BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans but use of this template for doing so is optional. Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

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.

An example answers and top tips document is available on the Better Care Exchange to assist with filling out this 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, housing organisations, district councils)

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). The plan plan has also involves Manchester University NHS Foundation Trust (MFT) involvement in the discharge planning process, the use of voluntary sector organisations (16 of which have contracts / grants with MCC) to support the delivery of community support for those discharged from hospital or to support people to avoid them needing to enter hospital.

MCC works with housing associations to enable people to receive the appropriate accommodation to meet their needs. There is involvement of several MCC departments including Manchester Care and Repair, which is an in house 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) have also been involved as they provide therapists to provide support disabled people with their equipment and adaption needs.

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 approach is a continuation of the approach adopted in 2021/22 which was presented to stakeholders within the Health and Wellbeing Board which includes representatives of the Voluntary and Community sector.

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 2022-23
- 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

The 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 is working on how on consolidate plans post Hospital Discharge Programme (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 Integrated Care Partnership. The finances for BCF are agreed through finance committees at MCC and previously at Manchester Health and Care Commissioning and now through Manchester Integrated Care Partnership.

All programmes related to BCF have gone through a business planning approval process. This has looked at what the individual programme will do, who they are targeted towards, the number of people being supported and expected outcomes. As part of the approval process this has meant explaining this process to finance, strategy committees and ultimately to the Health and Wellbeing Board. There has also been regular scrutiny of programmes including a review of performance against the identified targets for each programme. At a high level all programmes within BCF have to be focused on admissions avoidance, timely discharge and supporting people to be discharged to the most appropriate place such as their own home whereby they can avoid future admittance to hospital.

Performance is reported to MLCO Reform, Recovery and Portfolio Board and there is monitoring of performance through data supplied by the Manchester Integrated Partnership Business Intelligence team. Should there be shortfalls in performance there are mechanisms in place through the governance approach including through several committees/ Boards to ensure that senior managers ensure that a plan is put in place to increase capacity or flow. Going forward Manchester Integrated Care Partnership (MICP) is seen as a full partnership of key stakeholders within Manchester which should continue to ensure that we continue to deliver the objectives of the BCF.

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 two months 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 BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2022-23
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to integration. Briefl describe any changes to the services you are commissioning through the BCF from 2022-23.

In Manchester all stakeholders within health, social care and housing have the priorities to support patients and residents to be able to be discharged home or 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.

In addition to reablement patients are supported with their immediate care needs on being discharged from hospital. Home from hospital gives residents a range of immediate support to enable them to get home as quickly as possible, This includes immediate help from a handyman, help with shopping and providing advice and guidance which may include providing details of the voluntary sector activity that is available.
For people who need a longer term solution Homecare provision is now in place. New contracts are now in place with community Homecare providers who are all skilled in applying the strengths based approach which is about providing the care and support to help people to achieve their own goals. In many cases this will involve supporting people

to live more independently and to access the local support from friends, family and the voluntary and community sector which helps them to be as independent as possible,

There are also 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. Th ae 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 from 2021/22 are discharge pathways and the increase in neighbourhood apartments.

Through having a neighbourhood approach all partners and stakeholders are working towards the same goal which is admissions avoidance, early discharge and supporting people to live independently at home or in their community for as long as possible.

Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

Please use this section to outline, for each objective:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care
- How BCF funded services will support delivery of the objective

Plans for supporting people to remain independent at home for longer should reference

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level.

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

- Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.

- Carry out collaborative commissioning of discharge services to support this.

Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

In Manchester, the processes that are in place to support safe, timely and effective discharge in 2022/23 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 2022/23. Data analysed for 2021/22 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 in 2022/23.

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.

Although the BCF plan for 2022/23 builds on the plan for 2021/22, it also takes into consideration 'Managing Transfers of Care – A High Impact Change Model'. The process has included reviewing Manchester's proceses against each of the changes included within the model.

1. Early discharge planning – is a clear focus of timely discharge. It includes having community staff linked to, or part of hospital discharge teams to ensure that timely discharge can happen when patients are medically fit, as well as having appropriate reablement capacity to facilitate people to undergo rehabilitation at home.
2. Monitoring and responding to system demand and capacity – Manchester has comprehensive Business Intelligence in place to monitor demand and to ensure that there is appropriate system flow.
3. Multi-discipliary working – is at the heart of the joint approach with Multi-disciplinary teams being available within each of the integrated neighbourhood teams.
4. Home first discharge to assess – by working closely with hospital discharge teams Manchester is able to ensure that support can be put in place to facilitate timely discharge planning along with the continued support including reablement to ensure that people can remain at home and avoid future hospital admittance.
5. Flexible working patterns – have included changing the contracts of reablement workers to ensure that they can be more flexible to meet the needs of patients and residents.
6. Trusted assessment – the strengths based approach to assessing needs is adopted in Manchester. This is ensures that patients have the support that they need on being discharged from hospital.
7. Engagement and Choice – Manchester Integrated Care Partnership has an engagement team which is focused on ensuring that service offerings are in line with the needs of people in the local community.
8. IImproved discharge to care homes – Even during the pandemic Manchester ensured that patients were tested for Covid prior to discharge to care homes. Enhanced designated services are in place with care homes to ensure that patients receive effective follow up and support including structured medications reviews. When complex patients are discharged to care homes they will often be reassed once in the care home to ensure that it remains the appropriate place for them if they have received effective rehabilitation.
9. Housing and related services – Manchester Care and Repair and Manchester Manchester Equipment & Adaptations Partnership (MEAP) are in place to support people to receive the support they need when being discharged from hospital. This is includes the Home from Hospital Service which is supplied as a free service by Manchester Care and Repair to residents over 60. The service offers a free handyman service, advice and support with services or welfare benefits, advice on home safety and falls prevention and a helping hand with immediate needs such as shopping and buying equipment.

Supporting unpaid carers.

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Manchester City Council and the MICP work in partnership with ‘Carers Manchester’ a network of local Carers organisations. All people with a caring responsibility are encporaged to make contact with the Carers Manchester Contact Point, to find out what support would be helpful to you, now or in the future.

Carers Manchester is a group of organisations that form the Carers Manchester Pathway, which provides support to carers in a variety of ways including telephone and face to face support, a learning and development programme

Carers Manchester is a 'first point of contact' service that offers tailored support and advice to all unpaid carers in the Manchester City Council area.

Carers Manchester is a partnership of Gaddum, LMCP Care Link, Manchester Carers Forum and Wai Yin Society, working together to provide the contact point as part of the new Carers Pathway in Manchester who can offer to support to a range of communities and age groups.

Unwaged carers in Manchester are able access the contact point for information, advice and support for a range of issues by phone or email.. Trained advice workers from all four organisations are able to answer your queries or direct you to the relevant service.

Advice workers available to offer advice and support in different languages, on a range of issues including:

- Benefits and financial advice
- Bereavement support
- Employment advice
- Your rights as a carer
- Older carers
- Support for parent carers

Manchester City Council are responsible for undertaking carers assessments. A Carers Assessment is a good way for carers to find out about the support available. Carers can have an assessment even if the person they care for doesn't receive services themselves. The Carers Assessment carers explain how caring is affecting their health and wellbeing and helps them to think about what would happen if they were unable to care for whatever reason, and make a Carer's Emergency Plan.

Support are directed to the Carers Guide to Respite should they need respite support, which includes getting the carers assessment which could lead to funding where appropriate.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, social 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. This is used to support timely hospital discharge.

The demand for mandatory DFG has increased significantly over the last 2 years, in terms of numbers, value and also in terms of the complexity of works assessed for. Major adaptations would usually be assessed for following discharge from hospital. However, if the discharge teams can notify Manchester Equipment & Adaptations Partnership (MEAP) well in advance, this can be facilitated in advance of discharge.

90% of MEAP service users do not use or are not known to Adult Social Care for any other services. If the service can reach citizens early enough ythey can delay citizens requiring services for an average of 5 years or more. This also prevents admissions to hospital.

Discretionary DFGs are awarded as Home Repairs Assistance Grants and Emergency Heating Grants for works of a Health and Safety nature, where the disrepair can exacerbate existing health conditions. For instance, this could be to make the property wind and weather tight, deal with damp, dangerous electrics, hazards, etc. These works are undertaken by Care and Repair.

The DFG Emergency Heating Grants are just for heating, where the heating system has broken down, or is very faulty, leaving the citizen without heating and/or hot water.

MEAP work closely with Registered Housing providers to ensure that appropriate adaptions are put in place. Over 300 Assessments of Need related to registered providers were requested in August 22. Adaptions which have been undertaken include complex works such as bedroom adapations/bathroom extensions and providing ground floor facilities to help disabled people to be able to live independently in their own home and reduce the likelihood of them requiring hospital admissions.

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.

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 BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

The community services operated by Manchester Local Care Organisation (MLCO) has a very 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 the Manchester Health and Care Commissioning (MHCC) which was the partnership between the CCG and the Manchester City Council 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.

Previously Manchester Health and Care Commissioing and now Manchester Integrated Care Partnership (MICP) has had a comprehensive Business Intelligence data which has helped to improve the equity of the service offer that is in place. This Business Intelligence data is linked to improvements in data recording including ethnic on patients care records. This data can then be used to interrogate data across all services. This data has been used to help with the risk stratification process which is able to identify those people in the community who need the greatest amount of support to help them to remain out of hospital.

Community services are now working with MFT hospital data to identify some cases where there are higher incidents of presentations from ethnic minorities such as people with respiratory conditions and those presenting with complications due to diabetes. The analysis of this data then helps to identify if there are any trends related to specific ethinicities and other protected characteristics whereby specific groups can be targeted for additional support.

Manchester Integrated Care Partnership has a strong focus on equality with a equality leads within the organisaiton. A key focus of this is now on Core20plus5 with the current addressing inequalities plan being reviewed to ensure that it is line with this approach. There remains a focus on long term conditions including respiratory and cardiovascular conditions as well as increased support for people with mental health conditions and ensuing the delivery of annual health checks against Manchester's Primary Care Quality Resillence and Recovery Scheme. These processes are helping to ensure that as a system we are more aware of the people who are most likely to need services, with support interventions being able to be put in place as part of multi-disciplinary teams at an Integrated Neighbourhood Team level.