Report to HEALTH AND WELLBEING BOARD

Better Care Fund 2023-25; End of Year 2024-25

Portfolio Holder:
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Purpose of the Report

In order to meet the national funding conditions of the Better Care Fund, this report seeks the Health and Wellbeing Board's approval on the submission of Oldham's:

- 2024-25 End of Year report

The Board should note, that in order to meet the deadlines set for the above, the template has been submitted.

It should be noted that the Board has already approved to delegate the decision to submit quarterly reports to the Better Care Fund team, with the understanding that the reports will be noted at the next available Health and Wellbeing Board meeting.

Requirement from Oldham's Health and Wellbeing Board

1. a) Note the content of the 2024-25 End of Year report, and
   b) Provide retrospective approval for its submission to the Regional Better Care Fund panel

1. Background

The Better Care Fund

1.1 The Better Care Fund's vision has been to support people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person. The BCF Policy Framework centres on these objectives and now sets separate National Condition for each:

- enable people to stay well, safe and independent at home for longer
- provide people with the right care, at the right place at the right time.

1.2 As well as supporting delivery of the *Next Steps to put People at the Heart of Care*, the BCF programme underpins key priorities in the NHS Long Term Plan by joining up services in the community and the government's plan for recovering urgent and emergency care (UEC) services.

1.3 Differing from previous years, the current BCF plan spanned two years for the period 2023-25, with the delivery of the BCF supporting two key priorities for the health and care system that align with the two existing BCF objectives of:

- improving overall quality of life for people, and reducing pressure on UEC, acute and social care services through investing in preventative services
- tackling delayed discharge and bringing about sustained improvements in discharge outcomes and wider system flow.

2024-25 End of Year Report

1.6 The Better Care Fund requires an End of Year report to be completed. For 2024-25 the deadline for this was 6th June 2025, with reports to be approved by the locality's Health and Wellbeing Board. The approval process allows for submission of the plan prior to approval of the Health and Wellbeing Board.

2. Current Position

2.1 The BCF continues to consist of three main funding contributions: NHS Greater Manchester Integrated Care Board (NHS GM ICB) contribution to the BCF; the Disabled Facilities Grant (DFG); and the Improved Better Care Fund (iBCF).

2.2 Due to increases being received for the Disabled Facilities Grant and Discharge Funding, the total value of the BCF in Oldham for 2023-25 period is £81,584,498. This is broken down as follows for 2023-25:

Funding Sources	**Income Year 1 (2023/24)**	**Income Year 2 (2024/25)**
DFG	£2,343,287	£2,555,942
Minimum NHS Contribution	£21,951,512	£23,193,968

iBCF	£11,187,623	£11,187,623
Additional LA Contribution	£0	£0
Additional ICB Contribution	£822,739	£462,916
Local Authority Discharge Funding	£1,568,487	£2,614,146
ICB Discharge Funding	£1,420,360	£2,275,895
Total	**£39,294,008**	**£42,290,490**

2.3 The use of the funding is dependent on meeting the following four national conditions:

National Condition 1: Plans to be jointly agreed
Plans must be agreed by the ICB and the local council chief executive prior to being signed off by the Health and Wellbeing Board.

National Condition 2: Enabling people to stay well, safe and independent at home for longer
Localities agree on how the services they commission will support people to remain independent for longer, and where possible support them to remining their own home.

National Condition 3: Provider the right care in the right place at the right time
Localities agree on how the services they commission will support people to receive the right care in the right place at the right time.

National Condition 4: NHS minimum contribution to adult social care and investment in NHS commissioned out of hospital services
The NHS minimum contributions for social care and NHS commissioned out of hospital spend for all HWB areas in 2024-25 has been uplifted by 5.66%. ICBs and Councils may agree a higher level of spend, where this will deliver value to the system and is affordable.

2.4 The BCF policy framework sets out the vision, funding, oversight and support arrangements and is focused on two overarching objectives:

- reform to support the shift from sickness to prevention
- reform to support people living independently and the shift from hospital to home.

2.5 Working collaboratively across health and social care, the funding is focused on schemes to support the above objectives, of ‘prevention’ and ‘living well at home’ and is utilised for Oldham residents to support the following initiatives and services:

- Residential enablement at Butler Green and Medlock Court
- Falls prevention
- A range of dementia services across the borough
- Community equipment and wheelchair provision
- Minor adaptations
- A range of Falls Services
- Alcohol liaison
- Carers’ support
- Dementia support services

- Stroke support services
- A range of services to support hospital discharge.

2.6 The End of Year (2024-25) reporting template requires data to be submitted on capacity and demand of the locality. For instance, how many units of a service are available compared to the number of individuals anticipated to require a service. The Oldham BCF team has found this to be a useful exercise in reviewing what services are available across the borough and to further understand the gaps in provision, therefore directing the funding to where is required to support people the most.

2.8 Work is taking place to review the section 75 agreement for it to be in place as soon as possible as per the national BCF deadline.

3. Case Studies on use of the Better Care Fund

3.1 Medlock Court – Bed Based Reablement

- The woman had carers at home prior to Hospital admission so the main goals were to improve transfers and mobility and some kitchen tasks to a safe level to return home to previous or reduced package. A care plan and therapy plan/goals were put in place on arrival, completing alongside the lady.
- Staff encouraged, reassured and motivated throughout her stay as the lady could become anxious at times. A holistic way of working was operated, looking at both physical and emotional needs. The lady's main goal was to be able to return home.
- Staff/therapy managed to progress the lady through her stay and reached her baseline and better for mobility and kitchen tasks. Transfers were being worked on against usual transfer heights at home. There was question of the lady needing a short stay due to struggling with transfers without the use of a hoist and therefore her safety was priority, but we wanted to ensure all avenues were explored as the lady's wish was to return home. MioCare utilised the Helpline service for the loan of a mobile hoist in order to carry out a home visit with the lady and the therapists (Helpline delivered and collected the piece of equipment afterwards), the result being the lady managed well in her own home environment without the use of a hoist. Further equipment was identified and ordered for discharge.

Outcomes

- As a result of her 3 week stay at Medlock she was discharged home with a restart of her existing care package, remained at one carer supporting and with the additional equipment in place was able to remain as independent as possible and stay at home. Therapy conducted a follow up visit on the day of discharge.
- Feedback later received was she was managing well at home and thanked the team in helping her meet her goal(s).

3.2 Community Reablement

- 96-year-old woman, who was returning to borough from staying with family following having a pacemaker fitted which had reduced mobility in her arms.

She had previously not been receiving care, but had returned from family without a plan in place due to a family conflict.

- Following an urgent referral via the ARCC Team, the Reablement Service arrived at the home within 10 minutes of the woman arriving home. The woman was shaken up and unable, able to manage on her own as she had no food in the house, which was cold and required cleaning.
- Staff assisted with getting food and settling the woman for the first night and made referrals in to Age UK Oldham for support with shopping and meals.
- Following the start of the support the staff could quickly see an improvement in mood and confidence. This meant she was able to work with the service on her mobility and regaining the confidence to take on her own task and regain her independence.

Outcomes

- Three weeks of reablement were provided after which point she was back in the community alone doing what she had previously enjoyed, which was walking and catching the bus to town.
- No other services were required long-term.

3.3 Urgent Care Response Team (UCR) – Hospital Avoidance

- 75-year-old woman with Guillain-Barre Syndrome who is quadriplegic, with a tracheostomy, night ventilation, PEG fed, with a long-term catheter. She lives at home with husband and has 24-hour double cover package of care.
- Had a fall from her wheelchair whilst out with carers, attended hospital and had her legs splintered due to fractures, discharged with district nurse support.
- A week later she returned to hospital due to low blood pressure and confusion. She was reviewed and sent home before blood tests were returned.
- The following day the GP referred her to UCR asking for monitoring over the weekend following the return of the blood test which indicated infection. The GP had prescribed anti-biotics for a possible chest infection on urinary tract infection.
- UCR visited the next 3 days and monitored condition. Patient felt well and declined to attend hospital. She was reviewed by the Out of Hours GP and Urgent Care Hub. Her carers monitored for deterioration and took hourly observations to ensure she did not deteriorate.

Outcome

- The patient was able to remain in her own home whilst receiving treatment, which was what she wanted and where she was most comfortable.

4. Key Issues for the Health and Wellbeing Board to Discuss

4.1 a) Note the content of the 2024-25 End of Year report, and
b) Provide retrospective approval for its submission to the Regional Better Care Fund panel

5. Recommendation

5.1 It is recommended that the Health and Wellbeing Board agree to sign off of the Better Care Fund End of Year Report 2024-25

5. Appendices

1. 2024-25 End of Year report

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