# Better Care Fund Performance Update

# Q3 2022/2023

# Southampton Health & Care Partnership Board
# December 2022

Hampshire and Isle of Wight

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# Priorities for 2022/2023 BCF plan

The BCF priorities below support the delivery of the 5 year health and care strategy and ensure compliance with the BCF policy and planning requirements –

- **Priority 1:  Delivering on Avoidable Admissions/enable people to stay well, safe and independent at home for longer -** Strong focus on prevention, admission avoidance through our urgent Response Service, proactive care at home (reducing preventable admission to long term care), carers services and Enhanced Health in Care Homes (EHCH) arrangements.
- **Priority 2: Further developing the discharge model to promote right care in the right place at the right time:** including Recovery and Assessment and Home First as a feature of the BCF plan.
    - Hospital Discharge process and out of hospital capacity
    - A flexible and broad offer of recovery and assessment, promoting a home first approach
    - Particular focus on discharge capacity for those with the most complex needs
- **Priority 3:  Increase the number of people who see benefit from Rehabilitation and Reablement,** meaning a continued focus on reducing dependency on longer term care provision.
- **Priority 4:  Implement new models of care (within Adults and Children's)** which better support the delivery of integrated proactive care and support in our communities.
- **Priority 5: Effective utilisation of the Disability Facilities Grant –** promoting independence and personalised care/strength-based approaches

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# Financial performance

| | Mandated level | ICB contribution | SCC contribution (inc DFG) | Total |
|---|---|---|---|---|
| Plan – 2022/2023 | £22.892m | £91.259m | £52,303m | £143,564m |
| Position after Q3 | £22.892m | £91,020m | £53,736m | £144,706m |

Variation from plan –

- Additional contributions in excess the total figure are -
  - Adult Social Care Discharge Fund = £924k
  - Community Discharge Grant – Learning Disability Clients = £131k
  - DFG previous years carry forward - £5,580k of which £2,954k allocated to date
- ICB – reduction of £289k
  - Adult Social Care Discharge Grant = £1,830k
  - Primarily related to budgetary corrections linked to the change in organisation from the 1st of July 2022
  - JES cost pressure of £105k – related to rise in the complexity of client group.
- SCC – increase of £1,433k
  - Increase of approximately £1,464k on care package costs for clients living with a learning disability. Including clients whose provisions not on Care Director and clients for whom there are back dated payment requirements.
  - Increase of approximately £422k related to agency costs within the Hospital Discharge Team, with £349 of this off set by the ASC Discharge Fund.
  - Joint Equipment Service cost pressure of £106k – related to rise in the complexity of client group
  - Reduction in predicted spend within Children's Resource Service of approximately £330k – recruitment plans progressing well likely to see this figure reduced a little by year end.

# Metrics position at Q3

- The metrics monitored through the BCF are as follows –
  - Avoidable Admissions – Indirectly standardised rate of admission per 100,000. The performance noted below indicates the rate for Southampton is below that of the plan i.e. fewer people than projected have required admission for ambulatory care sensitive admissions. Contributing to this good position will be Urgent Response Service, One Team and wider prevention and early intervention work.
    - Q2 plan 233 per 100k – **185.3**
    - **Q3 plan 260 per 100k – 217.8**
  - Discharge to usual place of residence – percentage of people, resident in the HWB, who are discharge from acute hospital to their normal place of residence. This is an important measure which reflects joint working between local partners with the level of achievement in Q3 above/better than plan. The work of the discharge team, SPOA and brokerage service contribute significantly to this delivery.
    - Q2 plan 96.6% - **94.8%**
    - **Q3 plan 95% - 95.4%**

# Metrics continued

- Residential admissions – long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population. Performance in Q2 and Q3 below indicates a better than plan position, a position which is challenging given there is a greater number of highly complex individuals requiring longer term adult social care support. The work of our rehab and reablement service, the SPOA and social work teams significantly contribute to this performance.
  - 2022/2023 plan 206 per 100k
    - Q2 actual 97.1 per 100k
    - **Q3 actual 141.3 per 100k**
- Reablement – proportion of older people who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.
  - 2022/2023 plan 76.8% - **Data will not be available until April 2023 as this information is collected between January and March 2023.**

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# Scheme Highlights

Plan agreed and implemented for ASCDF

Prevention and Early intervention engagement gets underway

Progressing the next phase of Carer Strategies implementation

Continue to implement the Southampton Health and Care Strategy for people with Learning Disabilities

Transformation Programme

Continued role our of One team – Proactive Case Management, four practices go live

Successful recruitment to the service for children with complex behavioural and emotional needs

Progress on implementation of the recommendations from the DFG review

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# Scheme highlights – Right Care in the right place/Hospital Discharge

Improving operational processes – particularly for inpatient settings and DC

Home First – developing the home care market, enhancing therapy, and working with VCSE

Making the most of short term beds – improving assessment and flow, enhancing therapy and refining & recommissioning the beds

Improving support to care homes – Training and development offer, anticipatory care planning, improving communication between homes and services and increasing the prevalence of telecare/medicine

# Risks

- Projected overspend within BCF schemes – in particular
  - Learning Disability Integrated Commissioning – transformation programme seeks to promote financial stability and forecasting
    - Increased cost of care packages
    - Further work on promoting service and financial planning for Children transitioning into adult care provision as part of Preparing for Adulthood transformation programme
  - Joint Equipment Service – working through opportunities to manage this risk area.
    - Increase in complexity evidenced in the risk in mean number of pieces of equipment per person.
    - Increase in number of people remaining at home following rehabilitation/reablement
- Capacity in the Home Care Market
  - Challenges to meet the rise in complexity of people requiring care either on discharge or following a crisis which was managed in the community.
  - Significant workforce pressures remain – programme of work underway to support the sector in managing this challenge.
- Financial certainty and funding shortfall
  - This risk was noted at the beginning of the year as a result of the hospital discharge fund ceasing on the 31st of March 2022. This risk has in part been managed with addition of the Adult Social Care Discharge Fund
- Meeting the key requirements of the carers strategies
  - Work is underway with the existing providers along with planning for future service provision to meet mitigate this risk, significant development and procurement work required to meet the key requirements.