BCP Health and Wellbeing Board

Report subject	**Better Care Fund and Home First Programme Update**
Meeting date	14 October 2021
Status	Public Report
Executive summary	This report considers budget issues, for extending existing BCF Section 75 agreements to include the impact of COVID 19 pooled expenditure. The Dorset Integrated Care System has been providing an enhanced supply of out of hospital care and support services, commissioned via BCP and Dorset Council on behalf of the system. This service is to be extended to the end of March 2022. The enhanced supply of out of hospital care and support services can be approved by delegated authority as outlined in the recommendations. (Please note agenda item 9 – Hospital Discharge Programme Funding) This report provides an update on progress and performance of the Better Care Fund (BCF) Plan and Home First Programme for 2020/21 including information against each scheme. A national programme of work has taken place led by NHS England considering changes to the BCF from 2021 onwards. This report takes account of the new requirements. This content of this report in line with the BCF changed requirements recently provided (August 2021) and we will continue to monitor changes and adhere to these as we progress.
Recommendations	**The Health and Wellbeing Board is asked to note:** 1. the performance against the 2021/22 BCF plan 2. the revised BCF Guidance for 2022/23 – has additional focus on the Hospital Discharge Arrangement. 3. the progress made on the Home First Programme supported by Impower.
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Wards	All
Classification	For Decision

1. Introduction

1.1. The report considers how the budget is being managed. This includes the arrangements for extending existing Better Care Fund (BCF) section 75 agreements to include the impact of COVID 19 spending. The Dorset Integrated Care System has designed an enhanced supply of out of hospital care and support services that will be commissioned via BCP and Dorset Councils on behalf of the system. This is presented in a separate paper (Agenda item 9 – Hospital Discharge Programme Funding).

1.2. The report provides an update on the Health and Wellbeing areas performance against the national framework for 2021/2022. The new BCF Policy Framework was recently published in August 2021. Although there are minor changes, there is more emphasis on Condition 4 – Improving Outcomes for People being discharged from hospital.

1.3. The report includes an update of the enhanced hospital discharge arrangements across the system. This strategic programme is the Home First Plan supported by Impower.

2. Background and Better Care Fund 2020/21

2.1. Since 2013, the BCF has been a programme spanning both the NHS and local government which seeks to integrate health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible.

2.2. The majority of pooled resources for the BCF came from existing expenditure within the health and social care system, such as the Disabled Facilities Grants (used for aids and adaptations) and financial contributions from Local Authority or Clinical Commissioning Group (CCG) budgets. Additional short-term grants from central government have been paid directly to local authorities such as the Winter Pressures Grant and Improved Better Care Fund. These are used for meeting adult social care needs, reducing pressures (including seasonal) on the NHS, and ensuring that the social care provider market is supported. In addition, the BCF is funded by a CCG contribution, which is a national condition for meeting the national assurance process.

3. Extending existing Better Care Fund section 75 agreements to include the impact of COVID 19 spending arrangements

3.1 The Government has allocated £1.3 billion to the NHS, via CCGs (Clinical Commissioning Groups), to be used to enhance the discharge process and fund the cost of new or extended out of hospital health and social care packages as part of the Covid 19 response. The funding will cover the follow-on care costs for adults who receive social care support, or people who need additional support, when they are out of hospital and back in their homes or care settings and extra costs incurred in preventing people having to go into, or return from, hospital.

3.2 The national hospital discharge guidance issued by NHS England during the Covid 19 period came into force on 19th March 2020 resulting in health and care systems and providers having to change their discharging arrangements and the provision of community support during the period. The new national approach is a Discharge 2 Assess model, which is based on assessment happening in the community with Hospital Therapists and Social Workers following people out of hospital and completing their assessment at home or in a care setting.

3.3 The national hospital discharge guidance outlines that additional financial support provided to CCG's and local councils should be pooled locally using existing statutory mechanisms (namely Section 75 agreements). The guidance says that existing Section 75 agreements can be extended to include these services and functions and the council should commission the health and social care activity on behalf of the system. The activities covered will be in line with the national discharge requirements. For the Dorset Integrated Care System, the activities for BCP Council covered in the Section 75 agreement will be in line with Dorset Council apart from the additional budget for the contract with the Community Equipment Service, which will sit with BCP as the lead commissioner.

3.4 Currently the arrangements for managing the Section 75 agreement extensions are being discussed between BCP Council, Dorset Council and Dorset CCG. There will need to be underpinning arrangements in place for separately identifying spend within the agreement and monitoring of this to ensure funding flows are correct. NHSE&I will reimburse CCGs through a monthly allocation process. The BCF and its Section 75 agreement are formally governed through the Health and Well-Being Board. To make decisions in relation to the extension of the Section 75 agreement in a timely manner, the Board is recommended to delegate to the Chair and Vice Chair of the Health and Well-Being Board the authority to approve additions to the Section 75 agreement on behalf of the Board on recommendation from senior officers.

4. Approach to integrated Services at Health and Wellbeing level

4.1. Dorset CCG and BCP Council working in conjunction with local NHS providers and the wider care market continue to invest all BCF allocation under the five operational schemes detailed below:

4.1.1 Maintaining Independence via Equipment

1. The Pan-Dorset Integrated Community Equipment Service ensures 70%+ of standard equipment was delivered within three days and 84%+ within seven days of being requested.

2. Service capacity and resources, since March 2020, has been focused on discharge and admission avoidance activities which has impacted on the timely delivery of NHS and Local Authority Business as usual demand. The service has coped well to date, but this has been in the context of significant disruption to non-covid related work. 2020-2021 saw fewer people (847) receiving more complex equipment packages. This points to service users with complex needs being discharged into the community with equipment levels emulating what is available in a hospital environment. As society continues to move into the Covid 19 recovery phase, significant additional pressures will be generated from backlogs of business-as-usual cases which will make the equipment service highly vulnerable to failure.

3. Home First has generated an increased focus on the delivery of core electrical mechanical equipment. This has seen an increase in the supply of profiling beds, riser recliner chairs, moving and handling equipment and pressure care mattresses and cushions. The increase reliance on urgent deliveries means stock need outstrips the supply that can be collected from the community in the timescales being dictated. This has made the purchase of new stock essential for maintaining stock levels but in the context of National and International supply shortages and interrupted logistics. Discharges are being facilitated in the expectation that key equipment will always be available despite the risks associated with a strained supply system still impacted by the Pandemic and import difficulties. Equipment has become *the* solution of preference with little consideration of contingencies should supplies be interrupted.

   Note: paragraphs 2 and 3 above from Equip for Living Budget Recovery Plan 2021-2022

4.1.2 Maintaining Independence via My Life My Care

1. The online information and advice service My Life My Care has worked hard to engage with GP (General Practitioner) Surgeries, Pharmacies, and small businesses to promote the website, with positive feedback from the public. The Covid19 information pages include food and meal delivery services, pharmacy prescription services, carers support, FAQs (Frequently Asked Questions), volunteering and befriending and general advice such as exercising at home and how to care for your wellbeing and mental health.

4.1.3 Early supported discharge

1. This scheme responds to the national 8 high impact changes that make a difference to discharge planning. This includes working with acute hospitals in planning for safe discharge into community settings.

2. Dorset CCG have been working with the national team the “Emergency Care Intensive Support Team” (ECIST) to review the system pathways into and out of hospital and use the recommendations to implement improvements during 2020/21 and 2021/22. Dorset CCG has been actively monitoring Long Length of Stay performance via the contracting route, with the Head of Urgent and Emergency care now attending all acute contracting meetings.

3. The nationally mandated discharge requirements during the Covid 19 period have brought radical changes to hospital discharge arrangements which has generated local and national interest to understand the learning from a Discharge 2 Assess model and how this could influence future models of care post-pandemic.

4. A short-term contract providing rapid response, discharge from hospital domiciliary care capacity is in place to ease pressures. Daily system leader calls are in place when the hospital reaches Opel 3 and 4 levels to facilitate flow within the hospital.

4.1.4 Carers

1. A comprehensive review of the support available to unpaid carers, including young carers, is being planned. Learning from the experiences of carers before and during the Covid-19 pandemic will be an integral feature of this review.

2. The Pan-Dorset Steering Group has been undergoing a refresh looking at updating the terms of reference, membership, and governance of the group.

3. Local measures[1] identified that over 2300 carers had accessed services and information and advice up to August 2021.

Note: [1] From Corporate Scorecard 2021/22

4.1.5 Moving on from Hospital Living

1. This pooled budget funds integrated personalised care for people with complex needs who have moved on from long stay hospital accommodation. From 1 April 2019, this has been a pooled budget between BCP Council and Dorset Clinical Commissioning Group.

4.1.6 Integrated Health and Social Care Locality Teams

1. These are multi-disciplinary teams made up of GPs and GP Practice staff; physical and mental health team; adult social care staff and the voluntary sector to support people who have long-term conditions; are frail and those with complex needs. Work is also underway to more clearly define our rapid response offer provided in the community as well as deliver in-reach into ED (Emergency Department) departments with a view to implement changes from 2020/2021.

2. This all links to roll out of work across wider Dorset, which was established as part of the Clinical Services Review, about growing capacity in primary and community services to reduce the reliance on hospital interventions and reducing non-elective admissions. This is work taking place across the county and is about growing capacity and making best

use of what we already have within the Primary Care Networks, not just GPs, but extends to community services and social care workforce. This is to ensure we engage with people earlier in community settings and have appropriate rapid interventions and response services in place.

Scheme Description	CCG contribution	BCP contribution	Total
	£000	£000	**£000**
Maintaining Independence	8,094	13,565	**21,659**
Early Supported Hospital Discharge	5,755	2,997	**8,752**
Carers	1,168	0	**1,168**
Moving on From Hospital Living	7,265	2,182	**9,447**
Integrated Health & Social Care Locality Teams	19,105	0	**19,105**
Total	**41,387**	**18,744**	**60,131**

5. Strong and Sustainable Care Markets

5.1. A key strategic theme within the Better Care Fund Plan is to enable further integration by developing and maintaining strong and sustainable care markets. Key elements of this work are:

1. Remodelling Coastal Lodge care home to offer an enhanced intermediate care bedded unit for the ICS.

2. The joint Homecare Framework for BCP and Dorset CCG continues to provide an integrated approach to maintaining people in their homes.

3. The Brokerage Service has established a new Care Allocation Team to directly support the hospitals with speedy discharge and flow.

4. The reshaping of the existing reablement services, strengthening an integrated reablement offer to facilitate with discharges and enhance the outcomes for the individual.

5. Provider relationship management and meaningful partnership working between the market and LAs. Dedicated provider engagement incorporates forums, workshops, focus groups and information sharing.

6. A strong focus on improving and supporting providers to deliver quality services. The Team has implemented a programme of actively, monitoring both care homes and domiciliary agencies, to ensure quality is delivered with the Council’s contracted providers. This information is shared through the ICS Care Quality Monitoring and Intelligence Group and Quality Surveillance Group.

7. The recently published BCP Council Extra Care Strategy, which was subject to Provider consultation, the next steps will be a co-produced implementation plan.

8. The recently published Home Care Strategy, which was subject to Provider consultation, the next steps will be a co-produced implementation plan

6. Summary of financial implications

6.1 The non-recurrent nature of funding solutions in 2021/22 and the challenges to the sustainability of funding for both the CCG and LAs (local authorities) means that managing the BCF budget creates risks for both Dorset Clinical Commissioning Group and BCP Council. The table below summarises the sources of funding and area of spend.

Sources of funding	Area of spend		Total
	Social Care £000	Community Health £000	
BCP contributions			
- Disabled Facilities Grant	3,518		**3,518**
- iBCF	13,044		**13,044**
- Additional LA (Local Authority) contribution	2,182		**2,182**
CCG contributions	12,107	29,280	**41,387**
	30,851	**29,280**	**60,131**

6.2 During the period April – August 2021 there has been budget pressure experienced by the Dorset wide (CCG, BCP Council and Dorset Council) Integrated Community Equipment Service of £565,000. For this first part of the financial year the overspend has been attributed to demand from hospital discharges and has been covered using the Hospital Discharge funding. The Government has announced that the Hospital Discharge funding will continue until March 2022, however we have not yet received the conditions of the next period of funding, therefore we cannot be certain at this stage that any future demand above budget can be covered with the Hospital Discharge funding.

6.3 In respect of Moving on from Hospital Living, Partners agreed to split this arrangement into two separate pooled budgets in 2019/20 - East (CCG/BCP) and West (CCG/DC). The outturn projection for 2021/22 is currently showing £135,000 pressure. Discussions are ongoing between partners to finalise the longer-term arrangements of the pooled budgets.

6.4 The Winter Pressure Grant and the improved Better Care Fund were combined in 2020/21 and are not ring fenced for winter pressure spending. The improved Better Care Fund allocation for 2021/22 has remained at the same level as 2020/21.

7. The Home First Programme

7.1 About the Home First Programme

The Dorset Home First Programme was established in response to the national mandate to implement a full 'discharge to assess' model in each local system; and supported by national hospital discharge funding.

Considerable progress has been made since March 2020 with partners working together at pace to put in place the processes and infrastructure necessary to support more people to be discharged safely to their own home; and to reduce avoidable delays in discharge pathways that negatively impacts outcomes and flow.

Following a period of review and evaluation (supported by Professor John Bolton), the next phase of the programme is focused on embedding the changes made to date and to establish a sustainable long-term model for intermediate care that will meet the evolving needs of the Dorset population. A strategic partner has been appointed to support and enable this work.

7.2 Programme Focus

- **Implementation of national D2A requirements**
    - Criteria to Reside
    - Twice daily board rounds
    - Single point of access
    - MDT Assessment out of hospital
    - Case management approach
    - Joined up intermediate care

- **Understanding system data**
    - Demand by pathway
    - Capacity across health and social care
    - Flow in and out of hospital
    - Outcomes – long-term care needs

- **Development of future model and commissioning**
    - Sufficient capacity commissioned to meet demand for each pathway
    - Outcome based services focussed on rehab/reablement principles
    - Improved processes - reduced hand offs, duplication, and fewer delays
    - Collaborative delivery model across all partners

7.3 Progress in the Last Quarter

- System Flow Director now in post to provide senior programme leadership. Focus on three area: Short-term actions to improve flow (linking into Integrated Resilience Unit); Capacity and flow for winter delivery (linking into UEC Board) and long-term model development and refreshed programme governance (in conjunction with IMPOWER).

- IMPOWER appointed as strategic partner and have commenced diagnostic phase to support long-term model as well as supporting system in identifying high impact interventions to address immediate system flow issues. Priority interventions agreed by Design and Delivery Group and will be signed-off by Home First Board on Sept 20.

- Home First Winter proposal drafted with focus in 3 areas: Extension of short-term/rapid response capacity to support P1 (Priority 1) discharges; increasing capacity in End-of-Life Care and scope to open additional interim beds to support discharge and flow over winter months. This is being presented to CCG governing body on Sept 14 for agreement to deploy HDP4 and Section 256 funding to support these proposals

- Acknowledged that unlocking constraints in therapy workforce is key to improving system flow. Work underway to map therapy resource across all partners with a view to targeting earlier input post-discharge to optimise care needs and recovery potential. Current focus on looking at tasks that could be undertaken by non-registered workforce (supported by ICS (Integrated Care System) workforce cell) and scoping how multi-disciplinary resources in cluster teams can better support 48h therapy review. Pilot work underway in Bournemouth and Poole clusters and due to commence with Weymouth and West cluster from October.

- Review of Home First dashboard and metrics in train. Refreshed set of requirements identified and now being worked with a view to using data to drive better understanding of system flow, drive operational improvements and enable patient-level tracking across partners. IMPOWER are supporting this work.

- Progress made in demand and capacity work linked to development of Urgent Community Response (part of Ageing Well agenda but linked into Home First). Using population health management data to understand needs at cluster level and how service model can support this going forward.

7.4 Performance in the Last Quarter

- System flow continues to be challenging with numbers waiting in both acute and community hospitals increasing in line with wider system pressures

- Average of 264 people waiting for discharge on P1-P3 at any one time. Over half of these are people in UHD beds and the majority are waiting for P1 discharge (discharge to home with care support). 19% of delays are people in COHO beds.

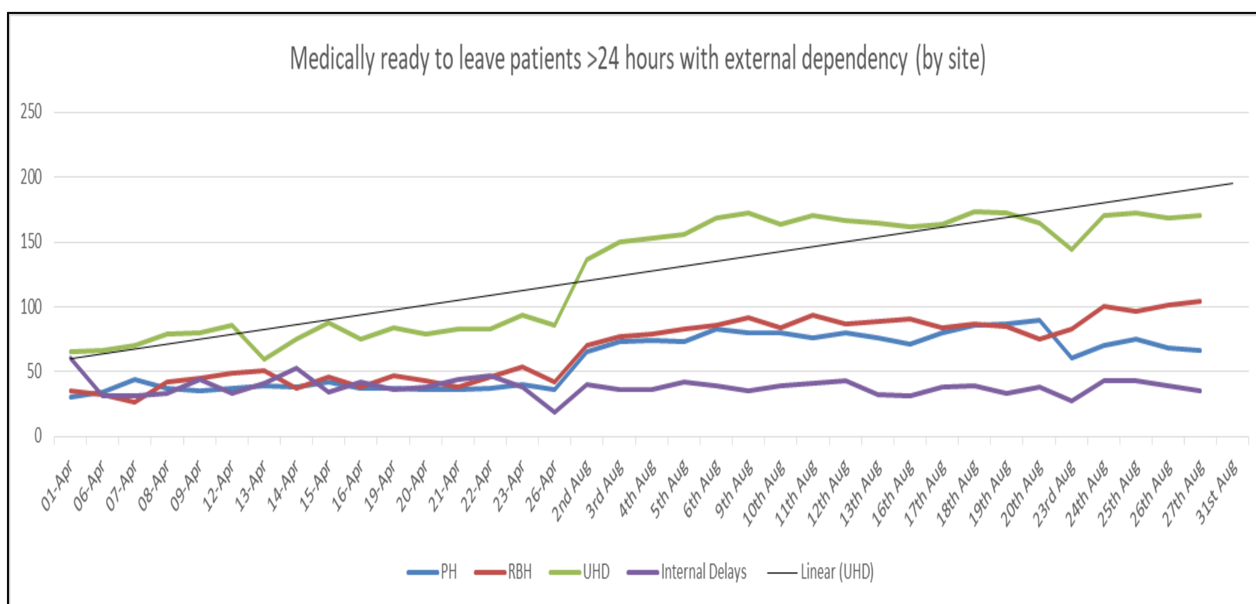
- There are increasing waits for home care support and growing numbers of people waiting for large packages of care. Existing provision is saturated and there are significant backlogs of people waiting for care in the community as well as supporting hospital discharge. There are similar backlogs in community therapy.

- There is capacity in care homes but limited staffing to provide nursing and wraparound care (risk that people get stuck).

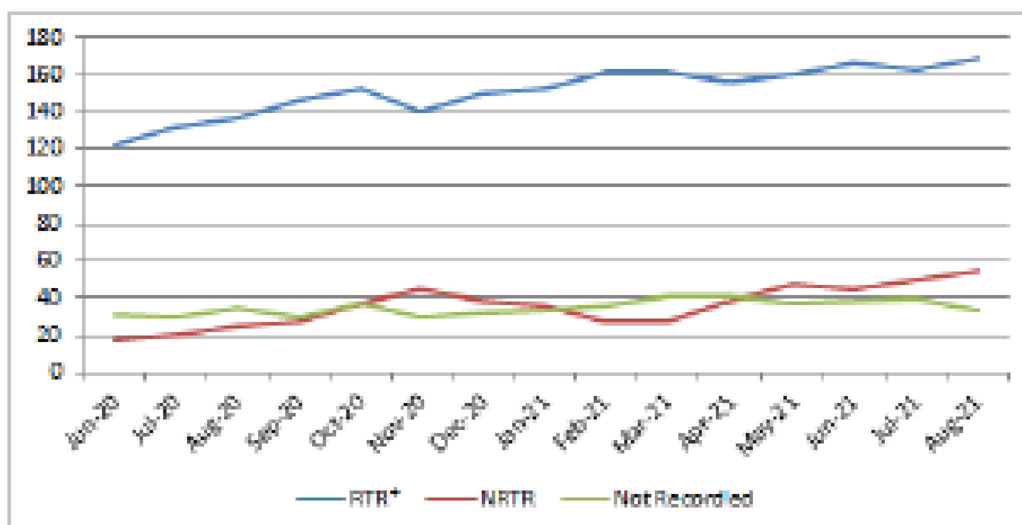
- All of this is contributing to a lack of flow in the system and increasing delays in hospitals. Partners continue to explore solutions to both expedite processes and increase capacity and throughput but few quick fixes available.

- Expectation that Home First winter plan will help but requires process improvement alongside to reduce handoffs and delays

7.4.1 University Hospitals Dorset (UHD)



7.4.2 Dorset County Hospitals (DCH)



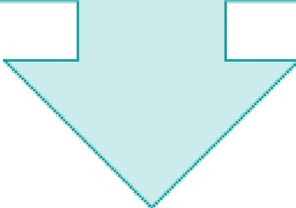
7.4.3 Discharge Statistics and Numbers Waiting

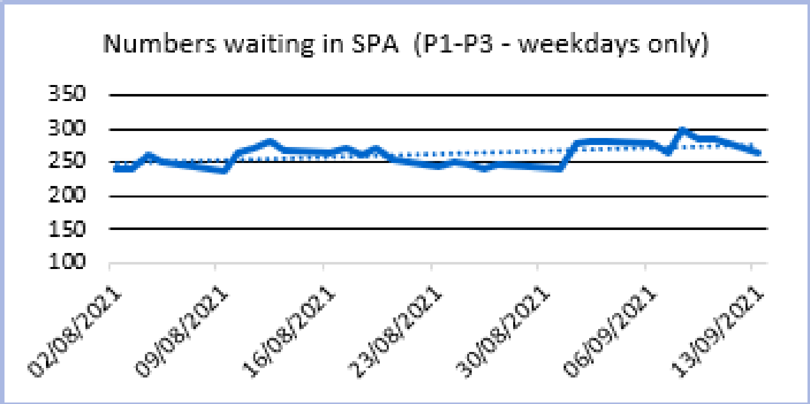
- 55% referrals are UHD
- 18% referrals are DCH
- 19% referrals are COHO

- 46% BCP residents
- 53% Dorset residents

- 56% waiting on Pathway 1
- 37% waiting on Pathway 2
- 8% waiting on Pathway 3

- Ave time to discharge 7.3 days (all pathways)





7.4.4 Plan for next quarter

Progress priority interventions to address immediate challenges of increased demand, reduced flow, and resilience in existing services

- Further develop and Implement winter capacity plans to improve and maintain flow and resilience over Q3/Q4
- Refresh financial framework to support HDP4 and transition to long-term model
- Refresh programme governance and stocktake of position against national discharge guidance

Progress work with Impower to develop long-term model focusing on:

- Data/intelligence/gap analysis of need and linked to pathways
- Assessment and agreement of change/transformation required for existing services (in line with national operating model)
- Determination of future model for intermediate care
- Development and agreement of a financial strategy

8. Summary of equality implications

8.1 An overall Equalities Impact Assessment (EqIA) was completed when the 2017-19 BCF plan was agreed. The plan for 19-20 has minimal changes. An EqIA (Equality Impact Assessment) will be carried out during 2021/2022 as there are some changes to the policy of service delivery.