Better Care Fund 2024-25 Update Template

7. Narrative updates

Selected Health and Wellbeing Board: Stockport

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 Stockport system has improved the detail and accuracy of the data around discharges into each pathway and as a result revised the numbers around Pathway 1 discharges in particular. These updated figures, alongside the work on further embedding home first have driven the planning around demand and therefore capacity for 2024/25. There is an assumption that the numbers of people coming through acute trusts will increase over this financial year by 6% and that this will impact on people coming through the discharge pathways.

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?

The additional focus on reablement and pathway 1 discharges more broadly which has developed through Q3 and Q4 of 2023/24 will continue into 2024/25. Gaps in capacity have not been identified at this point but the system will continue to develop the iterative approach to ensuring sufficient capacity is in place to support flow through the acute hospital system in particular using the data developed. The system will also continue to review the impact on individuals and seek to prioritise services which deliver the best outcomes for people in terms of their independence. There are also systems in place to optimise the block booked capacity for hospital discharge pathways and there is continued development around where there is additional capacity required to minimise the time required to access this capacity.

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

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

The focus on avoiding admissions; for example having a social worker in the local acute trust emergency department is projected to reduce the need for admissions into the hospital, ensuring that people can return home without the need for an acute admission. The local acute trust High Intensity use service is an example of how the system is seeking to deliver impact for people locally and support the system as a whole. By identifying people who are using A&E frequently, alternative pathways and support is being established. The system locally has seen impact from the use of the Urgent and Emergency Social Care Fund and is looking to build on the approaches taken with the addtional funding in place. Recent increased flexibility in the use of domiciliary support which has been developed in consultation with the market locally, is beginning to show an impact on the rate of admissions into residential and nursing care which remains a priority locally. By being able to access intensive support in your own home on a short term basis the system is seeking to delay the need for residential and nursing care for individuals.

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

System partners locally are reviewing Standard Operating Procedures for commissioned support through pathway 1 and pathway 2 in particular to ensure that discharges and interventions from professionals are timely and optimise the impact for individual people who are leaving hospital. The review and analysis of outcomes for people who have left hospital across the pathways will provide information to both focus the interventions but also to iteratively make better decisions about what pathways people leave the hospital on and the support that is commissioned to enable this to happen. The intensive domiciliary support development in Q4 of 2023/24 are an example of this and relects the approach that system partners are seeking to take with the care market to improve outcomes by developing new models of support with providers.

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.

The assumptions around intermediate care capacity and demand have been developed alongside urgent and emergency care recovery plans with system partners. In particular supporting the improvement of accident and emergency performance on the target of 78% of patients being admitted transferred or discharged within 4 hours by March 2025. These plans seek to further optimise the use of care transfer hubs as well as a sustained focus on earliest early discharge planning and seven day discharge arrangements whilst embedding the home first approach to support people in their own homes wherever possible. The approach will continue to analyse the data with regular system flow meetings and focus areas to iteratively improve support to individuals and flow through the system.

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**

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.

The system has collectively developed 30, 60 and 90 day plans to impact on emergency and urgent care demand with the anticipated support and impact being integrated into demand and capacity planning for intermediate care. There are specific plans within the emergency and urgent care performance improvement plan which relate directly to intermediate care which will facilitate improvement across the system. For example support into step up community beds by primary care through crisis response on virtual wards well enable services to respond to same day need and better avoid hospital admissions. Another example is the use of the community discharge to assess bed base which will be reviewed to make maximise utilisation supporting flow and length of stay in those bed bases.

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.

Linked KLOEs (For information)

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

The Better Care Fund plan is part of a system wide integrated approach to address delays in discharge and drive better outcomes for local people. There is a particular focus on accident and emergency waiting time performance and the developments across the urgent and emergency care performance improvement plan set out to improve this but also two support a reduction in bed occupancy and patient staying more than 14 & 21 days in an acute setting. This approach to the use of additional discharge funding is in line with the relevant better care fund schemes approach, strategically maximising the impact of funding allocated locally.	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 o **Local learning from 23-24** o **the national evaluation of the 2022-23 Additional Discharge Funding (Rapid evaluation of the 2022 to 2023 discharge funds - GOV.UK (www.gov.uk)**		
Local learning from the work undertaken in 2023-24 has been used in developing the capacity and demand for 2024/25 with one example being around the impact of introducing greater flexibility into pathway 1 discharge packages and driving swifter discharges. This is continue to drive the system priorities around home first and support flow through the acute system. Again the system has reflected the learning from the national evaluation of the 2022/23 funding with a broader plan to support system improvements being the implementation of a new role around brokerage to support the co-ordination of discharge where people are leaving acute trusts via pathway 2 or 3.	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?		
The iterative approach to reviewing system data, impact on system pressures and the outcomes for individuals described will ensure that the funding is used strategically to maximise impact and to address the developing needs of the population and system as it develops and evolves. The metrics around admissions are a key part of the local BCF approach and embedded within many schemes so the projected target within the metrics tab can be achieved, the system schemes also focus on falls prevention and management within individuals' usual place of residence so there is further projected progress on that metric. There are further impacts anticipated from schemes within the BCF funding which will support a greater number of people to return home directly following an acute episode with synergistic benefits to the rates of admission to residential and nursing care. There are challenges conditions anticipated through the data analysed and capacity and demand predictions made but the platform and actions for progress against these priorities seek to drive improvement in these areas.	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?

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