Report No
ACH23-029

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**Better Care Fund (BCF) and Improved Better Care Fund (iBCF) Q4 (January to March 2022/23) Performance Report**
Contact Officer:	Ola Akinlade, Integrated Strategic Commissioner Early Intervention, Prevention and Community Services Commissioning, Programmes Division.
Chief Officer:	Kim Carey, Director of Adult Social Care, London Borough of Bromley Angela Bhan, Managing Director, Bromley Clinical Commissioning Group
Ward:	All Wards

1. Purpose of report

This report provides the Health and Wellbeing Board with an overview of Bromley's performance against the Better Care Fund and the Improved Better Care Fund metrics and an update on expenditure and activity up to and including the period January to March 2022-23 (Quarter 4).

2. Reason for the report going to Health and Wellbeing Board)

This report provides an update to the Health and Wellbeing Board on progress made against BCF targets up to and including the period January to March 2022-23 (Quarter 4)

3. SPECIFIC ACTION REQUIRED BY HEALTH AND WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS:

Health & Wellbeing Strategy

1. Related priority: Not Applicable

Financial

1. Cost of proposal: BCF: £30,296k; iBCF: £7,730k

2. Ongoing costs: BCF: £30,296k; iBCF: £7,730k

3. Total savings: N/A

4. Budget host organisation: LBB

5. Source of funding: NHS Southeast London ICB (revenue element of BCF) and Department of Levelling Up, Housing and Communities (DLUHC) (BCF capital element (DFG) and iBCF)

6. Beneficiary/beneficiaries of any savings: London Borough of Bromley and NHS Southeast London ICB (Bromley)

Supporting Public Health Outcome Indicator(s)

Not Applicable

4. EXECUTIVE SUMMARY

The Better Care Fund (BCF) programme supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers.

In Bromley, the BCF grant is ring fenced for the purpose of pooling budgets and integrating services between Southeast London Integrated Care Board (Bromley) (SELICB) and London Borough of Bromley (LBB). The Improved Better Care Fund (iBCF) was a funding element added to the Better Care Fund from 2017-18 paid to the Council as a direct Local Authority grant for spending on adult social care.

4.1 Purpose of this Report

The purpose of this report to update Bromley's Health and Wellbeing Board on the progress made against the 2022-23 Plan, including an update on performance against BCF metrics up to and including the period January to March 2022-23 (Quarter 4)

4.2 BCF PERFORMANCE METRICS

The delivery of the Better Care Fund Metrics is a key requirement of BCF funding and a key way of measuring local partnership programme performance and delivery of BCF aims and objectives. Bromleys BCF 2022 -23 plan includes a requirement to deliver against four metric targets (targets and performance is detailed in the table below and in section 4.2.1)

Metric	Bromley BCF 22-23 Target	Performance up to Q4 22-23
Avoidable Admissions: unplanned hospitalisation	529	453
Discharge to normal place of residence	93.3%	93.5%
Rate of permanent admissions to residential care	410	355
Proportion of older adults (65 and over) who were still at home 91 days after discharge into reablement	93%	93.%

Quarter 4 performance has seen Bromley continue to achieve performance targets against these metrics. Performance against each of these metrics is provided in more detail under section 4.2.1 below:

4.2.1 ***Update on Quarter 4 (22-23) performance against Metric Targets***

Metric 1 Performance

Metric 1:	*Target for Reporting period (April 22 to March 23)*	*Actual for Reporting period (April 22 to March 23)*
Avoidable Admissions: *Unplanned hospitalisation for chronic ambulatory care sensitive conditions*[1] *per 100,000*	*529*[2]	*453*[3]

The aim of this metric is for unplanned admissions in Bromley to be less than 529 for Month 1-12 cumulative. Bromley has performed better than the planned target thus 76 fewer patients had unplanned hospital admissions than were predicted (453 unplanned admissions for the same period.)

This demonstrates that Bromley continues to perform well against this metric and follows a long-term trend of positive performance against our unplanned admissions target.

Risks to performance against this metric: No current risk to performance identified.

Metric 2 Performance

Metric 2	*Target for Reporting period (April 22 to Feb 23)*	*Actual for Reporting period (April 22 to Feb 23)*
Discharge to normal place of residence [4]	*93.3%*	*93.5%*

The aim of this metric is for patient discharges to normal place of residence in Bromley to be no less than 93.3%. Bromley has met this target with 93.5% being discharged to place of residence. (For M1-11)

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Risks to performance against this metric: No risks identified

Metric 3 Performance

Metric 3	*Target for Reporting period (April 22 to March 23)*	*Actual for Reporting period (April 22 to March 2023)*
Rate of permanent admissions (65 and over) to residential care per 100,000 populations [5]	*410*[6]	*355* [7]

This aim of this metric is for the rate of permanent admissions for adults aged 65 and over in Bromley to be less than at 410 per 100,000 for M1-12 (April 22 to March 23). Bromley has exceeded this target thus 20 fewer patients were permanently admitted to residential care

[1] 2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions - NHS Digital
[2] Agreed Metric Target for Bromley BCF 22-23 plan (M1-M12 cumulative 22-23)
[3] Actual Bromley performance (M1-M12 cumulative 22-23)
[4] 2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions - NHS Digital
[5] 2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions - NHS Digital
[6] Based on planned target of 410 target for 22-23
[7] Reported through Bromley Digest

hospital than predicted (355 against a target of 375 for Month 1-11, permanent admissions to residential care)

Risks to performance against this metric No risks identified

Metric 4 Performance

Metric 4	*Target for Reporting period (April 22 to March 23)*	*Actual for Reporting period (April 22 to March 23)*
Proportion of older people (65 and over) who were still at home 91 Days after discharge into reablement/rehabilitation	*93%*	*98%*

The aim of this metric is for the percentage of older people still at home 90 days after discharge to be no less than the target of 93%. Bromley continues to perform well on this metric with 98% achieved.

Reablement continues to build on its successful outcomes in offering an enabling service for all residents in the community, both supporting those patients being discharged from hospital and those requiring assistance to regain function already in their homes. Further scoping, planning and exploratory work is ongoing to develop work to expand the resource required to offer the service to more clients by increasing the daily capacity of the service to support the increased need, particularly in supporting hospital discharges. This ongoing work is also developing an Assistive Technology offer that incorporates the issuing of wearable digital devices for appropriate patients leaving hospital as part of the reablement package

Risks to performance against this metric No performance risks identified.

4.3 UPDATE ON BCF POLICY PRIORITIES

4.3.1 Increasing system capacity. There are a number of initiatives that the Bromley Partnership are delivering to increase system capacity. These include:

- Investing in additional care management social work and brokerage capacity during the winter period.
- Recruiting a dedicated Extra Care Housing Stepdown Care Manager to support admission avoidance.
- Facilitate social work presence at the emergency department within the hospital to support admission avoidance and ensuring where possible people get the right support earlier and return home to maximise their independence.
- Providing an admission avoidance offer within the local authorities "front door" with the Initial Response Team being maintained through the use of winter scheme monies.
- Plans have been set up to facilitate Social Work/Care Management and Brokerage mobilisation into the Single Point of Access. Multidisciplinary working will continue to aid and support Hospital discharge and any increase in demand.
- Additional occupational therapy budget has been identified to provide additional therapy support during the winter period.

4.3.2 Meeting seasonal demand- There are a number of initiatives that the Bromley Partnership are delivering to meet seasonal demand. These include:

- The identification of resource to meet any increase in demand around the broader domiciliary care offered to support systems to return or remain at home preventing admission to hospital or a care home.
- Sourcing additional nursing beds to support additional admission avoidance capacity and /or carer breakdown during the winter period
- Securing domiciliary care cover to deliver care packages over holidays including bank holidays and weekends

4.3.3 Supporting Unpaid Carers

- The new Carers Initial Assessment form has been used to conduct an initial assessment of carers needs for every new carer being referred into the service across the carer pathways in Age UK Bromley & Greenwich. For Q 3 & 4 of the new contract, there has been an 18% increase in referrals following the launch of the new form (114 compared to 94 for previous contract.) This has enabled a more coherent approach to identifying and assessing the needs of carers and arranging interventions to support Carers. A new Carers Plan for Bromley will be agreed in June 2023.

4.3.4 Prevention and Early Intervention

- In Q4, the service continues to see queries around the cost of living and queries related to benefit and income support and the service continues to provide support through income maximisation interventions as well as information, advice and guidance on managing debt
- The service is also collaborating with commissioners to develop a client led outcomes framework designed to increase the focus on feedback from clients in terms of their outcomes as evidence of the effectiveness of the service. Further information will be provided in subsequent updates

4.3.5 Home First

The integrated health and care discharge triage and care pathways for our most complex and end of life people are well established and embedded and supported by system partners. The pathways provide timely hospital discharge and post discharge care and support to enable people to safely transition out of hospital and back to the community.

Since December 2022, the home first approach and huddles have significantly cut the number of patients entering care homes directly from hospital. This is a significant success from an integrated team with all providers inputting into the success and positive outcomes for these service users.

4.4 DFG and Adaptations

Developments continue to include:

- Planning with a view to putting in place a local Housing Assistance Policy as allowed for under the Regulatory Reform (Housing assistance) Order with a plan to include a Discretionary DFG scheme.
- Piloting Landlord Applications for DFG which will allow the speeding up of processes and eliminate the need for time consuming means testing of personal applicants.
- Exploring the possibility of employing one or more additional Grants Officers to shorten the waiting time for applicants and increase the quantity of work done by the team.

5 IMPACT ON VULNERABLE PEOPLE AND CHILDREN

All services are targeted at vulnerable adults with a focus on avoiding people who are vulnerable reaching the point of crisis where they would be seeking support of statutory services and/or requiring unplanned admission. Funds also support the supported discharge of patients from hospital into the community.

6 FINANCIAL IMPLICATIONS

6.1 The 2022/23 budget and provisional outturn for both the Better Care Fund and the Improved Better Care Fund are detailed in the tables below:

	Scheme Type	Scheme Name	2022/23 Budget	2022/23 Provisional Outturn	2022/23 Variation
BCF Minimum ICB Contribution					
ICB	Assistive Technologies and Equipment	Assistive Technologies	585	585	0
LBB	Assistive Technologies and Equipment	Assistive Technologies	461	461	0
ICB	Bed based intermediate Care Services	Intermediate Care Services	1,390	1,390	0
LBB	Bed based intermediate Care Services	Intermediate Care Services	1,286	1,170	-116
ICB	Carers Services	Support for carers	576	576	0
ICB	Community Based Schemes	Risk pool	1,472	1,472	0
Joint	Enablers for Integration	Community and Social Care Development Fund	1,046	1,046	0
LBB	Enablers for Integration	BCF Post	44	46	2
LBB	Enablers for Integration	Learning Disabilities	27	1	-26
ICB	High Impact Change Model for Managing Transfer of Care	Risk pool	617	617	0
LBB	High Impact Change Model for Managing Transfer of Care	Risk pool	56	55	-1
ICB	Home Care or Domiciliary Care	Improving healthcare services to Care Homes	343	343	0
LBB	Housing Related Schemes	Improving healthcare services to Care Homes	457	457	0
ICB	Integrated Care Planning and Navigation	Assistive Technologies	413	413	0
LBB	Integrated Care Planning and Navigation	Assistive Technologies	58	56	-2
ICB	Personalised Care at Home	Personalised Support/care at home	678	678	0
ICB	Personalised Care at Home	Reablement services	1,040	1,040	0
LBB	Personalised Care at Home	Protecting Social Care	10,850	10,850	0
LBB	Personalised Care at Home	Dementia Universal support service	569	490	-79
LBB	Prevention / Early Intervention	Support for carers/assistive technology	1,837	1,837	0
LBB	Reablement in a persons own home	Reablement services	1,276	1,276	0
LBB	Home Care or Domiciliary Care	Discharge to Assess	458	458	0
LBB	ASC Discharge Fund	Discharge to Assess	992	894	-98
ICB	ASC Discharge Fund	Discharge to Assess	1,322	1,322	0
			27,853	**27,533**	**-320**
DFG					
LBB	DFG Related Schemes	Disabled Facilities Grants	2,443	2,131	-312
			2,443	**2,131**	**-312**
iBCF					
LBB	Assistive Technologies and Equipment	Equipment	214	214	0
ICB	Enablers for Integration	D2A staffing	95	95	0
LBB	Home Care or Domiciliary Care	D2A DomCare	321	321	0
LBB	Home Care or Domiciliary Care	DomCare	72	72	0
LBB	Home Care or Domiciliary Care	Whole system reserve	1,677	1,677	0
LBB	Personalised Budgeting and Commissioning	Reducing pressures	4,863	4,863	0
LBB	Residential Placements	D2A Placements	83	83	0
LBB	Residential Placements	Placements	405	405	0
			7,730	**7,730**	**0**
Grand Total			**38,026**	**37,394**	**-632**

6.2 Funding for the BCF is from NHS Southeast London ICB (£27,853k, including the £2,314k ASC Discharge Fund) and the Department for Levelling Up, Housing and Communities (£7,730k for iBCF and £2,443k for DFG).

6.3 There was a total underspend of £632k on BCF (£320k revenue and £312k capital) and £50k underspend on IBCF. These amounts will be carried forward to 2023/24.

7 LEGAL IMPLICATIONS

7.1 The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund. It provides the mandate to NHS England to include specific requirements relating to the establishment and use of an integration fund. NHS England and the Government allocate the Better Care Fund to local areas based on a framework agreed with Ministers.

7.2 The amended NHS Act 2006 gives NHS England the powers to attach conditions to the payment of the Better Care Fund. For 2017-19 NHS England set the following conditions to access the CCG element of the funding:

- The requirement that the Better Care Fund is transferred into one or more pooled funds established under Section 75 of the NHS Act 2006.

- The requirement that Health & Wellbeing Boards jointly agree plans for how the money will be spent with plans signed off by the relevant local authority and clinical commissioning group(s).

7.3 Under the amended NHS Act 2006, NHS England has the ability to withhold, recover or direct the use of CCG funding where conditions attached to the BCF are not met, except for those amounts paid directly to local government.

7.4 For 2017-19, NHS England require that BCF plans demonstrate how the area will meet the following national conditions:

- Plans to be jointly agreed.
- NHS contribution to adult social care is maintained in line with inflation.
- Agreement to invest in NHS commissioned out-of-hospital services, which may include 7-day services and adult social care; and
- Managing Transfers of Care

7.5 The Improved Better Care Fund Grant determination is made by the Secretary of State under section 31 of the Local Government Act 2003. The grant may be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready and ensuring that the local social care provider market is supported.

7.6 The Council is required to:

- Pool the grant funding into the local Better Care Fund, unless the authority has written ministerial exemption
- Work with the relevant Clinical Commissioning Group and providers to meet National Condition 4 (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19 (revised 2019-20)
- Provide quarterly reports as required by the Secretary of State

Non-Applicable Sections:	
Background Documents:	None