Better Care Fund 2021-22 Template

2. Cover

Version 1.0

HM Government

NHS

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- 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

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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

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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

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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

>> link to NHS Digital webpage

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.

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
	Proportion of inpatients resident for 21 days or more	1.8%	1.7%	Q2 21-22 14 day admissions 21 day admissions Total admissions

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.

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.