To: Health and Wellbeing Board
8 June 20201

Better Care Fund – Year End Report
Executive Director of People

1 Purpose of Report

1.1 The government's mandate to the NHS, published in March 2020, set a deliverable for the NHS to 'help ensure delivery of its wider priorities, which include manifesto commitments to further improve the experience of NHS patients, working with local government to support integration and the sustainability of social care through the Better Care Fund (BCF)'.

1.2 Given the Covid19 pressures experienced during 2020/21 on systems, government Departments, NHS England and NHS Improvement had agreed that formal BCF plans would not need to be submitted to NHS England and NHS Improvement for approval in 2020 to 2021.

1.3 Health and Wellbeing Boards (HWB) are required to provide an end of year reconciliation to Departments and NHS England/ Improvement, confirming that the national conditions have been met, total spend from the mandatory funding sources and a breakdown of agreed spending on social care from the CCG minimum contribution.

1.4 This report asks the HWB to approve the attached Year End template. The report also provides additional information about the performance against national metrics, local achievements in 20/21 and areas for development in 2021/22.

2 Recommendation(s)

2.1 For the HWB to approve the Year End Report for the Bracknell Forest Better Care Fund 2020/21.

2.2 For the HWB to note the emerging priorities for the 2021/22 Better Care Fund.

3 Reasons for Recommendation(s)

3.1 To comply with the NHS and Departments' requirement to submit HWB approved Year End Report.

4 Alternative Options Considered

4.1 No alternative to approving the Year End report has been considered as this is a national requirement.

5 Supporting Information

5.1 The drafting of the Better Care Fund plan and budget for 20/21 commenced in early 2020 and plans were established to refresh priorities and complete improvement work, identified in a 2019 BCF review. However, these plans were put on hold in spring 2020 to deal with the pressures of the emerging Covid19 pandemic. The current section 75 was extended to cover 2020/21 and a roll-over approach to the budget was adopted for 20/21.

National Metrics

5.2 The BCF in 19/20 reported against key four national metrics, this was not required in 20/21 however locally the performance monitoring continued:

Metrics	Summary 20/21
Non-Elective Admissions	**There were much fewer Non-Elective Admissions than planned for Q1 20-21**, and much fewer than previous years. This was most likely due to the Covid19 pandemic and people avoiding A&E admission where possible. Further data was not available from the CSU.
Permanent Admissions to Residential Homes (65+)	**This metric was consistently below target**. This is positive, particularly given the increased pressure to expedite hospital discharges, and illustrates the focus on Home First/ Discharge to Assess as a policy. This also indicates the Covid19 impact on lowering demand for care home placements.
Delayed Transfers of Care	**DTOC reporting was paused in March 2020.** National guidance for 21/22 including information on the future of this metric is awaited.
Effectiveness of Reablement	Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. **The target for this metric was 81.3% for the year, and we achieved 86.1%.**

See Appendix A for more detail.

Local Success 2020/21

5.3 Notwithstanding the pressures and devastation caused by Covid19, the pandemic acted as an accelerating factor for integration between health and social care, as a system and at Place. Operational and strategic relationships and processes between partners strengthened to allow for swift hospital discharges, admission avoidance and the delivery of crucial joint up community care (see case study in para 5.5). Some integration areas that progressed at pace in response to the pandemic include:

- Embedding of discharge huddles in acute hospitals and implementing national discharge guidance including 7-day working during the height of the pandemic
- Jointly securing additional Discharge to Assess provision
- Improving the monitoring and reporting of the Risk Funding Protocol
- Refreshing the Discharge & Flow governance and workplan at system level, while improving discharge flow reporting
- Joint work with the third sector to support vulnerable residents through the Community Response Hub

5.4 As a system, there has also be an added impact of the hospital discharge fund which was put in place last year and which is funded nationally and topped up by the system for the first 6 months of this year. This will have enhanced our performance on

discharge to assess and forms a risk should this funding not be available going forward.

5.5 Covid19 also acted as a key driver for closer collaboration with the care market. This has improved commissioners' understanding of local provision, market sustainability and how to support providers during the pandemic. Further learning from the Covid19 pandemic will be harnessed through a local winter plan review, currently in progress.

5.6 A key example of closer multi-disciplinary working and integrated decision-making at Place is the embedding of the Locality Access Point (LAP) in 20/21. During the peak of the pandemic the team supported acute settings with complex discharges and provided follow up welfare calls or visits to support with settling back home and access community services as required. The team continues to have strong links with social prescribing teams and the voluntary sector, this supports a proactive preventative approach. The collaborative approach of the team supports those in needs, they have to only tell their story once, and are reassured to know all their needs are assessed and onward referrals completed without them having to navigate complex pathways.

Moving forward

5.7 With the Integration White Paper published in February 2021, it has become evident that the pace of integration is accelerating: "Frequently, place level commissioning within an integrated care system will align geographically to a local authority boundary, and the Better Care Fund (BCF) plan will provide a tool for agreeing priorities." The Better Care Fund will retain its policy intention but will have a standalone power, separating it from the annual NHS mandate setting process.

5.8 The integration journey for Bracknell Forest will be informed by the evolution of the Frimely ICS and the development of Place. Also, national plans are expected for adult social care reform in 2021, which will further guide integration in Bracknell Forest.

5.9 Local authorities and CCGs are still awaiting the national policy guidance for the Better Care Fund 2021/22. Once this is received, a final plan and budget will be developed and presented to the Health and Wellbeing Board for approval.

5.10 In the meantime, the Better Care Fund will pick up areas of work that were halted last year and will be guided by the updated High Impact Change Model which gives Housing a stronger emphasis. The BCF will reflect locally identified priorities and learning from the pandemic and explore opportunities for collaborative work at East Berkshire and ICS level. A BCF Delivery Group has been set up to increase operational collaboration between local health and care partners. Emerging priorities include:

- Assistive technology to enable swift discharges and people to stay independent at home for as long as possible
- Continued focus on dementia, frailty and falls to support the older population in remaining independent as long as possible (Ageing Well Programme)
- Wider use of the Disabilities Facilities Grant to enable people to stay longer at home through adaptations
- Review of schemes to improve value for money and outcomes reporting, using key performance information to better measure and report on the impact of the BCF
- Establishing an inclusive and effective governance structure to drive and deliver integration at Place

- Backed by a refreshed S75 to reflect updated structures, service schedules and policy drivers

5.11 Further, the BCF will be supporting emerging areas of need and priorities identified in the upcoming Health and Wellbeing Strategy (due September 2021), as well as any appropriate joint commissioning areas identified in the Joint Working Blueprint programme between the Council and the CCG. This could include mental health / isolation and other covid19 related pressures identified by system partners.

5.12 It is recommended to continue to confer delegated authority to the Director of People to sign off BCF templates.

6 Consultation and Other Considerations

Legal Advice

6.1 Section 75 of the National Health Service Act 2006 contains powers enabling NHS bodies and local authorities to pool funding into a pooled fund. The Section 75 Partnership Agreement is such an arrangement which enables the management of BCF schemes in accordance with the national conditions. The year-end reporting requirements have been considered elsewhere in the body of this report and the Council plans to comply with such requirements.

Financial Advice

6.2 Finance have completed the financial elements of the NHS year-end template. There are no financial implications from this report.

Other Consultation Responses

6.3 The Year End report received input from financial, operational and strategic stakeholders from the local authority and the CCG.

Equalities Impact Assessment

6.4 No formal EIA was completed as part of the delivery of the 20/21 BCF. However, it is anticipated that the provision of the Better Care Fund schemes have had an overall positive effect on residents with protected characteristics, especially older people, those with disabilities or long term conditions and carers.

Strategic Risk Management Issues

6.5 Some risks have been identified in the sign off of the Year End report:

Risks	Mitigation
Overriding strategic priorities for BCF are currently unclear (e.g. national strategic direction for social care, BCF national guidance delayed)	Draft budget planning is progressing with principles to guide business cases to be agreed Continuing to work closely as local partners on Place Plan and Health and Wellbeing Strategy
Rising prices in the social care market	Managing the market – ASC commissioning: MPS and strategy for residential and nursing

	Managing uplift process as a council Heathlands for dementia nursing care - block contract
Unmet / delayed need in the system stemming from Covid19 putting surge pressure on health and social care provision	Close monitoring of volume coming into system (mental health, acutes / social care) in discharge and flow Ongoing collaboration to plan for and respond to surge demand
Staffing and recruitment issues in health and social care following high stress periods during covid19 and Brexit	Recruitment campaign across EB in Q4 20/21 and Q1 21/22 ICS level Workforce Planning
Hospital discharge funding not continuing	Continued joint working around discharge to assess Robust market analysis and effective market management

Climate Change Implications

6.6 The recommendations in Section 2 above are expected to have no impact on emissions of CO_2. The reasons the Council believes that this has no impact on emissions are that the Better Care Fund year-end report is a financial summation of the joint health and social care spend in the area and thus carbon neutral.

Background Papers
Bracknell Forest Better care Fund - Year End report

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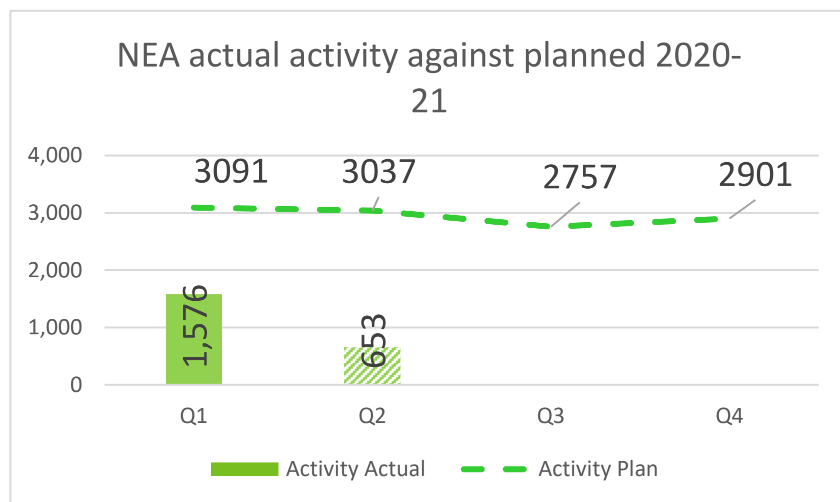
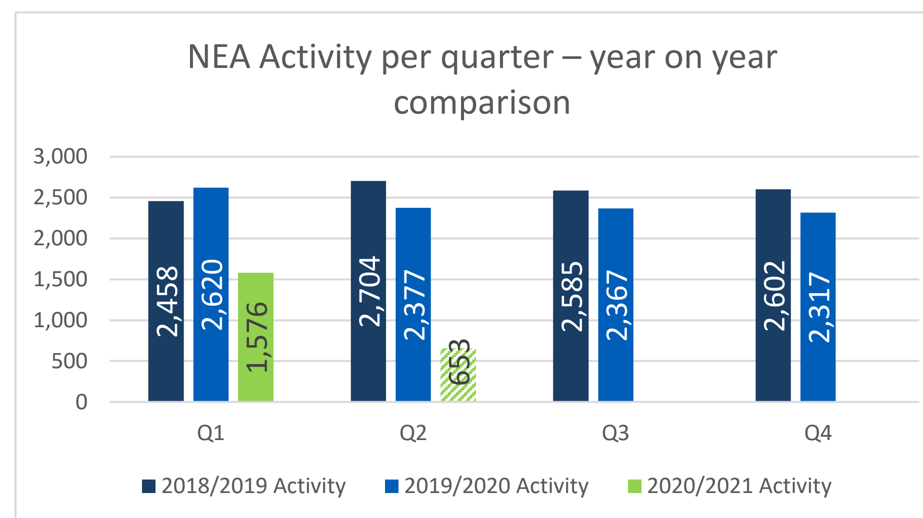
Appendix A – Better Care Fund National metrics 2020/21

Non-Elective Admissions

Total Non-elective spells (specific acute) per 100,000 population (all ages)





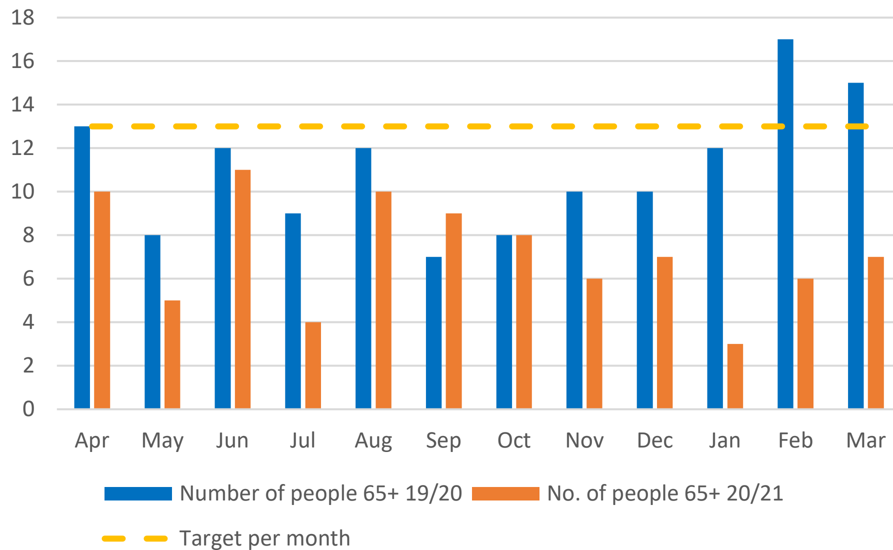
Looking at Q1, there have been much fewer Non Elective Admissions than planned for 20-21 (top left), and much fewer than previous years (top right). In April and March, numbers were approximately 43% lower than they had been for the same months in the preceding years (See below, circled). This has picked up to around 600 for June, and into Q2 (NB: Q2 at present only includes July's figures).

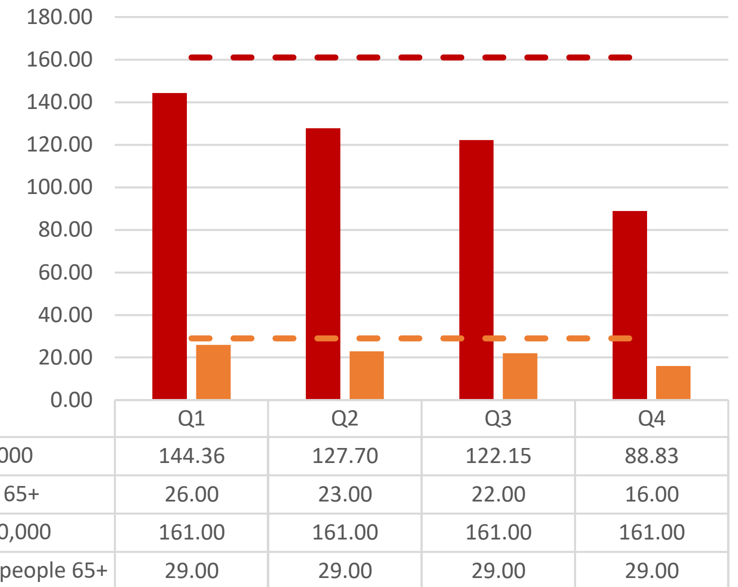
It has not been possible to obtain any updated figures for this metric from CSU. Alternative datasets available (e.g. A&E attendances per hospital or referrals received by Adult Social Care) would not capture the same cohort in order to be comparable against the targets.

	2018/2019		2019/2020		2020/2021	
	Activity	Cost	Activity	Cost	Activity	Cost
Q1	2,458	£4,908,981	2,620	£5,631,858	1,576	£3,867,668
Apr	783	£1,606,941	855	£1,891,827	473	£1,092,169
May	835	£1,687,385	890	£1,946,374	496	£1,213,786
Jun	839	£1,614,655	876	£1,793,657	607	£1,561,713
Q2	2,704	£5,174,083	2,377	£5,383,222	653	£1,371,491
Jul	893	£1,736,224	851	£1,785,349	653	£1,371,491
Aug	955	£1,752,398	775	£1,868,531		
Sep	857	£1,685,461	751	£1,729,342		

Permanent Admissions to Residential Homes (65+)

Long term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population





	Q1	Q2	Q3	Q4
Rate per 100,000	144.36	127.70	122.15	88.83
No. of people 65+	26.00	23.00	22.00	16.00
Target per 100,000	161.00	161.00	161.00	161.00
Target No. of people 65+	29.00	29.00	29.00	29.00

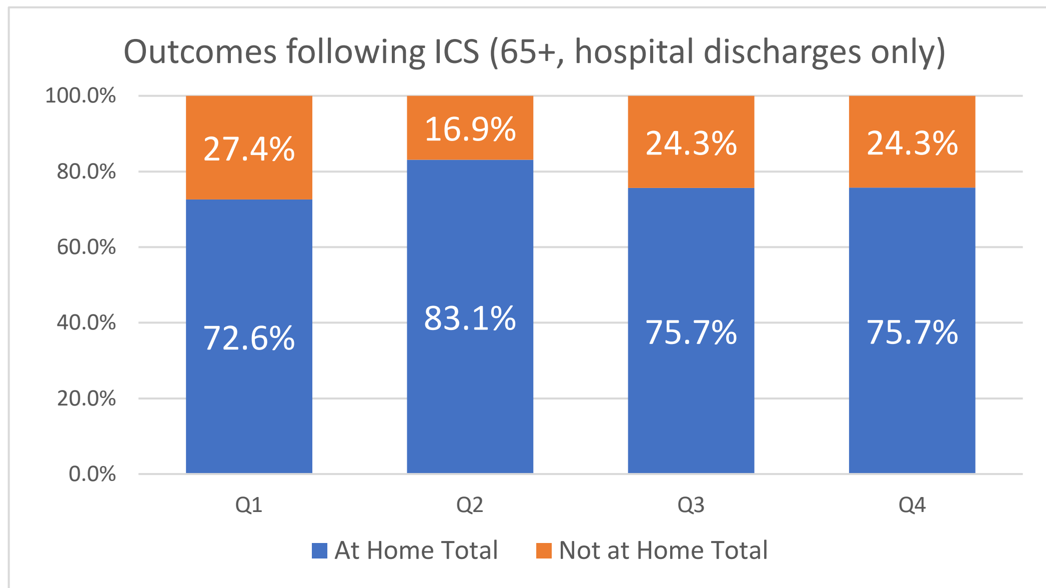
This metric has been consistently below target in 20/21. This is positive, particularly given the increased pressure to expedite hospital discharges, and illustrates the focus on Home First as a policy.

Looking at the comparison against last year (top right), the numbers of admissions followed similar patterns in terms of peaks and troughs for the first part of the year but Q4 shows a distinct reduction. There was an increase in admissions during the winter months in 19/20, which hasn’t repeated in 20/21. This may demonstrate ongoing effects of the pandemic and may return to previous levels in due course.

Effectiveness of Reablement

Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services*

The national 91 days metric is not available quarterly as it reports on a snapshot between October and December (followed up between January and March). **The target for this metric is currently 81.3% for the year.** For 20-21, preliminary reports shows **we achieved 86.1%** although this may be subject to a slight change following ratification.



The graph (left) shows an **equivalent metric**, with outcomes immediately following ICS throughout the year. Interestingly, this shows that the target was not met for Q1, Q3 or Q4. This could be due to a number of reasons, but the key difference is the BCF metric takes a snapshot at 91 days post discharge which is not always representative of a person's situation. In this case, the higher percentage at 91 days could indicate that although people were readmitted to hospital after receiving ICS, they may have then been discharged to a different home-based service.

*The BCF metric does not include those under the age of 65 or those referred for reablement from the community. These figures also exclude anyone referred to the service for End of Life support.

	Not at Home				At Home				
Row Labels	**Admitted to Hospice**	**Admitted to Hospital**	**Deceased**	**New Placement**	**Declined support**	**Family to support**	**New/increased LT POC**	**No further care needs**	**Returned to previous levels**
Q1	0.0%	21.9%	5.5%	0.0%	1.4%	2.7%	34.2%	31.5%	2.7%
Q2	0.0%	15.5%	1.4%	0.0%	4.2%	5.6%	23.9%	43.7%	5.6%
Q3	0.0%	24.3%	0.0%	0.0%	2.7%	5.4%	13.5%	54.1%	0.0%
Q4	1.4%	21.4%	0.0%	1.4%	5.7%	5.7%	18.6%	41.4%	4.3%

At home: Family support / New or increased POC / No further care needs / Returned to previous support levels / Declined support
Not at Home: Deceased / New Placement / Admitted to hospital / Admitted to hospice