South Tyneside Partnership

item 10

Health and Wellbeing Board

Date of Board Meeting	7 June 2023
Title of Report or Presentation	Better Care Fund 2023-2024

Executive Summary Section

The Better Care Fund (BCF) plan for 2023/2024 was submitted to the Health and Wellbeing Board and approved in October 2022.

The 2022 / 2023 year-end report was submitted to NHSE 23rd May 2023. The submission and overall delivery of the BCF promotes joint working between Health and Social Care in our locality. The South Tyneside BCF plan for 2022/23 was a transitional plan, and we have made steady progress in the direction of travel which will be further delivered in our plans for 2023-25. The shared vision at Place for South Tyneside has strengthened and is becoming more embedded and this will allow for greater progress in the coming years.

We have taken the opportunity to strengthen our shared commitment to integrated working across health and social care, with several examples of good practice including Urgent Care Response Team, community nurse in-reach to the Emergency Department of the hospital, early discharge planning pilot with integrated workforce, therapy services working into extra care services and a trusted assessor model for home care. Our plan for 2023/25 will begin to focus on the prevention agenda, admission prevention and further improving timely and appropriate discharge pathways.

Health and Wellbeing Board Action Request

[Double click on box]	Type	Reasoning
☐	**Decision Needed**	If a decision is needed or additional funding is sought, please indicate whether a funding stream has been identified:
☒	**Endorsement Needed**	If an endorsement of a way forward is needed, please provide details: The Better Care Fund Report is being shared for endorsement. We have reviewed the s75 agreement building upon the previous arrangements and a renewed Section 75 agreement is now in place as of 26th May 2023.
☐	**Information Sharing Only**	

Health and Wellbeing Board Theme

[Double click on box]	Outcome
☒	Giving Every Child and Young Person the Best Start
☒	Financial Security to Lead Healthy, Fulfilling Lives
☐	Safe and Healthy Places to Live, Learn, and Work
☒	Good Mental Well-Being and Social Connectivity Across the Life Couse

☒	Fair Delivery of Service
☐	Public Involvement and Community Engagement

Author of Report	Rebecca Eadie
Health & Wellbeing Sponsor	Vicki Pattinson

South Tyneside **Partnership**

Health and Wellbeing Board
Date: 31st May 2023

Title Better Care Fund 2023-2024

Report of: Vicki Pattinson, Director of Adult Social Services and Commissioning, South Tyneside Council and Claire Nesbitt, Place Based Director, South Tyneside, ICB, NHS Northeast and North Cumbria

Why Has this Report Come to the Health and Wellbeing Board?

1.The Better Care Fund Report is being shared for endorsement. We have reviewed the s75 agreement building upon the previous arrangements and a renewed Section 75 agreement is now place as of 26th May 2023.

2. The Board approved the Better Care Fund Plan 2022/23 in October 2022, this End of Year Report provides a progress update for the End of Year Report which is a national requirement.

3. **Legal-** It is a requirement that the Better Care Fund is managed locally through a pooled budget. The power to pool budgets between the Council and the ICB is set out in the NHS Act 2006 and requires a formal Section 75 Agreement. The Health and Wellbeing Board is asked to note that there is a renewed Section 75 agreement in place as of 26th May 2023 which will continue to be jointly renewed when applicable.

Which Outcome is this Linked to Within the Health and Wellbeing Strategy and How?

4. It links firmly to three outcomes of the Health and Wellbeing Strategy through integrated working and outcomes through the focus on Prevention and improving hospital discharge processes and pathways:

- Financial security to lead healthy, fulfilling lives.
- Good mental well-being and social connectivity across the life course.
- Fair Delivery of Service

National Conditions
5. The Health and Wellbeing Board signed off on the BCF plan in October 2022. A requirement of the BCF End of Year Report is confirm that all national conditions have been achieved as set out by NHS England. For the South Tyneside submission we have reported all four requirements have been achieved.

a) a jointly agreed plan between local health and social care commissioners, signed off by the HWB. – ***Signed plan and Section 75 in place.***

b) NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution. – ***The Integrated Care Board (ICB) has provided funding in line with the national minimum contribution. In addition the Council and ICB worked together to ensure distribution of the Adult Social Care Discharge Fund to support schemes to improve discharge timescales and reduce delays.***

c) invest in NHS-commissioned out-of-hospital services: - ***There continued to be commissioning of care and services with health partners in the community.***

d) a plan for improving outcomes for people being discharged from hospital - ***Pathways to support the timely discharge for patients have been developed further in line with "home first" principles.***

Metrics

6. The South Tyneside BCF plan for 2022/23 was a transitional plan, and we have made steady progress in the direction of travel which will be further delivered in our plans for 2023-25.

7. We carried out the plan of which there were four metrics, whilst we had some achievements across these areas we were also faced with system challenges such as 'Winter Pressures'.

a) Avoidable admissions

Whilst we had success in implementing a number of schemes including: placing a community nurse practitioner in Emergency Department, early stages of implementing our virtual ward approach including the implementation of the urgent response service.

We are not on track to achieve our plan, our target was to reduce avoidable admissions to 1,080 and the performance to February 2023 was 1123. We have identified a number of preventative schemes which will be brought together into a single Prevention Plan which will support a reduction in avoidable hospital admissions. We will use the High Impact Change Model - Reducing Preventable Admissions to Hospital as a framework to understand the current position and potential areas for improvement.

b) Discharge to normal place of residence

In South Tyneside we have improved our discharge systems, including; improving our assessment for discharge processes, increasing our community capacity to support people to return to their own homes, introduced an integrated urgent response team, increased the use of the voluntary sector and technology and well being services. In the development of our Home First model, we have also increased the use of trusted assessors and living made easy assessor roles.

We are on track to achieve our plan with performance of 90.1% against a plan of 90.2%. This has been a significant challenge with unprecedented pressures across the urgent care system over the winter, including high levels of winter viruses, and industrial action across the NHS. Work continues in respect of implementing standards against the High Impact Change Model

c) Residential Care Home Admissions
Over the year we have increased capacity in extra care services and home care to support people to be discharged back to their own home, and there are plans to increase this capacity further including a new community based re-ablement facility within a housing scheme which will see people accessing re-ablement within an individual flat rather than a care home setting. However the pressure of discharging people from hospital when they are medically optimized has been very challenging over the winter period.
We are not on track to achieve our plan with performance of 930 admissions per 100,000 population against a target of 759. We recognise the need to further develop intermediate care beds with appropriate therapy services, increase short term placement review capacity, step down bed facilities to avoid people being dispersed and delayed and reduce short term placements to facilitate discharge to people's homes.

d**) Reablement (91 day target)**
In South Tyneside we have increased the home care hospital discharge capacity, and improved our review and multi-agency approach including the use of wellbeing and technology services to discharge planning.
For the proportion of people aged 65years and older who remain at home 91 days after discharge into re-ablement services our performance of 76.6% has exceeded our plan. We have increased community integrated care services requiring therapy, and aligned work with Urgent Care Response Team which will further improve outcomes for people as the service becomes more established.

8. The shared vision at place for South Tyneside has strengthened and is becoming more embedded through the BCF and this will allow for greater progress in the coming years. Pooled or aligned resources, enabling different approaches to support system challenges and demand pressures, collective conversations about best use of funding, despite often short term nature and late notice of funding to maximise its usage

Summary of Finance
9. Finance is managed in pooled budgets, we have reported that all income streams have been fully spent to plan and are on budget.

ASC Discharge Fund
10. The ASC discharge fund consisted of six delivery areas:

a) Bed Based Intermediate Care
b) Community Intermediate Care
c) Early Discharge Planning
d) Mental Health
e) Social Work Capacity
f) Winter discharge pressures

During the period of the program adjustments were made to respond to the changing needs of people and system pressures over the winter period for example influenza outbreaks and industrial action within hospital services, to meet the needs of people and ensure continued flow of discharges from hospital. This funding was to support our overall discharge into the community capacity.
Our learning comes from our continued development and implementation of our Adult Social Care Strategy, focusing on our principles of "Home First", and our review of BCF services focused on effective discharge planning and ensuring appropriate and timely discharges from hospital for people.

Further information can be found on the BCF submission for 2022/2023.