FOR PUBLICATION

DERBYSHIRE COUNTY COUNCIL

DERBYSHIRE HEALTH AND WELLBEING BOARD

03 October 2024

Report of the Executive Director of Social Care and Health

Derbyshire Better Care Fund 2023-24 BCF Outturn

1. Purpose

1.1 The Health and Wellbeing Board is asked to:

a) Approve the outturn position of the Discharge Grant and Better Care Fund (BCF) for the period 2023-24.

2. Information and Analysis

2.1 The Department of Health and Social Care's Better Care Support Team published the National Return templates on the 20 March 2024. The Council on behalf of the BCF partnership submitted the BCF Discharge Grant return template by 02 May 2024 to the Department of Health and Social Care with the remainder of the BCF template submitted on the 23 May 24.

Due to the meeting structures of the Health and Wellbeing Board this report detailing the BCF submission is reported retrospectively. It should be noted National Return Template was submitted on time.

2.2 The reporting requirements of the template are like those in previous periods with an additional section for the local Partnership to reflect on successes and challenges over the course of the fiscal year. These

additional sections are in-line with the Logic Model for Integrated Care (developed by the Social Care Institute for Excellence, SCIE).

3. Alternative Options Considered

3.1 The approval and oversight from the HWB of the BCF reporting arrangements is a condition of the BCF Grant.

4 Implications

4.1 Appendix 1 sets out the relevant implications considered in the preparation of the report.

5 Consultation

5.1 There is no consultation requirement for this report.

6 Partnership Opportunities

6.1 The BCF programme works across a number of organisations including the Derby and Derbyshire Integrated Care Board (ICB), Acute Hospitals, Community health providers, private and voluntary sector and District and Borough Councils. The BCF offers opportunities to provide better outcomes for clients with collaborative working and commissioning jointly to be more cost effective. The ICB are an integral part of the process for the BCF as the resources and projects are jointly shared and commissioned within the two organisations.

7 Background Papers

7.1 Derbyshire Better Care Fund Plan 2023 - 2025, 05 October 2023 Health and Wellbeing Board:

8 Appendices

8.1 Appendix 1 Implications.
8.2 Appendix 2 BCF spend and metrics.
8.3 Appendix 3 Year End Feedback
8.4 Appendix 4 Successes and Challenges
8.5 Appendix 5 Hospital Demand and Supply
8.6 Appendix 6 Community Demand and Supply
8.7 Appendix 7 Metrics
8.8 Appendix 8 Hospital Pathways

9 Recommendation(s)

That the Health and Wellbeing Board:

a) Receive and support the report and note the responses provided in the BCF Statutory Returns.
b) Continue to receive quarterly reports of the Better Care Fund in 2024-25

10. Reasons for Recommendation(s)

10.1 The Health and Wellbeing Board will be able to assure itself that the BCF programme is delivering its priorities through community services to keep people healthy and independent as appropriate to a high standard and is meeting the necessary reporting and governance arrangements. It is important that the HWB has oversight of the key developments within the BCF both for assurance across arrangements and awareness of developments, collaboration, and innovation for the benefit of the Derbyshire population. The HWB should signoff any key changes to the programme including fundamental changes to the plan and or governance.

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Appendix 1

Implications

Financial

1.1 The total planned expenditure for the BCF for 2023-24 was £125.483 million, including the Discharge fund, the actual spend was £125,751 million on the BCF inclusive of the Discharge grant. The BCF was spent in line with the schemes outlined in the HWB report of 05 October 2023. As reported, there was a small overspend in home care provided by Derbyshire Community Health Services. The detail is in Appendix 2.

Legal

2.1 A Section 75 legal agreement was entered into in April 2015 between Derbyshire County Council Adult Care and the NHS body Derby and Derbyshire CCG and Tameside and Glossop CCG under section 75 of the National Health Service Act 2006 (updated under the Health and Social Care Act 2012). It enables the local authority and NHS bodies (including clinical commissioning groups and foundation trusts) to enter arrangements in relation to the exercise of each other's health-related functions where such arrangements will provide a more streamlined service if they are likely to lead to an improvement in the way those functions are exercised. The arrangements can mean that one body carries out the functions of both in providing the service; that the two bodies share functions with a pooled budget; or that one body commissions services on behalf of both. Where one party is commissioning services on behalf of both parties, that organisation's procurement rules apply to the procurement.

2.2 Under the Health and Care Act 22 The Clinical Commissioning Group has been reformed and is now named Derby and Derbyshire ICB which came into force on 01 July 2022. It now includes Glossop as part of the ICB and is co- terminus with the Derbyshire geographical footprint.

2.3 There is a finance and performance group in operation that supports the schemes in the BCF with clearly defined objectives, shared performance measures, outcomes, aims and objectives, setting out the services to be delivered.

2.4 The frequency of reporting of performance of the BCF programme has changed for 2023-24 and now includes quarterly reports that have to be submitted to the DHSC by defined deadlines. The Assistant Director in ASC who oversees the completion of these reports will meet with the

Chair of HWB if the submission dates do not align with HWB meetings to gain agreement to submit before presenting to the next HWB meeting.

Human Resources

3.1 There are no human resource implications of this report.

Equalities Impact

4.1 There are no equalities implications for this report.

Partnerships

5.1 There are no further considerations other than those already outlined.

Health and Wellbeing Strategy priorities

6.1 The BCF enables people in Derbyshire to live healthy lives by improving health outcomes through better access to services and initiatives to help people stay in their own home for as long as possible.

Some of the schemes in the BCF support individuals with mental health and wellbeing with a number of projects supporting mental health enablement.

The BCF programme supports our vulnerable populations to live in well-planned and healthy homes working with our District colleagues to improve housing through adaptations, safer home environments.

Other implications

7.1 Performance

- Performance against the BCF national metrics was reported and is summarised below, Appendix 7 details each metric performance.

- Avoidable admissions for unplanned hospitalisation for chronic and ambulatory conditions

The planned target was 776.4 per 100,000 population and actuals were 615.5 which has exceeded the target and has improved with each quarter primarily due to the urgent community response team and home

visiting service which has targeted people to reduce avoidable admissions.

This was a new BCF indicator originally introduced in 2022-23 in relation to avoidable admissions.

- Percentage of people who are discharged from acute hospital to their normal place of residence.

This is in relation to discharge to normal residency. This has been extremely challenging given the local context, however performance was 93.3% in line with the planned level of 93.6%. Availability of home care provision for those being discharged home still requiring some support has been an ongoing challenge but we expect that recent procurement activity will increase capacity and response times.

- Re-ablement 91-day indicator for people over 65

Year-end result for 2023-24 shows that 69.1 % of clients remained at home after 91 days against a target of 70.2 %, The target has been broadly been achieved although the target was lower than in previous years due to the service implementing a restructure and is still embedding the-new ways of working which will improve efficiency and effectiveness for residents and the service.

- Residential and Nursing Care Admissions for over 65's – per 100,000 population

Performance as at year end 2023-24 showed admissions of 810 against a target of 631 admissions. This target was not met due to constraints in the home care market which resulted in higher numbers into short term residential care whilst alternative home care was sourced. The establishment of the county wide reablement community-based service, improved bed based reablement and increased private sector home care capacity will reduce the admissions back to target.

- Emergency hospital admissions due to falls for people aged 65 and over per 100,000 population.

The target for 2023-24 was 1966.4 and actuals were 1508.1 per 100,00 which is below the target. This positive performance is in part due to the impact of the falls recovery service and the establishment of a falls communication and action plan being introduced across Derbyshire to support falls and reduce hospital admissions.

Year-end feed back

The year end feedback offers details of the joint working and integration across Derbyshire including reference to the multidisciplinary teams within the discharge hub which are working together to provide safe hospital discharges and supporting people to return home and maximising reablement capacity. The detail is outlined in Appendix 3.

Successes and challenges

The successes have come from developing a pathway 0 with the Community Voluntary Services for a 'hospital to home' service. They support people who have no personal care needs to settle home after a stay in hospital.

The long-term home care market remained settled over the period covered by this report with no provider failure experienced in 2023/24 and most providers utilised have a good CQC rating. The procurement framework of available providers has been refreshed with more capacity now available. See appendix 4.

Capacity and Demand hospitals and community

The capacity and demand data is a new ask from NHSE for the BCF in 2023-24 and is still being refined in terms of data collection showing demand and activity. The information will improve with time to ensure better quality of recorded data alongside improved accessibility and analysis of the data. The primary data is used to consider hospital demand for pathways 1, 2 and 3 (See appendix 8 for details of pathways) and short-term residential care and how that demand will be met. The hospital demand and supply is detailed in appendix 5.

The community capacity and demand considers the provision of short term support including reablement and urgent community response and the available capacity to meet that demand through the various pathways. The details are outlined in appendix 6 and for reference the blue tables detail demand and the yellow table details actual supply.

The overall estimated demand for hospital discharges was 6,988 referrals for 2023-24. The actual commissioned activity was 8,041 people supported out of hospital with a further 3,481 placements purchased on a one-off basis resulting in an overall total of 11,522 an over provision of 4,534.

The community demand for support at home was estimated at 21,028 referrals and actual provision was 17,678. The shortfall in required community provision assisted in meeting the increased demand reported in the hospital activity.

Overall, the demand across both community and hospital demand was met, and improved demand modelling will assist for future years.

Appendix 2 Income and Expenditure

Better Care Fund 2023-24 Year End Reporting Template

5. Income actual

Selected Health and Wellbeing Board:	Derbyshire

Income

	2023-24	
Disabled Facilities Grant	£8,587,181	
Improved Better Care Fund	£35,732,659	
NHS Minimum Fund	£70,152,435	
Minimum Sub Total		£114,472,276

	Planned	
NHS Additional Funding	£0	
LA Additional Funding	£1,463,267	
Additional Sub Total		£1,463,267

Actual			
Do you wish to change your additional actual NHS funding?	Yes	£268,063	
Do you wish to change your additional actual LA funding?	No		
			£1,731,330

	Planned 23-24	Actual 23-24
Total BCF Pooled Fund	£115,935,543	£116,203,606

Additional Discharge Fund					
	Planned		Actual		
LA Plan Spend	£5,009,663		Do you wish to change your additional actual LA funding?	No	
ICB Plan Spend	£4,537,311		Do you wish to change your additional actual ICB funding?	No	
Additional Discharge Fund Total		£9,546,974			£9,546,974

	Planned 23-24	Actual 23-24
BCF + Discharge Fund	£125,482,517	£125,750,580

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2023-24	overspend on some schemes

Expenditure

	2023-24

Plan	£124,793,339

Do you wish to change your actual BCF expenditure?	Yes

Actual	£125,750,578

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2023-24	overspend on some schemes

Appendix 3 year end feedback

Better Care Fund 2023-24 Year End Reporting Template

. 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.
There is a total of 5 questions. These are set out below.

Selected Health and Wellbeing Board:	Derbyshire

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	Agree	The continued joint focus of health and social care on how to improve discharge and maximising reablement activity has ensured continuous improvement. Adult Social Care have undertaken a comprehensive restructure of hospital and short term reablement teams to be more responsive noting that these changes are part of activity towards even greater joint working so that health and social services provision are co-terminus.
2. Our BCF schemes were implemented as planned in 2023-24	Strongly Agree	Several contracts were retendered with new specifications further promoting strength based person centred outcomes. All historical activity continued to be funded and performance maintained.

3. The delivery of our BCF plan in 2023-24 had a positive impact on the integration of health and social care in our locality	Agree	Discharge Assessment and Review Team working in partnership with Acutes and Community Health Services, on a journey towards greater engagement via hospital discharge teams embedded in acutes, Direct Payment team in acutes. Extra support to help people live fulfilling lives at home. Supporting timely and safe discharge from hospital with a robust P1 offer. Aligns with Derbyshire Health and Social Care Team Up and Community Response Teams. (DCHS) Maximising reablement capacity.Supports planning for independent lives. Living Well a multiagency team model that includes mental health professionals with input from VSCE Social Care and Health and includes the voices of those with lived experience.

Appendix 4 successes and challenges

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 2023-24	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes
Success 1	6. Good quality and sustainable provider market that can meet demand	For Pathway P0 we have established in partnership with VCSE a Home from Hospital service made up of paid and unpaid workers to facilitate safe discharge. For P1 we have reviewed and established new county wide short term reablement service increasing capacity, this was supported via a privately commissioned bridging service whilst being established. Long term home care services, we had no provider failures, overwhelming majority rated Good by CQC, available capacity increased over the year and have since adopt new framework and increased capacity. Care Home provision has remained stable across the past twelve months with a small number of planned closures of services that were no longer sustainable due to size and suitability of the buildings alongside a small number of new entrants. Nursing and residential beds remain good supply with possibility of offering choice, with majority rated Good or above.

Success 2	9. Joint commissioning of health and social care	Several services are jointly commissioned/funded via the local BCF programme which contribute towards local Team Up priorities. The majority of the activity is undertaken by VCSE organisations with service specifications informed by co-production with people with lived experience and with defined outcome measures. The Council procures and performance manages these arrangements on behalf of the BCF partnership. Services include; support for carers, people with a diagnosis of dementia, advocacy, home from hospital for people on P0 pathway, sensory services, provision of mental health services.

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2023-24	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges
Challenge 1	2. Strong, system-wide governance and systems leadership	Local aspiration to further improve the system governance and oversight. This is a notable challenge to use the BCF as a catalyst for change and to move forward system improvements when much of the BCF is tied up with historical Care Act and Community Health services, this is not helped when the system is supported with ADF which is short term. This puts strain on system partners to make necessary changes in context of the substantial savings being required in health and Local Government
Challenge 2	5. Integrated workforce: joint approach to training and upskilling of workforce	There are already excellent examples across our system of joint working across our system via our Team Up initiative, working at Place, our Mental Health Living Well service and D2a provision. It is the system aspiration to further develop these opportunities for joint and integrated working noting constraints referenced above.

Appendix 5 hospital demand and supply

Better Care Fund 2023-24 Capacity & Demand EOY Report

7.1. Capacity & Demand

Selected Health and Wellbeing Board: Derbyshire

Estimated demand - Hospital Discharge		Prepopulated from plan:							Q2 Refreshed planned demand				
Service Area	**Metric**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
Reablement & Rehabilitation at home (pathway 1)	Planned demand. Number of referrals.	316	359	353	394	330	362	386	328	312	344	330	371
Short term domiciliary care (pathway 1)	Planned demand. Number of referrals.	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	Planned demand. Number of referrals.	205	190	170	173	199	162	164	182	185	180	169	195
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Planned demand. Number of referrals.	54	46	54	60	49	50	59	49	49	54	51	54

Actual activity - Hospital Discharge		Actual activity (not spot purchase):											
Service Area	**Metric**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients.	394	496	493	455	446	465	454	508	460	451	395	467
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients.	192	215	199	216	215	193	207	230	212	241	217	220
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0

Actual activity - Hospital Discharge		Actual activity in spot purchasing:											
Service Area	**Metric**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients.	145	124	114	116	120	140	113	103	107	136	103	125
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients.	73	100	88	61	58	61	77	85	56	69	88	80
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients.	91	91	116	93	86	91	93	101	88	107	97	85

Appendix 6 community demand and supply

Better Care Fund 2023-24 Capacity & Demand Refresh

7.2 Capacity & Demand

Selected Health and Wellbeing Board: Derbyshire

Demand - Community		Prepopulated from plan:							Q2 refreshed expected demand				
Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Planned demand. Number of referrals.	50	50	50	50	50	50	50	50	50	50	50	50
Urgent Community Response	Planned demand. Number of referrals.	931	931	931	931	931	931	937	937	937	937	937	937
Reablement & Rehabilitation at home	Planned demand. Number of referrals.	936	868	814	824	822	684	817	615	678	693	656	669
Reablement & Rehabilitation in a bedded setting	Planned demand. Number of referrals.	12	12	12	12	12	12	12	12	12	12	12	12
Other short-term social care	Planned demand. Number of referrals.	0	0	0	0	0	0	0	0	0	0	0	0

Actual activity - Community	Actual activity:

Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly activity. Number of new clients.	68	85	80	87	105	97	114	152	148	134	220	185
Urgent Community Response	Monthly activity. Number of new clients.	637	571	666	626	644	663	718	715	623	765	610	651
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	579	635	730	657	613	685	665	703	649	767	688	770
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	12	14	14	15	14	14	15	16	15	16	14	14
Other short-term social care	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0

Appendix 7 Better Care Fund metrics Dashboard - Derbyshire County Council 23/24

		Data Source	Period	Plan	Q1			Q2			Q3			Q4		
					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Admissions to residential and nursing care homes	Permanent admissions of older people (aged 65 & over) to residential and nursing care homes per 100,000 population	Adult Social Care Outcomes Framework Data Submitted Quarterly by Local Authorities	2023/24		47.6	69.9	65.1	72.3	60.8	63.8	71.1	72.9	72.3	73.5	76.5	64.4
				631	182.5			197.0			216.2			214.4		
Reablement/ rehabilitation services	Proportion of Older People (65 & Over) Who Were Still At Home 91 Days After Discharge From Hospital Into Reablement / Rehabilitation Services	Adult Social Care Outcomes Framework Data Submitted Quarterly by Local Authorities	2023/24		65.3%	52.6%	61.2%	72.6%	65.5%	69.9%	65.0%	63.8%	73.3%	70.9%	65.7%	65.1%
				70.2%	65.7%			71.1%			72.2%			67.4%		

		Data Source	Period	Actual / Plan	Q1	Q2	Q3	Q4
Avoidable Admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (rate given as instances per 100,000 population)	Quarterly NHS Outcomes Framework (HES)	2023/24	Actual	167.2	144.7	168.2	135.3
				Plan	194.1	194.1	194.1	194.1

		Data Source	Period	Actual / Plan	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Discharges	Proportion of patients discharged to place of usual residence	Monthly Secondary Uses Service Data	2023/24	Actual	94.96%	93.07%	93.11%	93.84%	93.11%	93.96%	93.48%	92.06%	91.92%	92.38%	93.20%	94.77%
				Plan	93.6%											

		Data Source	Period	Actual / Plan	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Falls	Number of Falls Admissions aged 65+ per 100,000 population	Monthly Secondary Uses Service Data	2023/24	Actual	135.39	139.67	174.99	138.06	150.37	155.72	108.63	147.16	105.42	90.88	78.80	83.00
				Plan	1966.4											

Appendix 8 details of hospital pathways

Pathway 0 – Simple discharge

- Discharge home / usual place of residence
- Discharge back to care home
- Restart packages of care

Pathway 1 – Support to recover at home

- Patient returns to usual place of residence with interim support

Pathway 2 – Rehab/reablement in a bedded setting

- Patient transferred to non-acute bed for period of rehab/reablement
- Patient transferred to non-acute setting for a period of assessment of ongoing needs

Pathway 3 - Complex

- Majority of patients are no longer able to return home and require a long term placement (include health, social care or self-funding placements)
- Life changing event
- A small number may return home with significant support