## Walsall Council – Health and Wellbeing Board

## 13th June 2024

## Better Care Fund: End of Year Report 2023-24

## For Assurance

### 1. Purpose

This update will retrospectively inform members of details contained within the Better Care Fund (BCF) 2023-24 End of Year Reporting template, as per national requirements.

Agreed retrospective reporting is in place with delegated authority to Place Integrated Commissioning Committee (PICC) to support national submission dates, which fall outside Board meeting dates.

### 2. Recommendations

2.1 That the Health and Wellbeing Board retrospectively receives and agrees the BCF 2023-24 End of Year Reporting template following national submission in May 2024 as per national assurance.

### 3. Report detail

**Background**

3.1 The BCF 2023-2025 Policy Framework, reaffirms a clear direction for the fund to be one of the government's national vehicles for driving health and social care integration.

3.2 The BCF vision over 2023-2025 is to support people to live healthy, independent and dignified lives. National leads continue to prioritise integration as key driver, through joint approaches between health and social care, with a new emphasis on housing services to wrap seamlessly around the individual. To ensure alignment, the vision underpins two core BCF objectives:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time - making sure people are supported with a discharge to the right place, at the right time, and with the right support that maximises their independence.

**2023/24 End of Year**

3.3 The five metrics agreed as part of the planned BCF targets for 2023-2024 in the 2023-25 BCF Plan include:

- Unplanned hospitalisations for chronic ambulatory care sensitive conditions
- Proportion of hospital discharges to a person's usual place of residence
- Admissions to long term residential or nursing care for people over 65

- Reablement outcomes (people aged over 65 still at home 91 days after discharge from hospital to reablement or rehabilitation at home)
- Emergency hospital admissions for people over 65 following a fall.

3.4 The NHS metrics namely discharge to place of residence and avoidable admissions have been determined based on Integrated Care Board (ICB) baselines for a consistent approach across the Black Country. Social Care ambitions have been set as per Adult Social Care Outcomes Framework (ASCOF) measures.

All metrics met targets for the 2023-24 period.

3.5 The spend and activity reporting represents cumulative spend and outputs in the year to date for specific BCF schemes for 2023-24. The expenditure and actual numbers of outputs delivered are therefore reported to the end of the year (1 April to 31 March).

No implementation issues have been noted for spend and activity during the 2023-24 period.

<table>
<tr><th>Key Messages to Note<br><br>End of Year 2023/24 Update</th><th>Walsall Place BCF Programme – End of Year Report<br><br>FINANCIAL YEAR 2023/2024</th></tr>
<tr><td>Metrics Summary</td><td>All metrics were on track and met target at year end.<br>Summary of main challenges and achievements for each metric:
<table>
<tr><th>Metric</th><th>Challenges</th><th>Achievements</th></tr>
<tr><td>Avoidable admissions</td><td>High levels of activity across all areas supporting avoidance, in comparison to predicted performance.</td><td>Avoidable admissions remain a priority with teams working closely to support reduction in hospital admissions and length of stay: Virtual Wards at the Care Navigation Centre, Rapid Response and support to Care Homes.</td></tr>
<tr><td>Discharge to Normal Place of Residence</td><td>Impact on demand for services post-discharged.</td><td>The Walsall Intermediate Care Service works with Virtual Wards towards a home first approach and with care home teams to reduce re-admissions.</td></tr>
<tr><td>Falls</td><td>No dedicated falls service</td><td>Responding to falls is currently the responsibility of the locality community nurse teams with a focus on an integrated approach.</td></tr>
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| Residential admissions | Variation in Residential care fees | Below ASCOF outcomes |
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| Reablement | Increase in readmissions | High number of discharges returning home via Pathway 1 |

**Spend and Activity Summary**

All schemes were on target and no implementation issues were noted. All schemes reported on target for expenditure.

**Finance Summary**

Planned spend for 2023/24: £48,474,183

Actual expenditure for 2023/24: £50,833,644

This overspend when compared to the original plan is mainly due to the following:

1. £0.37m relating to the additional Disabled Facilities Grant (DFG) funding announced in September 2023 (this has been fully utilised)
2. £1.63m relating to increased demand within the Intermediate Care Services
3. £0.17m relating to increased demand in relation to Integrated Care Equipment Service.

Expenditure for year 2024/25 will address the demand and plan with service providers accordingly to achieve balance in year.

**Successes**

**NHSE Intermediate Care Frontrunner Project**

- Walsall Intermediate Care Service (ICS) was selected, along with four other Intermediate Care pilot sites, to test and evaluate a new model of Community Recovery Service post-discharge.
- Teams assessed the economic viability of the model of care and the impact across the health and social care with a focus on Workforce, Commissioning, Performance and Data, Capacity and Demand and Funding.
- Learning from pilot sites enabled publication of the national Intermediate Care Framework (Autumn 2023), supporting the delivery of intermediate care services, including rehabilitation and reablement.
- Walsall's Transfer of Care Hub (also known as Discharge Team) were recognised as an area of exemplar practice in the published framework.
- An additional £300,000 investment was aligned to the Black Country Integrated Care Board because of Walsall's participation.
- Recognition of the strong health and social care partnership in Walsall and set up of Walsall Together.

**Launch of Discharge to Assess: Pathway 2 & Pathway 3 Virtual Ward**

- Preventing hospital re-admission with the Development of a Virtual Ward for patients being discharged into bedded Pathway 2 & Pathway 3.
- Enabling patients to be monitored and supported in the sub-acute phase, for up to two weeks, by a multi-disciplinary/multi-agency team across Health and Local Authority organisations including

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| | pharmacy, medical staffing and health and social care professionals.<br>• Supporting Care Homes in monitoring patients' observations using a digital system. |
| **Challenges** | **Activity, Demand and Capacity**<br>• Increase in outturn levels within the Intermediate Care Service and Integrated Care Equipment Service.<br>• Strong need to sustain the amount of funding allocation provided to continue supporting demand and growth of the services.<br><br>**Staffing Capacity in the Intermediate Care Service**<br>• Not enough staffing capacity within the health and social care team to meet the demands in Pathways 1, 2 and 3.<br><br>**Technology in the Intermediate Care Service**<br>• Intermediate Care Service would benefit from the development of an electronic dashboard to enable real time reporting of data across the health and social care interface ensuring one version of the truth and facilitation of workflow in times of peak demand or in areas experiencing pressure points. |

**4. Implications for Joint Working arrangements:**

Partners in Adult Social Care, Black Country ICB Walsall Place, Walsall Healthcare Trust and our main provider service for Intermediate Care have contributed to the completion of the year end template by providing data on metrics and activity.

4.1 **Financial implications:**

Following increased capacity, demand and complexity overspend remained a pressure for the programme.

As part of risk management, monitoring of this pressure was overseen at PICC level.

4.2 **Legal implications:**

A Section 75 Agreement is in place for the BCF.

As part of risk management, the current risk share agreement under the Section 75 is being reviewed by PICC.

**5. Health and Wellbeing Board Priorities - impact:**

5.1 The programme supports the local approach to a healthy population, by aligning the outcome of supporting the independence to older people.

**Appendices:**

Appendix 1: **Better Care Fund: End of Year Report 2023-24**
Appendix 2: **Better Care Fund: Planning Template 2023-25**

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