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.