Report to HEALTH AND WELLBEING BOARD

TITLE: Better Care Fund Plan 2022-23 Year End Return

Portfolio Holder:
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Purpose of the Report

To provide the Health & Wellbeing Board with details of the Oldham Better Care Fund (BCF) Plan year end return for 2022-23 and to obtain sign off in line with the requirements of the national conditions of the BCF.

Requirement from the Health and Wellbeing Board

1. That the Health & Wellbeing Board considers the content of the Oldham BCF year end return and provide any suggested amendments.

2. Subject to any agreed amendments Health & Wellbeing Board agrees to sign off the year end return in line with the requirements of the national conditions of the BCF.

Title

1. Background

1.1 In line with the Better Care Fund policy framework and planning requirements, Oldham's BCF Plan for 2022-23 was signed off at Health and Wellbeing Board in November 2022. In late November 2022, following submission, government announced the Adult Social Care Discharge Fund, with a value to Oldham of £2,573,295. The use of this additional funding was approved at Health and Wellbeing Board on 24th January 2023. Use of the funding was required to be reported on a fortnightly basis from January to the end of March, and as a partial submission of the BCF year end return by 2nd May 2023, with the full return being submitted by 23rd May 2023.

1.2 In line with the national requirements the BCF year end return was submitted on 2nd May (for the Adult Social Care Discharge Fund element) and in full on 23rd May 2023. The process allows for submission of the plan prior to approval of the Health and Wellbeing Board.

2. Current Position

2.1 The BCF Plan includes four key metrics to be measured and reported on. The metrics, planned performance, achievements and supporting narrative are summarized in the table below:

Metric	Planned performance	Achievement	Comments
Avoidable admissions - Unplanned hospitalisation for chronic ambulatory care sensitive conditions	1,160	Local estimate is 1,113	Oldham are on track to achieve this due to the number of avoidable admissions services in place. The Urgent Care Hub (part of Oldham's Urgent Treatment Centre) managed over 70,000 patients with a 96% success rate of keeping them out of hospital. Community health and social care services have also significantly contributed to the achievement with existing and newly developed pathways for patients, including reablement, 2 hr rapid response service, and district nursing care. Extensive work across health and social care has taken place with care homes in order to better manage patients and enable them to stay in their own place of residence.
Discharge to normal place of residence (from acute setting)	92.3%	90.8% for 12 months to Feb-23	We have seen a decrease in patients returning to their normal place of residence due to two main factors. The emphasis on Discharge to Assess has meant that patients are discharged earlier to a D2A setting (often a care home or

			intermediate care setting) in order to best establish their needs without being in an acute hospital bed. These patients often do return to their usual place of residence, but the extra move within their journey has an impact on this metric. The other significant impact is the acuity of patients presenting and subsequently being discharged from hospital. Oldham are seeing an increased number of patients who are sicker or more advanced in their disease than in previous years and so their final destination once treatment has taken place is often needed to be long term care and/or hospice care.
Residential admissions - Rate of permanent admissions to residential care per 100,000 population (65+)	681	590	Actual rate is better than planned, and this equates to 229 permanent admissions to residential care of people aged 65+
Reablement - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	93.3%	88% - of 108 people 13 didn't stay at home.	To meet target an additional 8 people would have needed to stay at home for 91 days. The acuity of people at the point of discharge is significant and this is having an impact on this measure.

2.2 The Adult Social Care Discharge Fund element of the Better Care Fund was utilized in accordance with the plan that was signed off by Health and Wellbeing Board in January 2023. Adult Social Care related hospital discharge activity was reported to the national Better Care Team on a fortnightly basis in line with grant requirements.

2.3 The majority of the funding was used to manage demand for adult social care services as a result of hospital discharge, and ensured appropriate care, equipment and technology was available to support on discharge. The funding supported the discharge of 417 people to bed based services, 5271 hours of home care and reablement and c500 people supported with equipment and technology from mid December until 31st March 2023.

2.4 The second largest proportion of funding was distributed to care at home, care home and reablement services who provide the majority of support at the point of discharge, to support them to put in place measures to address workforce challenges in the most effective ways for their individual circumstances. For care homes 84% was spent on a combination of agency staff, overtime, retention bonuses and bringing forward planned pay rises. For community based services, 93% was spent on a combination of incentive payments, local recruitment initiatives, retention bonuses and overtime.

2.5 An extract from the year end return is below, and sets out each scheme, the planned and actual expenditure.

Scheme Name	Scheme Type	Sub Types	Planned Expenditure	Actual Expenditure	Actual Number of Packages
Administration	Administration		£25,730	£25,730	
Bank holiday incentives	Improve retention of existing workforce	Incentive payments	£333,177	£129,000	
D2A demand	Residential Placements	Other	£380,000	£437,185	100
Demand management	Other		£780,711	£1,018,603	
Domiciliary care service retention	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	£20,000	£3,800	100
Hospital discharge premium	Residential Placements	Care home	£100,000	£25,300	253
Workforce incentives	Improve retention of existing workforce	Incentive payments	£934,270	£934,270	

2.6 The planned Better Care Fund for 22-23 prior to the inclusion of the Adult Social Care Discharge Fund was £35,119,107. The actual total was £34,952,229. The difference was as a result of the realignment of funding following the creation of Greater Manchester ICB and some elements of funding being managed centrally at a GM level, in common with other localities across Greater Manchester. This change did not impact on the delivery of services funded through the BCF.

2.7 The total Better Care Fund for 22-23, including the discharge fund element was £37,525,524.

2.8 The year end return requires the inclusion of two successes and two challenges, each aligned to one of the SCIE Logic Model Enablers. For 22-23 the successes and challenges reported were:

Success	**SCIE Logic Model Enabler**	**Response**
Joint working on the delivery of the integrated contract for residential and nursing homes.	Joint commissioning of health and social care	The focus of the work was to refresh the commissioning and contracting arrangements in place for residential and nursing homes supporting Oldham residents. Whilst predominantly the arrangements are for in-borough provision, they also cover out of area placements supporting Oldham residents. The work was made possible by partners coming together having clear principles, processes and clarity on roles and responsibilities for the lead organisations involved. The approach has provided clarity to internal staff and also external partners such as providers of care. This success could also meet additional 'SCIE Logic Model Enablers' such as: 2 "strong, system-wide governance and systems leadership"; 5. "integrated workforce"; 6. "joined-up regulatory approach"; and 8. "pooled or aligned resources".
Carers	Empowering users to have choice and control	"The carers team, which is jointly funded between the Council and ICB, through the BCF, have seen a significant increase in the identification of hidden carers and individuals who do not identify themselves as carers.

	through an asset based approach, shared decision making and co-production	Since 2021/2022, we have seen an increase in carers receiving some form of support including information, advice, support for the person they cared for, access to prevention services, use of AT/digital or a personal budget. The additional carers were identified through effective place-based outreach working across primary care, community and acute. 2022/23 saw a coproduction focus on the refresh of the Carers' Strategy in Oldham. Various focus group sessions were held encouraging participation from all stakeholders including carers and people with lived experience, staff and support workers to gather views on the practical ways support can be provided to unpaid carers of all ages. The sessions covered the following: reflection on previous strategy; carers' priorities; the strengths of the services; and key areas of improvement. Positive and improved outcomes were achieved for carers through the use of strength-based practices which have enabled continuation of the caring role. Examples include the use of assistive technologies including epilepsy pendants, to enable carers to take a break whilst knowing they will be alerted should the person they care for have a fit. The benefits of this approach minimised the risk of readmittance to acute settings. Another example is funding for a specialist chair to enable the carer to safely move the person they care for and remain in their home environment, rather than be at risk of falls and requiring more intensive care and support. These approaches have enabled both the carer and the person they care for to live independent lives with their wellbeing significantly improved whilst minimising more intensive and clinical interventions across the health and care system."
Challenge	**SCIE Logic Model Enabler**	**Response**
Care home market	Good quality and sustainable provider market that can meet demand	During 2022-23 the care home market has become increasingly fragile, this has in particular impacted upon the nursing market in Oldham and a number of providers have approached the council and ICB about de-registering nursing or changing the profile away from general needs nursing towards specialisms such as mental health. Given that the Oldham Market Position Statement articulates an increased need for nursing provision this presents a challenge to joint working both in terms of the number of beds available but also potential needs to move residents where provision changes. We are seeking to address this by reviewing our care home rates, and in particular nursing fee rates, which will have longer term implications for us from a funding perspective enabling us to meet the needs of the Oldham population.
Discharge to Assess	Other	The 'Discharge to Assess' process places additional pressures on an already stretched social care resource. This can result in reviews not taking place as quickly as the system would wish. It can also place pressures on community health services such as GPs and Therapy teams where people are placed in short term placements away from where they are normally registered. The Oldham health and social care system is currently exploring opportunities for block booking 'Discharge to Assess' beds in one or two locations which may streamline the review and therapy inputs but more resource/support is required in this area.

3. Key Issues for Health and Wellbeing Board to Discuss

3.1 For the Health and Wellbeing Board to consider the contents of the BCF Year end return for 2022-23 and make any suggested amendments.

3.2 To agree whether the HWB is prepared to sign off the return, in line with national conditions

4. Recommendation

4.1 It is recommended that the Health and Wellbeing Board agree to sign off the Better Care Fund Return for 2022-23.