MILTON KEYNES BETTER CARE FUND PLAN 2023-2025

Author: Mick Hancock, Group Head of Commissioning MKCC

Date: **20 September 2023**

Purpose of Report:

To provide detail of the Milton Keynes Better Care Fund Plan for 2023 - 2025

Recommendation

The Partnership is asked to approve the Milton Keynes Better Care Fund Plan for 2023-2025

1. Executive summary

In Milton Keynes our Better Care Fund (BCF) plan has been agreed through a collaborative process. This approach is evident not only in the development of our plan but also in the governance, commissioning, monitoring and evaluation of our BCF schemes e.g. our joint approach to supporting carers, dementia, intermediate care services and community equipment. For 2023/24 whilst many of our schemes will continue and remain largely unchanged, we have seen a new and significant departure in our approach to the BCF. This is based upon our 'MK Deal', a ground breaking agreement brokered between the key health and social care partners in Milton Keynes and the Bedfordshire, Luton and Milton Keynes Integrated Care Board which delegates responsibility for improving four areas of health and care to Milton Keynes as a 'place'. The four areas are improving system flow, tackling obesity, children and young people's mental health and supporting people with complex needs.

We have sought to prioritise a number of areas, several of which are outlined below:

- Whilst we have had some success with our approach to hospital discharge, we are reviewing our Discharge to Assess pathways. We are now moving towards developing a fully integrated Home First service, with a single management structure. **This is a priority area for 2023/24**
- Similarly, we are looking to ensure that we have a co-ordinated, efficient and effective approach to bed-based support in care homes. It is currently fragmented and we expect to rationalise our use of care home beds, as we move towards supporting more people in their own home. **This is a priority area for 2023/24**

- We will also be introducing two new short term services to ensure speedier and safe discharge: a 'bridging care' service to provide immediate support at the point a patient is ready for hospital discharge; and live-in support in the persons own home, when they may be experiencing a deterioration in their cognitive abilities or suffering from delirium. **This is a priority area for 2023/24**

- We are continuing our investment in community equipment services as we rapidly move to integrate with three other local authorities and the ICB. **This is a priority area for 2023/24**

- In relation to our aim to improve system flow we will be reviewing our approach to falls, to see how we can further avoid admission to hospital. **This is a priority for 2023/24**

- Finally, we are developing further our commitment to support carers, especially in relation to maximising opportunities for carers breaks. **This is a priority area for 2023/24**

2. Overall Better Care Fund plan and approach to integration

Milton Keynes' BCF plan has continued to be successfully implemented over a number of years. A significant number of our schemes are longstanding, several since the introduction of the BCF. For 2023/24 we will maintain our position in relation to many of our schemes, ensuring they continue to achieve excellent outcomes and are sustainable. This will allow us to evaluate and review our BCF plan for 2024/25 in light of the MK Deal.

Following the creation of the Bedfordshire, Luton and Milton Keynes Integrated Care Board (ICB) there has been agreement across key partners to develop new arrangements for Milton Keynes to influence system improvements and jointly commission at a local level. To this end we have agreed the MK Deal with our key health and social care partners. A new collaborative approach between Milton Keynes City Council (MKCC), Milton Keynes University Hospital (MKUH), our community health services provider Central and Northwest London NHS Foundation Trust (CNWL), the ICB and our voluntary sector has resulted in a joined up approach over four key priority areas – improving system flow, tackling obesity, children and young people's mental health and manging complex needs. In terms of BCF the focus is on improving system flow.

We recognise the year round pressures on our health and social care system, and that our BCF schemes are very much focussed on ensuring timely and safe hospital discharge and admission avoidance. Our aim is to provide a functionally integrated approach in relation to improving system flow.

As in previous years we have seen the development of our BCF plan through a collaborative approach, which is now very much incorporated into the MK Deal and improving system flow. Our Improving System Flow Steering Group (IFSG) and project team has led the preparation of the plan. This group includes representation from all key partners – MKCC, MKUH, CNWL, ICB and the voluntary sector. As such we are now well positioned to jointly commission services that align to the priorities in our BCF plan. We see this approach as key to ensuring alignment of our priorities and reducing duplication of services. For example, our new Care and Therapy Academy is being jointly commissioned by MKCC, MKUH and CNWL (see Section 3). A further example of our joint commissioning is the work we are undertaking in relation to our integrated discharge hub (see below) and improving our Discharge to Assess pathways (see Section 3).

The BCF plan has been developed with regard to the uplift in the overall NHS minimum contribution. This has ensured that the expenditure on social care services has been maintained or increased. For example, in relation to intermediate care services once again there has been additional expenditure allocated to recuperation services. Similarly, with NHS commissioned out of hospital services, expenditure has been maintained or increased. For example, in relation to nursing assessors to improve hospital discharge, expenditure has been increased. Overall there is an increase of 5.6% in the BCF, which for 2023/24 totals £29.3m.

Our vision for integrated services is integral to our BCF plan - to support people to live independently in their own home, and within their local communities, wherever possible. To achieve this we will: simplify and improve pathways of care; renew our focus on getting people home; develop a more integrated workforce.

- We will continue to invest in our Home First approach that sees MKCC and CNWL provide therapeutic interventions, community nurse support, intermediate care beds and reablement to enable timely hospital discharge and admission avoidance. Our current approach is agreed by MKCC, ICB, MKUH and CNWL and builds upon the work undertaken as part of our 'Getting People Home Programme' that commenced in 2016. This programme developed our strategy for ensuring that, as a health and social care system, we were able to jointly commission suitable services to support hospital discharge. We successfully maintained our Seacole virtual community hospital, that can also accommodate higher acuity patients who need more intensive sub-acute care before going home or to a suitable placement. However, in line with our improving system flow project, we recognise that our Home First approach is not fully integrated. This can result in duplication and delays in providing necessary support to enable timely discharge from MKUH and community services. Following a review of the pathways, referral and assessment processes and community provision, we will be seeking to

fully integrate our provision (See Section 3 and 4 below). **This is a priority for 2023/24**

- The provision of community equipment services remains a vital component of our integrated approach. The Section 75 between the ICB and MKCC has ensured a joined up approach to developing appropriate support for promoting and improving independence. As a result investment in our community equipment services is ongoing and has made an impact in the management of hospital discharge delays, and also maintaining independence for people with more complex needs. We are now in the process of jointly commissioning a new integrated community equipment services across the wider Integrated Care System. This remains a priority for the ICB and four local authority areas: Milton Keynes, Luton, Central Bedfordshire and Bedford. **This is a priority for 2023/24**

- We will maintain dementia services for diagnosis, post diagnostic support and hospital discharge. These services continue to be at the forefront of our joined up approach. We have increased our investment in Admiral Nurses, who are key to supporting carers, ensuring that they have a valuable lifeline to continue their caring role. Over 160 referrals were received and 333 face to face contacts took place over a twelve month period. We will also continue to invest in our care home practitioner to aid diagnosis and support and train care staff. Our dementia step down beds continue to be very well utilised, and provide an opportunity for post-hospital discharge assessment. However, we recognise that demand often exceeds supply (see Section 3 below). Our investment in dementia support and awareness is seen as crucial to ensuring excellent outcomes and improving health and social care services.

- We also continue to invest in admission avoidance services. This includes our CNWL led Urgent Community Response team and funding for community based geriatricians. This service remains very responsive to meeting the needs of those individuals who may be at substantial risk of hospital admission or be high intensity users of health services. The team incorporates a swift response to those in the community as an alternative to referring to accident and emergency or calling an ambulance. The service has developed some key initiatives recently which has enabled taking patients directly from the local ambulance service and supporting our new Virtual Ward.

- Whilst we have successfully established a multi-disciplinary approach in the hospital's Accident and Emergency department, including a community nurse, social worker, Occupational Therapist and Physiotherapist, we recognise that a more integrated model is required from Accident and Emergency through to a ward admission and date of discharge. We are in the process of developing an integrated hospital discharge hub that focusses on the whole patient journey, to provide a co-ordinated multi-disciplinary team to facilitate timely

and appropriate discharge and where possible avoid admission.

This is a priority for 2023/24

Through the joint approach between the ICB and MKCC we have continued to support collaborative service delivery.

- The ICB and MKCC continue to work jointly in quality monitoring and safeguarding. This has enabled us to have a targeted and robust approach to compliance, safety and risk. Joint meetings between the ICB and MKCC take place monthly to oversee and plan monitoring activity, seek resolutions to quality issues and assess current intelligence. Information sharing, jointly agreed protocols and procedures and significantly less duplication are all well embedded in the Milton Keynes health and social care system.
- We have maintained our investment in CHC assessment and case management processes. The synergies between MKCC and the ICB are evident in managing complex care and support. This has resulted in improved quality oversight, reduced assessments/hand-offs, improved local intelligence and increased trust and confidence in assessment and review processes.

As a unitary authority MKCC is both the statutory lead authority for social care and housing. We have seen the success of the integration of adult social care and housing services in our Adult Services directorate. Services such as homelessness prevention, rough sleeper support, community support, housing allocations and the acquisition of temporary and long term accommodation are all embedded alongside more traditional social care services. This has been particularly beneficial in the management of complex care and homelessness.

3. Enabling people to stay well, safe and independent at home longer

We have, over a number of years, made strategic decisions to ensure we are:

- enabling people to remain at home independently for longer
- able to support safe, timely and effective hospital discharge.

We have embedded our commitment to commissioning appropriate service provision in community and home settings, continuing to shift away from acute care to community care. Whilst we are seeing unprecedented demand for services we have continued to maintain the progress we have made in: managing the number of admissions to residential and nursing care; discharging people from MKUH to their normal place of residence; increasing the numbers of people still at home following reablement after 91 days. These achievements, through the use of BCF, have come through targeted schemes.

The High Impact Change Model (HICM) remains at the core of our processes. This tool encapsulates the actions we have taken in the use of BCF from early discharge

planning through to trusted assessment. It runs through the schemes we have developed and continue to employ. Again we have reviewed how we employ the HICM and consider that currently our processes continue to function well. However, we still consider that there is room for improvement. This is in the context of our improving system flow project.

Through the BCF we have invested in intermediate care and recuperation services for those people being discharged from hospital.

- In relation to Discharge to Assess pathway 1, we have focussed on our Home First Reablement and recuperation at home services to support and keep people in their own homes longer. Our reablement service has consistently achieved its target of keeping people at home 91 days after hospital discharge. Whilst our recuperation service, commissioned to provide up to 800 hours per week, has enabled people to recover at home to minimise hospital stays. We will continue to invest in these services during 2023/24. However, although we have seen many years of collaboration between MKCC's reablement service and the CNWL therapy led service, we recognise that they are not structurally integrated and are functionally separate from each other. Our capacity and demand work has also shown us that demand for reablement is often high, whilst our capacity is often stretched. To this end we will be looking to improve the efficiency and effectiveness of pathway 1 services through integration. We anticipate that during 2024 we will have developed one Home First Team to provide care, support and therapies, with a single management structure. **This is a priority for 2023/24**

- Our CNWL and MKCC therapy services provide very effective support to promote and maintain independence. However, we are consistently faced with recruitment difficulties in delivering therapeutic interventions. This impacts on our ability to meet demand, evidenced in our care capacity and demand work. As a result we are exploring how we can upskill our Reablement Assistants and Health Care Assistants to enable them to provide structured interventions to a therapy plan. This new approach, referred to as our Care and Therapy Academy, will require investment to educate and train these workers. We envisage that in 2024/25 we will be able to refocus a proportion of the BCF to support this initiative. This cannot be seen in isolation from our integrated approach to Discharge to Assess pathway 1. **This is a priority for 2023/24**

- Regarding Discharge to Assess pathway 2 both our care home bed-based services, Seacole and recuperation, have been crucial in ensuring that choice and independence are of the highest importance for individuals. Decisions about long term care needs are made outside of an acute setting and most importantly recuperation /recovery is maximised. This allows for the promotion of independence and self-care, whilst enabling choices to be made in a non-acute environment. At the same time de-compensation is reduced

and there is a more effective use of rehabilitation and reablement. We currently utilise the BCF through commissioned care homes for 19 recuperation beds, of which 3 are dedicated to dementia care, and 48 beds through Seacole, our therapy and nurse led service. Both bed-based services allow us to minimise hospital stays and provide support to enable people to maximise their independence. However, we have recognised, as part of our review process, that our approach is: not fully integrated; is provided across multiple sites; and at peak periods of the year demand exceeds supply (evidenced by our capacity and demand work). As a result we will be seeking to rationalise our bed-based support and integrate our support provision. The expectation is that we will begin to move the focus away from care home support to support in the person's own home. **This is a priority for 2023/24**

- The Trusted Assessor role, for those returning to a care home from hospital, has continued effective collaboration between the care home sector, acute hospital and social care. This has shown clear benefits in term of speedier discharges, improved information sharing and the development of professional relationships.

- Our integrated falls prevention service will continue to be funded through the through the BCF. This has been established to reduce hospital admission, provide speedier recovery post-admission and deliver a self-care approach through exercise programmes and physiotherapy. However, in view of our aim to improve system flow we will be reviewing our falls service, to see how we can further avoid admission to hospital. **This is a priority for 2023/24**

- Support services for people with direct payments and personal health budgets continue to be funded through the BCF. These services include: setting up Direct Payments; support to employ personal assistants; and administering a holding account service. They act as an ongoing essential aspect of promoting self-care, choice and independence.

- Primary care networks in Milton Keynes are now well embedded in 6 areas. Through our Integrated Community Support Teams we have maintained a joint approach with co-located social care, health and voluntary sector staff to provide interventions to reduce reliance upon GPs, admission to acute settings and promote preventative measures including social prescribing.

4. Providing the right care, in the right place, at the right time

As highlighted above we are now seeking to develop a fully integrated approach to support people from the date of their hospital admission, through to our Discharge to Assess pathways. Working collaboratively our key partners recognise that a functionally integrated approach to supporting people to receive the right care, in the right place, at the right time is crucial. Our plans are ambitious and are largely based upon our MK Deal priority to improve system flow. For example, we are now exploring how we can functionally integrate our Home First Reablement and Home First Therapy services.

We are utilising our capacity and demand estimates to inform our work. We have concluded that whilst our Home First Reablement service currently offers 28 spaces a week, and supports 65 people at any one time, our demand often outweighs this capacity. We have also seen evidence of variations in demand throughout the year. Our ambition is to increase the capacity within our Home First Reablement service to over 80 people at any one time. As a result we are now offering additional funding to supplement our workforce through a 'Golden Hello' scheme to recruit and retain more reablement assistants. We will largely keep intact and grow our reablement service, whilst we develop our integrated approach. This also links with upskilling our Reablement Assistants through our new Care and Therapy Academy.

We will also enhance and support our discharge processes through utilising the Hospital Discharge Fund, the deployment of which has been agreed between the key partners in the MK Deal. We recognise that more traditional approaches to providing care and support, especially when demand is particularly high, may not always be the right solution. Our capacity and demand work has, for example, led us to identify that all too often people were discharged onto the wrong pathway. Whilst this has further evidenced the development of our integrated discharge hub, we are also seeking to ensure we can: arrange speedier discharge to the person's usual place of residence; strengthen our Discharge to Assess pathway; and reduce hospital acquired deconditioning. We will during 2023 provide two new schemes that will seek to discharge as many patients as possible from hospital at the point they meet 'no criteria to reside'.

- Firstly, we will invest in a 'bridging care' service, commissioned to provide immediate care and support (within four hours, 8 am – 8 pm, seven days a week). Primarily this will be for people with no ongoing support package yet in place. Any subsequent intervention, for example from our Home First Reablement service or a social work assessment, will be completed with the person in their own home. **This is a priority for 2023/24**

- Secondly, we will commission live in care options, to provide short term care for those who have had a deterioration in their cognitive abilities, or are suffering from delirium, to be discharged from hospital to their usual residence. Again this will aim to see subsequent interventions, such as a social work assessment, take place in the person's own home. Any ongoing support needs will be determined with the person, their family/carers in an environment that is familiar. **This is a priority for 2023/24**

Our approach to bed-based intermediate care has been a focus for a number of years. We have invested in both recuperation beds and Seacole, but our capacity and demand data is starting to show us that we are over reliant on such support. We have a strong domiciliary care market, which can be flexed to provide short term support where our reablement capacity is challenged during periods of high demand. As such we will continue to utilise our BCF innovatively. For example, to incentivise our domiciliary care providers over the winter months, when demand is high, to ensure continuity and sustainable out of hospital domiciliary care services. This has been a very successful approach, which has now led us to provide incentivises at other peak times during the year. There is still is no waiting list for domiciliary care services, which has been the case since 2019.

We have also utilised the BCF, and will continue to do so, to provide two flats in sheltered accommodation specifically for hospital discharge. These self-contained flats offer a more independent environment than a care home, and allow for ongoing support and assessments to take place there. As we shift away from the over reliance on care home bed-based support, we are now seeking to provide more self-contained accommodation during 2024/25. This is closely linked to the work we are undertaking in relation to improving system flow and our Discharge to Assess pathways.

We further recognise that having sufficient therapeutic interventions is equally important to supporting safe and timely discharge. Our improving system flow work is evaluating our therapy pathways and will report shortly. However, early indications show that there is insufficient capacity in our ward-based therapy teams to support our Discharge to Assess pathways and optimise system flow. As a result we will also utilise the Hospital Discharge Fund to:

- Provide additional hospital ward-based therapy staff. They will focus on improving outcomes through increased patient activity and promotion of independence on the ward. This will aim to reduce hospital acquired deconditioning, leading to a shorter length of stay and risk of re-admission. It is also anticipated that this will positively impact on the levels of ongoing care and support needs.

- Provide a sustainable Occupational Therapy triage service. We have successfully piloted triaging patients, which has allowed the Home First Therapy service to prioritise essential visits. We are now in a position where we can commission this on an ongoing basis.

We have continued to provide a fully staffed team of social workers based in the hospital through the use of the BCF. They work closely with the current Hospital Discharge Team, ensure attendance at multi-agency discharge events (MADE) and participate in daily teleconferences to review patients with no criteria to reside. Through our new integrated discharge hub we will enhance the effectiveness of this approach.

We will continue to fund MKCC's Access Team, the 'front door' of adult services. This is an integral element to ensuring that those people living in the community, that are seeking or requiring care and support, are referred or signposted to the appropriate resource. For example, it will ensure that if intermediate care is the required intervention, it will refer on to the Home first Reablement service. During 2022/23 it dealt with over 43,000 enquiries. This team deals not only with requests for care, but also triages community occupational therapy referrals. Not only is this important in ensuring that people are directed to the right care and support, it also allows for low level equipment provision to be resolved at the front door. The team will also ensure that where a major housing adaptation may be required, they are able to make a timely and appropriate referral to the Disabled Facilities Grant team (see Section 6).

The Milton Keynes Community Alarm service will continue to be funded by the BCF. This is a service for all ages, supporting people: who have been discharged from hospital; are at risk of falls; are disabled or frail; are at risk of domestic violence, harassment or distraction burglary. The standard equipment provided is an alarm unit and pendant. During 2022/23 we had 4842 users of the service, of which 533 were new. It has been successful in promoting and maintaining independence, hospital admission avoidance and timely discharge. For example, if a person falls our Community Alarm Service Responders will go to the person's home, provide assistance and where necessary seek medical support. If additional equipment is required, following a risk assessment, this is provided e.g. assistive technology, additional sensors. We are also undertaking a project to determine how we can embrace new technologies to further support admission avoidance and discharge from hospital. We see this as strategically important to ensure that there is appropriate and sufficient availability of assistive technology, to support and promote independence in the person's own home.

5. Supporting unpaid carers

We will continue to prioritise support for unpaid carers, introducing more opportunities for carers to be resilient in their caring role. The BCF will continue to maintain the funding of the carers support service operated by Carers MK. However, as the contract for this commissioned service is reaching its end, we will review how we continue to support our carers. **This is a priority for 2023/24**

Carers MK have a physical presence in MKUH, referred to as the Carers Lounge. From this base they identify and support unpaid carers when either the cared for person, or indeed the carer themselves, is admitted to MKUH. They liaise closely with ward staff to ensure that they can provide valuable information, advice and emotional support, often when there has previously been no interaction with formal or informal support services. It has proved very beneficial in both providing and signposting to ongoing support services, and is an enabler for hospital discharge.

During 2023/24 we will be piloting a carers direct payment to enable timely hospital discharge. We will be offering carers, subject to assessment, the opportunity to be awarded a direct payment of up to £500 per week (for a maximum of two weeks) to provide the necessary care for the cared for person immediately following discharge. To enable safe and timely discharge the direct payment could cover loss of earnings, travel costs, childcare costs etc. We anticipate that this informal carer support will replace any formal/commissioned services that would otherwise be put in place.

As part of our improvements to carer support we have simplified the carers assessment process and brought in our Carer's Conversation. This has already seen the number of carers assessments increase. In April 2022 16 carers assessments were undertaken, whilst in March 2023 68 carers conversations took place. We have also introduced several new offers to carers:

- We have successfully introduced a new annual direct payment of £240 per carer, subject to assessment. This has seen the number of carers receiving a direct payment increase from 80 in 2021/22 to 259 in 2022/23. We will continue to use the BCF to fund direct payments.

- Following consultation with carers and carers groups, we have introduced innovative approaches to meaningful carers breaks. These include working with the voluntary sector to provide services, such as My Time and Carefree, which are focussed on ensuring carers are able to access leisure, cultural and educational activities. We will review these new carers break services during 2023.

- We have also commissioned a pilot of an online carers service called Mobilise. The range of online service provided by Mobilises includes: information, advice and guidance; peer support; and signposting to support services. We will review the efficacy of this during 2023.

6. Disabled Facilities Grant (DFG) and wider services

In relation to the DFG our process remains multi-disciplinary in relation to adaptations.

- Following an assessment of need our social care and housing teams work closely to ensure that in relation to adaptations or community equipment, their statutory duties are carried out effectively.
- This includes: promoting and maintaining independence; supporting carers; finding cost effective solutions; ensuring equipment, adaptations are appropriately provided. We have found this leads to a sustainable approach to adaptations.

MKCC's Principal Occupational Therapist, the Lead Clinician and DFG Service Manager, has been involved in the process of agreeing our BCF plan. The DFG budget is devolved to them, and any expenditure associated with decisions agreed through our DFG process is monitored by them.

The use of our mandatory DFG has been key to delivering a key BCF priority, ensuring that people maintain their independence in their own home, preventing and delaying the need for care and support. During 2022/23 we supported 237 DFG applications.

We have successfully introduced Occupational Therapy Support Assistants into our Access Team, the 'front door' of adult social care. They are able to triage requests for services, and where major adaptations are required ensure this is actioned swiftly and with the appropriate team/service. During 2022/23 1950 occupational therapy related enquiries were triaged. Of these 471 were dealt with by the Access Team, preventing any referral to the Community Occupational Therapy team. This included signposting to other services, advice and guidance to purchase or acquire low level equipment etc.

7. Equality and health inequalities

The Milton Keynes health and social care system are committed to ensuring that our BCF plan will not negatively impact groups with protected characteristics. The characteristics are in relation to: age, disability, gender, reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Once again an equality assessment identified that we have set out plans to ensure better outcomes for older and disabled people, especially in those areas we have prioritised. At the heart of our approach is a strong commitment to promote independence and for people to have a greater control over their own lives. Our plans for developing and further integrating our intermediate care services in a strengthened Home First service evidence our commitment. It is paramount that we are able to offer safe, timely care and support in a suitable environment.

Nonetheless we recognise that there are difficulties and preferences that need to be given more attention. Examples include those with mental health issues, cultural and religious differences and communication, especially speakers of other languages. Our BCF plan offers several means by which these preferences or difficulties can be addressed. These include:

- Our ongoing investment in dementia awareness and support (including our new live in care approach for the delirium pathway). The work to date has shown that there are much needed support networks in relation to community groups and appropriate cultural and faith groups, including better understanding of the effects of dementia to lessen stigmatisation.
- Ongoing efforts to improve our DFG processes to ensure full access to properties for disabled people.
- The use of BCF in relation to carer support (including carers for people with dementia), and support for those receiving a direct payment

In relation to reducing health inequalities we are focussed on improving and developing new solutions for people's care. Our BCF plan has a focus on reducing ill health and dependency, to significantly improve people's outcomes and lessen the need for more intensive care and support services. These include:

- Our work to jointly commission an integrated community equipment services
- The new bridging care service, which will provide a real option for people to be discharged at the optimum point in their recovery, allowing for more long term decisions to be made in their own home
- The ongoing funding of our falls reduction services, and importantly our plans to review and improve these services

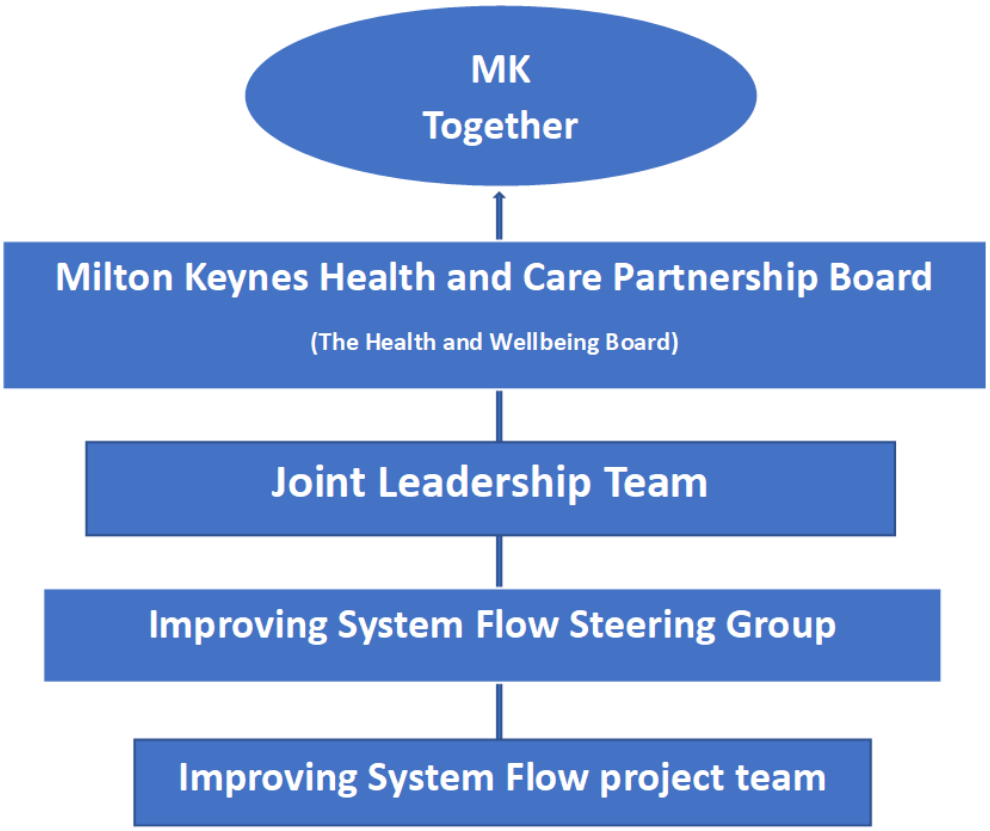
We will continue to assess and evaluate the evidence about what works to reduce inequalities. However, we believe that our BCF plan makes real advances in lessening health inequalities, and provides further opportunities to have due regard to various characteristics. Whilst the process of change is long term, this can only happen through sustained improvement in services and engagement with care users and communities.

8. Governance

The overarching governance for the BCF (see below) is our MK Together Partnership arrangements, which includes our Health and Care Partnership Board (the Milton Keynes Health and Wellbeing Board). It is composed of senior managers from the ICB, MKCC, CNWL, MKUH, voluntary sector representatives and Healthwatch. This approach is now well embedded. As a system wide partnership it is helping us align our priorities across Milton Keynes. As a result, we have developed a forum to foster relationships and partnerships that support integration.

As part of our approach the Improving System Flow project team has collaboratively developed our plan. This group has representation from MKCC, MKUH, CNWL and the ICB. The plan has been reviewed by our Improving System Flow Steering Group (ISFSG), comprised of senior representatives from MKCC, CNWL, the ICB, MKUH and the voluntary sector. The ISFSG has in turn reported to our Joint Leadership Team, which oversees the MK Deal and reports to the Health and Care Partnership. Both the ISFSG and Joint Leadership Team have agreed our plan, including the allocation of the additional Hospital Discharge Fund.

The lead accountable officer for the BCF is the Group Head of Commissioning at MKCC.



9. Approval Summary

HM Government

NHS England

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

		Complete:
Health and Wellbeing Board:	Milton Keynes	Yes
Completed by:	Mick Hancock	Yes
E-mail:	Mick.Hancock@milton-keynes.gov.uk	Yes
Contact number:	01908 257967	Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	Yes
If no please indicate when the HWB is expected to sign off the plan:	Wed 20/09/2023 << Please enter using the format, DD/MM/YYYY	Yes

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Peter	Marland	peter.marland@milton-keynes.gov.uk	Yes
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Felicity	Cox	felicity.cox1@nhs.net	Yes
	Additional ICB(s) contacts if relevant		Wendy	Rowlands	wendy.rowlands1@nhs.net	Yes
	Local Authority Chief Executive		Michael	Bracey	michael.bracey@milton-keynes.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)		Victoria	Collins	victoria.collins@milton-keynes.gov.uk	Yes
	Better Care Fund Lead Official		Isla	Rowland	i.rowland2@nhs.net	Yes
	LA Section 151 Officer		Steve	Richardson	steve.richardson@milton-keynes.gov.uk	Yes
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->						

10. Expenditure Summary

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Milton Keynes

<< Link to summary sheet

	2023-24			2024-25		
Running Balances	Income	Expenditure	Balance	Income	Expenditure	Balance
DFG	£1,267,783	£1,267,783	£0	£1,267,783	£1,267,783	£0
Minimum NHS Contribution	£19,640,705	£19,640,705	£0	£20,752,368	£20,752,369	-£1
iBCF	£6,176,149	£6,176,149	£0	£6,176,149	£6,176,149	£0
Additional LA Contribution	£0	£0	£0	£0	£0	£0
Additional NHS Contribution	£0	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£865,887	£865,887	£0	£1,446,031	£865,887	£580,144
ICB Discharge Funding	£1,326,649	£1,326,649		£2,273,248	£1,344,972	£928,276
Total	**£29,277,173**	**£29,277,173**	**£0**	**£31,915,579**	**£30,407,160**	**£1,508,419**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24			2024-25		
	Minimum Required Spend	Planned Spend	Under Spend	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£5,578,254	£11,767,360	£0	£5,893,983	£12,433,529	£0
Adult Social Care services spend from the minimum ICB allocations	£6,518,285	£7,394,426	£0	£6,887,220	£7,812,680	£0