Integration and Better Care Fund

# Better Care Fund 2025-26

# Health & Wellbeing Board Submission

# Narrative Plan

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| **Health & Wellbeing Board** | **Halton** |
| **Integrated Care Board** | **NHS Cheshire & Merseyside** |

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Department of Health & Social Care | Ministry of Housing, Communities & Local Government | NHS England

# Section 1: Overview of Better Care Fund (BCF) Plan

## 1.1 Priorities for 2025/26

In line with the national BCF objectives for 2025/26, locally our key priorities are as follows: -

- Support Local Authorities duties within the Care Act – namely provide resources to support care homes and domiciliary care provision.
- Maintain and expand the Home First / Discharge To Assess (D2A) approach with additional resources invested to support hospital discharge and trusted assessment processes, so achieving timely and effective discharge from hospital settings.
- Support community health (including Urgent Community Response (UCR) and Virtual Wards) and social care, intermediate care and equipment services, to not only support timely hospital discharge, but to also help prevent avoidable hospital admissions.
- Maintain and improve support for unpaid carers.
- Align the BCF programme with the wider Urgent & Emergency Care (UEC) Recovery Plan and the NHS Operational and Planning guidance, including the development of Neighbourhood Health Services and it's core components.

## 1.2 Key Changes Since Previous BCF Plan

The plan is kept under review in line with the governance arrangements laid out in the Joint Working Agreement (Section 75) in place between Halton Borough Council and NHS Cheshire & Merseyside (Halton Place) and at the time of writing this plan, as at the end of Quarter 3 2024/25, all outputs included in the 24/25 BCF Plan are expected to be met.

As the new key national metrics are in line with the previous intentions within the local systems i.e. aim to bolster community and intermediate care services, to support the reduction in admission and acute discharge, with the care and management of people in their own homes, we do not intend to make any significant/key changes to the 2025/26 plan which would impact adversely on the metrics which have been set and are outlined in the associated BCF Planning template. Our approach to delivering the plan and associated metrics will increasingly be through neighbourhood approaches in line with relevant planning guidance.

## 1.3 Approach to Joint Planning & Governance

One Halton's Health and Wellbeing Strategy 2022 – 2027 was developed and approved with the aim of improving health and reducing health inequalities.

A number of stages to the development of the Strategy took place, involving various stakeholders, based around a shared ambition to:

*"To improve the health and wellbeing of the population of Halton by empowering and supporting local people from the start to the end of their lives by preventing ill health, promoting self-care and*

*independence, arranging local, community-based support and ensuring high quality services for those who need them".*

Stakeholders included (list not exhaustive):-

- Halton Borough Council
- NHS Cheshire and Merseyside
- Bridgewater Community Healthcare NHS Foundation Trust
- Mersey Care NHS Foundation Trust
- Mersey & West Lancashire Teaching Hospitals NHS Trust (Previously St Helens and Knowsley Teaching Hospital NHS Trust)
- Warrington and Halton Teaching Hospitals NHS Foundation Trust
- Runcorn and Widnes primary care networks
- Halton Housing
- Halton and St Helens Voluntary and Community Action
- Healthwatch Halton

With partners being fully involved with the development of the Health and Wellbeing Strategy, as described in our previous plan, the BCF plan for 2025/26 will run parallel to this and all members of the Health and Wellbeing Board (HWB) will approve the plan and the ambitions for the metrics.

To support the HWB, the specific development and monitoring of the BCF Plan, associated pooled budget and Joint Working Arrangements (Section 75) sits with Halton Borough Council (HBC) Adult Social Care and NHS Cheshire & Merseyside (NHSCM) (Halton Place).

HBC and NHSCM have established a Joint Senior Leadership Team (JSLT) which is responsible for the direction, oversight, monitoring and use of the BCF, as part of the Joint Working Arrangements. The JSLT is supported in this duty via the Better Care Commissioning Advisory Group (BBCAG) which reviews in detail information pertaining to BCF Plan, associated pooled budget, quality, performance, local learning and national best practice, activity and finances and make recommendations to the JSLT on remedial action plans or future use of the BCF as appropriate.

The work that is undertaken, on an ongoing basis, between HBC and NHSCM, with partners and stakeholders supports the identification of priorities and therefore the development of schemes which feature within the plan. For example the work undertaken as part of the UEC Improvement Programme has helped inform the schemes such as 2-hour Urgent Community Response and the Hospital Discharge Team.

In line with national requirements, the BCF Plan is signed off by the HWB and regular update/monitoring reports are presented to the Board on the progress of the BCF Plan priorities, metrics, schemes etc on a quarterly basis.

## 1.4 Alignment with Improvement of Urgent and Emergency Care Flow

Halton is activity involved in the UEC Improvement Programmes being undertaken at Warrington and Halton Teaching Hospitals NHS Foundation Trust and Mersey and West Lancashire Teaching Hospitals NHS Trust, with a particular focus on the areas outlined below: -

- Attendance and Admission Avoidance
- Reducing Delayed Discharges
- Optimising Intermediate Care
- Oversight and Governance

A number of schemes are included within the BCF Plan, which fund associated services, specifically intended to address these issues e.g. funding a proportion of Intermediate Care beds within Halton, high intensity users, hospital discharge team, 2-hour Urgent Community Response etc.

See the BCF Planning template for further details.

## 1.5 Priorities for Developing Intermediate Care

As part of the UEC Improvement Programmes, as Optimising Intermediate Care is a key objective of these, work continues to take place to ensure pathways and processes are reviewed and updated as necessary to ensure Intermediate Care services in Halton, are robust and of a high quality.

Home/Reablement First principles are embedded within the system to support residents to remain in their own homes and communities and to reduce the dependency on long term bed-based placements.

At the time of writing this plan, during 2024/25, capacity has not exceeded demand in respect to Halton's intermediate care provision.

## 1.6 Collaboration across HWBs

This BCF Plan has been developed within the boundary of Halton and therefore only covers one HWB.

However, a number of programmes of work, supported by various schemes within the BCF Plan, that Halton are actively involved in, such as the UEC improvement programme and the intermediate care flow through the local acute hospitals and into the community, are undertaken on a collaborative basis centred around wider hospital catchment systems, as well as the Integrated Care System, as a whole.

# Section 2: National Condition 2 – Implementing the Objective of the BCF

## 2.1 Reform to Support the Shift from Sickness to Prevention

The focus of the plan is on ensuring sufficient resources are not only available for hospital discharge but also for community services/responses to support people to remain independent for longer and prevent escalation of their health and care needs.

Domiciliary care, intermediate care, wider community services including Unpaid Carers and UCR are the main features of the expenditure plan. The UCR function that sits within Halton Intermediate Care and Frailty Service plays a key role in responding to urgent need in the community to prevent admissions to hospital or care homes. It provides proactive assessment and care planning for patients to reduce exacerbation of their conditions and coordinates ongoing care from wider community teams within the borough.

Similarly, the BCF funds the High Intensity Users services which supports residents, who often have chaotic lives and are frequent attenders to urgent care services. The service collaborates through a Multi Disciplinary Team (MDT) approach in both acute A&E teams to identify suitable individuals and supports them to recover their mental and personal wellbeing.

Our approach to Home First/D2A and the capacity and demand assumptions made (as outlined in the capacity & demand plan) will inform the investment strategy for the NHS Minimum Contribution, Disabled Facilities Grant (DFG) and Local Authority Better Care Grant and how these resources will be used.

## 2.2 Reform to Support People Living Independently and the Shift from Hospital to Home

Our approach to Home First/D2A and the capacity and demand assumptions made (as outlined in the capacity & demand plan) will inform the investment strategy for the NHS Minimum Contribution, DFG and Local Authority Better Care Grant and how these resources will be used.

As above and in addition, Halton's Home Assistance Policy describes how Halton Borough Council use's its powers under the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 to provide home adaptations for disabled people. The policy aims to ensure that residents with disabilities are provided with support to adapt their home so that it meets their needs and they are able to continue living safely and independently at home. The assistance offered through this policy is funded through the DFG allocation, which forms part of the BCF.

The DFG is used as a means of financing a wide range of equipment and adaptations within and around the home to ease accessibility, aid independence and promote wellbeing and as a result help people remain independent for longer.

Halton is engaged with a series of programs to avoid hospital admissions through the use of community-based alternatives, including the test for change with the ambulance service for Call before Convey and

to have earlier access to patients on the stack, who would benefit from a more timely community intervention.

### 2.2.1 Home First Approach

The principles of Home First are embedded within the borough, including when patients require community rehabilitation or transition, with their ultimate aim is to return to their usual place of residence.

Investment will continue in 2025/26 to further strengthen our Home First / D2A approach.

As part of the UEC Improvement Programmes, work across the 2 hospital footprints on processes through and out of hospital to home will support improved pathways and processes to reduce length of stay and no right to reside numbers.

## 2.3 Joint Approach to Best Value

As part of the Joint Working Arrangements (Section 75) between HBC and NHSCM, the JSLT is responsible for the direction, oversight, monitoring of the BCF Plan and associated Pooled Budget. The JSLT is supported in this duty via the BCCAG. The BCCAG reviews in detail information pertaining to BCF Plan, impact of the Pool Budget, quality, performance, local learning and national best practice, activity and finances etc. and makes recommendations to the JSLT on remedial action plans or future use of the funding as appropriate to ensure value for money etc.

## 2.4 Metric Ambitions Support Alignment to System Partner Plans/Capacity & Demand

Halton has previously set high stretch targets within the BCF ambitions and consistently performs within the top quartile for the ICS. The new metrics align with the ambitions that are already set within the UEC recovery programmes for admission avoidance, reduction of no-right to reside occupancy and timely discharge, following the discharge ready date. The Trusts are currently developing their required planning return and working in partnership with all stakeholders to model the trajectories for the coming year.

There are a number of data quality issues relating to the metrics that results in errors in national reporting, and these are trying to be addressed locally to ensure a clear representation of the position is submitted within the various situation reports.

There is also inconsistency across hospitals on their recording of MFD/NRTR/DRD and the level of discharge planning undertaken prior to this date being recorded. This means that a high proportion of discharge planning occurs after the attending consultant has deemed them to be medically fit of discharge.

Currently across Cheshire and Merseyside 84% of discharges are on pathway 0, 10% are pathway 1, 3% pathway 2 and 3% pathway 3. The local expectation is that Pathway 0 should be discharged the same day, Pathway 1 will be discharged within 2 days, Pathway 2 within 3 and Pathway 3 within 7, recognising the additional assessment needs and the scarcity of complex/EMI beds.

Due to the recoding of patient being discharged to back to the existing package of care or to their originating care home, these are now pathway 0 and not pathway 1 or 3, and therefore not all pathway 0 are able to be discharged on the date they are medically fit as there may be additional requirement that are essential for discharge.

Ongoing improvement programs continue within the UEC recovery systems with a focus on admission avoidance, in hospital improvement and discharges, and to address some of the delays in discharge there is a focus on reducing the deconditioning of patients during their stay and the advance planning of their discharge on admission. This work is outside the scope of the BCF schemes, but all aspects inter-relate and serve to ensure improved flow within acute settings when there is a need to admit and ensure services in the community are available as alternative to bed based care.

## 2.5 Consolidated Discharge Funding

There are no planned changes to the schemes that have previously been supported via the Discharge Funding now the funding has been consolidated into the National Minimum Contribution and the Local Authority Better Care Grant.

The relevant schemes continue to support the resilience within the health and social care system within Halton as a whole, by supporting flow out of the acute trusts with the aim of reducing length of stay.

## 2.6 Intermediate Care Capacity & Demand

Work has taken place on the 2025/26 capacity and demand for intermediate care and details can be found in the associated capacity and demand plan. As previously done, information from Halton's Hospital Discharge Teams and provider services have been used to develop the capacity and demand plan.

At the time of writing this plan, during 2024/25, demand for Intermediate Care services has not exceeded the capacity available.

When or if demand does exceed capacity, additional resources are secured, when necessary, via agency staff or spot purchasing, to ensure that people are supported to avoid admission or to enable discharge.

Halton's Intermediate Care Services are delivered on a multi disciplinary team basis, including therapy and therefore therapy provision is taken into account when plans are developed.

# Section 3: Local Priorities and Duties

## 3.1 Promoting Equality & Reducing Inequalities

The One Halton Health and Wellbeing Strategy 2022 – 2027 sets out how, as a system, we will work together to develop pro-active prevention, health promotion and identifying people at risk early, when physical and/or mental health issues become evident. This will be at the core of all our developments, with the outcome of a measurable improvement in our population's general health and wellbeing.

The BCF is considered as part of the wider borough work on health inequalities, and will contribute to the following actions to reduce inequalities in Halton:

- Supporting a community development asset-based approach and community-led initiatives that build capacity for local people to become more informed and involved in decisions about their health and wellbeing.
- Improving access to services for people and groups most at risk of poor health.
- Developing the health and social care workforce to ensure that they have the knowledge, skills and understanding about how to identify and respond to need and inequalities, signposting and referring appropriately.

## 3.2 Engaging/Consulting with People Affected

As outlined above, the work that is undertaken by HBC and NHSCM with partners and stakeholders on an ongoing basis e.g. UEC Improvement Programme etc., inform the development of the plan.

All members of the HWB will approve the plan and the ambitions for the metrics.

## 3.3 Reducing Inequality in Access to NHS Services

Halton lies with the top 20 local authority districts with the highest proportion of neighbourhoods in the most deprived 10 per cent of neighbourhoods nationally.

The Halton HWB Strategy encompasses the need to reduce inequalities and recognises the additional health and care demands associated with the levels of deprivation across the wards.

The BCF plan and the wider joint arrangements within Halton provides capacity to meet the higher demands within the borough and lower self-funding or contributing levels for ongoing care. The plan ensures that all residents and registered population of the borough have equal access to services in the community, across the two towns, closer to home and not having to travel out of the borough to the acute hospitals.

## 3.4 Supporting and Involving Unpaid Carers

Halton's all-age Carers Strategy aims to take a more joined-up and holistic approach to supporting carers in Halton. It describes areas for improvement based on the views of carers in Halton and links into national statutory guidance.

Our Carers Strategy group (a multi-agency partnership) provide strategic oversight of our approach and has membership from health and social care sectors, including representation from both adults and children's services, alongside third sector representation.

In delivering against our Care Act duties, there is a jointly commissioned service with our Halton Carers Centre, with service specification and performance monitoring jointly reviewed between NHS and Social Care commissioners.

Halton Carers Centre are the primary point of contact for all carers', including young carers and young adult carers, to access a wide range of universal and targeted services that will support them to improve their quality of life throughout all stages of their caring role. This is delivered via services to meet these objectives including:

- Identification of carers
- Provision of information, advice and guidance
- Signposting carers to appropriate advice and support
- Advocating on behalf of carers
- Providing short term intensive support to carers where there is significant risk of carer breakdown
- Expanding and diversifying provision of activities and peer support for carers
- Supporting carers to take part in education, training or work opportunities

Further funding is allocated to support provision of a home-based respite care service, which provides breaks for carers and to assist people to live in their own homes to remain independent for as long as possible. This service provides home care normally provided by the unpaid carer and allows that carer to have respite from their role.