DECISION-MAKER:	Health & Care Partnership Board
SUBJECT:	Better Care Fund 2023-2024 Quarterly Update
DATE OF DECISION:	25 January 2024
REPORT OF:	COUNCILLOR LORNA FIELKER LEADER OF THE COUNCIL

CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY		
N/a		
BRIEF SUMMARY		
The report provides an update on the Better Care Fund quarterly performance for 2023/2024.		
RECOMMENDATIONS:		
	(i)	For Southampton Health and Care Partnership Board to note the content of this report.
REASONS FOR REPORT RECOMMENDATIONS		
1.	The Southampton Health & Care Partnership Board (SHCPB) is responsible for oversight of the Better Care pooled fund. This responsibility has been delegated to SHCPB from the Health and Wellbeing Board (HWBB).	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2	N/a	
DETAIL (Including consultation carried out)		
3	**Background** The Better Care Fund (BCF) programme supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers. NHS England, for the first time, has set a requirement for the Better Care Fund, to be a two year plan covering April 2023 to end of March 2025, to	

	further support and encourage integration by requiring integrated care systems and local authorities to enter into pooled budget arrangements and agree an integrated spending plan. **BCF local reporting and oversight** The BCF Finance and Performance Group provide the oversight of the Better Care Fund S75 agreements and assurance to the Boards that the funding and performance are being - • appropriately and effectively managed • Southampton is compliant with the national conditions • Issues and risks are raised, and mitigations taken where appropriate and/or possible.
4	**Priorities for 23/25 BCF Plan** **First year of plan 2023/2024** Priority 1 **Delivering on Avoidable Admissions to enable people to stay well, safe, and independent at home for longer** Strong focus on prevention, admission avoidance through our Urgent Response Service, proactive care at home (reducing preventable admission to long term care), carers services and Enhanced Health in Care Homes (EHCH) arrangements. Priority 2 **Further developing the discharge model to promote right care in the right place at the right time** • Recovery and Assessment and Home First • Hospital Discharge process and out of hospital capacity • Recovery and assessment, promoting a home first approach • Focus on discharge capacity for those with the most complex needs Priority 3 **Supporting unpaid carers** Priority 4 **Effective utilisation of the Disability Facilities Grant** promoting independence and personalised care/strength-based approaches Priority 5 **Health and Health Inequalities** reducing health inequalities and disparities for local population, taking account of people with protected characteristics.
5	**2023/24 Quarterly Financial Performance** Since the previous report to the Health and Care Partnership Board on 19 October 2023, reporting to the end of Q2, month 6, there has been little change in the financial situation. The three areas, where there is a variation from plan remain as previously reported as follows:

	Variation from plan • **Changes in Learning Disability packages** causes fluctuations in overall budget. Due to the complexity of these individuals, a change in one person's care has a significant impact, positively or negatively, on the budget. In addition service provision which had increased due to uplifts have recently been agreed with providers and backdated to 1 April 2023. o ICB: Current forecast overspend of £526k o SCC: Current forecast for this service is £729k overspend A Learning Disability Transformation programme has been established to identify and progress commissioning and operational improvements in services for people with learning disability focussed on improving outcomes, quality, and value for money. This includes a specific focus on housing and accommodation, ensuring that people are supported in the least restrictive housing settings to meet their needs which has led to deregistration of residential provision and development of new supported living schemes. There is an increase in the use of TEC, and practitioners have been able to reconfigure support hours into Supported Living schemes to right-size care and support plans. The programmes also include developing a broader respite and meaningful opportunities offer through the Inclusive Lives project that is underway to procure a more strengths and community based, personalised support with greater focus on progression e.g. development of life and employment skills to increase independence and reducing the risk of social determinants. The Inclusive Lives tender is due to be issued in Spring 2024 for service provision to commence Autumn 2024. There is strong focus to reduce or delay onset of need, and this includes working in partnership with the VCSE sector and wider health partners to support a reduction in health inequalities experienced by people with learning disabilities and their carers, for example by increasing uptake of the learning disabilities annual health checks and cancer screening. Planning for those with complex needs and to bring forward potential joint opportunities with wider system is part of the overall transformation. This has included to date, development of a Trauma informed Care (TiC) Concordat, and Least Restrictive Practice/TiC Forum and the implementation of a Crisis Space where a person is at risk of breakdown. • **Joint Equipment (JES).** Across each of the prescribing organisations, numbers of orders have increased through to October compared to last year along with repair costs increasing. Further work is underway to better understand where these increases are, whether they will persist for the remainder of 2023/24 and what mitigations can be put in place. Early findings would suggest that there has been an increase in complexity – potentially driven by the "home first" focus for hospital discharge – and increases related to implementation of single handed care which reduces reliance on double handed packages and therefore the costs of packages of care. o ICB: Current forecast overspend of £227k o SCC: Current forecast overspend of £230k

- **Disability Facility Grant (DFG).** The DFG is forecasting an underspend of £3,247k and steps have been put into place to expedite client backlog.

  At the time of writing, Month 9 (Apr – December) finance data for both ICB and City Council spend is unavailable but will be available week commencing 22 January for inclusion in the final Q3 BCF report submitted to NHSE.

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Quarter and Monthly Metrics position

Red indicates not on target

Green indicates meeting target

BCF National Metrics	Q1		Q2		Q3 estimated (M7 data)	
	Planned	Actual	Planned	Actual	Planned	Actual
Avoidable Admissions Unplanned hospitalisation for chronic ambulatory care sensitive condition rate of admissions per 100,000 population	218.41	272.00*	200.45	225.40	249.19	213.00
Falls Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000	752.64	743.60*	752.64	762.70*	752.64	Data not available to report at this time
Discharge to normal place of residence Percentage of people who are discharged from acute hospital to their normal place of residence	95.00%	95.31%	95.00%	94.72%	95.00%	95.45%
Residential Admission Rate of permanent admissions to residential care per 100,000 population (65+)	140.47	202.28	140.47	179.81	140.47	196.66**
Reablement Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	75.00%	***		***		***

NB: Timings of the available National Data.
Owing to national data reporting timescales, only month 7 (April – October data) is available for all indicators. Month 9 (April – December) data is expected the third week in February, therefore for comparison purposes the M7 (October) data has been used to estimate a Q3 position in the table. However, it should be noted that as this is only 1 month's data, there is a strong likelihood that the final position for Q3 will change.
The data is approximately available 6-7 weeks after the end of the reporting month and then is updated each month thereafter, continually validating coding and delayed entries.

*****This is an increase as previously reported – the SUS figures do change for previous months, most likely the increase is due to the delay in some records not initially containing relevant diagnosis codes which have then been updated.

** A deep dive is currently taking place to understand the data which is being collected for this metric and its accuracy.

	***Data currently manually collected between Oct- Dec, reporting provided Jan-Mar 24 in line with national reporting timeframes). Systems underway to see if this data can be reported digitally locally to enable more frequent reporting. **Metric Narrative** <u>Admission Avoidance</u> Our plans to reduce the rate of avoidable hospital admissions by 5% compared to last year have been impacted by financial and recruitment challenges in some of our key schemes, in particular impacting our ability to expand virtual ward roll out and urgent community response. We have also needed to pause the roll out of Population Health Management (PHM) owing to lack of data analyst resource. This, coupled with increased demand this year compared to last, has meant we have not achieved our 23/24 planned position. The following developments are in progress to improve performance on this metric: • development of Proactive Case Management. • URS working with South Central Ambulance Service (SCAS) to receive referrals directly from the SCAS Urgent Care Desk enabling URS to respond quickly to assess patients within 2 hours thereby preventing an admission. <u>Falls</u> Plans to improve performance are aligned with the Admission Avoidance work but specific work in relation to falls includes: • Continued Focus on Falls through the Falls Link Meeting that brings together a range of professionals from across the City. • Audit programme in place looking at a range of falls related issues e.g. medication, follow ups etc. • URS and Community Independence Service (CIS) also undertake the Comprehensive Falls Assessments (RAG rated) which can then be undertaken rapidly through internal referral when URS picks up a falls referral from SCAS (as mentioned above) • The Saints Foundation who provide Falls Recovery Classes increasing the workforce expertise in relation to Falls. • CIS have started to roll out vestibular work (balance exercises) as there is evidence that there is an increase in the incidences of vertigo in older patients <u>Discharge to normal place of residence</u> We have based our ambition on consistently achieving 95% throughout 23/24 based on the national expectations. We continue to strengthen our focus on home first through: • Increasing community health and social care presence on the hospital site to be part of early discharge discussions with staff and families, promoting the home first messages and culture. • Strengthening our reablement offer to support more people to regain/improve their independence. • Increased partnership working with the VCSE through our VCSE hospital discharge navigation pilot which went live in November to connect

	people with the support available in their own communities to keep them well and prevent social isolation. <u>Residential Admissions</u> Southampton has seen a steady improvement in performance over the last 4 years however, particularly given the increased complexity across the system and the capacity within our teams to ensure timely assessment and reviews, sustaining this area of work is challenging. We will be looking to further improve on this metric through: • Continued focus on strengths based practice across the system, promoting the home first message • Expanding our reablement offer to focus on community referrals as well as hospital discharge • Strengthening reablement through increasing therapy oversight to assessment and review of process to ensure goals are realistic and met • A stronger focus on Home First for hospital discharge • Greater use of technology and equipment to support people in their own homes, ensuring that this is central to the assessment process <u>Reablement</u> Data for this metric has historically been reported annually in line with the Adult Social Care Outcomes Framework (ASCOF) reporting requirements, however work is underway to find a way of reporting the metric more frequently locally. This includes development of a local dashboard which shows performance against a range of measures. In particular this records the percentage of clients who completed reablement each month who were either independent or still needed ongoing care, the aim being to help more people to become independent. In November (latest reported figures), 67% were reported to have been independent at the end of their reablement care This is lower than the average for the year to date (70%) but should rise for the remaining months of the year as strengthened criteria are introduced into the service which more clearly identify realistic reablement goals and therapy oversight is brought into the service.
7	**Disability Facility Grant (DFG)** Following on from the October 23 report, the following actions have happened: • Housing Assistance Policy in place enabling a more flexible approach to delivering home adaptions • A new manager has been appointed. Will begin towards the end of February 2024, 12 months fixed term, full time. • Four new case workers have started. • Reviewing team structure to understand efficiencies and working practice • A new process is being developed regarding DFG funding bids for the purposes of audit. However, the plan has stalled due to a manager not being in post and a delay until a new manager starts. The backlog has increased and is now at 280 which is mainly due to two things:

- Occupational Therapists have increased throughflow of referrals (with more being classed as priority),but
- the DFG team structure is currently not delivering efficiencies, due to imbalance. Whilst 4 caseworkers were recruited, we failed to attract and recruit 2 Senior Technical officers which means that despite being able to take some of the burden, the team still needs more technical staff to get through the caseload.

The plan is being developed to address this within the financial year, subject to necessary approvals.

RESOURCE IMPLICATIONS

Capital/Revenue

The overall pooled fund for 2023/2024 is £168,322,000, split as follows:

BCF Funding 2023/4	**Planned £'000**
ICB	£99,381
SCC (including the iBCF allocation)	£57,727
BCF Discharge Fund (ASCDF)	£3,130
Disabled Facility Grant (DFG) inc c/f from previous years	£8,084
Total	**£168,322**

Property/Other

N/a

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

N/a

Other Legal Implications:

N/a

RISK MANAGEMENT IMPLICATIONS

There is a risk of overspend against a small number of schemes within the pooled fund as explained in section 5, quarterly performance. Each scheme is under close scrutiny and where possible the overspend is mitigated but will be notified when mitigation is at risk.

POLICY FRAMEWORK IMPLICATIONS

The BCF planning and narrative plan for 2023-24 were submitted on 28 June 2023 and approved by NHS England.

The Better Care Finance and Performance Group provides assurance to Southampton Health and Care Partnership Board on the delivery of the Better

	Care Fund against the plan. Areas of concern are escalated as appropriate and in line with the governance and assurance process.

KEY DECISION?	**No**	
WARDS/COMMUNITIES AFFECTED:		All
SUPPORTING DOCUMENTATION		
Appendices		
1.	N/a	

Documents In Members' Rooms

1.	N/a
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	**No**
Data Protection Impact Assessment	
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out.	**No**