Health and Wellbeing Board

18 September 2024

Better Care Fund 2023-2025: Quarter 1 2024/25 Discharge Fund Template

For Decision

Cabinet Member and Portfolio:
Cllr S Robinson, Cabinet Member for Adult Social Care

Local Councillor(s):
All

Executive Director:
Jonathan Price, Executive Director of People - Adults

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Report Status: Public

Recommendation:

1. To retrospectively approve the Better Care Fund (BCF) Reporting Template for:
   - Quarter 1 2024/25

2. To confirm whether the additional narrative included at section 3 to 6 provides sufficient details, and is helpful context to outline the intended focus of the BCF Discharge Funding and effectiveness to date at resolving the challenges we face as a local Integrated Care System.

Reason for Recommendation:

1. NHS England (NHSE) require the Health and Wellbeing Board (HWB) to approve all BCF plans, this is one of the national conditions within the Policy Framework. This includes planning documents at the beginning of a funding period, and template returns reporting progress against the plans mid-year, and at the end of the year.

2. There is usually a relatively short window of time between NHSE publishing the reporting templates and the submission date. NHSE allow areas to submit their plans under delegated authority, pending HWB approval. At the HWB meeting on 12 January 2022 delegated authority to approve BCF plans, if a HWB meeting could not be convened within the NHSE sign off period, was granted to the Executive Director for People – Adults, following consultation with the HWB Chair.

3. In response to discussions at HWB on 26 June 2024 in respect of sharing earlier sight with HWB Members, including more detail as to the purpose and effectiveness of BCF investment, HWB Members were provided with the template by email in advance of submission. Further details about the challenges we are trying to address via the Discharge Fund investment, and effectiveness is included in this report. The Quarter 1 Template was submitted on 19 August 2024 on behalf of Dorset Council and Dorset NHS in line with delegated approvals. Retrospective approvals are now sought from the Board at its meeting on 18 September 2024.

1. Introduction

1.1 The Quarter 1 2024-2025 Report is at Appendix A. The sole focus is the Discharge Fund element on Better Care Fund, and we have been required to report spend and activity achieved during Quarter 1 against our full 2024-25 Plan.

1.2 For 2024/25 the BCF in total brings together Dorset resources worth £152,958,153, including a number of significant external funding streams from central Government. This includes the £6,410,023 Discharge Fund, which is split between the ICB and Local Authority. We report on both elements through the template.

1.3 In Dorset, both ICB and Local Authority have invested a substantial amount of the Discharge Fund into the Home First Accelerator Programme, which was introduced in 2023/24 as a two year programme to re-set and invest into key initiatives that would ultimately improve outcomes for individuals requiring support associated with hospital discharge and address significant challenges in our homecare market. HWB Members may recall the Case Study that was submitted as part of the Quarter 3 2023-24 return (please see 14 below ‘Background Reports’.

2. Discharge Funding Schemes

2.1 As outlined at Appendix A, the funding has been allocated across the following workstreams. Appendix A details the number of individuals who have been supported during quarter 1:

2.1.1 Home care market investment / Home care packages

2.1.2 Recovery and Community Resilience Contracts

2.1.3 Trusted Assessors

2.1.4 Reablement Beds

2.2 The sections that follow explain each workstream in more detail, setting out the challenges, impacts achieved, and further developments planned.

3. Home care market investment / Home care packages

3.1 **The challenge, or gap we are addressing**; Dorset, like many areas of the country was severely lacking in home care during Covid pandemic and up to end of 2022/23. We invested this element of funding in a programme of home care optimisation; to make best use of the scarce resource we had by more efficient deployment and embedding local geographical 'zones' into our framework contracts. We also, through early adoption of Fair Cost of Care approach to inform fee setting, increased home care rates, which included enabling better pay for staff.

3.2 **The impact to date**; For Dorset Council (DC), this funding line represents just 11% of annual homecare spending, yet it has been central to the recovery of the local homecare market. As, we report via BCF metrics, there is a continued reduction in the rate of admission to long term residential care, and although overall demand continues to challenge the System, we have good flow through home from hospital services due to long term care availability. Now 89% of DC homecare packages are from framework providers (at our published rates) – an improvement from 72% in Jan 23 and we have maintained both a far-reduced waiting list and reduced waiting times. There is often no waiting time for care searches in some zones.

3.3 **Future areas of focus;** maintaining a stable, good quality homecare market is key to ongoing success. Working closely, as an ICS, with providers to be well-equipped to support continued demand, that we expect will continue to rise in acuity, is a key area of focus. DC is keen to

further develop opportunities linked to greater zonal optimisation, creating more place-based provision that would further strengthen local community and VSCE networks, linking to wider System priorities of Integrated Neighbourhoods and Integrated Care Partnership.

4. Recovery and Community Resilience Contracts

4.1 **The challenge, or gap we are addressing;** It is well documented and evidenced that the best place for a person to recover is in their own home. In the back drop of limited homecare capacity we needed to increase availability of Reablement focussed services in order to offer the greatest chance of achieving good outcomes for individuals, through a swift, yet effective offer. Recovery and Community Resilience (RCR) Home Care delivers short term, enhanced support to an Individual following discharge from hospital or to avoid hospital admission. This takes place in an Individual's own home, in order to bring them back to their baseline, prior to their illness or crisis to improve their current situation. RCR Providers can alter care needed during the recovery phase, and contribute to ongoing longer term care and support assessments, when needed, which enables people to move into long term care. A better outcome for the individual, whilst also enabling improved hospital flow.

4.2 **The impact to date;** The scheme supports a large number of people, 2,700 individuals since its inception in November 2022, with an average of only 30% going on to need longer term care and support, and this is usually at a reduced level of care from that at the point of discharge. On average there are approx. 160 people being supported at home at any one time. For Dorset County Hospital (DCH), RCR provision supports 50% of discharges via pathway 1, a representative picture of the allocation of support for all Dorset Residents from East Dorset area and bordering acutes.

4.3 **Future areas of focus**; closer working and alignment of RCR provision to core discharge co-ordination, decision making and ongoing clinical oversight is required to further improve outcomes for individuals. Existing RCR contracts will require re-tender later this year, and we plan to include these enhancements, along with improved data sharing arrangements to reduce manual administration. In response to NHS England concern about the financial position of the local system, a decision was taken to cease some additional NHS investment in supporting RCR provision this year (and associated brokering costs). Contracts have not been terminated, whilst partners have agreed to share the risk that further

investment will not be forthcoming to plug this gap in resources. At the time of writing this report, Newton Europe, the system's recently appointed Strategic Improvement Partner, are working through their diagnostic phase of reviewing the Urgent Emergency Pathways, of which Intermediate Care is included. We anticipate their findings being key to informing how we can further improve Pathway 1 provision, and importantly deploy and sustainably fund RCR more effectively to support admission avoidance.

5. Trusted Assessors

5.1 **The challenge, or gap we are addressing**; Care Homes require an up-to-date assessment of a person's care and support needs, to ensure they can safely provide care. Prior to 2021/22, the assessment process was regularly adding several days to a person's hospital stay. This was negatively impacting those individuals' outcomes, but also 'blocking' acute hospital beds for others needing treatment. Conflicting pressures for both providers and hospital teams had led to often strained relationships, with reduced levels of trust. This had resulted in every individual needing an in-person assessment by the provider, even if the person was returning to their care home placement. The Dorset System needed an independent party, appropriately skilled and experienced, who could carry out swift assessments on behalf of providers, to build trust, but also reduce demands on the hospital staff by improving discharge rates, helping people home as soon as they are medically fit to leave, freeing resources for those waiting. The Dorset Care Association (DCA) now host the independent Trusted Assessor (TA) Service, based in the Acute hospital, to attend the ward to; conduct initial assessment on behalf of identified provider; track the patient through discharge pathway, reducing impact of potential delays, such as pharmacy, paperwork, transport, and follow up with provider within 48 hours of the individual getting home to ensure they had settled.

5.2 **The impact to date;** Since implementation there have been no failed discharges within the cohort of people the TAs have supported. Each month approx. 65 people are supported to their permanent. residence more quickly than prior to the scheme's implementation. Approx 130 adult social care providers are signed up to the TA scheme. Admission avoidance support via on-call arrangement is also provided, meeting individuals at the Emergency Department (ED) and updating directly to the home, or community provider, to secure a return home rather than admission. Several younger aged adults, with more complex needs have

benefited from this ED offer, with TAs able to support the individual, but also offer advice and guidance to hospital staff, as to the most appropriate approach and environment to treat the individual due to more complex Learning Disability or Mental Health related conditions. This has resulted in quicker treatment and a return home, rather than admission. This Service is deemed an example of best practice, with the Dorset Care Association receiving much interest from other systems, keen to understand how we have made this a success.

5.3 **Future areas of focus**; If further funding would allow, the service could be expanded to support more people. Further integrating of TAs in to community settings, such as Community Hospitals, may also offer more opportunities to support people home.

6. Reablement Beds

6.1 **The challenge, or gap we are addressing**; As described at 3.1, our community based reablement capacity had been hampered by similar challenges to homecare. A shortage of therapists, that has been well documented in previous BCF reports, meant that as a System we were unable to offer consistent therapy support to any additional surge response beds, which was leading to longer length of stays and reduced opportunities to maximise individual's longer term independence. Care Dorset, (DC's Local Authority Trading Company) effected a rapid stand up of 30 short-term bed capacity in winter of 22/23, with a plan to strengthen the therapy leadership as resources allow.

6.2 **The impact to date**; Average bed occupancy is 80%, with the average length of stay around 27 days. As the services have embedded, we have improved referral and admission rates. Trend data on long term weekly care requirements of individuals following discharge is consistently reduced from that estimated at start of intervention.

6.3 **Future areas of focus**; To date, we have been unsuccessful in fully embedding therapy led support due to the lack of availability of therapists. Primary Care and Community Health colleagues have been able to increase the support available and further training provided to Reablement staff to support a broader range of needs, however there is more work to do to properly embed the full range of wrap around resources to enable an optimum bedded Reablement offer.

6.4 The Council's Cabinet has agreed a programme of capital investment to develop new Reablement Centres. This would deliver more effective and

efficient recovery and rehabilitation services, in modern and high-quality environments. DC are working closely with Dorset County Hospital (DCH) Trust following in-principle agreement to utilise part of the DCH site in Dorchester. Scoping is also underway for a centre to replace Sidney Gale House in Bridport, which closed in its current form last month, as well as further sites being considered in the east of the county. The longer-term costs of operating such services will be significant, given current cost of building and borrowing, but equally have the potential to deliver significant system cost avoidance and more effective discharge support. They would therefore be ideal new initiatives for the BCF investment, and could be considered within the next two year planning round.

6.5 To support the development of the future Allied Health Professional workforce that will be required to operate the centres and enhance community reablement, we are working in partnership with The Health Science University to ascertain, how together we can:

6.5.1 Develop a workforce strategy for the Reablement Centres considering a diverse range of advanced health practitioner and therapeutic inputs to enhance the level of service delivered

6.5.2 Support the Reablement Centres to become a place of learning and innovation by supplying students from the Chiropractic and Allied Health Professions courses, including Dietician, Occupational Therapy, Physiotherapy, Podiatrists etc on a rolling programme.

6.5.3 Develop pathways and new opportunities for college level Health and Social Care programmes into the care sector.

6.5.4 Harness an opportunity for research across social care through their MsC and PhD student cohort in the University.

6.5.5 Support workforce planning and recruitment through the University’s new central London base**.**

A more detailed update on our Reablement Centre and Community Reablement development will be bought to a future HWB.

7. Financial Implications

7.1 The Council and Dorset NHS are required to work within the financial envelope and to Plan, hence continuous monitoring is required. Joint commissioning activity and close working with System partners, including Acute Trusts, allow these funds to be invested to support collective priorities for Dorset.

7.2 The Joint Commissioning Board of the Council and Dorset NHS continue to monitor BCF budgets and activity for 2024-25 Plan.

8. Environmental Implications

8.1 All partner agencies are mindful in their strategic and operational planning of the commitments, which they have taken on to address the impact of climate change.

9. Well-being and Health Implications

9.1 Allocation of the BCF supports individuals with health and social care needs, as well as enabling preventative measures and promoting independence.

9.2 Dorset, like many other areas across the South West and nationally, is continuing to experience many challenges in providing and supporting the delivery of health and social care. For Dorset, as referenced above, the highest risks continue to be the increasing acuity of health, care and support needs of those being supported both in the community and in hospital, and also lack of lack of therapy led care and support to promote the regaining and maintaining of longer term independence.

10. Other Implications

10.1 Dorset Council and Dorset NHS officers will continue to work closely with Dorset System Partners to plan measures to protect local NHS services, particularly around admission avoidance and hospital discharge to ensure flow is maintained to support and respond to additional demand.

11. Risk Assessment

11.1 Dorset Council and Dorset NHS officers are confident Appendix A provides appropriate assurance and confirms spending is compliant with conditions.

11.2 The funds provide mitigation of risks by securing continuation of essential service provision and provides preventative measures to reduce, delay and avoid demand.

11.3 Dorset is actively working to alter approaches that enable enhancement of provision to mitigate risks, and promote recovery, regaining and maintaining of independence.

12. Impact Assessment

12.1 It is important that all partners ensure that the individual needs and rights of every person accessing health and social care services are respected, including people with protected characteristics so the requirements of the Equalities Act 2010 are met by all partners.

13. Appendices

A: Dorset's Better Care Fund 2024-2025 Q1 Template

14. Background Papers

2023 to 2025 Better Care Fund policy framework - GOV.UK (www.gov.uk)

Addendum to the 2023 to 2025 Better Care Fund policy framework and planning requirements - GOV.UK (www.gov.uk)

Health & Wellbeing Board, 20th March 2024, Item 7 : BCF Q3 Reporting Template.pdf (dorsetcouncil.gov.uk) & Home First Accelerator Case Study