NHS
North Somerset
Clinical Commissioning Group

North Somerset COUNCIL

Appendix 1

North Somerset Better Care Fund and Improved Better Care Fund Interventions

North Somerset has undertaken local discussions about the use of BCF and IBCF funding that can support delivery of improved outcomes. Local teams have had a series of meetings and we have also undertaken an internal assessment of the change agents and will develop key performance indicators /targets to assess impact and delivery.

The process has involved reviewing the current needs and gaps in provision for North Somerset, whilst reviewing the criteria as outlined within the guidance.

- Stabilising the care market
- Protecting Adult Social Care
- Adult Social Care that supports the NHS deliver
- Avoidance of unnecessary admissions to hospital;
- Improving patient flow after admission;
- Ensuring prompt discharge from hospital either for further social care assessment or into a sustainable on-going care setting (community, residential or nursing) when patients are medically optimised.

JSNA data and refresh for 2016/17 shows an increase in number of residents in North Somerset with dementia and other co morbidities

Scheme BCF	Intervention	Area of need	Impact	Evidence contribution to national metrics
Integrated Health and Social Care Teams	The Integrated health and social care objective is to deliver health and social care services to the public through integration of community health services, acute services and adult social care, with strong links to mental health services, as well as related prevention and early intervention services including housing, public health and voluntary sector services	North Somerset has a high proportion of people aged over 65 years and is currently above the national average. Projections indicate that this is set to rise from 23% to 30% by 2025. Therefore, in order to address the inevitable pressures that will be placed on health and social care services, all local partners have signed up to reconfiguring existing services and care pathways	Patients/service users being able to remain in their homes and communities and maximise independence. Multidisciplinary support for the most vulnerable service users in the community.	Reduction in unplanned admissions/attendances to hospital. Evidence of joint care plan/assessment Multidisciplinary support for the most vulnerable service users in the community.
Specialist Older People's Team	The Older Peoples Team will provide increased senior clinical decision making to the health system	North Somerset is an area with a significant, and	The SOPT will ultimately support many aspects of the	Increased 'complex older patients'* treated in a community setting

	complimenting pathways that are already in place.	growing, elderly population. Year on year there has been a 3.3% increase in the number of patients aged 65 and older, and there has also been a growth on the local nursing home population	healthcare system and it has been designed with specific principles to ensure it supports current pathways with expert advice supporting the whole system to achieve its aims • providing earlier and more timely access to senior clinical decision making support • provision of early assessment appraisal • monitoring of care and treatment of patients in a community setting • facilitation of planning and implementation of comprehensive care packages.	Reduced acute length of stay for appropriate patients Reduced ambulance conveyance to a secondary care setting Increased positive patient experience and outcomes Increased access to senior clinical decision making for community/primary care teams
Home from Hospital Partnership	The HfH partnership is a hospital based initiative offered by a range of community based, voluntary sector	North Somerset has a high proportion of	Wider range of services available in avoiding unnecessary	Support to promote ED discharges and assist with 4 (and 12) Hour

	support services who coordinate their input and support for improved outcomes for people returning home after an acute phase of ill health. HfH offers a wide range of interventions from housing advice and support, benefits advice, practical support, older people specialist services, mental health support as well as linking with relevant statutory services	people aged over 65 years and is currently above the national average. Projections indicate that this is set to rise from 23% to 30% by 2025. Using and developing community capacity and voluntary sector support will be one component in helping to address the pressures posed by this demographic growth on health and social care services.	admission/readmission to and supporting effective discharge from hospital.	performance (treatment or discharge from ED) supplementing Red Cross input Early identification of needs and issues and promoting timely, effective discharge Increase in effective community based support to promote confidence and independence on return home and address any environmental factors underpinning health status Follow up support post discharge, including follow up at home in the event of swift discharge during escalation Assistance to address needs of self-funders and people not eligible for social care assistance
SPA	The single point of access co-ordinates the service response for community support from health and social care services and address the	North Somerset has a high proportion of people aged over	This scheme seeks to continue to develop the SPA offer in the advent of continued	Sufficient capacity to resolve referrals and enquiries in an efficient and effective way.

	individual's concerns in a timely way; ensuring all necessary information is collected effectively, interventions coordinated and referrals triaged to appropriate services or resolved at point of first contact.	65 years and is currently above the national average for this age group. Projections indicate that this is set to rise from 23% to 30% of the population by 2025. Improving access to timely advice, information and support will help maximise the use of local services, provide effective service delivery for individuals and professionals and help avoid families/individuals reaching crisis points in their care pathway	increased demand on services, service development, new legislation and increased public expectation on health and social care services.	Development of a wide range of services and information sharing. . Capacity in the scheme to address demand.
Appropriate use of residential/nursing care home beds and therapy support to reduce length of stay and avoid admissions to hospital	The focus of the pathway since its inception has been on changing pathways, processes, values and cultures across North Somerset. Now that enablement is established it is time to shift this focus towards service improvement and development.	North Somerset has a high proportion of elderly residents and this population is expected to increase further over the next	Increase the support available to individuals after the Enablement period (Join up Enablement and Reablement as one continuous package of care	An increase in numbers moving down the tariff from Nursing to Residential Homes Increase in the number of patients with dementia accessing the enablement pathway

		twenty years. The area also has a disproportionately high number of nursing and residential homes for the population size. This has resulted in a very high number of care home placements (one of the highest in the country). In response to this, the Care Home Enablement Pathway was initiated in early 2012.	(regardless of the provider) Tailor the service to meet the needs of people with dementia or memory deficit issues Review the impact that Enablement will have in the long term on other services Target training or development at particular Care Home's that have been shown to be engaging less or having less positive outcomes is recommended.	Reduction in number of service users moving from residential homes to nursing homes in the long term post enablement A reduction in the size of care packages following enablement and reablement. An increase in the number of self-funders accessing the service
Development of Community Rehabilitation Model	The model is part of a BNSSG piece of work to develop a pathway where patients are treated in hospital until they have reached a point where they can continue their treatment in the community, and medically complete patients will no longer stay in hospital to receive rehabilitation.	This scheme has been driven by the growing pressure on local acute hospital beds and the recognition that by providing rehabilitation in an environment closer to home, patients have a greater chance of regaining functional ability	Rehabilitation patients who are no longer acutely unwell will be able to leave hospital earlier freeing up bed capacity in hospitals	Reduced delays in hospital as a result of improved hospital flow Reduced length of stay as a result of reduced deconditioning in elderly patients Improved hospital 4 hour performance Improved rehabilitation outcomes

		and management over their lives.		Improved patient satisfaction
7 day working for health and social care	This scheme seeks to provide enhanced seven day working across the health and social care system in order to support the avoidance of unnecessary hospital admissions and supporting system flow via hospital discharge across North Somerset	Evidence of patient flow indicates a reduction in discharge activity over the weekend and limitations in the acute trusts to fully respond to needs of people in discharge as a result of reduced community service support. This can impact on the success of the discharge, on readmission rates and management of Emergency Department attendances and patient flow.	A smoother and continued flow of work from the acute trusts, avoiding the need to delay discharges over the weekend due to the lack of services in the community.	Increased activity and availability of services over 7 days
Extension of social care provision to enable elderly people to stay well at home	To support elderly people to remain independent for as long as possible by ensuring access to services and facilities to enhance their wellbeing	Frail older people are the most significant patient group in terms of complexity, growing demand and potential for improved care pathways.	The expected outcome of this aspect is that there will be increased capacity in domiciliary care services and a broader market in terms of services to support people to remain at home. The	An increase in availability of information regarding health and social care interventions in North Somerset and a corresponding reduction in demand on statutory agencies for

			outcome of an increase in Extra Care Housing will be to ensure a more even access to this provision across the area	information and advice. A change in culture from one of dependence to one of resilience in terms of responsibility for personal health and wellbeing. A reduction in avoidable and preventable health conditions as a result of increased understanding, awareness and access to preventative services. A reduction in reliance on the statutory sector for all services An increase in the provider market for users of personal budgets to find individual solutions to meet need. An increase in uptake of community based services, particularly in the private sector.
Support to Carers	A carer support service is commissioned which provides: Pro-active approach to the early identification of carers	Carers UK, 2012) identified that 87% felt that caring had had a negative impact on their	Raising awareness of carers amongst health and social care professionals	Locally expected outcomes are: • Improvements in carers' physical and mental health

		mental health and 83% felt it had had a negative impact on their physical health. 53% described themselves as having depression and 91% identified that they had felt an increase in stress and anxiety. Carers also reported an impact on their physical health, much of which may well be linked to or exacerbated by their mental health. 22% reported having a high blood pressure, 53% said they have a long term condition and 26% described their own physical health condition as having deteriorated. 52% described that their caring role	Pro-active early identification of carers Well-trained, knowledgeable Carer Assessment Recognition of carers as partners in care by health and social care professionals	• Carers better able to balance the caring role with other responsibilities • Increased number of carers able to sustain the caring role for longer • Reduction in pressures on local health and social care system which would have been caused by carers having to give up the caring role.

		impacted on their sleep and hygiene and 34% identified that their level of exercise had decreased.		
Assistive technology	To ensure a coordinated, consistent and integrated approach to the development, funding and delivery of Telecare and Telehealth services across North Somerset. Assistive technology provides an ad on service choice, with the aim for integral, to the increasing numbers of older people and those with disabilities who wish to remain within their own home. T	The focus has now moved on to the 3 million lives campaign which aims to have three million people in England benefit from Telehealth and Telecare over the next 5 years. The campaign reports that via the application of Assistive Technology 'professionals can be better informed of a person's health status which leads to early intervention and proactive care Deploying	Increased implementation and utilisation of Telecare and Telehealth devices Integrated delivery of Assistive Technology packages Improved choice and flexibility in support mechanisms to enable older and vulnerable people to continue to live independently Reduction in the number of anticipated Residential and Nursing placements in North Somerset	Raised awareness of the benefits of Telehealth and Telecare to both professional and public audiences to enable an ongoing source of appropriate referrals Wider application of AT prescriber capabilities to incorporate community partner organisations Utilisation of the Equipment and Demonstration Centre to communicate the potential benefits of Assistive Technology within a realistic independent living environment and subsequently support

				those in receipt of services and self funders
Increase support to people with mental health needs	The strategic objective of the scheme is to increase support for people with mental health needs and to deliver greater choice over services and providers. This scheme relates to a number of linked interventions including; Re-development of Extra Care Housing Scheme. Relocation of two specialist day services for organic and functional mental health services Development of an integrated health and social care model for commissioning mental health and learning disability placements including review of use of out of area placements Evaluation of provision of dementia services (and IAPT) for people with learning disabilities Provide specialist accommodation for people who have dementia in	An estimated 3,420 people in North Somerset have dementia, with GP practice records showing 53% having a formal diagnosis. The GP recorded prevalence of dementia (0.7%) is higher than England (0.5%), in part reflecting the relatively elderly population. Rates of serious mental health problems (0.8%) recorded in GP practices are similar to the England average (0.8%) and are higher in more deprived areas.	Reduction in mental health placements by 5% Increase in number of service users with a personal budget in mental health services. Increase in number of supported dementia care facilities	Key success factors are suggested as: Successful relocation of two specialist day services for organic and functional mental health services Adoption by NSCCG, NSC and AWP of a new integrated health and social care model for commissioning mental health and learning disability placements Completed review into use of out of area placements, with recommendations accepted by NSCCG and NSC. Completed evaluation of provision of dementia services (and IAPT) for people with learning

	the North of the district. Developing Personal Budgets for MH and LD service users Implement the improved post-diagnostic community support services contract for people with dementia and their carers	The number of cases has risen by 14% in the last 5 years. Higher than national average GP recorded prevalence of depression (7% against national average 5.8%)		disabilities, with recommendations accepted by NSCCG and NSC. Demonstrable increase in available provision of specialist accommodation for people who have dementia in the North of the district. Systems in place to offer and support deliver of Personal Health Budgets for MH and LD service users. Full Implementation of improved post-diagnostic community support services

Scheme IBCF	Intervention	Area of need	Data source	Impact	Contribution to metrics Existing /Suggested New Metrics
Stabilising the Care Market	Proud to Care recruitment support / promotion to independent care sector, and to promote volunteers	ADASS South West promotional campaign to promote care as a valued career. Recruitment portal to assist providers with recruitment and retention of staff	Usage activity from NSOD portal. Recruitment and retention stats for care sector	Reduce capacity problems particularly access to domiciliary care, but support to care homes and volunteerism	DTOC Excess bed days A/E attendance Reablement Expansion of community interventions (new metric)
Stabilising the Care Market	Contribution to raising care home fee increase to 3%	Several care homes have closed in last two years and bed capacity has reduced. NS has contained fees well below near neighbours but needs to ensure fees meet NLW obligations	National benchmarking on care home fees. Number of registered beds with CQC	Maintain sufficient care home capacity in North Somerset	DTOC Excess bed days A/E attendance Reablement Number of registered beds with CQC (New)
Adult Care Capacity	Block purchase of care home capacity to support discharge	Contingency resource to meet any Gap in capacity for patients awaiting family choice	DTOC data for 2016/17 shows an increase in number of	Creation of extra capacity to support discharge working closely	DTOC Excess bed days A/E attendance Reablement

		and requiring further social care assessments	patients awaiting nursing home bed. North Somerset are working across the system to improve data collection and ensuring system sign off.	with integrated discharge teams	
Adult Care Capacity	Out of hours assessment / brokerage / quality assurance measures to support improvements in care home sector. Improved information and advice for self-funders via NSOD	Identified need in capacity for weekend/BHs Promotion of NSOD to support constant information and advice to support early family choice in WGH		Reducing number of delays on patients awaiting social care assessment Consider options for, develop and pilot "Trusted Assessor" arrangements with a sample of large residential/ nursing care homes	Self funders supported by Care Navigators (new) Number of Adult Care self assessments completed on NSOD (new)
Support for the development of extra care capacity	Investment to support and incentivise the delivery of Extra Care and housing support. 3 schemes in pipeline to support success of	JSNA shows increases in elderly particularly dementia patients requiring supported packages of care at home or in a supported	JSNA data and refresh for 2016/17 shows an increase in number of residents in	Increase alternatives for discharge particularly with vulnerable dementia patients	DTOC Excess bed days A/E attendance Re ablement New Extra

	Tamar Court. Joint strategy for Housing with Support recently developed within North Somerset and is currently out to consultation outlines the need for housing support and its benefits to health and social care.	environment Housing support evidence the financial benefits for health and social care as an alternative to care home provision.	North Somerset with dementia and other co morbidities.		Care/housing support LA nominated /shared ownership units developed (new)
BNSSG Common Process Work	The three local authorities recently commissioned a review of the opportunities for increased collaboration and common processes relating to adult social care discharge arrangements.	Recognition of closer alignment across BNSSG	2016/17 data for DTOC shows a number of patients awaiting a social care assessment compared to NBT and UHBT	Design a single and consistent 7 days a week Hospital Discharge process to operate in each of the three main acute hospitals in the BNSSG STP area Consider options for, develop and pilot “Trusted Assessor” arrangements with a sample of large residential/nursing care homes.	DTOC Excess bed days A/E attendance Reablement
	Redesign of existing	Demand capacity	Local data	To ensure	A/E attendance

Single Point of Access	service working closely with community provider and developments with connecting care, MDT way of working. This funding is to continue initiatives aimed at demand management via proactive early interventions to reduce demand for long term care.		shows an increase in demand within our local single point of access Reduced levels of interventions.	services are in right place to ensure patients are directed to the right service at the right time and delays are not experienced	Reablement DTOC Excess bed days Reablement Expansion of community interventions (new metric) % age of referrals to SPA leading to an intervention (new)
Care Review Capacity	Additional care management capacity to ensure faster discharge arrangements and focused attention of periodic review of packages to ensure independence	Contingency resource to meet any Gap in capacity for patients to enable discharge.	Local DTOC data	Enabler to support patients to stay at home	A/E attendance Re ablement DTOC Number of Residential Beds per ….
Assistive Technology	Increase take up of assistive technology	North Somerset has seen year on year take up of Assistive technology. This funding is to continue and expand successful AT grants focused in particular on Extra Care and housing support initiatives	BCF local performance indicator shows an increase in the number of service users who are using assistive technology.	Enabler to support patients to stay at home	A/E attendance Re ablement DTOC Excess bed days Number of Residential beds …. Telecare/Telehealth numbers AT (new definition)

Adult Care Protection	Ensure protection of resources to ensure care package activity increases and ensure essential prevention and early intervention services are protected and consequential impact of Health service reductions on adult social care are nullified	MTFP savings in SP services partially offset. Contribution to meeting additional demand for adult social care services	Adult care packages increasing in volume, size and complexity	Creation of extra capacity to support discharges and avoid delay.	A/E attendance Reablement DTOC Excess bed days
Improved information and advice and integration of information systems	Connecting Care further developments, contributions, patient information via NSOD, interface with Health with new Adult Care service	Contributes to sharing patient information across providers	n/a	Enabler of capacity to support discharges and avoid delay.	DTOC Excess bed days Connecting Care usage (new) Number of Adult self assessments on NSOD (new) Number of Volunteers identified on NSOD (new)