HEALTH AND WELLBEING BOARD
Date: 28th July 2022

Derby City Council

ITEM 09

Report sponsor: Andy Smith, Strategic Director of People Services
Report author: Kirsty McMillan, Director, Integration & Direct Services

Better Care Fund Update 2021/22 - end of year out-turn report

Purpose

1.1 To provide the Health and Wellbeing Board with an update on the out-turn position of the Derby Integration and Better Care Fund (BCF) through reporting of the required statutory return for 2021-22.

Recommendation

2.1 To receive and sign off the report and note the responses provided in the statutory return.

Reason

3.1 The Department of Health and Social Care's (DHSC) Better Care Support Team published the statutory national return template on 8 April 2022 with the requirement that submissions would be made by 27th May 2022, following sign-off from respective local Health and Wellbeing Boards (HWBs). Due to the meeting structures of the Health and Wellbeing Board, this report is being presented retrospectively. It should be noted that, as with previous returns, the national return template was however submitted on time and has since been assured by DHSC.

Supporting information

4.1 The Health and Wellbeing Board (HWB) received and approved a summary of the planned activities of the Integration Better Care Fund (BCF) plan for Derby for 21/22 in January 2022. Since then, there has been a requirement to complete a template reflecting the out-turn position on finance and metrics, and a summary of successes and challenges over the course of the financial year. Performance against the national metrics was submitted using the data available at the time the returns were published as year-end data was not fully available. A summary of the main performance measures is provided in 4.3. A more detailed summary of the overall template and submission is in **Appendix 1**

4.2 The submission included a summary of successes and challenges in 2021/22 which were reported as:

- Rolling out of the Electronic Shared Care record to Adult Social Care within the Council so that patient level data can be seen by social care, as well as health.

- Enabling the role of Local Area Coordination (which is a BCF funded service) to become pivotal in driving culture change within the wider health and social care system, by using an asset based approach. This was accelerated during the pandemic and has now become a major strand of the wider ICS transformation plans for community services.
- Challenges with workforce shortages reduced capacity across the board and prevented health and care from responding in a timely way to escalating needs. In addition, there was no robust mechanism to share and redeploy staff between organisations to assist with this outside of the vaccination programme and Covid response. This was particularly acute during the Omicron Covid 19 wave where significant numbers of staff were unavailable to work.
- Major capacity reductions in the home care market were experienced for the first time in 2021/22 in Derby causing waits for care following hospital admissions, but also for people living at home with unmet care needs. At times neither the NHS nor the Council were able to meet the demand for care adding considerable risk to individuals' independence, pressure on informal carers and also on the resilience of families to cope in a crisis.

4.3

Metric	Progress	Challenges and any Support Needs	Achievements
Avoidable admissions Measuring unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	On track to meet target	Recruitment and retention of staff to ensure adequate management of conditions to avoid admissions Covid recovery still impacting on routine out-of-hospital services increasing demand pressures compared to the available capacity	Improved performance on the Urgent 2 hour community response
Length of Stay in hospital Proportion of inpatients resident for: i) 14 days or more ii) 21 days or more	Not on track to meet target	Discharge pathways were not always able to meet demand for post hospital discharge support, especially over the winter 2021/22 Increased demand for acute care led to higher than planned occupancy in acute beds	Creating additional discharge pathways during winter Maintaining relatively low waiting lists for home care Multi partner meetings to manage issues Using data to measure capacity and target resources
Discharge to normal place of residence Percentage of people who are discharged from acute hospital to their normal place of residence	On track to meet target	Patients not always able to access ideal pathway and faced longer delays in getting home Specialist care for the most complex of cases, was limited and covid pressures on	A number of designated Covid beds were created, including Perth House which is BCF funded Mental Health Enablement workers supported discharge from our acute inpatient beds

		community/ homecare provisions has led to some people, especially post hospital, accessing residential care for a short period, rather than returning home with care	Voluntary sector and wider community services such as the Healthy Housing Hub assisted Telecare was maximised to support discharge using technologies to support people returning home
Res identical Care Admissions* Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target		We have continued to see less permanent admissions to care and nursing homes through the use of preventative services to support enablement and independence
Reablement Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	On track to meet target	Due to scarce reablement resources, only those with the most complex rehab needs have accessed the service Community pathways (such as falls, ongoing rehab) have not been fully embedded or staffed, leading to some repeat admissions	The vast majority of people accessing reablement remain at home after the reablement period We have utilised care technologies to ensure people are able to maintain their independence at home as well as referrals into community and voluntary services, as well as Local Area Coordination

Public/stakeholder engagement

5.1 Social Care, Voluntary Sector and NHS providers who are recipients of funding via the Integration and Better Care Fund are aware how their interventions support the wider health and social care system. Although they are not involved in the detailed planning process, there are a variety of partnership and performance meetings whereby Integration and Better Care funded initiatives are discussed and improvements agreed and developed. Several of these form part of the Joined Up Care Derbyshire planning meetings, primarily under the Place, Urgent Care and Mental Health work streams and will continue into the new Integrated Care System.

Other options

6.1 The Integration and Better Care Fund is a mandatory national requirement and all areas normally need to submit a plan to NHSE/I should they wish to make use of the funding flexibilities between Councils and CCGs. There is full expectation that the BCF funding and spending arrangements continue as the integration agenda between health and social care remains a key priority for the government and as set out in recent White Papers and legislation.

Financial and value for money issues

7.1 The funding for 2021/22 was subject to an existing pooled budget between Derby City Council and Derbyshire CCGs. Monitoring and reviewing performance against the plan enabled the Council and the CCG to benefit from the flexibilities of the funding to support pressures in the local health and social care agenda, and to further progress the integration agenda.

Legal implications

8.1 The Council and the Derbyshire CCGs must enter into a section 75 agreement as part of the Planning expectations, under section 75 of the NHS Act 2006. This agreement remains in place and covers the Integration and Better Care Fund. As a direct grant to the Council, the use of the IBCF and Winter Pressures must be reported to DCLG via the Council's statutory s151 Officer (Strategic Director of Resources). From July 2022, the new arrangements will be with the Integrated Care Board.

Climate implications

9.1 None

Other significant implications

10.1 The Integration and Better Care Fund supports the Council's and the CCG's overall budget as an income stream to allow delivery of key care services to support the overall health and care system in Derby. The loss of this fund would present a significant financial risk to the shared ambition and key performance measures designed to serve patients and citizens well.

This report has been approved by the following people:

Role	Name	Date of sign-off
Legal	n/a	
Finance	Janice Hadfield, Head of Finance	
Service Director(s)	Kirsty McMillan, Service Director – Integration & Direct Services	7th July 2022
Report sponsor	Andy Smith, Strategic Director of People Services	18th July 2022
Other(s)		

Appendix 1: Extract from Better Care Fund 2021-22 Year-end Template

4. Metrics

Selected Health and Wellbeing Board:	Derby

National data may like be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Challenges and Support Needs	Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans
Achievements	Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2021-22 planning	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	1,118.8	On track to meet target	Recruitment and retention of staff in both NHS community and LA care pathway settings, to ensure adequate management of conditions to avoid admissions. Covid presented difficulty in accessing routine out-of-hospital services and increasing demand (plus	Improved performance on urgent community response

							workforce gaps) is adding pressure on existing capacity.	
Length of Stay	Proportion of inpatients resident for: i) 14 days or more ii) 21 days or more	**14 days or more (Q3)**	**14 days or more (Q4)**	**21 days or more (Q3)**	**21 days or more (Q4)**	Not on track to meet target	Covid, care home outbreaks, staff isolation and general workforce gaps has impacted the ability of discharge pathways to meet demand for post hospital discharge support, especially over the winter 2021/22. Increased demand for acute care has led to higher than planned occupancy in acute beds.	Used the discharge fund to create additional step down beds to facilitate discharge over winter (though not rehab was available to enhance the support on offer). Homecare market pressure has overall been managed well and waiting lists for care have remained relatively low compared to other localities (but is still a challenge). Twice weekly resilience meetings focussing efforts on D2A capacity, home care capacity and care home issues and led to increased use & prioritisation of the scarce community and discharge capacity allowed. We maximised use of data and intelligence to also measure flow and capacity and target resources.
		6.7%	7.2%	3.3%	3.6%			

Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	96.0%	On track to meet target	Covid pressures as outlined above limited availability and appropriateness of beds. We were not always able to provide people with their ideal pathway i.e patients were moved to step down beds with no rehab support to ensure flow into and out of our acute hospital or admitted to care homes when they may have otherwise been sent home with an appropriate package of care. Specialist care for the most complex of cases, was limited.	Perth House (D2A P2a facility) was able to take people on designated Covid beds (and also maintain a non Covid wing) until such time as they were able to return to their usual place of residence. Mental Health Enablement workers supported discharge from our acute inpatient beds. Voluntary sector and wider community services such as the Healthy Housing Hub were routinely drawn into discharge planning to faciliate transfers were housing matters may otherwise have prevented timely discharges. Our Carelink (telecare) service was maximised to support discharge using technologies to support people returning home.
Res Admissions*	Rate of permanent admissions to residential care per 100,000 population (65+)	620	On track to meet target	Covid pressures on community/ homecare provisions has led to some people, especially post hospital, accessing residential care for a short period, rather than returning home with care.	Despite community/ homecare provisions being severely restricted, we have maintained our trajectory and ensured a rate of permanent admissions to care and nursing homes and we are below target through the use of preventative

					services and enabling flow through D2A pathways to support enablement and independence.
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	78.0%	On track to meet target	Due to scarce reablement resources, only those with the most complex rehab needs have accessed the service. Community pathways (such as falls, ongoing rehab) have not been fully embedded or staffed, leading to some repeat admissions.	We have been able to maintain consistency in performance and outcome of reablement from otherwise extremely pressured services throughout winter and the Omicron wave. The vast majority of people accessing reablement remain at home after the reablement period. We have utilised care technologies to ensure people are able to maintain their independence at home as well as referrals into community and voluntary services, as well as Local Area Coordination.

5. Income and Expenditure actual

Selected Health and Wellbeing Board: Derby

Income

	2021-22	
Disabled Facilities Grant	£2,323,304	
Improved Better Care Fund	£11,690,858	
CCG Minimum Fund	£19,515,645	
Minimum Sub Total		£33,529,807

	Planned		Actual			
CCG Additional Funding	£0		Do you wish to change your additional actual CCG funding?	No		
LA Additional Funding	£269,682		Do you wish to change your additional actual LA funding?	No		
Additional Sub Total		£269,682				£269,682

	Planned 21-22	Actual 21-22
Total BCF Pooled Fund	£33,799,489	£33,799,489

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2021-22	

Checklist

Complete:

Yes

Yes

Yes

Expenditure

	2021-22
Plan	£33,799,489

Do you wish to change your actual BCF expenditure?	No

Actual	£33,799,489

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2021-22	

6. Year-End Feedback

The purpose of this survey is to provide an opportunity for local areas to consider and give feedback on the impact of the BCF. Covid-19 had a significant impact on services and schemes delivered on the ground which may have changed the context. However, national BCF partners would value and appreciate local area feedback to understand views and reflections of the progress and challenges faced during 2021-22 There is a total of 5 questions. These are set out below.

Selected Health and Wellbeing Board:	Derby

Part 1: Delivery of the Better Care Fund
Please use the below form to indicate to what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Neither agree nor disagree	Many of the services funded by the BCF have encouraged joint working, but there are other local governance mechanisms now that are driving integration beyond the BCF.
2. Our BCF schemes were implemented as planned in 2021-22	Agree	2021/22 saw all service fully resume as many of the Covid restrictions were lifted
3. The delivery of our BCF plan in 2021-22 had a positive impact on the integration of health and social care in our locality	Agree	This has been particularly true in relation to support acute pressures and overall in those schemes designed to manage demand for health and social care

Part 2: Successes and Challenges
Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and two Enablers which you have experienced a relatively greater degree of challenge in progressing. Please provide a brief description alongside.

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2021-22	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes
Success 1	3. Integrated electronic records and sharing across the system with service users	Roll out of the Electronic Shared Care record to social care so that patient level data can be seen by social care, as well as health
Success 2	4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production	The role of Local Area Coordination which is a BCF funded service has been pivotal in driving culture change within the wider health and social care system, by using an asset based approach. This was accelerated during the pandemic and has now become a major strand of our ICS transformation plans for community services.

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2021-22	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges
Challenge 1	5. Integrated workforce: joint approach to training and upskilling of workforce	There have been times where workforce shortage have reduced the capacity for social care and health to respond to escalating demand and there has not been a successful strategic plan or prioritisation mechanism developed to share and redeploy staff between organisations to assist with this. This was particularly acute during the Omicron wave where significant numbers of staff

		were unavailable to work.
Challenge 2	6. Good quality and sustainable provider market that can meet demand	Major capacity reductions in the home care market were experienced for the first time in 2021/22 in Derby (for a variety of reasons). This caused considerable waits for care following hospital admissions, but also for people living at home with unmet care needs. At times neither the NHS nor the LA were able to meet the demand for care adding considerable risk to individuals' independence, pressure on informal carers and also on the availability of families to cope in a crisis.

7. ASC fee rates

	For information - your 2020-21 fee as reported in 2020-21 end of year reporting *	Average 2020/21 fee. If you have newer/better data than End of year 2020/21, enter it below and explain why it differs in the comments. Otherwise enter the end of year 2020-21 value	What was your actual average fee rate per actual user for 2021/22?	Implied Uplift: Actual 2021/22 rates compared to 2020/21 rates
1. Please provide the average amount that you paid to external providers for home care, calculated on a consistent basis. (£ per contact hour, following the exclusions as in the instructions above)	£18.31	£18.57	£18.94	2.0%
2. Please provide the average amount that you paid for external provider care homes without nursing for clients aged 65+, calculated on a consistent basis. (£ per client per week, following the exclusions as in the instructions above)	£561.00	£561.73	£575.78	2.5%
3. Please provide the average amount that you paid for external provider care homes with nursing for clients aged 65+, calculated on a consistent basis. (£ per client per week, following the exclusions in the instructions above)	£563.00	£573.63	£592.83	3.3%

4. Please provide additional commentary if your 2020-21 fee is different from that reported in your 2020-21 end of year report. Please do not use more than 250 characters.		Home Care provided in Extra Care settings was subject to a pricing review in 2020-21 which lowered the overall fee rates (impacting on the total amount spent on home care and therefore the overall uplift).