable Admissions**
Definition: Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i). (This relates largely to respiratory and cardiovascular conditions.)

Performance against this target is supported by the effective integrated working via community multi-disciplinary teams who provide both preventative and effective, responsive urgent care, which is why it is one of the BCF metrics.

| Plan for 2022-23 | Actual for 2022/23 |
|---|---|
| 620<br>per 100,000 population | 604<br>per 100,000 population |

The target for avoidable admissions was over-achieved in 2022/23.

### 3.2.2 Discharge to Normal Place of Residence

Definition: The percentage of people who are discharged from acute hospital to their normal place of residence.

| Plan for 2022-23 | Actual for 2022/23 |
|---|---|
| 91.9% | 91.8% |

A key success in achieving the discharge to normal place of residence has been in the form of a good quality and sustainable provider market that can meet demand.

NHS and social care partners along with the independent sector work closely together for solutions to meet immediate capacity pressures and support pilot projects to drive longer term change.

Successes include more care homes beds being made available due to a peripatetic agency team supporting complex discharges, and joint training and enhanced support within hospital discharge short-term care home settings.

Partners have worked well to set out future demand and capacity needs which will inform long term market sustainability plans and funding decisions.

### 3.2.3 Residential Admissions (65 and over)

Definition: Long term support needs of older people (65 & over) met by admission to residential and nursing homes, per 100,000 population.

| Plan for 2022-23 | Actual for 2022/23 |
|---|---|
| 500.3<br>per 100,000 population | 516.1<br>per 100,000 population |

The pandemic resulted in a reduction in the numbers of older people with long term support needs being met in care homes. This was mainly the result of changes in family, friends and personal choice reducing demand.

Since the implementation of the Discharge to Assess pathway, we have seen a significant increase in the number of older people being permanently admitted to long term residential and nursing home placements. This is in part due to the use of care homes to support discharge from hospital with short-term support which then ends up converting to long term placements. Personal care market insufficiency has also impacted on this.

Proportionately the increase in nursing placements is more significant, reflecting the increasing needs of people discharged from hospital during 2022-23.

### 3.2.4 Reablement

Definition: The proportion of older people (65 & over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services.

We measure this as it indicates successful rehabilitation and reablement services, ensuring people are supported back to independence after a spell in hospital.

| Plan for 2022-23 | Actual for 2022/23 |
|---|---|
| 75% | 72.7% |

This is a very specific indicator tracking the outcomes for older people discharged from hospital in the period October to December into reablement/rehabilitation services, with outcomes measured between January and March.

The pandemic impact affecting this indicator since 2020-21 has now been reversed with qualifying discharges now typical to pre-pandemic levels. Actual performance for 2022/23 (72.7%) is marginally below target, but an improvement (by 5.6%) on the previous year

## 4.3 Financial Outturn

| | £ |
|---|---|
| Disabled Facilities Grant | £8,245,371 |
| Social Care Discharge Grant | £6,776,592 |
| Improved Better Care Fund | £29,126,836 |
| ICB Minimum Fund | £64,585,555 |
| Local authority additional funding | £21,786,715 |
| **Total funding** | **£130,521,069** |
| **Actual expenditure** | **£122,216,893** |
| Underspend | £8,304,176 |

- The underspend relates to non-use of a previous carry-forward, planned unders within ICB Income and Grant.
- £6.65m of this balance will be carried forward in to 2023/24.
- Hospital discharge costs were underfunded by £11.45m which was partly covered by £7m of additional local authority funding.

# 5. 2023/25 Planning

## 5.1 Governance

5.1.1 DCC and the ICB have reviewed the governance of the BCF to ensure visibility and accountability reflects the internal governance requirements of each organisation as well as wider system reporting.

5.1.2 Progress reports will continue to be provided to the Health and Wellbeing Board.

5.1.3 It is also proposed that a 'BCF masterclass' be provided to the Health and Wellbeing Board to provide more detailed insight into how the BCF makes a key contribution to the health and social care challenges faced in Devon.

## 5.2 Plan for 2023/25

5.2.1 The national planning requirements were published in April. covering two years 2023 to 2025.

The plans consist of:
- a narrative plan, using the framework provided by government
- a spreadsheet template (spending and metrics), as provided by government

5.2.3 DCC and NHS Devon ICB agreed the plans which were approved by the Chair of the Health and Wellbeing Board, to enable submission by the government deadline of 28 June 2023. The Board is therefore asked to endorse this approval.

5.2.4 Over the next two months the plans will be subject to regional and national moderation. NHS England will approve the BCF plans, in consultation with the Department of Health & Social Care and Department for Levelling Up, Housing & Communities by 8 September 2023.

5.2.5 Following confirmation of approval, DCC and NHS Devon ICB will then be permitted to finalise the s.75 (NHS Act 2006) agreement by 31 October 2023.

5.2.6 An executive summary of the plan for 2023 – 2025 is attached at appendix A

## 5.3 Metric Targets for 2023/24

**5.3.1 Avoidable Admissions**
Definition: Unplanned hospitalisation for chronic ambulatory care sensitive conditions rate per 100,000 population. Plan for 2023/24:

| Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|
| 149.6 | 145.1 | 154.4 | 153.0 |

Over one-third of emergency admissions are currently managed “same day”. All Trusts have developed their SDEC services this year. SDEC development is the first priority for the new Peninsula Acute Sustainability Programme, which is focusing on capacity and consistency in medical, surgical and paediatric assessment services.

A new 111/IUCS provider joined the Devon system on 27th September, Practice Plus Group. We have seen a significant improvement in call answering performance in 111 as a result and an increase in clinical assessment service (CAS) resources. Our priorities for next year are to grow the workforce across the service: better matching health advisor capacity to demand to improve call answering performance further and strengthening the clinical workforce out of hours to increase capacity and time to treatment. Additionally, we will be looking to embed digital development and dedicated end of life care out of hours.

Urgent Community 2-hour Response (UCR) services are in place across Devon, 08:00-20:00, 7 days a week. Referrals are increasing, with over 800 referrals in November 2022. Clinician to clinician referral pathways is in place for 111 and 999, C2% of referrals are from SWASFT. All services can respond to level 1 and level 2 falls and there are additional falls response services in south and west Devon. Next year will see consolidation of services and a further increase in referrals, with a focus on increasing numbers from 111/999 by streamlining the process.

A consistent approach to identification and management of frailty across the system was launched this year with a “Health Aging Handbook”, which utilises Population

Health Management approaches. Acute frailty services are in place across all acute hospitals, delivered through dedicated frailty teams and work is underway to enhance the SDEC offer here.

Increasing virtual ward capacity plays an important role in providing capacity equivalent to acute beds, avoiding overnight admissions. 95 virtual spaces are planned for April 2023, increasing to 227 beds by April 2024. Additional referral pathways are planned to make best use of these services.

### 5.3.1 Falls

Definition: Emergency hospital admissions due to falls in people aged 65 & over, directly standardised rate per 100,000 population.

This is a new BCF indicator for 2023/24.

| 2022/23 Actual | 2023/24 Plan |
|---|---|
| 1417<br>per 100,000 population | 1417<br>per 100,000 population |

As described above a consistent approach to identification and management of frailty across the system was launched this year with a “Healthy Aging Handbook”, which utilises Population Health Management approaches. Acute frailty services are in place across all acute hospitals, delivered through dedicated frailty teams and work is underway to enhance the SDEC offer here.

Increasing virtual ward capacity plays an important role in providing capacity equivalent to acute beds, avoiding overnight admissions. 95 virtual spaces are planned for April 2023, increasing to 227 beds by April 2024. Additional referral pathways are planned to make best use of these services.

### 5.3.2 Discharge to Usual Place of Residence

Definition: The percentage of people who are discharged from acute hospital to their normal place of residence.

| Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|
| 91.7% | 92.3% | 91.8% | 91.6% |

Investment in health and social care to support all discharges strengthened support for P1 discharges to facilitate a “home first” approach, which is complemented by voluntary sector support. “Live in care” options have enabled patients with higher levels of need to be discharged home too.

“Discharge hubs”, or lounges, are already in operation across all hospitals, enabling patients who no longer need an acute bed to move to a different part of the hospital whilst their discharge plans are finalised. These hubs work in tandem with improvements in ward processes to deliver earlier in the day discharge, and an

increase weekend rates too. All Trusts have identified the number of discharges needed per day to maintain flow.

Intermediate care bed capacity is in place across Devon and there is additional capacity planned across all localities to further reduce bed occupancy. Multi-disciplinary support including therapy has enhanced the offer

### 5.3.3 Residential Admissions

Definition: Long-term support needs of older people (65 & over) met by admission to residential & nursing care homes per 100,000 population.

| 2022/23 Actual | 2023/24 Plan |
|---|---|
| 516 | 520 |

We have seen significant impact of the Discharge to Assess pathway on our permanent admissions into residential and particularly nursing care settings. The placement trend remains upwards therefore the 2023-24 planned performance is to maintain performance at 2022-23 estimated levels.

A key plan under the Hospital Discharge Transformation Programme is to ensure there is sufficient capacity for long stay residential and nursing care home beds. There are plans in place to map current performance, utilisation, outcomes and to identify gaps. The system will ensure better value delivery mechanisms on a county-wide rather than locality level.

### 5.3.4 Reablement

Definition: The proportion of older people (65 & over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.

| 2022/23 Actual | 2023/24 Plan |
|---|---|
| 72.7% | 74.9% |

The Hospital Discharge Transformation Programme is already developing new models of hospital discharge. The programme will be using data and evidence-based best practice to drive greater integrated ways of working to have the greatest impact across all our service supporting hospital discharge and out-of-hospital care. The impact of the programme would be to see an increase in this descriptor within the current BCF cycle 2023-25. i.e., a greater proportion remaining in their home at 91 days following hospital discharge and will be considered as one of several indicators of the success and progress of the programme.

## 5.4 Finances

| Funding Source | 2023/24 | 2024/25 |
|---|---|---|
| | £'000 | £'000 |
| Disabled Facilities Grants | 8,245 | 8,245 |
| Minimum NHS Contribution | 68,241 | 72,104 |
| iBCF | 29,127 | 29,127 |
| Additional LA Contribution | 10,806 | 4,154 |
| Local Authority Discharge Fund | 4,084 | 6,779 |
| ICB Discharge Fund | 3,442 | 6,090 |
| **Total** | **123,945** | **126,499** |

NHS Commissioned out of hospital spend from the minimum ICB allocation:

| | 2023/24 | 2024/23 |
|---|---|---|
| | £'000 | £'000 |
| Minimum required spend | £19,906 | 21,033 |
| Planned spend | 40,760 | 43,865 |

Adult social care services spend from the minimum ICB allocations:

| | 2023/24 | 2024/25 |
|---|---|---|
| | £'000 | £'000 |
| Minimum required spend | 26,782 | 28,297 |
| Planned spend | 26,782 | 28,297 |

## 4) Options/Alternatives

None.

## 5) Consultations/Representations/Technical Data

None.

## 6) Strategic Plans

Plans for the BCF in Devon align with both DCC and ICB strategic intentions in respect of services to vulnerable adults.

## 7) Financial Considerations

The outturn for the BCF in 2022/23 is summarised in the report.
The financial plan for 2023/25 is also summarised in the report.

## 8) Legal Considerations

The lawful implications/consequences of the planned use of the BCF in Devon have been considered in the preparation of this report.

## 9) Environmental Impact Considerations (Including Climate Change)

There are no specific impacts on environment and environmental related issues. The majority of the BCF spend in Devon, has a socio-economic impact through the commissioning and provision of services to vulnerable people and employment of those providing those services.

## 10) Equality Considerations

The national planning requirements for the use of the BCF provide specific requirements for the delivery of the Public Sector Equality Duty. Regional and national moderation and approval of plans provides additional assurance regarding the consideration of equalities in the plans.

## 11) Risk Management Considerations

This report has been assessed and all necessary safeguards or action have been taken / included to safeguard the Council's position

## 12) Summary

The Health and Wellbeing Board has oversight of the BCF and is accountable for its delivery. This report describes the BCF outturn for 2022/23 and the plans for 2023/25 in accordance with national planning requirements.

Solveig Wright
Head of Integrated Adult Social Care Commissioning (Interim)

**Electoral Divisions**: All

## Local Government Act 1972: List of background papers

Background Paper: Nil
Date: Nil
File Reference: Nil

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## Appendix A: Executive summary of the narrative plan

Devon has a strong history of integrated working and can be proud of the many benefits that this brings to residents, our services and the ICS.

Several of our community services are now being provided by, or in partnership with, local acute trusts bringing many benefits to people, services, and the system. The establishment of the Integrated Care Partnership in Western Devon is an excellent example of our organisations working in more integrated ways towards common goals. Benefits from integration that we are now seeing include, improved collaboration between services, the opportunities for the standardisation of pathways across different sectors, and development of new ways of working for our collaborative workforce and importantly delivering better continuity of care for our local population.

In the coming months we will continue our journey of development as an ICS and within our Local Care Partnerships to harness the opportunities that these afford for further integration and partnership working, whilst embedding our overall Devon ICS Strategy and Forward Plan.

The BCF plan will support the One Devon Joint Forward Plan and the delivery of the 5-year (2022-27) One Devon Community First Strategic Framework and begin to address the inconsistencies in access and availability in our communities, as we learn from them and with them understand what matters and how best the BCF funding stream can meet their needs. A focus of the Community First Strategy is on preventative, proactive and personalised care to support people to live as independently as possible with greater connection to their local community ensuring people spend more time at home, wherever their home may be, rather than in a hospital bed. Community services supported by the BCF funding stream, play a pivotal role in keeping people well and managing acute, physical, and mental health and long-term illness.

A key system priority remains addressing the urgent care and system flow challenges frequently being experienced across the Devon ICS and the impact delayed discharge has on whole system flow, including for others timely access to services they may need. The success of delivering the Devon Urgent and Emergency Recovery Plans relies heavily on ensuring the integrated community services supported by the BCF remain responsive to the continued high demand and be able to enhance the support at times of greater pressure or demands across the care pathway. Transformation of these services, focusing initially on hospital discharge, will bring significant improvements to the experience of all those transitioning through our integrated health and social care services. The Hospital Discharge Transformation Programme Steering Group leads this, with Chair and Vice-Chair roles and membership from both DCC and ICB. The membership of this group will work in collaborative partnership at a locality and Devon County Council

footprint level and provide oversight and design of a new hospital discharge model in 2023.

The provision within our intermediate care services will look to the national Intermediate Care Framework delivery principles (awaiting national publication) to guide transformation, with a clear ambition in supporting individuals to remain independent for longer, recognising as these principles do, the need for local flexibility and innovation to account for local needs. This framework combined with high impact change model and the use of demand modelling using the improving patient flow between acute, community and social care (IPACS) tool, will ensure we establish clear pathways through the patient journey, from ward to exit from intermediate care pathways by, where necessary, the implementation of alternative best practice models of care.

The Devon BCF plan 2023/2025 responds to this with transformation of service provision explicably linked to best practice, available demand and capacity modelling. This reflects local needs and on-the-ground intelligence, that when combined support targeted long-term investments to build sustainable community services for individuals on discharge across all care pathways. The aim is to reduce pressure on urgent care through services that enable people to stay well, safe and independent at home for longer.

Our ambition is to ensure community services, including the voluntary sector, are recognised as being integral to our system response, with well thought out planning regarding the steps needed to achieve the vision, co-production of services with our system stakeholders and local communities, and in ensuring that they are funded to sustain delivery and outcomes in the longer term.

We will continue to build on our achievements to date and are now in a unique position to be able to understand and evaluate the different models of integration and to share learning about what works well in being able to meet the needs of the local population, by focussing on care outside of the hospital setting.

We also recognise the importance for us as a Devon ICS to be able to demonstrate the financial benefits of integrated working and how this model supports the flow of activity away from the hospital and crisis-management services, and supports funding out into the community, to create a more robust and resilient offer.

The work supported in the various BCF schemes will enhance both integration and partnership working and with it all the benefits that brings, whilst also building resilience for future on-going delivery of excellence across Devon.