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MANCHESTER CITY COUNCIL

Health and Wellbeing Board

Date: Wednesday, 3 November 2021
Time: 10.00 am
Venue: Council Chamber, Level 2, Town Hall Extension

This is a **supplementary agenda** and contains an item of urgent business that was not available at the time that the original agenda was published.

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Membership of the Health and Wellbeing Board

Councillor Richard Leese, Leader of the Council (Chair)
Councillor Bev Craig, Deputy Leader of the Council
Councillor Midgley, Executive Member for Adult, Health and Wellbeing (MCC)
Councillor Bridges, Executive Member for Children and Schools Services (MCC)
Dr Ruth Bromley, Chair Manchester Health and Care Commissioning
Katy Calvin-Thomas - Manchester Local Care Organisation
Kathy Cowell, Chair, Manchester University NHS Foundation Trust
Rupert Nichols, Chair, Greater Manchester Mental Health NHS Foundation Trust
Mike Wild, Voluntary and Community Sector representative
Vicky Szulist, Chair, Healthwatch
Dr Tracey Vell, Primary Care representative - Local Medical Committee
Paul Marshall, Strategic Director of Children's Services
David Regan, Director of Public Health
Bernadette Enright, Director of Adult Social Services
Dr Murugesan Raja Manchester GP Forum
Dr Geeta Wadhwa Manchester GP Forum
Dr Doug Jeffrey, Manchester GP Forum
Dr Shabbir Ahmad Manchester GP Forum (substitute member)
Dr Denis Colligan, Manchester GP Forum (substitute member)

Supplementary Agenda

1. Urgent Business 3 - 26

To consider any items which the Chair has agreed to have submitted as urgent.

- Better Care Fund - return

Further Information

For help, advice and information about this meeting please contact the Committee Officer:

Andrew Woods
Tel: 0161 234 3011
Email: andrew.woods@manchester.gov.uk

This supplementary agenda was issued on **Thursday, 28 October 2021** by the Governance and Scrutiny Support Unit, Manchester City Council, Level 3, Town Hall Extension (Lloyd Street Elevation), Manchester M60 2LA

Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board – 3 November 2021

Subject: Better Care Fund (BCF) return

Report of: Senior Planning Manager, MHCC

Summary

NHS England have requested that a BCF return is completed for Manchester which demonstrates the plan to successfully deliver integrated health and social care.

The plan focuses on the requirement to reduce long length of stay in acute settings and to provide support for people to remain in the community by having effective discharge pathways and social care provision.

NHS England request that the plan is approved by the Health and Wellbeing Board prior to being submitted to them by 16 November 2021.

Recommendations

The Board is asked to:

1. Approve the Better Care Fund return

2. Approve the narrative return in support of the Better Care Fund plan.

Board Priority(s) Addressed:

Health and Wellbeing Strategy priority	Summary of contribution to the strategy
Enabling people to keep well and live independently as they grow older	The plan sets out the support that is in place to support people to remain in the community. This includes the support that is provided by the crisis team to reduce the likelihood that patients will require hospital care. It also includes having effective discharge pathways including discharge to assess provision to minimise the length of stay of patients in hospital. The plan also includes the support that is provided to help people remain in the community once they leave hospital such as the reablement provision and the neighbourhood apartments which provide short term support to rehabilitate patients.
One health and care system – right care, right place, right time	
Self-care	

Links to the Manchester Health and Social Care Locality Plan

The three pillars to deliver the Manchester Health and Social Care Locality Plan	Summary of Contribution or link to the Plan
A single commissioning system ensuring the efficient commissioning of health and care services on a city-wide basis with a single line of accountability for the delivery of services	CCG funding is provided to support effective discharge pathways and community provision including care home support.
'One Team' delivering integrated and accessible out of hospital community-based health, primary and social care services	There is an integrated community approach including support which is being provided by crisis teams, reablement, intermediate care, residential and nursing care.
A 'Single Manchester Hospital Service' delivering consistent and complementary arrangements for the delivery of acute services achieving a fully aligned hospital model for the city	The hospital discharge policies have been produced in consultation with MFT to ensure that patients are able to leave hospital as soon as they are medically fit to do so.

Lead board member: Cllr Midgley

Contact Officers:

Name: David Regan
Position: Director of Population Health and Wellbeing
Telephone: 0161 234 3981
E-mail: d.regan@manchester.gov.uk

Background documents (available for public inspection):

The following documents disclose important facts on which the report is based:

- BCF planning template
- BCF narrative return

1.0 Introduction

1.1 This paper provides the Health and Wellbeing Board with an overview of the Better Care Fund (BCF) planning guidance for 2021/22 and the related reporting requirements related to the BCF plan and pooled budget.

Background

1.2 The Department of Health and Social Care (DHSC) have issued a policy framework for the implementation of the Better Care Fund in 2021/22. The framework sets out that plans should have stretching ambitions for improving outcomes against the national metrics.

1.3 From March 2020, in response to the pandemic, the Hospital Service Requirements set out revised processes for hospital discharges in all areas, including a requirement that people are discharged on the same day that they no longer need to be in an acute hospital; and implementation of a home first approach. This policy is supported by additional funding in 2021/22 for health and social care activity to support recovery outside hospital and to implement a discharge to assess model.

1.4 Improved Better Care Fund (iBCF) and Disabled Facilities Grant (DFG) are paid to local authorities with a condition that they are pooled into the BCF and spent on specific purposes set out within the BCF framework.

1.5 The reporting requirement requires the reporting template to be populated with the CCG minimum contributions to the BCF, Disabled Facilities Grant and the Improved Better Care Fund.

2.0 Reporting requirements

2.1 The BCF returns need to be submitted to NHS England by 16 November. There is a local requirement to submit the return to the GM Assurance office by 10 November in order that they can verify the return before forwarding to NHS England.

2.2 Part of the requirements of the return are that the approach and return must be agreed by stakeholders including the CCG, Local Authority and the Voluntary Sector and signed off by the Health and Wellbeing Board.

2.3 The return requires consideration of how health inequalities are taken into consideration in the delivery of services. Actions undertaken including trying to have a culturally competent workforce, having availability of translation services and engaging with communities at a neighbourhood level.

2.4 The BCF funding also requires that there is Section 75 agreement between the CCG and Adult Social Care for the pooling of health and social care budgets. A new Section 75 agreement is now in place between the MLCO and MCC as the deliverers of integrated health and social care. The CCG does however retain oversight of the BCF process by providing a CCG

contribution to MLCO activity and by MCC representation being retained on the MHCC Board and Strategy Committee.

3.0 Key aspects of the return

3.1 The BCF plan complies with the 4 BCF national conditions for 2021/22 which are:

1. A jointly agreed plan between local health and social care commissioners, signed off by the HWB
2. NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution
3. invest in NHS-commissioned out-of-hospital services
4. a plan for improving outcomes for people being discharged from hospital

3.2 The activity within the plan has been agreed by health and social care colleagues from the CCG, MCC and MLCO and the funding has been agreed in line with the NHS uplift requirements for the programme.

3.3 The programme concentrates on a range of activity to support people to be cared for in the community meaning that they either do not need to enter hospital such as by receiving support from the crisis response team or by having effective pathways in place to support people to be discharged from hospital on the day that they no longer need to be there.

3.4 A key aspect of the plan are the discharge pathways which are:

- Pathway 0 – Discharge home with no further care needs
- Pathway 1 – Discharge home with care needs
- Pathway 2 – Discharge to intermediate care
- Pathway 3 – Discharge to Residential or nursing care.

3.5 For patients that are unable to be discharged home straight away the care that they are able to access includes neighbourhood apartments which offer a short term solution to help support patient rehabilitation. Additionally, Pathway 3 includes Discharge to Assess beds within residential and nursing homes, helping to support patients who may have more complex short term care needs on leaving hospital.

3.6 Further details of the BCF plan are contained within the BCF narrative return.

4.0 Recommendation

4.1 The Health and Wellbeing Board are asked to approve the BCF planning template and narrative return and provide confirmation of sign off for the plan.

BCF narrative plan template

This is an optional template for local areas to use to submit narrative plans for the Better Care Fund (BCF). These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover the headings and topics in this narrative template.

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s)

Manchester Health and Wellbeing Board

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

How have you gone about involving these stakeholders?

The BCF plan has been completed in collaboration with Adult Social Care and community care colleagues from Manchester City Council (MCC) and the Manchester Local Care Organisation (MLCO). Data has been gathered from the Business Intelligence information gathered from Manchester Foundation Trust and from Quality Improvement managers who undertake performance reviews and sit on acute boards. The plan has been presented to representatives of the VCSE via the Health and Wellbeing Board. A process for the development of the plan was put in place for 2021 in which finance colleagues from the CCG and MCC agreed on the funding allocation for BCF activity along with the reporting arrangements. Meetings have taken place with colleagues from the MLCO, Provider Quality, Improvement and Reform and Business intelligence to develop the approach.

Executive Summary

This should include:

- Priorities for 2021-22
- key changes since previous BCF plan

Key priorities for the BCF plan are:

1. Ensuring that there are effective discharge pathways in place to allow people to leave hospital as soon as possible.
2. To deliver effective crisis response activities in place to prevent admissions
3. Ensure there is sufficient reablement provision to maximise the amount of people who are able to remain at home 91 days after leaving hospital
4. To ensure there is sufficient residential care and nursing care to meet the needs of the cohort

Plan involves working with North West Ambulance Service (NWAS) to have crisis responses that minimise the number of people who need to enter hospital. When NWAS workers receive a call an assessment can be made of the level of support that is needed. The crisis team are embedded within the City and include a nurse, a therapist and practitioner who can also call upon additional help to support people to stay at home. For patients who are supported to stay at home they also receive a reablement response with 72 hours which provides a long term approach to help them stay at home.

For people who do enter hospital, MLCO colleagues work closely with hospital discharge teams to ensure that they are able to be discharged once they are medically fit to do so. There are 4 pathways in place to support the discharge process:

Pathway 0 – Discharge home with no further care needs

Pathway 1 – Discharge home with care needs

Pathway 2 – Discharge to intermediate care

Pathway 3 – Discharge to Residential or nursing care.

Although currently not formally part of the BCF pooled budget, the discharge arrangements out of hospital in to pathway three have been significantly invested in since the previous BCF plan, in particular in response to the pandemic. Manchester are working on how on consolidate plans post HDP funding cessation – with proposals on continuation of blocked booking arrangements and risk share with the local authority on costs.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

The Governance of the BCF plan has been approved by the Health and Wellbeing Board.

The Discharge process and the delivery of all community activities have been approved by the MCLO Reform, Recovery and Portfolio Board which also has representation from Manchester Health and Care Commissioning.

The overall approach is supported by a crisis team who help to minimise the amount of people who need to attend hospital. For those who do need to be discharged from hospital there is an acceptance that many people may need significant support on leaving hospital. This is done in several ways including having Extracare provision which allows for intermediate support to be offered to people who are not fully capable of a return home following their stay in hospital. The provision is 25 short stay beds which is helping to get people out of hospital as soon as possible. With a further 5 Extracare beds becoming available for 2022/23 there will be further opportunities to support people to leave hospital in a timely manner.

Sufficient provision has also been procured with residential and nursing care to allow the system to maximise the speed of patient discharge. Additional support is also provided to care homes to ensure that people are reviewed within 4-6 weeks to ensure that they are moved to appropriate long term provision.

Overall system governance is also provided by review panels of experts and practitioners who ensure that when service users circumstances change that they are provided with the most appropriate provision for their needs.

The Health and Wellbeing Board sits every month and is able to ensure that there is fidelity within the system.

The Manchester Partnership Board is also in place including stakeholders from health, social care, Manchester City Council and the Voluntary and Community sector, working together to set Manchester's priorities and strategy.

Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- Joint priorities for 2021-22
- Approaches to joint/collaborative commissioning
- Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.

Health, social care and housing all have the priorities to support being able to remain at home or their normal place of residence for as long as possible. This is supported through crisis response activity which involves collaborative working between NWAS and social care to ensure that people are given the appropriate support to stay at home with support where their condition does not warrant attendance at hospital.

Reducing long length of stay is a joint priority. This involves community services working closely with hospital discharge teams to ensure that patients can be discharged as soon as they are medically fit to do so.

As a system four discharge pathways have been agreed, which ensure that when discharged patients are given access to the appropriate level of care for their needs. One of the overarching areas of support to help keep people at home is the reablement programme. The reablement team provide support to patients to cope with or manage their condition. The team are also able to work closely with adult social care colleagues to provide additional support if needed.

Reablement support is highly effective in Manchester. In 2019/20, 82% of people who were discharged from hospital with a reablement package (not including intermediate care) were still at home 90 days after discharge. Where patients are not able to return home straight away Short term neighbourhood apartments provide a viable short term solution to help support patient rehabilitation. Due to the success of the reablement programme it is believed that 85% of people discharged from hospital with reablement in 2021/22 will be able to remain at home 90 days after discharge.

There are currently 25 neighbourhood apartments, with 130 people benefiting from the provision since 2019/20, only 4% of which returned to hospital following their stay in the neighbourhood. 25% were able to return to their original home and 31% moved into long term Extracare provision. These neighbourhood apartments also provide step down provision from residential care. The neighbourhood apartments are also located in places which allow the provision to align with the Integrated Neighbourhood teams offer.

The main changes to the system for 2021/22 are discharge pathways and the increase in neighbourhood apartments.

Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

The processes that are in place to support safe, timely and effective discharge include having appropriate pathways and support in place. The BCF plan for Manchester aims to continue to build on the processes that were put in place during the pandemic by facilitating a reduction in long length of stay in 2021/22. Data analysed for 2021/22 so far suggests that over 96% of people who are discharged from hospital will be able to be discharged to the normal place of residence and is expected to continue for the rest for 2021/22.

Community discharge to assess teams including reablement teams (focusing on pathway 1) help to support the discharge process including making sure that patients receive the support that they need once released. Over 80% of people who have been discharged from hospital with a reablement package are still at home 90 days after being discharged.

On discharge from hospital patients current care needs will be checked to make sure that they are still appropriate and if not their care needs will be reviewed and alternative support put in place. The availability of neighbourhood apartments to provide a short term opportunity for patients to be rehabilitated to a level where they are able to return home also ensures an effective discharge which minimises the likelihood of the patient needing to return to hospital.

For those patients on pathway 3, in response to the pandemic a dedicated team was established to facilitate timely discharge from hospital. This team is part of the community service offering, and is fully integrated between health and social care – with all placements being made by one dedicated 'control room'. To ensure consistency of service and availability of beds Manchester had adopted a block booking approach – creating dedicated discharge to assess beds. Evidence to date has shown that patients discharged in to one of these dedicated beds is likely to receive all assessments required on a much more timely basis, and also more likely to be discharged home than those who have gone to a 'spot purchase' bed. Manchester is currently exploring the potential to invest in expanding the block booking approach, and investing post hospital discharge programme (HDP) funding expiry. It is noted that Manchester currently does not flow HDP funding through its BCF agreement, but it remains a key part of the discharge strategy.

There is also a role for integrated neighbourhood teams (INTs) who operate across 12 neighbourhoods to support the delivery of care. The teams support a joint approach to delivering care. The INTs work closely with GPs as the main point of access to care, as well as connecting with MLCO and wider health and wellbeing services. The INTs also work with other partners in the neighbourhood including Manchester City Council neighbourhood teams, local housing associations, police and VCS organisations to deliver the best possible care for service users.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Manchester Care and Repair have in house equipment and an adaptation service which ensures that patients are able to receive the adaptions they need quickly to return home.

The Manchester Equipment and Adaptions Partnership (MEAP) has occupational therapists who support disabled residents with equipment and adaptations for their home, or by rehousing them in a more suitable property.

There have been issues when people need an Occupational Therapists as there is a national shortage of therapists, but generally adult social care is able to arrange the appropriate care needs for service users including any adaptions, with social workers able to make rapid decisions to support services users to receive the adaptions that they need.

As part of the assessment of need, a Disabled Facilities Grant will be applied for and used where appropriate to make sure that housing can be fully adapted for the needs of the individual to allow them to continue to live in their own home,

Equality and health inequalities.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan.
- How these inequalities are being addressed through the BCF plan and services funded through this.
- Inequality of outcomes related to the BCF national metrics.

Community services has a multi diverse workforce which is able to provide support to service users in several different languages. Staff also have access to translation services including phone translation to support people for whom English is not their first language.

By linking in with local neighbourhood teams, engagement activities are undertaken to understand the needs of different communities. The assessment and support process that is in place mean that support is tailored to the needs of the individual including any of their long term health conditions.

An assessment is being taken to ensure that there is equity within service delivery. This is involving a review of the outcomes of acute activity by ethnicity. Disparity in outcomes will then help to identify whether additional support needs to be put in place to support specific groups.

Where patients are released from hospital consideration is made of patient's protected characteristics in order to make sure that the most appropriate care can be provided to service users.

An addressing inequalities action plan has been developed by MHCC to look at how actions to reduce inequalities can be evidenced. As part of this, effort is being made to ensure that there is a systematic review of Equal Impact Assessments to ensure that all programmes fully take the needs of the protected characteristics of service users. The plan is also about ensuring that there is sufficient data to analyse the impact of services on people based on different protected characteristics.

Better Care Fund 2021-22 Template

2. Cover

HM Government

NHS

Version 1.0

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Manchester
Completed by:	Owen Boxx
E-mail:	[redacted]
Contact number:	[redacted]

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Director of Population Health and Wellbeing
Name:	David Regan

Has this plan been signed off by the HWB at the time of submission?	Yes
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	

	Role:	**Professional Title (where applicable)**	**First-name:**	**Surname:**	**E-mail:**
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Bev	Craig	cllr.bev.craig@manchester.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)	Mr	Ian	Williamson	[redacted]
	Additional Clinical Commissioning Group(s) Accountable Officers	Mr	Ed	Dyson	[redacted]
	Local Authority Chief Executive	Ms	Joanne	Roney	j.roney@manchester.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Ms	Bernie	Enright	bernadette.enright@manchester.gov.uk
	Better Care Fund Lead Official	Mr	David	Regan	d.regan@manchester.gov.uk
	LA Section 151 Officer	Ms	Carol	Culley	carol.culley@manchester.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence -->					

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Manchester

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£8,482,757	£8,482,757	£0
Minimum CCG Contribution	£47,264,693	£17,103,241	£30,161,452
iBCF	£30,815,774	£30,815,774	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£86,563,224**	**£56,401,772**	**£30,161,452**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£13,431,286
Planned spend	£0 Planned spend is less than the minimum require

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£17,103,241
Planned spend	£17,103,241

Scheme Types

Assistive Technologies and Equipment	£418,959	(0.7%)
Care Act Implementation Related Duties	£2,002,751	(3.6%)
Carers Services	£0	(0.0%)
Community Based Schemes	£0	(0.0%)
DFG Related Schemes	£8,482,757	(15.0%)
Enablers for Integration	£28,149,724	(49.9%)
High Impact Change Model for Managing Transfer of	£365,000	(0.6%)
Home Care or Domiciliary Care	£3,410,731	(6.0%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£6,410,595	(11.4%)
Bed based intermediate Care Services	£0	(0.0%)
Reablement in a persons own home	£1,879,872	(3.3%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£0	(0.0%)
Residential Placements	£5,281,383	(9.4%)
Other	£0	(0.0%)
Total	**£56,401,772**	

Metrics >>

Avoidable admissions

	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	739.4	720.0

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients	LOS 14+	1.4%	1.3%
	LOS 21+	1.8%	1.7%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	0.0%	96.2%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	760	1,908

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes

	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Manchester

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Manchester	£8,482,757
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£8,482,757**

iBCF Contribution	Contribution
Manchester	£30,815,774
Total iBCF Contribution	**£30,815,774**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

CCG Minimum Contribution	Contribution
NHS Manchester CCG	£47,264,693
Total Minimum CCG Contribution	**£47,264,693**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£47,264,693**	

	2021-22
Total BCF Pooled Budget	**£86,563,224**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Manchester

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£8,482,757	£8,482,757	£0
Minimum CCG Contribution	£47,264,693	£17,103,241	£30,161,452
iBCF	£30,815,774	£30,815,774	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£86,563,224**	**£56,401,772**	**£30,161,452**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend	
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£13,431,286	£0	£13,431,286	Planned spend is less than the minimum required spend
Adult Social Care services spend from the minimum CCG allocations	£17,103,241	£17,103,241	£0	

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

One or more National Conditionals are not met (see second table at top of this sheet)

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	DFG	The DFG is a means-tested capital grant to help meet the costs of	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Local Authority	DFG	£8,482,757	Existing
2	Improved Better Care Fund	Address pressures on Adult Social Care budgets - It is well	Enablers for Integration	Integrated models of provision		Social Care		LA			Local Authority	iBCF	£28,149,724	Existing
3	Winter Pressures Grant	Additional social care posts to provide social care capacity for	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	iBCF	£2,196,050	Existing
4	Winter Pressures Grant	Additional funding to support increase in home care packages	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Local Authority	iBCF	£105,000	Existing
5	Winter Pressures Grant	Additional social care posts to provide social care capacity for	High Impact Change Model for Managing Transfer	Early Discharge Planning		Social Care		LA			Local Authority	iBCF	£365,000	Existing
6	Care Act	Funding to cover changes in the legislation relating to eligibility,	Care Act Implementation Related Duties	Other	Safeguarding, financial assessments,	Social Care		LA			Local Authority	Minimum CCG Contribution	£2,002,751	Existing
7	Social Care	Protection of ASC: variety of spend such as social workers,	Residential Placements	Care home		Social Care		LA			Local Authority	Minimum CCG Contribution	£3,250,113	Existing

8	Social Care	Protection of ASC: variety of spend such as social workers,	Residential Placements	Nursing home		Social Care		LA			Local Authority	Minimum CCG Contribution	£1,481,000	Existing
9	Social Care	Protection of ASC: variety of spend such as social workers,	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum CCG Contribution	£118,959	Existing
10	Social Care	Protection of ASC: variety of spend such as social workers,	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Local Authority	Minimum CCG Contribution	£300,000	Existing
11	Social Care	Protection of ASC: variety of spend such as social workers,	Reablement in a persons own home	Reablement service accepting community and		Social Care		LA			Local Authority	Minimum CCG Contribution	£1,879,872	Existing
12	Social Care	Protection of ASC: variety of spend such as social workers,	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	Minimum CCG Contribution	£2,191,055	Existing
13	Social Care	Protection of ASC: variety of spend such as social workers,	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Local Authority	Minimum CCG Contribution	£2,447,731	Existing
14	Social Care	Protection of ASC: variety of spend such as social workers,	Residential Placements	Other	Supported Accommodation, Day Care, Adult	Social Care		LA			Local Authority	Minimum CCG Contribution	£550,270	Existing
15	Social Care DTOC	Funding will be used to support existing services or transformation	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	Minimum CCG Contribution	£2,023,490	Existing
16	Social Care - Extra Care	Support for the extension of extra care, to enable people to	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Local Authority	Minimum CCG Contribution	£858,000	New

2021-22 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
3	Carers Services	1. Respite services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
17	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Manchester

8.1 Avoidable admissions

		19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only		739.4	720.0	Total admissions for 2020/21 - 4088. Population 552858. The crisis response team is embedded across the city. Team includes a nurse, therapist and practitioner who can then call out team to support the person to stay at home. They will then contact reablement within 72 hours to ensure that a full package of care can be put in	**Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**

>> link to NHS Digital webpage

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments	
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	1.4%	1.3%	Q1 21-22 14 day admissions 725 21 day admissions 903 Total admissions 51293	**Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**
	Proportion of inpatients resident for 21 days or more	1.8%	1.7%	Q2 21-22 14 day admissions 21 day admissions Total admissions	

8.3 Discharge to normal place of residence

	21-22 Plan	Comments	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	96.2%	2020/21 Normal place of residence 162996, Population 169484. There are 25 short stay neighbourhood apartments to help people to leave hospital quicker. This allows people to transitition to their own home or into other accommodation including Extracare or residential	**Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments	
Long-term support needs of older people (age 65 and over) met by	Annual Rate	784	809	760	1,908	D2A model pilot has reduced the rates of permanent Residential and Nursing home placements as more	**Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing**

people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Numerator	405	416	392	1,000	people are going home. People who are being discharged into residential care are still assessed and will be stepped down to more appropriate provision if their conditionn approves.	**homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**
	Denominator	51,631	51,441	51,557	52,417		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	80.0%	61.1%	85.0%	20/21 rate was 63.47% (note includes intermediate care as per the ASCOF 2B definition). For 19/20 the number of people who were at home 90 days after being discharged under a reablement package was over 82%. The lower figure for 18/20 will also reflect the amount of people who are discharged to intermediate care. Going	**Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**
	Numerator	824	299	850		
	Denominator	1,030	489	1,000		

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.