TRAFFORD COUNCIL

Report to:	**Health & Wellbeing Board**
Date:	**17th November 23**
Report for:	**Information**
Report of:	**Gareth James, Deputy Place Lead for Health and Care Integration, NHS GM (Trafford) and Nathan Atkinson, Corporate Director Adults and Wellbeing, Trafford Council**

Report Title

Better Care Fund Quarter 1 Report

Purpose

In July 2023, Trafford resubmitted its Better Care Fund Plan for 2023/24, and supporting narrative to NHS England, following a required set of revisions from an earlier submission in June 2023. This was shared and retrospectively approved by Trafford's Health and Wellbeing Board on 14th August, 2023 after which Trafford received formal approval from NHSE.

The national return for Q1, focuses on system resilience by establishing a detailed understanding of demand vs capacity within the community and in supporting hospital discharges. This return has been completed in partnership with NHS Greater Manchester (Trafford) and Trafford Council and was supported by each organisational leadership team prior to submission.

The full return to NHS England is attached alongside this paper, but to support ease of reading, key areas have been summarised within this paper.

Recommendations

The HWBB are asked to:

1. Note the content of the finalised BCF return for Q1, submitted on 31st October 2023.

Contact person for access to background papers and further information:

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1.0 Introduction

The Better Care Fund (BCF) reporting requirements are set out in BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF Programme.

The key purposes of reporting are:

1) To confirm the status of continued compliance to the requirements of the BCF fund.
2) In Quarter 2, to refresh capacity and demand plans, and in Quarter 3 to confirm activity to date, where BCF funded schemes include output estimates, and at the end of the year actual income and expenditure in BCF Plans.
3) To provide information from local areas on challenges and achievements and support needed in progressing the delivery of the BCF plans, including performance metrics
4) To enable the use of this information for national partners to inform future direction and for local areas to improve performance.

Following submission of our Better Care Fund Plan for 2023-2024 and supporting narrative in July 2023, this paper provides a summary report highlighting the pertinent updates, performance and changes to trajectories (rationale) within the detailed capacity and demand plan, submitted as Trafford's Quarter 2 return.

2.0 Better Care Fund Metrics

The BCF plan includes the following 5 metrics. Please find a summary of performance below, with detail of performance can be found within Tab 4: Metrics of the supporting excel spreadsheet.

1) **Unplanned Hospital Admissions for chronic ambulatory care sensitive admissions**
    - Expected performance within Q1 was 193.2. Actual performance is 166.0
    - Performance status: On- track
    - Achievements linked to BCF funding: The introduction of Trafford Crisis Response team provides further support hospital avoidance by providing short-term assessment and care service for patients in their own homes at a timelier rate that available within existing community services. It will also increase the number of patients attending A&E whose admission can be avoided by the navigator service referring into Crisis Response in A&E rather than after admission.
    - Upcoming plans: Further development of the Hospital at Home model is required. Once implemented further improvement in this target is expected.

2) **Percentage of people who are discharged from hospital to their normal place of residence.**
    - Expected performance within Q1 was 91.5%. Actual performance in Q1 is 90.89%
    - Performance status: On-track.
    - Whilst performance was lower in Q1, performance in Q2 to date shows improvement to 92.14% with YTD performance of 91.50%, in line with our submitted plan.
    - Achievements linked to BCF funding**:** The Rapid MDT for P3 Discharge to Assess Beds service undertakes MDT within 48 hours of a resident being admitted to an assessment bed. This service is supporting more of our residents to return home, moving from Pathway 3 Discharge to Assess bed to Pathway 1. Additional capacity of OT and Physio into this team has provided significant support. This team is also identifying residents who can be supported by bedded IMC to enable them to

subsequently go home, reflecting a much greater flexibility across discharge pathways, with Home First embedded within their ethos.

- Upcoming plans: The upcoming implementation of Pathway 1 team within Trafford Community Response Service will provide Intermediate Care at Home to residents. This is a new service, which will provide significant increased access to community physiotherapy and occupational therapy which will enable early discharge for a larger number of patients, by providing support to up to 6 weeks (in line with NICE Guidance for Intermediate Care).

3) Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000

- Planned performance/trajectory by end of Quarter4: 2,003. Actual performance at the end Q1: 490.2
- Performance status: On track
- Achievements linked to BCF Funding: There have been several capacity and demand challenges in community OT and Physio, much related to the legacy of Covid-19 pandemic which has impacted the capacity of preventative rehabilitation services, which were refocused to support hospital discharges. However, through the additional investment in therapy resource within the new Trafford Pathway 1 team within Community Response Service, the Community Rehabilitation Recovery Plan will fully actioned, increasing access and capacity back on its commissioned purpose, to provide in falls prevention interventions.
- The introduction of the Rapid MDT to P3 D2A beds, which includes social care, nursing and therapy has also supported a reduction in falls in the care home setting but providing MDT within the first 48 hours of an resident entering D2A bed.
- Upcoming plans: Full introduction of Pathway 1 Community Response Team and full action of community rehabilitation plan.

4) Rate of permanent admissions to residential care per 100,000 population (over 65)

- Planned trajectory of 559 by end of Q4. Performance in Q1 is 79 which consists of 26 Nursing and 53 Residential, not including Continuing Health Care figures.
- Performance status: Not yet on track. Q1 reporting is slightly higher than planned, however Q2 is showing a decrease which bring Trafford more in line within expected targets.
- Achievements linked to BCF Funding: The Rapid MDT for P3 Discharge to Assess Beds service, which reviews residents admitted into a bed within 48 hours, is supporting more of our residents to return home, moving from P3 to P1. This team has also identified residents who could be supported by bedded IMC to enable them to subsequently go home. This team has enable greater flexibility across discharge pathways, with Home First embedded within their ethos.
- Trafford Control Room (TCR) remains the centre point for all referrals who require Health and Social Care Pathway 1 and Pathway 3. The control room offer an integrated team of health and social care staff, with the skill-set to understand the holistic requirements of an individual with the ability to scrutinise referral pathways and challenge decisions for the most appropriate outcome for the individual.

- Upcoming plans: Continued roll out of and monitoring of Rapid MDT for P3 D2A beds to ensure continued impact on returning more residents home rather than long term residential and nursing care.

5) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement and rehabilitation services.

- Planned trajectory of 92% by Q4. Reported performance within Q1 is 86.2%.
- Performance status: On-track. 86.2% this is 8 percentage points better performance compared to the same period of the previous year, if this trajectory to improve over that reported in 22/23, then we will exceed our planned target**.**
- Achievements linked to BCF funding**:** In addition to the continued success of Stable and Make Safe services, the new Trafford Community Response Service will provide a 2- hour urgent response within the community, as part of a wider MDT model.
- Upcoming plans: Through the introduction of D2A Pathway 1 (IMC at home) model and the continuation of the success SAMS model, Trafford will have a much enhanced rehabilitation and reablement offer within Pathway 1.

3.0 Quarter 2: Capacity and demand Refresh

3.1 Areas which where estimates for capacity and demand have changed since the plan was changed in June 2023.

Pathway 1: Reablement and Rehabilitation (Community and Hospital discharge capacity)

There is significant change in our reported capacity to meet demand in Pathway 1 Hospital Discharge and Community. These figures can be found with 5.2 and 5.3 of the accompanying excel spreadsheet. There are two reasons for this increase. The first being that NHS England have amalgamated Reablement (Stable and Make Safe Services) with Pathway 1 Rehabilitation at home services, creating combined figures for capacity and demand. The second, is that prior to this submission Trafford did not have a Pathway 1 rehabilitation at home service. Subsequently these figures have changed due to the introduction of Trafford Community Response Service, which includes Crisis Response Team and Discharge Pathway 1 (IMC at Home) Team.

Figures of Hospital discharge capacity for pathway 1 is a total figure of reablement (76 per month) and Discharge Pathway 1 (IMC) capacity of Nov (216), Dec (279), Jan (279) Feb (261) and March (279). Please find a breakdown of these calculations below:

Urgent Community Response Assumptions and Calculations

Assumptions are based on new crisis response service going live from 25th October 2023. Demand is based on initial assumptions of services delivered within the Manchester and Trafford system via the LCO. Capacity based on current workforce within the team and projections of demand that the team could manage based on 3 visits per day to patients.

D2A/IMC at Home Assumptions and Calculations

Demand based on D2A hospital discharges and IMC at home projections from neighbouring locality managed by LCO with a 100% uplift due to twice the population within Trafford. Numbers are based on averages of current demand within South Manchester via the LCO for the same service, and numbers are based on actual patient demand of accepted referrals in neighbouring locality as a

baseline of service delivery. Whilst capacity is recorded as a total, limitations within workforce at present mean capacity at 50% of future potential.

Capacity within the Trafford Community Response Service is based on a new overarching MDT approach for two teams a 2 hour Crisis Response Team and D2A Pathway 1 team, incorporating a range of professions including Physio, Therapist, ACPs, Pharmacists, GP, Nurse and Social Worker.

Pathway 1 Homecare Market capacity

Capacity in the market for Homecare packages/ Pathway 1 has increased significantly over the past 18 months. The homecare contract operates in a neighbourhood model which has been very effective. In addition, extra capacity was created via a number of providers which were onboarded to alleviate system pressures during Covid.

In Trafford, the homecare market is now in a position where providers have fluid capacity to support hospital discharges and community packages with care being available within 24 hours of receipt of the referral in most cases to deliver a Stabilise and Make Safe service that is up to 3 weeks of assessment to establish if someone has long term care needs (SAMS).

One of the risks that we are supporting the provider market is sustainability due to the fluid capacity in the market. This is not unique to Trafford and a number of the 10GM local authorities are experiencing similar circumstances.

To stabilise the homecare market, procurement activity is planned to reduce the number of providers, with a focus on quality and enhance the current neighbourhood model that has been working well.

Reablement and Rehabilitation Pathway 2 – Hospital Discharges via spot purchases (tab 5.2)

Inclusion of additional capacity of 1 per month via spot purchasing for patients requiring a health recovery bed. These are required for a very small number of patients who require a period of recovery outside of hospital prior to rehabilitation. These patients, whilst low in number, have previously often had an extended length of stay in hospital

Reablement and Rehabilitation Pathway 2 – Community (tab 5.3)

Through the introduction of the Rapid MDT Team to discharge to assess beds (pathway 3) it is expected that after the MDT review has been undertaken, 1 patient per month will be identified as being appropriate for bed based intermediate care (rehabilitation) and be stepped into Pathway 2.

Short term residential/nursing care for someone likely to need long term care home placement (pathway 3)

The D2A offer has increased/decreased over the years in Trafford due funding arrangements each year and been dependent on specific demand or escalation. Where the provider is in agreement, we have moved away from a static approach to arrangements and over the years and knowledge and understanding gained, we have been able to develop these beds to offer a more flexible arrangement to meet locality need.

The D2A offer includes Ascot House, Independent Care Homes and Extra care.

D2A beds are monitored with a 28 day exit strategy, but this is sometimes exceeded if there are challenges with move on. Trafford Control Room track individuals and performance.

Subsequently, we have decreased the number of block beds from 45 to 37 beds within the latest submission. Some examples of why there has been an adjustment are as follows:

- We have gradually reduced block arrangements as the provider was simply not responsive to the contract terms and naturally phased these out allowing us to increase spot opportunities**.**
- We have also seen a natural phase down of block arrangements due to quality and practice issues to mitigate the risks to individuals being placed in these services. Suspension on services due to performance issues has seen us phase out block arrangements. As and when a block bed was vacated, we decommissioned this to the point we reached zero beds within the service. This was to reduce the risk posed to placing individuals with an outstanding assessment to avoid further destabilisation and/or risk with an unmet need. This allowed us to increase our block activity elsewhere in the system.
- Where we have underutilisation in nursing provision, we have worked with the service to flex the use. What this means is that we engage with the provider at escalation or a higher demand for example SDN or where there is an increased demand for residential. Where a service is carrying voids in the block, we will ask a service to review the current residents and see where we can use the nursing block for residential or specialist dementia for example. This can see benefits in that we are utilising the voids and therefore avoiding paying for a spot bed, however, the costs do not change so a residential bed rate generally be lower than a nursing and vice-versa.
- Utilisation will never be 100% in D2A due to the variables attached to individual needs and these complexities are not always compatible with the existing individuals utilising the stock, this means that over subscribing on complex needs could cause other challenges such as resident on resident altercations due to behaviours, which could see a failed placement or admission into hospital. We are reliant on the skill set of the service to manage admissions and understand their already existing residents against any new referrals. It is light of these reasons we have continued to plan for capacity of 6 spot purchase beds per month, however this is a reduction from 18 as previously planned.

Short Term 'other' – Community (tab 5.3)

Within Section 5.3 of the tabs, we have now included in "short term other" our 4 D2A apartments which is an offer for discharge from hospital and community step up to avoid admissions.

We have four D2A Flats across Trafford all based within our Extra Care facilities. 2 at Limelight, North Neighbourhood, 1 at Newhaven in South Neighbourhood and 1 at Fiona Gardens, Central neighbourhood. The D2A flat offers a home from hospital reablement and assessment offer, providing independent living within reach from a home care service.

Typically, Extra Care is based on age, not need (55+), however, the benefit of the D2A flat is that we can place under this age criteria. The flats are fully furnished an offer a hospital profile bed. The individuals accessing these flats are able to trial independent living, avoiding a 24-hour bed-based offer with access to a domiciliary care service. Typically, the challenge with the flats is that they often, exceed the 28-day assessment period as they are used for other hospital delays aside of reablement. What we experience is the excessive stays are linked that are often very complex cases and exit strategies are likely to be significantly delayed as a result. The main delays related to the longer stays are generally linked to:

- Housing

- Legal challenges – no recourse to public funding
- Safeguarding

3.2 Potential challenges in capacity over Winter period

There remains a challenge in the availability within Specialist dementia placements and nursing in borough.

Financial challenges in relation to non-recurrent funding streams exist, which pose a potential impact on the longevity of financial arrangements which propose significant financial risk to our short term P3 offer.

4.0 Next steps

Whilst the exact format and questions within the Q3 BCF submission are not yet available, it will require reporting on actual activity vs that detailed within this plan and submitted in Q2. This data is regularly monitored as part of our locality governance so there are no anticipated risks associated with providing the next return.