Annex A7:

Better Care Fund 2024-25 Update Template

7. Narrative updates

Selected Health and Wellbeing Board: York

Please set out answers to the questions below. No other narrative plans are required for 2024-25 BCF updates. Answers should be brief (no more than 250 words) and should address the questions and Key lines of enquiry clearly.

2024-25 capacity and demand plan

Please describe how you've taken analysis of 2023-24 capacity and demand actuals into account in setting your current assumptions.

The BCF Delivery Group regularly reviews the effectiveness of all schemes in supporting the BCF national metrics as well as ensuring we continue to reduce inequalities across the city. Our integrated data sets enable us to specifically target high risk areas with enhanced support offers. We have used our Adult Social Care Management Systems as sources of data to forecast capacity and demand within the community, based on our historical trends. To understand the capacity and demand in the hospitals, we used the NHS Operational Plan estimates along with the internal database to understand the levels of activity we aim to achieve. We work closely as a system to meet the demand on our hospital services by creating the capacity within the community (and equally for our hospitals). A breakdown of the expected numbers monthly can be found on the planning template.

Our current Social Care Data shows an increase in referrals into our front door services, building up a waiting list for people awaiting assessment. We have also seen an increase in referrals for our LAC service where demand has almost doubled in the past 5 months. Data received from Age UK and the CVS also shows significant increases of over 60% into low level early intervention services across York.

We acknowledge that there are some areas where we currently do not capture, as a service, the levle of data in the requested format. We are looking to set up a mechanism in year to reflect this including the development of a BCF performance card this will also involve a re-evaluation of the metrics in the scorecards to determine what outcomes and key performance measures can be attached to each scheme, in addition to the core BCF metrics. A report on the outcome of the appraisal of each of the schemes in the Better Care Fund will be presented to the Board when the work has been completed.

Have there been any changes to commissioned intermediate care to address any gaps and issues identified in your C&D plan? What mitigations are in place to address any gaps in capacity?

Partnership Working Groups support each programme area, ensuring we reduce duplication, align eligibility criteria, and explore joint training for our multi-disciplinary workforce. These groups also support implementation of our Integrated UEC and Community Offers (York Health and Care Partnership priorities), through work such as the development of the Frailty Hubs and Urgent and Emergency Care redesign.

Partners work collaboratively to jointly commission key services and we continue to develop our integrated team model, supporting in-reach and early intervention. Through our shared vision, partners have built strong, trusting relationships with improved communication. This is underpinned by robust governance, leading to effective decision making to improve outcomes for York's residents. Through the further development of the frailty hub we have developed a proactive place-based model of delivery, integrating the community health and social care offer. This involves proactive identification of individuals with complex needs, for example frailty and multiple long terms conditions, using data provided by our population health hub. Individuals have a comprehensive assessment, and review carried out by the right professional, development of personalised care and support plans resulting in the delivery of a range of health and social care interventions to support them to remain well and maintain their independence at home. We are looking to further expand the service and integrate more teams to offer a single point of access across Primary Care Networks. By varying capacity throughout the year to ensure capacity is aligned appropriately to take into consideration at times of greater need we are able to flex social care and NHS service to ensure to maximise the BCF. This includes the availability of reablement and social care beds in times over winter and reduce the beds and hours over periods of reduced demand.

What impacts do you anticipate as a result of these changes for:

i. Preventing admissions to hospital or long term residential care?

The BCF is led through partnership working at Place. Our Partnership is inclusive of our vibrant voluntary and community sector and Independent Care Group representing care homes and domiciliary care agencies.

We are committed to early intervention and preventative approaches, supporting early discharge of people who require hospital admission and providing support for people to remain at home for longer. Working together we are further developing strength-based approaches, supporting people and communities to build on their strengths, introducing self-care models of care and support building resilience and independence. Through partnership working we are developing stronger healthier communities by listening to what matters to our citizens and codeveloping services to meet needs.

Schemes that will support admission avoidance - funded via BCF:

1. Home from Hospital - providing critical support for pathway 0 discharges
2. Urgent Care Practioners - avoiding admissions by treating people at the scene as opposed to conveying to ED
3. Changing Lives - A Bed Ahead - Discharge support primarily for homeless people
4. York Integrated Care Team - Anticipatory Care, carry a caseload of 3,000 frail patients, short term support for patients, HCA support step up from RATS in ED, Care co-ordination function for patients on the caseload, running complex cases MDTs to support discharge
5. Rapid Assessment and Therapy Service - ED based team who's focus is to turnaround frail patients.

Admission avoidance - the Frailty Crisis Hub will support admission avoidance and is evidenced by its use by the wider system, with 24 different organisations having used the Frailty A&G line for support since November. The most frequent referring organisations have UCR, YICT, GPs, appropriate self-referrals from patients on the YICT caseload (as determined by YICT triagers), CRT and YAS paramedics. This Winter, ED conveyances across East Riding, Hull and North Yorkshire increased by an average 33%, whereas there was only a 1% increase York.

ii. Improving hospital discharges (preventing delays and ensuring people get the most appropriate support)?

Checklist Complete:	Linked KLOEs (For information)
Yes	Does the HWB show that analysis of demand and capacity secured during 2023-24 has been considered when calculating their capacity and demand assumptions?
Yes	Does the plan describe any changes to commissioned intermediate care to address gaps and issues? Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the capacity needed for additional services?
Yes	Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service?

As a system we are committed to reducing the number of unnecessary admissions into hospital, through helping more people to be supported at home with the right service and right support through a person-centred approach. A key aim of the Better Care Fund, and the Discharge Fund, is to reduce emergency admissions, which brings within it the potential to invest in services closer to home to prevent, reduce or delay the need for health and social care services or from the deterioration of health conditions requiring intensive health and care services. We acknowledge that some schemes are part of existing core services, however through innovative approaches and commissioning we are looking at ways to move resources and funds around the BCF and several sub contractual arrangements. These approaches include the expansion of an existing in-reach model aimed at identifying patients in ED who have low level needs and an admission can be avoided. With additional funding we have been able to expand the service by increasing the workforce meaning further reach into the hospital (SDEC/wards) to bring patients, facillitating earlier discharge.

The three scheme areas within the BCF are:

- Early Invention and Prevention
- Intermediate Care and Reablement
- Core Contracted Schemes

Yes

Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service?

Please explain how assumptions for intermediate care demand and required capacity have been developed between local authority, trusts and ICB and reflected in BCF and NHS capacity and demand plans.

We commissioned a review on our intermediate care services across the system. The review highlighted key areas for the system to consider:

- York has sufficient care services in the system; however, these services were not being utilised and allocated in the most effective way
- Our community and voluntary sector is a great asset in reducing admissions and enhancing this would have a greater impact on reducing admissions.
- An integrated approach to reablement and intermediate care would be beneficial and equally some initial quick wins were identified to improve pathways.

Following the review, a number of immediate and long-term recommendations were put forward for the system to consider and action. These were:

- Changes in eligibility criteria for intermediate care and reablement services based on need rather than service delivery
- Amalgamation of current intermediate care services as there are many different pathways and access points making pathways difficult to navigate
- Review of the discharge hub to develop an integrated hub
- Intermediate care and reablement alignment
- Embed home first approaches across the discharge pathways
- Additional investment into Occupational Therapy
- Further partnerships with the VCSE to support early discharge and admission avoidance using the BCF as a lever
- Develop a community single point of access to support care navigation
- Integrate a holistic mental health offer into our community services
- Improve data flows and interpretation of local data to ensure service improvements are data driven and prioritised based on local need.
- Enhance partnerships between health and social care regarding Urgent and Emergency Care.

During 2024-25 of our BCF plan, we aim to implement the recommendations of the system review and further build on the work carried out in 22/23, with a focus on innovation and enhancing digital options.

Yes

Does the plan set out how demand and capacity assumptions have been agreed between local authority, trusts and ICB and reflected these changes in UEC activity templates and BCF capacity and demand plans?

Have expected demand for admissions avoidance and discharge support in NHS UEC demand, capacity and flow plans, and expected demand for long term social care (domiciliary and residential) in Market Sustainability and Improvement Plans, been taken into account in you BCF plan?

Yes

Yes

Please explain how shared data across NHS UEC Demand capacity and flow has been used to understand demand and capacity for different types of intermediate care.

Demand by pathway was initially based on the NHS operational plan, and was subsequently adjusted based on local intelligence.

We have made significant progress in strengthening our data flows and will continue to build on this progress between 2023-2025. Data clearly shows that we have seen increases in access for all areas across the system through primary care, early intervention, secondary care and social care. We have seen some of the largest demand on our community voluntary sector services, reablement and intermediate care services in recent years.

Yes

Has the area described how shared data has been used to understand demand and capacity for different types of in

Approach to using Additional Discharge Funding to improve

Briefly describe how you are using Additional Discharge Funding to reduce discharge delays and improve outcomes for people.

We will ensure that available funds are directed to schemes that create the biggest outcomes for people, reducing inequalities and the need for acute care. We will continue to offer versatile services that are responsive reducing delays in discharges as well as supporting people with long term conditions through our developing frailty hub.

We understand the need to ensure we have a responsive well skilled workforce and through our joint workforce board we are working towards a multi-agency approach to training using generalist training models for health and care staff. We will further build on our intermediate care offer reflecting the needs of our wider population including people with dementia, mental health issues, learning disabilities and those with autism. Our jointly commissioned BCF services continue to:

- Reduce the need for ongoing support through social care, promoting independence and control
- Continue to enhance our VCSE and utilise resources to promote early intervention and prevention approaches.
- Build on the strength of local communities and provide services that build on peoples own abilities and strengths
- Enhance personalised care and support through commissioning tailored support through personal budgets
- Enhance mental health and wellbeing services building on the mental health hub and the connecting our city programme.
- Reduce waiting times for people contacting social care
- Reduce length of stay within a hospital setting through enhancing rapid response services and in reach integrated teams

Discharge Destination
There is an ackowledgement that higher levels of acuity continue to result in discharges that are not consistent with usual places of residence – patients who would normally be discharged home are often requiring additional onward/packages of care preventing them from being discharged to their usual place of residence in some cases. Our ambition is to ensure that all patients are discharged to their usual place of residence without the need for additional or onward care which prevents this. The Frailty Crisis Hub and the in-reach model are good examples of how we intend to achieve this ambition (identifying patients before they are admitted and getting them back home/ususal place of residence instead of a potential admission which may then result in additional care needs, preventing the patient from returning home.

The focus of our BCF services remain in line with the BCF policy objectives and national priorities. We will continue to build on the schemes that are supporting the delivery of good outcomes. An integrated workshop was held on the 16th June 2023. The workshop further confirmed agreement from partners to reduce the number of short-term pilots and focus building on effective and efficient BCF schemes that result in positive outcomes.

We are currently updating our 'Preparing for adulthood strategy' to support a seamless approach for young people transitioning out of adult services, particularly considering individuals using mental health services and learning disabilities services as well as those with Special Educational Needs. The policy is being co-produced by people using services and their family and carers. This will enable seamless pathways to services, reducing the number of young people falling through the transitional gap between children's and adult services. We will continue to work with partners, in particular mental health services and the acute trust, to build in specialist support for people who require hospital admission.

Yes

Does this plan contribute to addressing local performance issues and gaps identified in the areas capacity and demand plan?

Is the plan for spending the additional discharge grant in line with grant conditions?

Please describe any changes to your Additional discharge fund plans, as a result from

- **Local learning from 23-24**
- **the national evaluation of the 2022-23 Additional Discharge Funding (Rapid evaluation of the 2022 to 2023 discharge funds - GOV.UK (www.gov.uk)**

Through the BCF Delivery Group we will continue to monitor the success of these services and redesign and deflect resources as required. All services developed through the additional funding were agreed following reflection and learning from previous years, including the findings of the national evaluation of the 2022/23 funding. We have agreed that building on existing schemes and redesigning collectively new models will further support the delivery of our target, reducing LoS across all discharge pathways. As a system we may want to ask the LGA to undertake an independent appraisal of its BCF Plan and make improvements based on the outcome and recommendation. Additional funding was used to secure additional bed capacity to support flow through hospital over winter months of significant pressure. Key learning from this has been to ensure that mitigations are in place for the removal of the additional beds whilst still demonstrating timely discharge. Some existing challenges that impacted or limited the impact of the additional funding included

Yes

Does the plan take into account learning from the impact of previous years of ADF funding and the national evaluation of 2022/23 funding?"

Ensuring that BCF funding achieves impact

What is the approach locally to ensuring that BCF plans across all funding sources are used to maximise impact and value for money, with reference to BCF objectives and metrics?

Partnership Working Groups support each programme area, ensuring we reduce duplication, align eligibility criteria, and explore joint training for our multi-disciplinary workforce. These groups also support implementation of our Integrated UEC and Community Offers (York Health and Care Partnership priorities), through work such as the development of the Frailty Hubs and Urgent and Emergency Care Redesign.

Partners work collaboratively to jointly commission key services and we continue to develop our integrated team model, supporting in-reach and early intervention. Through our shared vision, partners have built strong, trusting relationships with improved communication. This is underpinned by robust governance, leading to effective decision making to improve outcomes for York's residents.

Yes

Does the BCF plan (covering all mandatory funding streams) provide reassurance that funding is being used in a way that supports the objectives of the Fund and contributes to making progress against the fund's metric?