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Date: 16 August 2023

Dear Sir or Madam

The Health and Wellbeing Board – ***Additional meeting
Thursday, 24 August 2023, 2.00 pm – Kenn Room, Town Hall Weston-super-Mare

A meeting of the Health and Wellbeing Board will take place as indicated above.

The agenda is set out overleaf.

Yours faithfully

Assistant Director Legal & Governance and Monitoring Officer

To: Members of the Health and Wellbeing Board

Members:

Georgie Bigg, Jeremy Blatchford, Colin Bradbury (Vice-Chairperson), Paula Clarke, Kirstie Corns, Emma Diakou, Carolyn Fair, Mandy Gardner, Cllr Catherine Gibbons, Mark Graham, John Heather, Cllr Jenna Ho Marris (Chair), David Jarrett, Matt Lenny, David Moss, Adam O'Loughlin, Sarah Pepper, Stephen Quinton, Julie Sharma, Sheila Smith, Cllr Dan Thomas, Cllr Helen Thornton, Cllr Joe Tristram and Hayley Verrico.

This document and associated papers can be made available in a different format on request.

Agenda

1. Public Participation (Standing Order 17)

To receive and hear any person who wishes to address the Board. The Chair will select the order of the matters to be heard. Each person will be limited to a period of five minutes. Public participation time must not exceed thirty minutes.

Requests to speak must be submitted in writing to the Assistant Director Legal & Governance or the officer mentioned at the top of this agenda letter, by noon on the working day before the meeting and the request must detail the subject matter of the address.

2. Apologies for absence and notification of substitutes

3. Declaration of disclosable pecuniary interest (Standing Order 37)

A Member must declare any disclosable pecuniary interest where it relates to any matter being considered at the meeting. A declaration of a disclosable pecuniary interest should indicate the interest and the agenda item to which it relates. A Member is not permitted to participate in this agenda item by law and should immediately leave the meeting before the start of any debate.

If the Member leaves the meeting in respect of a declaration, he or she should ensure that the Chair is aware of this before he or she leaves to enable their exit from the meeting to be recorded in the minutes in accordance with Standing Order 37.

4. Minutes (Pages 5 - 10)

Minutes of the Health and Wellbeing Board Meeting on 5 July 2023 to approve as a correct record.

5. Better Care Fund Plan 2023-25 (Pages 11 - 94)

Report of the Principal Head of Commissioning, Partnerships and Housing Solutions, North Somerset Council

Exempt Items

Should the Health and Wellbeing Board wish to consider a matter as an Exempt Item, the following resolution should be passed -

“(1) That the press, public, and officers not required by the Members, the Chief Executive or the Director, to remain during the exempt session, be excluded from the meeting during consideration of the following item of business on the ground that its consideration will involve the disclosure of exempt information as defined in Section 100I of the Local Government Act 1972.”

Also, if appropriate, the following resolution should be passed –

“(2) That members of the Council who are not members of the Health and Wellbeing Board be invited to remain.”

Mobile phones and other mobile devices

All persons attending the meeting are requested to ensure that these devices are switched to silent mode. The chairman may approve an exception to this request in special circumstances.

Filming and recording of meetings

The proceedings of this meeting may be recorded for broadcasting purposes.

Anyone wishing to film part or all of the proceedings may do so unless the press and public are excluded for that part of the meeting or there is good reason not to do so, as directed by the Chairman. Any filming must be done as unobtrusively as possible from a single fixed position without the use of any additional lighting, focusing only on those actively participating in the meeting and having regard to the wishes of any members of the public present who may not wish to be filmed. As a matter of courtesy, anyone wishing to film proceedings is asked to advise the Chairman or the Assistant Director Legal & Governance and Monitoring Officer’s representative before the start of the meeting so that all those present may be made aware that it is happening.

Members of the public may also use Facebook and Twitter or other forms of social media to report on proceedings at this meeting.

Emergency Evacuation Procedure

On hearing the alarm – (a continuous two tone siren)

Leave the room by the nearest exit door. Ensure that windows are closed.

Last person out to close the door.

Do not stop to collect personal belongings.

Do not use the lifts.

Follow the green and white exit signs and make your way to the assembly point.

Do not re-enter the building until authorised to do so by the Fire Authority.

Go to Assembly Point C – Outside the offices formerly occupied by Stephen & Co

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Minutes

of the Meeting of

The Health and Wellbeing Board
Wednesday, 5 July 2023

New Council Chamber - Town Hall

Meeting Commenced: 2.00 pm Meeting Concluded: 3.45 pm

Board Members:

Cllr Jenna Ho Marris (Chair)

Georgie Bigg
Jeremy Blatchford
Ros Cox (substitute for Colin Bradbury)
Emma Diakou
Matt Lenny
Sheila Smith
Dan Thomas
Helen Thornton
Joe Tristram
Hayley Verrico

Apologies: Colin Bradbury (Vice-Chairperson) Cllr Catherine Gibbons and Mark Graham.

Absent: Paula Clarke, Kirstie Corns, Mandy Gardner, John Heather, David Jarrett, David Moss, Adam O'Loughlin, Sarah Pepper, Stephen Quinton and Julie Sharma.

Officers in attendance: Sam Haywood, Georgie MacArthur (NSC Public Health), Leo Taylor, Harriet Isherwood (NSC Democratic Services)

HWB 1 Health and Wellbeing Board Terms of Reference and Membership

The Director of Public Health presented the draft Terms of Reference which included the designated Membership of the Panel.

In discussion there was reference to Board's "appreciative inquiry" approach to the informal in-depth examination of issues affecting the local area and the Director encouraged Board Members to submit suggested topics. The Healthwatch representative requested that a forward programme of appreciative enquiries be shared so that Member organisations could coordinate their work. There was also discussion around the possibility of holding Board meetings around the district, potentially dovetailing with Community events.

Resolved: that the Terms of reference be agreed and adopted.

HWB 2 Confirmation of Vice Chairman

Resolved: that Colin Bradbury, Director of Strategy, Partnerships and Population (BNSSG Integrated Care Board), be confirmed as the Vice-Chair for the 2023-24 Municipal Year.

HWB 3 Declaration of disclosable pecuniary interest (Standing Order 37)

None.

HWB 4 Minutes

Resolved: that the minutes of the meeting of 1 March 2023 be approved as a correct record

HWB 5 Joint Health and Wellbeing Strategy – Quarterly Update

Joint Health and Wellbeing Strategy – Quarterly Update (Agenda Item 7)

Dr Georgie MacArthur, Consultant in Public Health (North Somerset Council) presented the report which provided an update on implementation of the Health and Wellbeing Strategy, including the original actions, those included in the refresh of the action plan of 2022 (phase 1), and the actions being shaped as part of phase 2.

Since the joint Health and Wellbeing Strategy reached the end of its timeline in 2024, this paper sought to provide a foundation for discussion around the scope, design and content of the next joint Health and Wellbeing Strategy 2024-2028.

In opening discussion, the Director of Public Health emphasised that the Board continued to track the Strategy Action Plan and that the aim now was mainly about engaging with stakeholders and communities on how to further develop the strategy. A timeline would be provided to Members in due course.

Members commented as follows:

- the need to evidence where the strategy was making a difference together with the importance also of capturing qualitative data to demonstrate that improvement was being perceived (felt) in communities;
- the need to leverage budgets across other Council directorates and other partner organisations around delivering wider determinants of health outcomes;
- it was not just about money but also hearts and minds. The appreciative inquiry approach represented a useful opportunity to galvanise purpose and approach across the partnership.

In concluding discussions the Director of Public referenced the comment about leveraging other Council directorates, emphasising that the Integrated Care Strategy (which would be picked up later on the agenda) was challenging the Health and Care system to behave differently with focus on prevention and the

need for practical impact. The Board was exploring ways of delivering this focus across North Somerset.

Resolved:

(1) that the Board note the ongoing progress in implementing the joint Health and Wellbeing Strategy and the refresh of the action plan and the process for advancing the Equality, Diversity and Inclusion workstream.

(2) that the Board approve the recommendation to evolve and refresh the joint Health and Wellbeing Strategy building on the existing structure, guiding principles, overarching themes and priority topic areas, and responding to recent strategic development in the system, rather than developing an entirely new structure and strategy.

(3) that Board Members feedback views and perspectives about any critical considerations, strategic developments, insight and engagement activities and/or health and wellbeing needs to be taken into account during development of the next joint Health and Wellbeing Strategy 2024-2028.

HWB 6 North Somerset Mental Health Strategy 2023-2028

Dr Georgie MacArthur, Consultant in Public Health (North Somerset Council) presented the report providing an overview of the structure, ambitions and actions included in the Mental Health Strategy and the next steps regarding finalisation, approval and publication.

Members sought and received clarification on the following:-

- the need to reference mental health impacts of the menopause;
- communication issues around cross-border and private schools in the district. The Consultant in Public Health acknowledged that these had not specifically been considered so far but a pilot scheme had been established to better identify people and link them up with services through peer support and virtual hubs;
- how to address a lack of understanding around mental health in the community – the Director of Public Health referred to the issue as a "design problem" that could be resolved by targeting the issue more broadly, more effectively mobilising communities around wider understanding and application.

Resolved:

(1) that the timeline and next steps for engagement, approval and publication, including plans for the formal consultation be noted.
(2) that Members feedback suggestions on any additional groups or forums with which dedicated engagement should be completed regarding the final draft; and
(3) that in considering the high-level theme areas suggested for funding, Members feedback views on where this fixed-term investment could most effectively be targeted to address gaps in support.

HWB Recommissioning of the BNSSG Integrated Sexual Health Service

7

Samuel Hayward, Consultant in Public Health (North Somerset Council) presented the report which described the commissioning plan for integrated sexual health services that North Somerset Council was a party to. The report also summarised the approval for the recommissioning of the North Somerset elements of the BNSSG Integrated Sexual Health by the Council's Executive on 21st June 2023.

In discussion, Members sought and received clarification on engagement with digital providers (given the reference in the report to providing more online services).

The Director of Public Health commented that, whilst the strategy sought to address complex needs, there was also significant focus on prevention. He referred by example to current issues around toxic masculinity and the need to encourage healthy relationships. The Board was looking to do something around leveraging wider partnership around prevention.

Resolved: that

(1) that the outcome of the key decision from the Executive on the 21st June 2023 which agreed to North Somerset Council participating in the recommissioning of the BNSSG integrated sexual health services be noted;

(2) that the outcome of the related agreements from the Executive on the 21st June 2023 be noted; and

(3) that findings from the North Somerset Sexual health services workshop held on 9th June 2023 be noted.

HWB 8 Weston Worle and villages, Woodspring localities updates

The Head of Locality One Weston, Worle and Villages was unable to unable to attend the meeting and present the report, which outlined plans and work that the ICB localities in Weston Worle and Villages and Woodspring participate in and conduct with partners, was therefore taken as read.

Resolved: that the report be noted.

HWB 9 Integrated Care Strategy

Ros Cox, Associate Director, Partnerships (BNSSG Integrated Care Board) presented the report which summarised the work done to date by the Integrated Care Partnership (ICP) to develop a comprehensive strategic approach to improving the overall health and wellbeing of the residents of BNSSG. The first step was to develop a Strategic Framework which was approved and published by the Integrated Care Partnership in December 2022. The system-wide Editorial Group, which oversaw the production of the Strategic Framework, was then reconvened to coordinate the development of the first edition of the Integrated Care System Strategy which was due to be reviewed by the Integrated Care Partnership board on 16 June. The final document would then be published on 30

June, in coordination with the Joint Forward Plan, and would be circulated to all partners.

There was discussion around the role of the improvement groups and how their work would be reported back to the Health and Wellbeing Board. Members emphasised the need for assurance that the strategy was being actioned effectively. The Associate Director said that governance arrangements were still being worked through and confirmed she would report back the Board's views back to the ICB.

Resolved: that the report be noted.

HWB 10 The HWB Work Plan

The Director of Public Health reported that the Board's Operations Group would be developing ideas for the work plan and reiterated his request that Members put forward suggestions for appreciative inquiry topics.

Suggestions for items at forthcoming Board meetings included:

- the Better Care Fund as a standing item on all agendas;
- preparedness for Care Quality Inspections (including self assessment and risks);
- Special Educational needs and disabilities (SEND) Improvement Plan progress

Resolved: that the Director's update be received.

HWB 11 Board Meeting Review

Members reviewed the meeting against the three questions (criteria) set out in the Board's terms of reference.

There was discussion around the importance of building on common themes that had emerged at the meeting, particularly around a whole-system approach to health and wellbeing - with greater focus on prevention and the wider determinants of health - and how progress might be evaluated in terms of whole-system impact.

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Chairman

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North Somerset Council

Report to the Health and Wellbeing Board

Date of Meeting: 24th August 2023

Subject of Report: Better Care Fund Plan 2023-25

Town or Parish: All

Officer/Member Presenting: Gerald Hunt Principal Head of Commissioning, Partnerships and Housing Solutions

Key Decision: yes

Reason:
It is significant in terms of its effects on communities living or working in an area compromising two or more wards in the area of the Local Authority.

Recommendations
The Board is requested to approve the Better Care Fund Plan enclosed in Appendix One and to confirm the following contained in Appendix Two:

- Agreement on use of mandatory BCF funding streams
- An assessment of capacity and demand for intermediate care services
- Ambitions on making progress against the national metrics.

1. Summary of Report

To approve the Better Care Fund Plan for 2023/25 and to agree financial and planning assumptions for 2023/24.

2. Policy

The BCF Plan supports several of the Corporate Plan priorities, including:

BEING A COUNCIL THAT EMPOWERS AND CARES ABOUT PEOPLE.

- A commitment to protect the most vulnerable people in our communities.
- A focus on tackling inequalities, improving outcomes.
- Partnerships which enhance skills, learning and employment opportunities.

AN OPEN AND ENABLING ORGANISATION

- Engage with and empower our communities.
- Empower our staff and encourage continuous improvement and innovation.
- Manage our resources and invest wisely.
- Embrace new and emerging technology.
- Make the best use of our data and information.

- ❖ Provide professional, efficient, and effective services.
- ❖ Collaborate with partners to deliver the best outcomes.

The Corporate Plan details about Adult Social Care
"The system for funding adult social care is widely recognised as no longer fit for purpose with a national solution for sustainable funding being essential. Care markets locally and nationally are challenged by rising costs, staff shortages and the ongoing need to maintain quality. As demand for these services increase in line with an aging population, so does the cost to the council, coinciding with almost a decade of reducing government funding for local authorities."

We must commission a range of services across adult social care that prevent and / or delay people from needing to rely on statutory services for as long as possible. Details of how we will achieve this will reflect a move to offering better outcomes, that improve and maintain the confidence and therefore, wellbeing of service users. We also intend to focus on support for informal Carers to maintain their caring role, delaying the need for large packages of care and placements into care homes.

The services in this commissioning plan are key to the commitments in respect of Adult Social Services priorities for 2023/24.

Directorate Wide Commitments

Our Commitment	What is the Outcome we Expect
Enable people to have independence, access to services, and reduce inequalities.	North Somerset residents have good quality of life and good health and wellbeing.
Ensure we deliver and commission high quality services.	Residents have good quality of life and satisfaction with the services they receive.

Reablement and TEC Pathway Commitments

Our Commitment	What is the Outcome we Expect
Provide an effective wellbeing service.	We support people to remain part of their community and reduces overreliance on commissioned domiciliary care services.
Establish a therapy led reablement service, with TEC first approach for the whole community.	Preventing the requirement for statutory services and enabling people to stay in their own homes for longer.

Integrated Commissioning and ICP development commitments

Our Commitment	What is the Outcome we Expect
Contribute to the ICP development and ensure North Somerset has a voice.	Housing and social care voice is active in the delivery of ICP Partnership arrangements.
Contribute to the Development of Effective Housing with Support solutions for all adults with care and support needs	Supports quality of life for residents and satisfaction with the services they receive.

Operational Service Development commitments

Our Commitment	What is the Outcome we Expect

Ensure people have a variety of options for accessing information and identifying solutions.	People can get the right advice and information more quickly and conveniently.
Ensure carers are supported.	Carers have access to information and services to support them in their caring role.

3. Details

Details of the Plan are enclosed in Appendix One, the financial and planning assumptions are enclosed in Appendix Two BCF Planning Template and Appendix Three includes a short contextual presentation for the purpose and governance arrangements of the BCF, for background to the appreciative enquiry element of the Board.

4. Consultation

A comprehensive listing of the consultation and engagement over the Plan is outlined as part of the in the introductory section of the BCF Plan in Appendix One.

5. Financial Implications

The financial details of the BCF are included in Appendix Two in the Planning Template and summarised in the presentation in Appendix Three.

6. Legal Powers and Implications

The transfer of funding covered by the BCF are subject to legal agreement between the ICB and NSC.

7. Climate Change and Environmental Implications

Climate issues including TEC developments and the Innovation Grant funding are included as part of the BCF Plan in Appendix A.

8. Risk Management

The system risks associated with capacity planning for the Winter are included as part of the BCF plan in Appendix One.

9. Equality Implications

The Equality Implications of the Plan and measures to address health inequality are a key aspect of the BCF Plan in Appendix One.

10. Corporate Implications

BCF is a key financial and integration platform for system working and our wider relationship with the ICB.

11. Options Considered

N/A

Author:
Gerald Hunt Principal Head of Commissioning, Partnerships and Housing Solutions
Gerald.hunt@n-somerset.gov.uk 07766366097

Appendices:

Appendix One BCF Plan 2023/25
Appendix Two BCF Planning Template
Appendix Three BCF Presentation

Background Papers:

None

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Table of Contents

1. Cover

Health and Wellbeing Board(s).

North Somerset

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, t councils).

North Somerset Health and Wellbeing Board
North Somerset Council
BNSSG ICB
Weston, Worle and Villages Locality Partnership
Woodspring Locality Partnership
Care and Support West/ Social Care Provider Representatives
Voluntary Action North Somerset and other VCSE representatives.
Alliance Homes (Home from Hospital and Carers Support Service Provider)
Sirona Community Health Provider

How have you gone about involving these stakeholders?

. We have shared priorities and integrated funding plans for locality Ageing Well and anticipatory care funding with the BCF at both North Somerset Locality Partnerships.

Stakeholder engagement on the D2A programme is undertaken in the following ways:

- Insights work with frontline staff to understand barriers to delivery and mitigations to address these.
- Developing demand and capacity modelling of services to have a shared view of the changes needed across the full discharge to assess pathway.
- Developing a shared focus on outcomes and evaluation

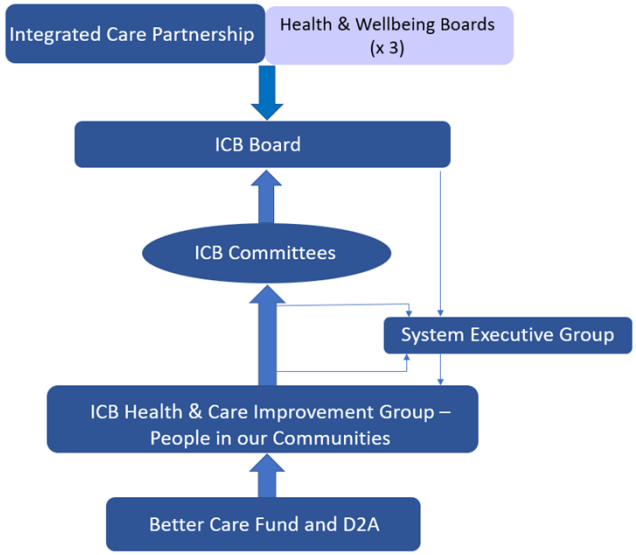
2. Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

The Bristol, North Somerset, and South Gloucestershire (BNSSG) local authorities are partner organisations in the BNSSG Integrated Care System (ICS), which builds on the extensive system working already in place for both strategic planning and shorter-term plans for responding to system-wide operational pressures. The ICS has an agreed governance

infrastructure that encompasses planning, financial management, system performance and six Locality Partnerships.

The ICS is made up of an Integrated Care Partnership (ICP), and Integrated Care Board (ICB) and the six Locality Partnerships. ICS organisations include Avon & Wiltshire Mental Health Partnership NHS Trust, Bristol City Council, BNSSG ICB, North Bristol NHS Trust, North Somerset Council, One Care, Sirona Care and Health, South Gloucestershire Council, South Western Ambulance Service NHS Foundation Trust and University Hospitals Bristol and Weston NHS Trust. The ICP brings together a broad range of partners – including from the local voluntary sector and community groups and is jointly chaired by our three constituent Health and Wellbeing Board chairs, on rotation.



The integrated care board is establishing four groups with a key role and purpose in the Decision-Making Framework - Health & Care Improvement Groups (HCIG). The BCF programme will report into the People in our Communities HCIG. The HCIG includes representation from all ICS partners, with the purpose of providing system oversight; ensuring ICS partners are working together effectively, collaboratively, and symbiotically with one clear focus: Person first.

HCIGs will be delegated responsibility by the ICB Board for achieving specific outcomes, strategic and in-year plan objectives in pursuit of the ICSs vision and mission.

The People in our Communities HCIG will oversee the Discharge to Assess programme, along with programmes which delivery anticipatory care, ageing well and frailty projects. Bringing together these key BNSSG -wide change programmes to deliver integrated care, which includes agreed ICS joint working on the related BCF objectives.

There is extensive and ongoing consultation and involvement of key partners, including VCSE organisations, in strategic planning and shorter-term plans for responding to system-wide operational pressures.

North Somerset

The North Somerset Health & Wellbeing Board is responsible for approving the BCF plan each year and the newly created Senior Officer Group (which provides support to the Board) provides oversight of the governance arrangements and financial mechanisms.

The new Executive Member for Homes and Health has been appointed with responsibility for the Health & Wellbeing Board and BCF plan sign off.

The North Somerset Health & Wellbeing Board will formally receive and 'sign off' the Better Care Fund Plan at its next meeting, (to be determined). At this meeting the Chair for 2023-24 will also be appointed.

3. Executive Summary

This should include:

- Priorities for 2023-25

Priorities for 2023-25

Across BNSSG:

- Further development of models of intermediate care; including Sirona Reset.
- Locality and provider collaborative focus on Community and place – reducing inequality gap.
- focus on prevention, early intervention, and de-escalation of need in all areas of work.

North Somerset Local Priorities include:

- Continued development of work across both our locality partnerships.
- Mitigation of the impact of the cost-of-living crisis and its impact on health inequalities
- Developing more integrated and collaborative approaches to health and social care delivery, supporting the wider workforce and developing innovative preventive care infrastructure, from First Response, Rapid Response, Virtual Community Hub, TEC, Home from Hospital and Dementia pilot.
- The importance of Housing as a determinate of health and social care outcomes and the significance of DFG, TEC and other housing initiative's to maximising independence.

Key changes since previous BCF plan

BNSSG

- System D2A business case – longer term planning and funding – supporting transformation and focused on better outcomes for individuals. Included supporting Virtual Frailty Wards, Social Work in Reach and trusted assessment between Health and social care providers,

North Somerset

North Somerset Local Priorities reflect a continuation of the focus on Maximising Independence and investing in support services to deliver this, from expanded reablement capacity, TEC, and work with the voluntary sector. These shared priorities with our maturing Local Partnerships are consistent with the LGA findings, albeit a frustration with the work was the lack of local analysis, as whilst we concur with the findings and the actions recommended. Namely to reduce LOS and bedded care in DTA discharge pathways, the modelling of this change is very different between the three authorities, which recognises the historically a much lower bed base has operated in North Somerset.

Bed shift over the months						
	Bristol		NS		SG	
Month	P2	P3	P2	P3	P2	P3
Mar-23	102	72	28	39	61	37
Apr-23	102	72	28	39	61	37
May-23	98	67	29	37	58	35
Jun-23	94	62	31	34	54	33
Jul-23	90	58	33	31	50	31
Aug-23	86	54	35	29	46	29
Sep-23	82	50	37	27	42	26
Oct-23	77	46	39	25	39	24

Whilst the D2A programme reduces the total number of beds commissioned from the current bed base, the total bed requirement is still greater than original baseline funding, which were particularly low in North Somerset. Hence the ICB utilisation of funding to support beds. Our shared aim is to continue to reduce the use of bedded provision as part of discharge except where it offers an improvement in personal outcomes or promotes a better likelihood of discharge to original residence.

An area of change has been the expanded population health management focus of the Local Partnerships, building on the ongoing Joint Strategic Needs refresh to develop join priorities to address our local health inequalities. Data analysis has provided additional information in terms of impactful conditions in Weston & Worle and Woodspring areas. It is recognised the top 5 impactful conditions by age in North Somerset changes between the ages of 50 to 74 and 75+ years. It is also recognised that our two LP areas are very different with their own unique challenges.

The emerging priorities for both Partnerships based on our joint work can be summarised in Appendix 1, 2 and 3.

Appendix 1. Weston Worle and Villages.do

Appendix 2. Top 5 impactful conditions b

Appendix 3. Impact of Conditions.pptx

In North Somerset this information is now informing our prevention work, and key locality partnership work including our dementia pathways, funding established for a dementia carers block, frailty pathway and expansion of our TEC, reablement and First response services. These are critical developments to support the rurality challenges of the Woodspring community, where domiciliary care travel times remain a challenge.

While life expectancy in North Somerset is broadly in line with the England average, it varies by area, with Weston-Super-Mare Central Ward having the lowest life expectancy (69.3 years for males and 76.6 years for females).

Healthy Life Expectancy at Birth

	Male	Female
England	79.8	83.4
South West region	80.4	84.1
North Somerset	80.7	84.6
Weston Central Ward	69.3	76.6
Clevedon Yeo	85.2	93.1

In Weston the focus is on the cost-of-living crisis reflected by Weston Central ward having one of the worst deprivation scores in England. The percentage of working age people claiming out of work benefit is also extremely high within Weston-Super-Mare. COVID-19 has presented challenges for a number of people financially. The health and wellbeing of people in deprivation are negatively impacted by the wider determinants of health including housing, employment, education, access to social networks and lifestyles. It should also be noted that people with more limited financial means may use more public transport. The impact of the rising cost of living also needs consideration, with lower income families being most at risk of facing negative impacts on their health and wellbeing.

4. National Condition 1: Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

The BNSSG ICS has a shared ambition to build an integrated health and care system, where ‘home first’ is the preferred setting of care, utilising hospital services only when needed, and where people can maximise their health, independence and be active in their

own wellbeing. We want to increase the number of years people in BNSSG live in good health; reduce inequality in health outcomes between social groups; and help to create communities that are healthy, safe and positive places to live. We also want to make it easier for staff to work productively together and develop a healthy and fulfilled workforce".

Joint Commissioning is undertaken through joined up work between local authorities and the ICB through both a shared programme approach to deliver the longer term change programme, and through joint commissioning governance arrangements. LAs are active members of the Discharge to Assess programme, and are involved in both the development of the programme priorities, as well as supporting implementation and delivery. Joint commissioning arrangements are coordinated via the weekly Commissioning Arrangements meetings, organised by the ICB with representation from all three LAs. New ideas for BCF funding would be brought to this D2A programme for consideration as part of the system wide priorities, and, commissioning and contracting consequences would be undertaken jointly through the Commissioning Arrangements forum.

The ICB is currently implementing a new governance structure – and this will include reporting and oversight for this work from the 'People in our Communities' Health and Care Improvement Group. This group includes LA representation.

A recent example of joint commissioning aligned to the change programme is the joint commissioning of P2 and P3 beds across BNSSG. The D2A board (as a joint endeavour with ICB and LAs) developed the ambition to reprocure a reduced number of beds on a new service specification, with enhanced performance and quality indicators to support delivery of the D2A programme ambitions. The development of the specification and procurement approval was coordinated jointly through the Commissioning Arrangements forum, and signed off by all partners at the ICB Board.

North Somerset

In North Somerset, our approaches to collaboration and joint commissioning, include:

- Expand and make permanent via BCF the promising results from pilot with Response 24 to support people who fall in the community – First Response Service.
- Improving End of Life experiences by increasing the number of people discussing their end of life wishes and dying in their place of choice, e.g., the Weston 'Good Grief' festival which was extended across North Somerset.
- North Somerset Together Virtual Hub – a collaborative partnership led by Citizens Advice North Somerset a 2 year pilot jointly funded by NSC and North Somerset Locality Partnerships. A new service taking direct referrals from front line staff within health and community settings, providing a one-stop connector service to support navigation of support systems, community assets and social welfare support Helping to reduce inequalities by addressing the wider determinants of health, such as debt, poor housing, employment and physical activity.
- Expansion of Wellness Service following merger with NSC Rapid Response service to provide telephone support and access to TEC with an emphasis on loneliness and social isolation.
- For Woodspring area addressing inequity of opportunities and outcomes derived from our rurality and large, older population.

- Mobilisation of the North Somerset Ageing Well model focussed on prevention, pro-active care and complex care (including dementia). Dementia carers support a local funding priority in BCF discharge grant.
- Expansion of capacity in our reablement service, our virtual TEC hub, Home from Hospital service which will be expanded particularly to support Discharges from our Bristol Acutes to incorporate the Link Workers.
- Continued commitment to Proud to Care, retention bonuses in domiciliary care retention fees and retainer payments for domiciliary care providers whilst client are in hospital.
- Incentive payments for care homes to complete faster discharge assessments. These incentives, £250 per assessment and placement completed in 24 hours, was introduced this Winter with dramatic impact (length of placement time reduced by c25%) on LOS and will be maintained via BCF this year.
- Despite the sizable contraction in headcount within ICB funding settlements, NSC and our two Locality Partnerships have agreed a jointly commissioned Service Development post to support progress on joint priorities and identify further joint commissioning opportunities.
- The use of the Winters discharge grant to advance payment of pay awards for care workers has improved recruitment across the board and we have had great success across social media including local television and radio on our Proud to Care Campaign promoting the positives of working in care, particularly following the award of a local charismatic carer winning the national carer of the year award.
- Current Retendering of domiciliary care contracts are designed on establishing two strategic provider partners for each Locality and boundaries co-terminus with each Locality. Access Your Care one of existing Strategic Partners, plays an active engagement role in Locality Partnership Business and in particular our local priority to upskill our local Care workforce.
- The BCF has been used in the Winter to support these initiatives and collaboration with local strategic providers and Locality Partnership stakeholders creating a shared vision for collaboration across health and social care to develop a local care academy. Please refer to Appendix 4.

Appendix 4. Local Care Academy.pptx

5. National Condition 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

BNSSG ICS is committed to ensuring our combined health and care resources are used to promote a Homefirst ethos, and has a suite of programmes from anticipatory care planning in the community, through to crisis response and facilitated discharge from Hospital. Following system wide research as part of the Better Care Fund support Programme in 2022, we know there is opportunity to reduce the number of times an interim bed is chosen and increase rates of return to usual place of discharge. Our investment plans across 23/24 and 24/25 include bolstering MDT working within the acute setting through establishment of new Transfer of Care hubs and increasing the complexity of our at home options to better meet the needs of service users including: investment in night sitting, and expansion of voluntary sector resources, increased home care options, alongside wider BNSSG Homefirst plans such as virtual wards and stroke community services

The system's focus on admission avoidance includes:

- Development of the "Assessment and Coordination of Emergency and Urgent Care "(ACE) model being piloted in Q1 23/24
- Enhanced Care Home support model
- PCN Care co-ordination

The Home First Portfolio is a group of change programmes that bring health and care partners together across the ICS to either keep people at home when they need extra support; or get people back home as quickly as possible if they need to be displaced from their home environment for their needs to be met. This might be unplanned and needed in response to managing an existing condition or a change in the home circumstances (e.g. carer or housing), as an alternative to being admitted to hospital, or to support an earlier discharge from hospital.

The Home First Portfolio includes Discharge to Assess and NHS @ Home (virtual wards) alongside a range of programmes focused on specific conditions, for example CVD and end of life care.

The Home First Portfolio aligns closely with the main Better Care Fund priorities to: provide people with the right care, in the right place at the right time and enable people to stay well,

safe and independent for longer. Although the Better Care Fund covers all Intermediate Care services, in the last year the Department of Health and Social Care's key focus has been on hospital discharge, and this will be a key focus for 2023/24 and 2024/25.

The aim of the D2A Programme is to address the significant and urgent pressures on the health and social care system across BNSSG. These include:

- Too many people in the BNSSG system are discharged from hospital into community beds. Many of these people could be treated in a home first setting with wrap around support with greater integration and joint working between health and social care services.
- There are also too many people in hospital beds who no longer require acute medical care.
- Delays and the high number of people in post-acute care beds is having a significant impact on our ability as a system to maintain hospital flow, reduce ambulance delays, and deliver elective recovery.
- A number of areas to improve integration across D2A pathways in BNSSG and joint working between health and care services.
- Average length of stay remains significantly higher than targeted across all D2A pathways.

Following a Local Government Association Peer Review of hospital discharge pathways in Summer 2022, BNSSG received diagnostic support from the national Better Care Support Fund to understand the causes of these challenges and develop a long-term improvement plan. The diagnostic was carried out from July to November 2022.

A refreshed system improvement and transformation plan is being developed via the D2A Programme with input from all system partners. Key priorities for investment identified following the diagnostic include:

- Focusing the social care workforce in hospitals to achieve the cultural shift and reduce the number of times a non-ideal pathway is chosen (all 3 acutes sites have significant investment to establish multi-disciplinary transfer of care hubs).

- Expanding domiciliary care/reablement to support anticipated increase in the Home First model

- Matching community assessment and therapy/ case management support to the community short stay bed base to meet new capacity plans

- Providing recurrent funding for VCSE infrastructure in the acutes and community to support extended use of Pathway 0 (support to go straight home from hospital).

- Investing in change capacity to support delivery in the short term.

Alongside this there is a key focus on Admission prevention and keeping people well and independent in the community:

- There is an opportunity to avoid admissions/readmissions through high quality coordination of the response to urgent care needs in the community, combined with data-driven approaches to risk (identification of most at-risk patients) and increased

capacity to proactively work with these patients and their families. This is a good example of community provider led innovation which will make a real difference and our intention is to prioritise system funds to enable this initiative.

- The development of the 'Assessment and Coordination of Emergency and urgent care' (ACE) model is key example of this. This service brings together expertise from primary and community care, acute and social care providers to coordinate and enable an integrated community response for people with urgent care needs and complex comorbidity/ frailty. Early data evidences a significant reduction in admissions to hospital for the segment of our population, which utilises the largest proportion of our non-elective bed days
- Care coordination across services in primary and community care on discharge based on care coordinators based in each PCN supporting patients on discharge and proactively work to prevent readmission. These would develop into the frailty teams based on the South Somerset PCN anticipatory care frailty teams.
- Care home support is also key building on the current wrap around support to care homes, incorporating the learning from North Bristol Care Home Interface Project (NCHIP) NCHIP model and the Weston model. This would help ensure quality support for care homes across BNSSG working with PCN's. This would support both discharge into home and prevent admissions.
- The wrap around support to the community beds including P3 beds needs to be enhanced as part of the development.

Please refer to Appendix 5 which demonstrates the system's approach to supporting people in BNSSG:

Appendix 5. System approach.pptx

Our health and care system is developing new models focused on keeping people at home when they need extra support; or getting people back home as quickly as possible if they need to leave their home environment for their needs to be met. There are five key pillars to our Home First approach in BNSSG:

A. Anticipating people's care and support needs and managing them proactively – this includes through advance care planning, multi-disciplinary teams across health and social care focused on people's needs in the community, providing enhanced health support to care homes, investing in greater use of technology enabled care and maximising the use of local community assets through locality working.

B. Coordinated response to events or changes in a person's needs – this includes through setting up a multi-disciplinary ACE-F (assessment and coordination for emergency and urgent care for people with frailty). This is a co-located hub that brings together. The aim for ACE-F now is to include social care as well. The co-located ACE hub brings together clinical and social care expertise as a 'team of teams', working across traditional provider and service boundaries to coordinate urgent care responses tailored to individuals' needs. It is hoped this can support urgent care in the community wherever possible and appropriate. Person-centred care, trusted assessment, shared decision making, risk-sharing, and management of uncertainty are fundamental aspects of this approach.

C. Deploying coordinated home first services to meet people's needs at home where

they need additional support, as outlined in B above.

D. Providing acute care at home where possible – for example through the development of step up and step down virtual wards for people who require acute medical care but are able to remain at home or return home from hospital and continue to receive acute medical care, rehabilitation support and in some cases short term live in care before they are medically fit.

E. Home after hospital – we have invested significantly in improved processes and pathways to allow more people to return home following a hospital stay under Pathway 0 and Pathway 1.

In January we sent practices across BNSSG a list of patients who met an eligibility criterion (As defined by NHSE Anticipatory Care and high impact user definitions), and who were missing one of a small number of evidence-based interventions over the winter period to support their health and wellbeing. 3711 patients were included in the lists across 70 practices. The list was ranked by patient score, which searches for how many of the following interventions the patient has not received (score out of 6):

- Flu/Pneumococcal vaccine in the last six months
- 12+ repeat polypharmacy and not having had a structured medication review
- A chronic disease review (for those in the cohort with one or more of COPD, diabetes and congestive heart disease
- Completing a Respect Form

Providing an “impact ability” rating showing not just patients at risk but those for whom the most could be done to help. The aim was that focusing on these patients will enable them to avoid becoming ill over winter and/or to stay at home safe and independent for longer. Completing the interventions required MDTs at PCN or practice level to deliver the most suitable intervention to the identified patients.
Current results 1241 (or 33.4%) patients on these lists saw their intervention score decrease by at least 1. With over 200 seeing their score drop by 2.

North Somerset

Aligned to the system wide progress outlined above local developments have included:

Dementia Pilot:

The BCF discharge grant has been used to match fund NSC funding for a six-month test and learn short-term intervention service, non-clinical, focused on:

- Diverting people who would now be discharged to Pathway 3 instead of discharge to P1 with intensive support to return home
- Testing a “Reablement” approach to avoid packages increasing
- Avoiding hospital or care home admission/ readmission
- Based on best practice for people living with dementia at home, utilisation of TEC, and the upskilling care staff in dementia and support for carers
- Supporting crises intervention and exploring night time cover arrangements

A ley priority for the last year has been the development of Integrated Mental Team (IMHT) within both localities, albeit not directly funded by the BCF, these has been developed to reinvent how we provide people with the wrap-around care and support they need, to address

poor physical and mental health - and more broadly - social care needs, access to public funds, education, employment and more constructive interactions with the wider system such as criminal justice.

The IMHT will support the person to co-produce a plan that, with the support of their lead coordinator, will help them to smoothly navigate systems and access the support they need.

Direct Payments and Discharge Support Grant

NSC has funded via separate sources a Project post to encourage direct payment take-up, this has focused on operational barriers to take up, and has seen significant increases in direct payments rates for paid carers. Similarly, Sirona have launched a pilot discharge support grant scheme with aims to help improve 'flow' through local hospitals and free up beds for those who are medically unwell, by covering the minor costs associated with bringing a loved one home following their discharge.

It can be used to support the costs of childcare support, pet care, carers breaks or equipment. Funding can also pay for short-term personal care from a self-employed personal assistant to help with day-to-day activities or it may be possible for a family member or friend to be supported to provide care.

As part of the DSG agenda are reviewing our local offer to:

- Support an increase in the number of people who could be discharged from hospital, enabling them to recover in a more comfortable home environment and releasing the beds to others who need them, we are extending this to mental health acute services with a referral pathway now in place.
- Relieve pressure on commissioned community services by enabling people to design and fund new, personalised & bespoke solutions working with the discharged person's friends and family to identify the best options and coproduce good solutions for care and support, we have been proactive in-reaching to community rehabilitation units across the BNSSG area to listen to individual need and where the DSG may be utilised to improve a person and their families quality of life.
- Promote personalised agenda
- Proactively help grow a new workforce by empowering local people in their communities to provide support to people leaving hospital, which supports inclusive growth & climate change
- Promote 'describe' not 'prescribe' ethos by identifying specific needs
- Test new ways of working by employing self-employed PAs to provide personal care

Information and Advice

Access to information on care and community services is essential to carers and families as well as the network of social prescribers across the health and social care network. A refresh of North Somerset's Online Directory is recognised to improve information and Voluntary Action North Somerset have been commissioned to refresh and own the ongoing update of stakeholder's information. An engagement piece is underway as part of our Locality Partnership joint priorities to look at integrating the system requirements of the Partnership whilst improving and enhancing our Care Act information and advice requirements. An emergency but still to be finalised direction of travel is to consolidate the requirements on a single Information and advice platform MIDOS, currently being implemented in South Gloucester and Bristol

Integration and Co Location:

North Somerset has single joint services for brokerage and Quality Assurance across North Somerset, trusted assessment is in place with our reablement and therapy teams working closely with Sirona on MDM decision making and moving to avoid duplication of provision across the intermediate care space. Joint commissioning is standard for contracts as is coterminous contracts and operational teams' boundaries for Sirona and social work teams based on the two locality partnerships. As referenced elsewhere, a jointly commissioned service development post is being recruited. Operational teams are co located at Clevedon office as is our reablement and HFH provider as part of the MDM process and the transfer of care hub will integrate and co-locate the same services in Weston General.

6. National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

  how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Hospital demand was calculated using demand for P1-P3 has been calculated using last years hospital discharges. The LGA review identified that 58% of P3 patients were more appropriate for P2, 61% P2 would have been better on a P1 pathway and 40% of P1s should have been P0. The demand profile next year includes a shift towards these more ideal patient outcomes achieving 20% of the shift by the end of the year and will ensure that all patients are receiving the correct care by the end of 24/25. P0 Demand includes the

patients who would previously have received P1 support as well as demand for Red Cross, Home from Hospital, Link Workers and DSGs.

Community demand includes demand for both 2 hour emergency response and 24 hour response. Providing data for demand and capacity has been complex as the UCR 24 hour response pathway is being remodelled in 23/24 as a result of the uplift. For the UCR 24 hour response we have assumed that Q1 and Q2 are spent developing the model and undertaking recruitment to additional posts, with the expectation that we can achieve a 6.5% uplift in Q3 working to a 13% uplift in capacity in Q4. This will be reviewed in line with recruitment progress and be subject to change depending upon how successful recruitment is.

Capacity Hospital Discharge for pathways 1-3 has been calculated using the Maximum commissioned Activity / beds then applying the current LOS and occupancy rate to give the capacity for new patients each month. We have then factored in a 10% improvement in LOS in Q3 and a 25% improvement in LOS in Q4 for P2 and P3 only. We are unable to split Between reablement and rehab so have included all capacity under rehab. P0 includes Red Cross, Home from Hospital, Link Workers and DSGs.

Community capacity. Social support data has been provided by the Red Cross. Urgent community response has been calculated using the methodology above and also includes elements that are provided by North Somerset council. A full breakdown of all calculations and contributions is available if required.

7. National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

Under National condition section 2 we have described how the BNSSG Discharge to Assess improvement programme will contribute to the reduce the number of over 65s whose long-term support needs were met by admission to residential and nursing care homes.

BNSSG already meets the national standard for 70% of UCR referrals receiving a response within two hours. The service is in place 8-8, 7 days a week across all six of the BNSSG localities, including provision of a level 2 falls service. Work locally is therefore focussed on

reviewing referrals pathways and ensuring the potential of the service is maximised by other community clinicians including 111, 999 and general practice. The UCR service since its inception in 2020 has been open to self-referrals and referrals from family and carers directly via the community single point of access (SPA); such referrals represent approximately 80% of current demand. An analysis of referrals in the first half of 22/23 showed good uptake by individuals (or their carers/ families) on the community caseload, but very low referrals from 111 and 999 in particularly.

GP referrals are established but local intelligence suggests that more same day (rather than 2 hour) capacity is required to satisfy potential demand from within general practice (see below). It is important to note that this increase in UCR capacity will sit outside activity coded within the 2 hour service, but will nevertheless represent a significant increase in same-day capacity which is known to be a rate-limiting factor for community admission avoidance referrals from various system providers.

Within BNSSG's operational plan for 23/24, the ICS is recurrently funding additional advanced clinical practitioner (ACP) capacity within the community single point of access to respond directly to healthcare professional referrals, which will support referrals from any clinicians including within SWAST, 111 and ED. This was the subject of a 999-focussed pilot in Q3 22/23 which showed a 27% increase in referrals from paramedics on scene, and initiative of referrals from clinicians within the 999-emergency operations centre (call centre). Early data shows that 69% of referrals have converted to referral to the UCR 2-hour or same day teams. This pilot has been supported by significant communications and engagement with SWAST to establish this pathway. Extrapolated across the year this has the potential to avoid over 1,000 conveyances to ED.

A priority in 23/24 will be moving to the third phase of this initiative and establish a digital referral pathway from 111 to the UCR team via the SPA 111 referrals. This will be a test and learn approach to determine the relative merits of this versus integrating capacity from the SPA into the Clinical Assessment Service (CAS) within 111.

As referenced above, local intelligence from general practice and community teams suggest that more same day (rather than 2 hour) capacity could further increase community admissions avoidance capacity within BNSSG. This is partly based on historical configurations of community teams in Bristol and the 'rapid response' model. Initial modelling shows that increasing this capacity within UCR could recurrently respond to an additional 2,500 referrals a year, releasing the equivalent of 17 G&A beds. Significant funding for this increase has been included in BNSSG's additional investment plan submission, representing a substantial commitment to community-based alternatives to admission. The workforce requirements for this increase are also significant (see workforce section above) and are predicated on delivery of a local development model for Band 6 nurses within BNSSG, which develops the competencies for individuals to attain ACP status within 12-18 months. This has proven successful in BNSSG to date, with recruitment and retention of B6 nurses showing more success than for already-qualified ACPs.

Increasing referrals from local authority level 1 falls teams and pendant alarms companies has also been a focus of improvement in 22/23. Engagement with local authority teams and a review of referrals data and pathways highlighted the need to establish referral pathways in Bristol and South Gloucestershire to the Sirona UCR teams for Level 2 falls, both from 'on scene' falls responders, and from falls coordination hubs. To address this, the Sirona falls team have rolled out in Q3 a 'traffic light' tool to support the triage of individuals who have fallen, into Level 1,2, or 3 services. Critically this will support greater utilisation of UCR for Level 2 falls, where existing pathways are geared towards a 999 response which is potentially avoidable.

Specifically, in North Somerset the First Response pilot referenced elsewhere, has had fantastic outcomes in its pilot phase and is an Ageing Well as well as BCF priority for permanent funding to expand capacity beyond those supported by the LA Carelink pendant. This will expand on the existing NSC commission to support callers relating to our pendant alarm service.

The UCR service is also a key component of another integrated community initiatives focussed on UEC: the community emergency medicine service (CEMS) (further detail below) is being funded recurrently within BNSSG and the UCR service is a key 'receiving' team for individuals seen physically or remotely by the emergency medicine consultant working within the ambulance service.

In addition to the UCR-specific investments summarised above, BNSSG has agreed to recurrently fund a range of initiatives in 23/24 that aim to support delivery of the UEC Recovery Plan with respect to admitted pathways.

These are summarised below:

1) SDEC expansion at BRI, Southmead and Weston Hospitals. Recurrent investment of £3.7m is planned to support the acute trusts to build on the capacity increases made during Winter 22/23 and consolidate a seven-day service offering covering 12 hours per day. This includes medical and surgical SDEC at all three acute sites. The forecast benefit is equivalent to 33 G&A beds. Paediatric SDEC is being scoped by the BRHC using the BNSSG SDEC network, however early indications show that a large volume of appropriate SDEC is being undertaken within the emergency zone, and therefore the local priority is to alleviate capacity in ED resulting from minor acuity presentations that can be seen in an alternative setting (see below).

2) Community Emergency Medicine Service – following a pilot in Q3/4 2022/23, this service will be recurrently funded from October 2023. The service marries a senior ED clinician with a paramedic, vehicle and nursing/ UCR support to respond to the highest acuity cases on the 999-call stack that are deemed to be avoidable in terms of conveyance to ED. The pilot showed that around 80% of cases avoided ED, 60% avoiding a conveyance altogether. The service has the potential to avoid 300 admissions in the second half of 23/24.

3) Increasing capacity within the System Clinical Assessment Service (SCAS) – this clinical service provides off-pathways remote assessment of 111 cases, and was increased in 22/23 and subject to a full evaluation which showed significant reductions onward demand for 111 cases: both for Category 3_4 cases, and ETC dispositions. In 23/24 BNSSG will expand the service according to a graduated ramp up in recruitment to shifts, moving to a seven-day service from Q3. The £1.5m investment will avoid an additional 1,320 ambulance dispatches over 22/23, releasing 9 additional G&A beds, and preventing 7,100 calls being passed to SWAST.

8. National Condition 3

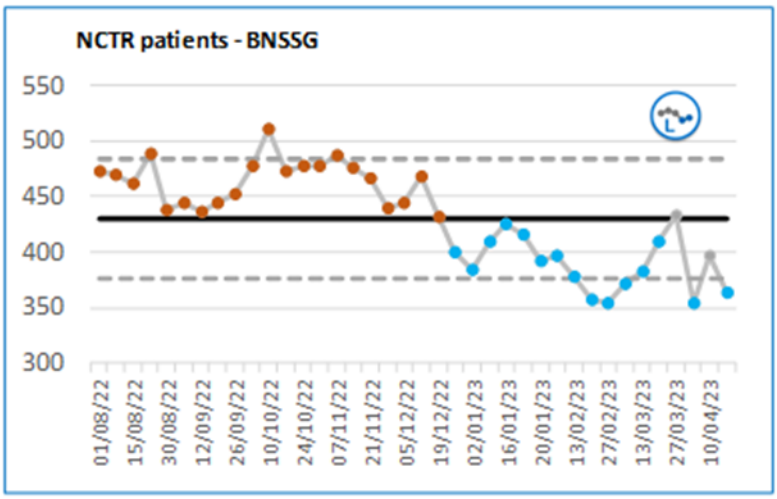
Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.
- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.
- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

The system has been working collectively to reduce discharge delays in all pathways.

- NBT and UHBW have focussed in 2022/23 on internal flow processes via the NBT Perform Programme and UHBW Every Minute Matters this work has been built into the transfer of care hubs that are being developed in quarter 1 of 23/24.
- The system recurrently invested into Discharge to Assess Business Case in 21/22, being supported by LGA review, the system has amended the business case to reflect the learning in 22/23.

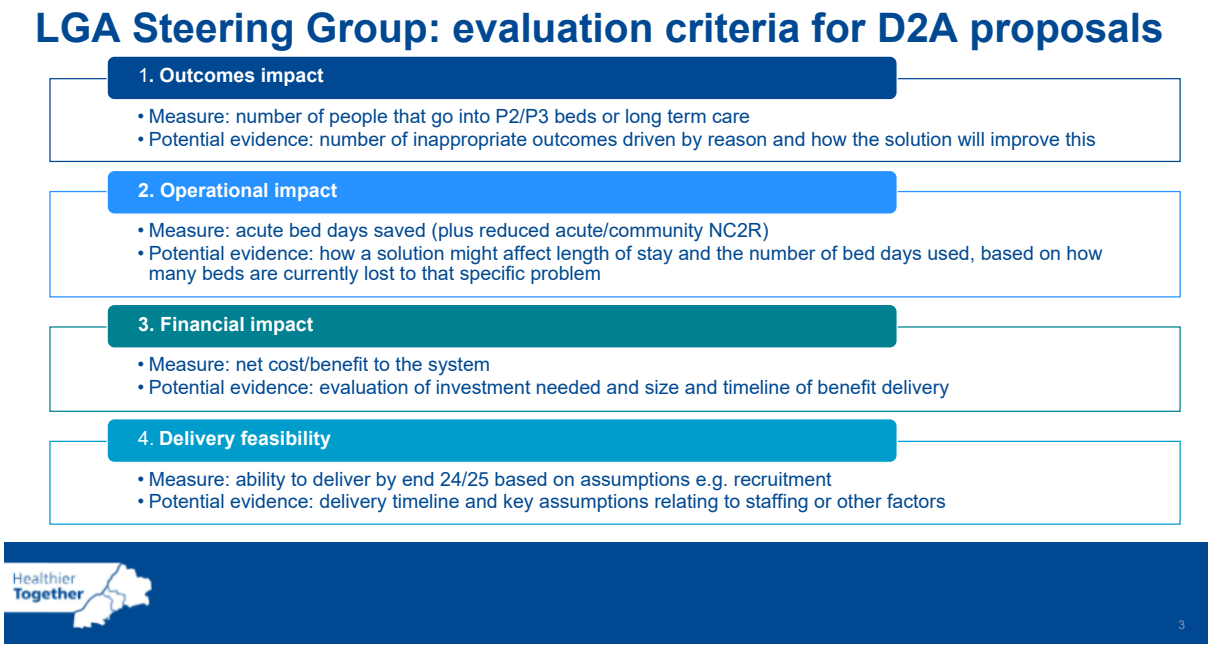


The LOS for pathways 1-3 and % of NCTR in the acutes has reduced from December 22.

This has been as a result of the actions taken within the acute hospitals to help facilitate earlier referral for D2A support, the impact of the D2A programme and additional capacity provided through the ASC discharge fund and NHS winter allocation.

During this period we have seen waiting list clearance most notably in the P1 waiting list, but also a shift of patients discharged from pathway 0 to discharge 1 which is under review.

Prioritisation of Additional discharge funding was via a Discharge to Assess system governance, with partner options evaluated under one framework approach and based on lesson learnt associated with the 22/23 short term ASC non recurrent funding:



Recommendations:

1. Options in line with the BCFS diagnostic were funded:
    - Expand domiciliary care/reablement to support Home First model and complement the planned shift away from bedded community capacity
    - Uplifting the P3 staffing model (case management, therapy input) and LA assessment capacity to match 250 recurrent beds. Assessment delays in P3 caseload are the primary cause of NC2R in the community and therefore new funding comes with new operational targets for improving Pathway 3 community length of stay.
    - Recurrent funding for VCSE infrastructure in the acutes and community to support extended use of Pathway 0
    - Change capacity to support delivery

The D2A programme through its use of the Better Care Support Fund diagnostic has identified priority actions that do not simply rely on increasing the supply of care, instead recognising the opportunity that exists to streamline processes and improve decision making (increase in ideal outcomes) that will lead to better use of pre-existing System capacity – not simply an approach to increasing capacity given workforce issues.

North Somerset Local Services

- We have continued to invest via the BCF and other sources in our prevention infrastructure to support hospital discharge and to maximise the independence of our residents. These services are summarised in the attached document and have been critical in achieving significant improvements in LOS numbers since last Winter, enhancing the options available to local MDT decision making.
- Adult Social Care uses a person-centred strength base approach to practice through multidisciplinary teams embedded in place, using a 3 conversations approach. Teams work closely with Health and other partners through MDTs, best outcomes for individuals.
- Access Your Care our reablement provider and operator of our Wellness and Rapid Response services and Alliance Homes our Home from Hospital service provider are actively engaged in these MDT's the Home from Hospital service will be a key link in social prescribing terms to the wider Community VCSE sector via the North Somerset Together Virtual Hub. Our TEC service is also part of the MDT process. The service is looking to further develop Technology Enabled Care support and DFG and OT Housing Adaptations and Rapid Response services as part of Locality Intermediate models of care. Please refer to Appendix 6:

Appendix 6.
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Of these services two are particularly key, and more detail provided below:

Home from Hospital -

- A small team of support workers based at the hospital and actively involved in the local MDM's supporting hospital discharge arrangements. This service was created a decade ago but has continued to expand, it is managed by Alliance Homes as part of a wider Housing Floating Support service, this service will be expanded by the introduction of the 4 link workers funded in the Discharge Grant and work closely with the new Transfer of Care Hub.
- In 2022/23 the team dealt with 832 total referrals, and themselves made 365 ongoing carers referrals and onward referrals in total of 835.
- During the year the service undertook 30 deep cleanse and issued over £1,000 of emergency cost of living payments to families on discharge to support with fuel costs. Please refer to Appendix 7 and 8 below for information about two recent case studies from the service.

Appendix 7. R24 Case Study 1 - Slide.pptx

Appendix 8. R24 Case Study 2 - Slide.pptx

First Response

A shared priority across our two localities evidenced by population health management, was to improve the response to falls, enhance outcomes and experience for individuals who fall, and increase system efficiency. Currently, residents with care link pendants who fall receive a timely response from Access Your Care (AYC), an independent care provider funded by

North Somerset Council. However, many of these cases were escalated to the ambulance service, resulting in long waits for help and unnecessary conveyance to the Emergency Department (ED) and hospital admissions.

By collaborating with NSC, AYC and Care Link (CL), Sirona clinical teams and utilising the NHS England SWAST falls traffic light assessment tool, the partnerships aimed to provide a more efficient and effective falls response service.

The partnership approach has enabled each partner to bring its expertise into a holistic joined up offer for the person on the end of the falls service, rather than the traditional boundaries just doing one element of a pathway. Considerations about governance, care records, indemnity and risk management across the parties have been agreed and resolved through strong relationships established through closer partnership working.

The key teams and roles include:

- Woodspring and Weston Integrated Neighbourhood Teams (INT): Responsible for coordinating the overall falls response service, providing clinical advice, and dispatching appropriate clinicians to support individuals who fall.
- Access Your Care (AYC): An independent care provider that responds to falls and refers individuals in the amber category to the Woodspring INT.
- Care Link (CL): Works in partnership with AYC to identify individuals in need of falls response services and refer them to AYC.

The planning includes real-time call passing from SPA to the Woodspring coordination centre, the use of the SWAST falls assessment form by AYC, and data collection by AYC, Care Link, and Sirona to monitor referrals, and ambulance service calls prevented. The targets include achieving a timely response within 2 hours for assisting individuals off the floor and completing necessary follow-up visits within 24 hours. Financial goals look to optimise the use of ambulance services by redirecting non-urgent cases to the UCR service, reducing unnecessary conveyances and associated costs. The First Response partnership has added significant value to services by increasing capacity, efficiency, and sharing of information. By utilising the SWAST falls traffic light assessment tool, the partners have established a standardised and evidence-based approach to assessing falls. This tool ensures that the appropriate level of response is provided based on the severity of the fall, enabling efficient allocation of resources. The BCF and a top slice from Anticipatory Care funding, will share the cost of expanding this service to all citizens of North Somerset, which will provide an urgent responsive care capacity particularly at night, to not only support reduction in hospital discharge pathways levels but encourage a broader utilisation of TEC monitoring devices as our ability to respond to heightened risks, particularly given our development of centralised monitoring for TEC. Please refer to Appendix 9:

Appendix 9. Outcomes from Pilot.(

Please refer to Appendix 10 for more information:

Appendix 10. Ageing Well Patient Story.ppt

Population Health Management Approaches

Across BNSSG, and through the North Somerset Locality Partnership, population health management is being further developed based on data and shared information, enabling the focus of activity. These approaches are fundamentally impacting on local prioritisation and work such as our prevention fund and ageing well. A BNSSG core segmentation model has been developed using the Cambridge Multimorbidity Score (CMS), which has allowed us to explore the health needs of the population and to identify health inequalities that affect people in North Somerset. A CMS scored is calculated for each individual and assigns a segment based on their scores, with Segment 1 containing the healthiest members of the population and segment 5 the least healthy, with Segment 5 being the smallest proportion of the population, but with the highest annual spend per person, representing over 20% of the total spend. As part of our work on Proactive Care, those in segments 4 and 5 are considered to match the criteria set out in the draft Anticipatory Care framework from NHS England, which focuses on specific populations:

- Those with multiple long term conditions including frailty.
- Those at greatest risk of using unplanned or emergency care.

Please refer to Appendix 11 for further insight:

Appendix 11. North Somerset Insight.pptx

Prevention

Our Vision for Adult Social Care, “Maximising Independence and Wellbeing”, sets out how it would promote wellbeing by helping people in North Somerset to be as independent as possible, for as long possible. To deliver our Vision, we are committed to work closely with people with care and support needs, their families, partner agencies, as well as the voluntary and community sector. Our aim is to empower communities, build relationships and strengthen networks to achieve the best possible outcomes for people with care and support needs. There are various approaches utilised in the delivery of social services, by staff and this is expected to be passed on to commissioned providers in the spirit of commitment and accountability to our principles.

As part of the Health and Wellbeing Strategy we aim to always take a Home First Approach, as we know that people do better in their own environments, and this applies to hospital discharges as well as longer term care provision. Independence is the ultimate aim and what we can do to help people achieve their goals in remaining as independent for as long as possible, with support if needed

Drugs and Alcohol

Drug and alcohol misuse are drivers of inequalities and a risk factor for poor health throughout the life course. They are system issues and as such need to be tackled as a system. The funding from the ICB through the Better Care Fund Funding is for specialist drug and alcohol misuse services in the community to reduce harm across that system. Following publication of the National Drug Strategy 2021 – From Harm to Hope, the Government set out a requirement for all areas to develop a Combatting Drugs Partnership),

that would include a comprehensive group of partners from across the system to tackle drug and alcohol harm.

Digitalisation and TEC

Work in North Somerset includes:

- Working to develop and address digital Maturity in Care Homes, via last year's Innovation Grant mechanism, care home compliance with digital social care records is well over 70% in North Somerset.
- Engagement with Partners in VSCE sector in replacing North Somerset Online Directory with a new integrated information portal, serviced by Voluntary Action North Somerset, but to include information services for Health and social care.
- Increased use of Technology Enabled Care in care Home with the Acoustic Monitoring and an innovative investment in centralised monitoring team linked to our Rapid Response/First Response service which will monitor a range of pioneering TEC options. Linking Primary Care, community nursing, and social care in the community.
- Discharge funding to bolster our virtual TEC hub with referral routes for reablement and DTA pathways including a new pilot deployment of Genie Connect..
- The establishment of additional 24/7 capacity from the merger of the Wellness /Rapid Response service, the central monitoring of TEC service and permanent funding of our First Response pilot, will give us the opportunity to mainstream TEC solutions to reduce reliance on formal responsive care and increase the opportunity to reduce pathway tariffs.

Climate Emergency

North Somerset is committed to measures aimed at carbon reduction, last year our Innovation Grant supported Care Providers with a series of financial incentives to invest in measures to support carbon reduction, A fund of £1,2m was used to support care providers with TEC investments aimed at reducing care visit, investing in e-bikes to reduce waste and widen recruitment in urban areas, contributions to care home's investing in energy efficient boilers and solar panels. This process was well received and subject to future funding opportunities NSC is keen to replicate the process.

9. National Condition 3 (cont)

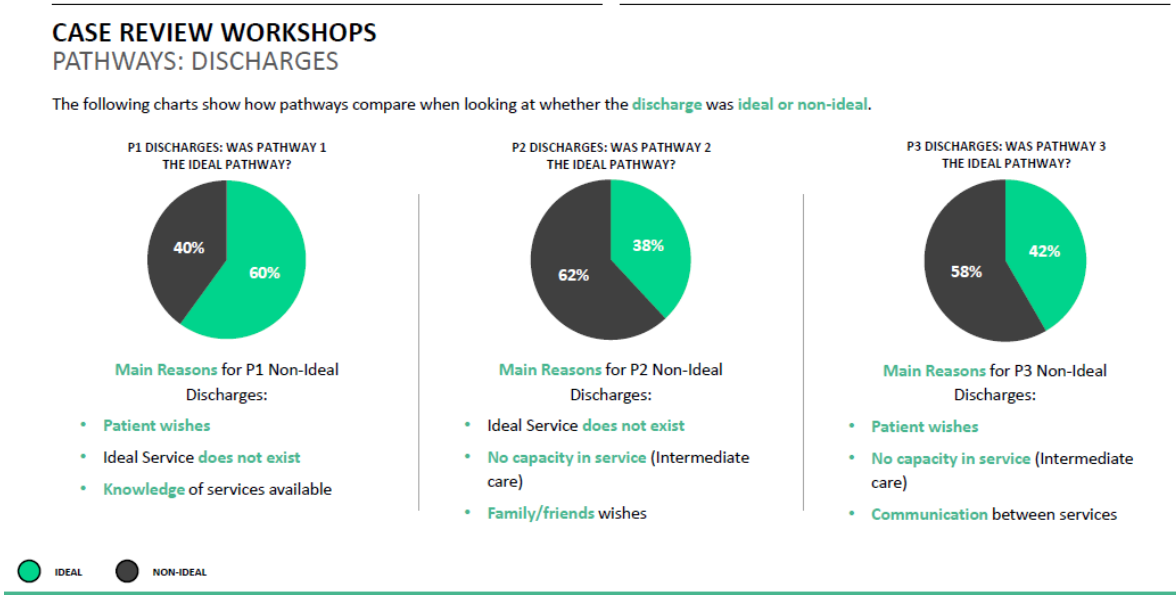
Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
    - how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

All ICS partners agree based on the Better Care Fund Support diagnostic conducted in 2022/23 that too often the right people are not being discharged through the right pathways and there are significant opportunities for improvement. Our focus as a system is therefore concentrated on process improvements, as well as addressing capacity and demand gaps.

Case reviews carried out in Autumn 2022 identified that:

- 40% of people discharged onto P1 could have gone home on Pathway 0
- 62% of people discharged onto Pathway 2 could have gone home on Pathway 1
- For 58% of people discharged into Pathway 3, this was not the ideal pathway



People not going down the right pathways is also driving poor long term outcomes for individuals and avoidable spend on long term care placements by our Local Authorities:

- 34% of people who are discharged to pathways 1 & 2 have a non-ideal long term outcome
- Of the people who went to short term interim placement (P3), 80% had a non-ideal outcome.
- 32% of people in receipt of homecare after D2A had too much, meaning that 25% of homecare commissioned (hours) following a D2A pathway was avoidable
- Over half of all long term care home placements following P2 or P3 could have been avoided and the individual could have been at home (50% for residential, 54% for nursing)
- 84% could have left hospital sooner, reducing average LoS from 29.1to 13.2 days. Half of the no CTR is driven by capacity. But half is driven by process delay and starting discharge planning too late.

As a result of the above findings decision-making has been identified as a key area for improvement alongside the development of more integrated pathways that make best use of existing capacity.

The BNSSG 23/24 & 24/25 D2A improvement plans have 3 prioritised benefits:

- Occupying 200 less acute beds at any one time through reductions in total no criteria to reside bed days (focusing on both process delays across all Pathways (P0 to P3) as well as capacity blockages
- Maintaining a stable BNSSG community bed base of 250 P2 and P3 beds (with seasonal profiling to support winter system management); this represents a reduction of 72 beds vs baseline of Nov 21 to Oct 22)
- Reducing long term care placements (112 avoidable placement starts per annum across BNSSG)

By reducing the number of non-ideal pathway choices, the community capacity will see shifts in discharge numbers from hospital away from P1 to P0 supported by increased contracting recurrently of voluntary sector partners and a reduction in bedded pathways to a Home First model. The shifts in activity have been reflected in the BCF capacity and demand templates.

To meet the needs of people who have to date received community bedded care in their usual place of residence, health and care teams are required to increase the complexity of the Home First offer: including more night sitting, greater integration between health and care teams to provide the right care at the right time, and a blended pathway with virtual wards were appropriate. In addition, the system has planned for an uplift in homecare capacity (total need modelled at c. 2,300 additional care hours across BNSSG).

Please refer to Appendix 12 for more information:

Appendix 12. What we need to change.pp

North Somerset:

One frustration with the LGA findings was the lack of local analysis, as whilst we concur with the findings and the actions recommended. Namely to reduce LOS and bedded care in DTA discharge pathways, the modelling of this change is very different between the three authorities, which recognises the historically a much lower bed base has operated in North Somerset.

LGA Predicted Bed shift over the months						
	Bristol		NS		SG	
Month	P2	P3	P2	P3	P2	P3
Mar-23	102	72	28	39	61	37
Apr-23	102	72	28	39	61	37
May-23	98	67	29	37	58	35
Jun-23	94	62	31	34	54	33
Jul-23	90	58	33	31	50	31
Aug-23	86	54	35	29	46	29
Sep-23	82	50	37	27	42	26
Oct-23	77	46	39	25	39	24

North Somerset has seen a continued growth in take up of its prevention services and the First Response service provided critical support particularly during periods of Industrial Action, and since Xmas performance in North Somerset in terms of LOS at the Acutes and community services have improved significantly and had not diminished on the closure of the Care Hotel. Enhancing P0 take up for our main hospital location in Weston given its age weighted profile is essential and the focus of both the BCF and other funding sources. Domiciliary care recruitment has improved in the New Year and our reablement service expanded from the original 2021 DTA business case is continuing to exceed targets. As part of our reablement contract, additional capacity is actively being recruited as a bridging service to hold domiciliary care capacity during any delays in hand off to our strategic domiciliary care providers. This capacity will provide additional assurance that this Winter performance can be maintained. Bedded capacity remains throughout the Spring welcomingly underutilised, which suggests we go into the Winter planning round with renewed confidence. The MDM process in North Somerset has embedded well, with HFH, AYC and TEC active in the decision making. Trusted assessment with Sirona has led to faster handover of packages and our intermediate care beds pilot in the Winter has seen some excellent outcomes, with ten beds across two local homes utilising LA OT capacity and AYC; s reablement staff, to support independence and cascade skills to care home staff.

Given the bed reduction trajectory is modest and the LOS performances have already

improved, we are confidence that the continued expansion of our preventative services, the take up of TEC and expansion of Home from Hospital, First Response and the Transfer of Care Hubs will make a difference and we will exceed the LGA outcomes.

10. National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

- Transfer of Care Hubs (ToCH) will adopt Home First approach
- Robust internal governance established with further reporting into system
- Development of a milestone plan which includes all partners high level deliverables
- ToCH's developing models of care with system partners
- Development of a Shared Vision for ToCH
- Development of an operational agreed dashboard for real time flow management
- Create a senior leadership team within the ToCH encompassing all partners, with a focus on improvement opportunities – data driven
- Focus on maximising P0 opportunities by working collaboratively with VCSE
- Working with VCSE to provide a longer term model of care for supporting patients following discharge to ensure effective use of P1 resources

Please refer to Appendix 13 for more information on ToCH's:

Appendix 13.
Transfer of Care Hubs

ToCH's are being developed in collaboration with all partners, including primary, community, VCSE and local authorities organisations. The interface with primary care is in the design phase, with other partners, including VCSE organisations, are incorporated into the design of the hub staffing models.

11. National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

Work on the BNSSG Home First approach has been informed by use of the High Impact Change Model, to improve our performance, as follows. As part of these changes, we have developed and a milestone plan which includes all partners high level deliverables.

- **Early discharge planning:**

Work is focusing on introduction of Transfer of Care Hubs, following our successful pilot in-reach team. The vision and model of care is being developed across all partners. Link officers will expand on the existing success of the HFH service

- **Monitoring and responding to system demand and capacity:**

Development of an operational agreed dashboard for real time flow management in addition to our daily system flow meetings that include all partners. The bridging service will provide additional capacity in domiciliary care to address challenges flexibly as will earmarking contingency Winter Pressures funding to respond to unexpected demand or supply issues rather than rely on less effective and expensive contingencies such as Care Hotel or additional bed capacity.

- **Multi-disciplinary working**:

Improved through Transfer of Care hubs, virtual wards, and locally based MDTs.

- **Home First:**

System wide Home First Programme as set out in this plan. Robust internal governance established with further reporting into system, and data driven performance.

- **Flexible working patterns.**

The transfer of care hub posts will be recruited on a seven day basis ensuring contractual commitment to support a seven day service. Similarly assessment incentives will reward weekend and Bank Holiday discharges.

- **Trusted assessment.**

Support for Trusted Assessment by care homes has been mixed, in comparison the pilot adopted this Winter of incentivising same day assessments and weekend discharges, has been welcomed and seen end to end placement times reduce by more than a quarter.

Through the P1 enabling infrastructure we are focussed on new ways of working that offer improved outcomes for people, improved satisfaction for staff, supporting the strategic aims of the system. As part of this work and the diagnostic carried out by Ethical HealthCare, we intend to improve relationships, culture and trust across organisations and staff groups. This supports the conditions required to develop trusted assessment opportunities, reducing data / assessment burden and improving efficiency of process with the intended outcome of a smoother journey for people requiring home-based intermediate care.

- **Engagement and choice: improved partnership with VCSE and their expertise**
  Focus on maximising P0 opportunities by working collaboratively with VCSE.
- Working with VCSE to provide a longer-term model of care for supporting patients following discharge to ensure effective use of P1 resources.
- **Engagement and choice: improved partnership with VCSE and their expertise**

This work focused on HFH service is a mature and effective service which will be bolstered

by the Link Officers and Virtual Community Hub.

12. National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

The Winter Discharge grant and other grant allocations have strengthened our social work capacity to address previous challenges in completing assessments as timely as desired. Recruitment to four additional social work posts last Winter and the additional social work and therapy capacity emerging from the Transfer of Care Hubs have contributed to much improved LOS performance and generally we are confident that Care Act assessments will be completed timely and professional social work and therapy support at the hospital will assist with flow and enhance decision making.

As referenced earlier our refresh of our information and advice services and work with the VCSE sector generally will support timely and better-informed decision making.

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Please refer to Appendix 14 for North Somerset insight relating to carers:

Appendix 14. Carers - North Somerset Insigl

Unpaid Carers

Carers assessments are completed by NSC in house teams whilst Carers support and development are commissioned via Alliance. A key priority in the Carers Strategy is to improve carer identification across health, social care, and the wider community. This includes Young Carers under 18. The NHS Commitment to Carers and its Long-Term Plan (para 1.19) states that a framework of quality markers will be introduced for GP practices to improve identification and support in primary care. Research evidences that caring is a social determinant of health . Carers told us that they need GP practices to allow them to book forward appointments to enable them to arrange replacement care for the person they care for. The Action Plan will involve working with BNSSG to communicate to practices the need for this. We want to ensure there is no ‘wrong door’ to a carer getting support by improving identification including through GP practices and hospital attendance.

Another priority is that carers and the person they support will have access to services

support them, and carers will have access to breaks for themselves. This is key to carers being supported to take care of their own health and wellbeing. Within this is the need for contingency planning. This ties into the NHS Commitment to Carers and Long Term Plan (para 2.34) which states that carers will be aware of their options for out-of-hours support through contingency planning conversations. The Strategy's Action Plan aims to promote contingency planning with carers in social care. If the NHS is willing to engage on this by staff in health settings promoting contingency planning, it will meet their commitment too.

Carers tell us they want to see a more joined-up health and social care system to improve their experience of using these. The challenges of obtaining and sharing reliable data on carers for the Covid vaccination programme highlighted the need for this. The Strategy's Action Plan recommends that data-sharing agreements are sought across the new Integrated Care System and Integrated Care Partnerships and primary care so that carers can be better supported.

A key finding was that carers do not feel recognised or valued by professionals. The Action Plan will look at ways to ensure carers' voices are heard at all levels of the ICB, ICS, ICP and PCNs, and that carers are at the heart of co-production.

There is a significant gap in emotional and mental health support for carers. There is no funded counselling service available for carers in North Somerset and carers do not easily fit into the BNSSG-wide VitaMind service. VitaMind does not replicate its predecessor's (Positive Step) carer-specific pathway, which provided a quick response time plus carer-specific workshops. North Somerset carers have therefore had reduced mental health support since the Positive Step carer service (CCG-funded at £120k pa) was decommissioned in North Somerset in 2019. A recent North Somerset Healthwatch report Unheard Carers recommends that appropriate emotional support is especially required for Syrian refugee carers, with the assistance of an interpreter.

Unheard Carers also recommends that networks are built with minority communities, and information made available in different formats and languages. Similarly the forthcoming Care reforms will be an area of information and comms with carers to understand how the proposals will impact.

To underpin all of this we are seeking to constantly improve the information and advice offer for carers. Improvements have included:

- Multi-Agency co-produced Dementia Directory for Woodspring residents and providers

- Merger of NSC Wellness service and Rapid Response service to provide 24/7 additional emergency capacity, over 130 service users supported via the Wellness service with emergency referral routes during the weekend for crisis support.
- North Somerset First Response pilot has supported over 200 fallers in three months with 97% success rate in terms of lifting service users (response time an average 23 minutes), working with Sirona and SWAST to provide clinical assurance, preventing hospital admissions and providing the level of wrap around emergency care in the community to support our ambition to increase P0 significantly with support from these services the VCSE and our expanding TEC offer. This service will be expanded to all citizens from its existing offer to Carelink pendant holders and its expansion is funded via Discharge Grant.

- Above inflation increases ion direct payment allowances for carers to support the take up of direct payments.
- Multi agency Cost of living group providing support and advice, warm spaces network and via the Discharge grant, one off financial support with heating costs to support carers following hospital discharge.

Carers in North Somerset have also reported lower quality of life and increased difficulty finding information about available services in recent years. Addressing these issues is necessary to reduce carer fatigue and improve efficacy of their efforts.

Weston & Worle and Woodspring's Ageing Well programme aims to address both downstream and upstream effects with targeted solutions to both provide care to those in need but also enable anticipatory care for residents, that they might extend their quality of life and reduce the burden on their carers. We recognise that numerous conditions that disproportionately affect our elderly residents begin earlier in life, necessitating early intervention.

To support specific groups of people within the community a number of pilot schemes have been commissioned under the Ageing Well Programme and recently evaluated against key objectives and outcomes. Within Woodspring, these pilots included:

- Digital Health Apps
- Hospital Avoidance Pathway for Emergency Department (ED) / Geriatric Emergency Medicine Service
- Dementia Meeting Centres
- Support for Dementia Care Homes
- STAR Bereavement sessions
- Live Longer Better (LLB); Fall-proof campaign
- LLB: Increased activities across nature, arts, physical activity
- LLB: Live Longer training offer
- LLB: Strength & Balance
- Dementia Training and Coproduction

Most of the pilots had a strong preventative focus with improved health and wellbeing as its primary purpose. Others are orientated towards improving awareness of strength and balance, improved mobility, training for health and social care staff and providing support for people with dementia and their carers. The pilot schemes have enabled the partnership to consider the benefits achieved and have helped to inform the emerging model within Woodspring.

The sub-group were material in identifying the early priorities, these were:

- Falls and mobility
- Dementia
- Care homes*
- Prevention*
- Anticipatory Care*
- Carers.

13. Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

The mandatory Disabled Facility Grant is critical to achieving system goals for maintaining independence in the home for older and disabled people, also supporting their families. DFG resources have also supported North Somerset's ambitions to deliver a comprehensive TEC offer to maximise independence. Structural changes in NSC will ensure closer working between housing services and health and social care and better alignment of accommodation ambitions via refreshed Housing Strategy, ensuring the development of accommodation options as an alternative to residential care, also innovation when considering individual options. This will also strengthen the governance links of the DFG services with wider Better Care Fund Management.

Our emerging ICP's have engaged in the refresh of our housing strategy for 2022 to 2027, and Older Person Housing Needs Assessment modelling future needs to 2030. Partners working across North Somerset working together across several workstreams to ensure that people are supported to live in their own home and that the importance to health and wellbeing of that home being safe warm and appropriate is supported. Meeting people's needs through appropriate housing, whether specifically designed, or adapted, including provision with care and support is part of our generic approach to housing and not seen as an additional and separate area of concern.

Our vision has three strategic aims:

Deliver affordable homes in sustainable neighbourhoods

Improve and sustain existing houses

Provides solution, support and choice to those in housing needs.

The two North Somerset ICP'S have established a joint housing forum in recognition of the consequential impact on health and social care outcomes from housing and the need to influence the growth in housing required as part of the Council's Local Plan.

Our DFG programme is administered through the Housing Adaptation and Improvement Team who also operate an in-house agency for bathing adaptations and lift installation and maintenance. This has proved particularly beneficial having secured enhanced delivery, local contractors, lifetime warranty for stairlifts and fully serviced and maintained. A detailed process has been designed to prioritise cases in line with best practice and guidance; working closely with Occupational Therapy Team on recommendations. The significant impact from the cost-of-living pressures particularly affecting the construction sector has required a collaborative approach working with contractors to respond to inflationary increases.

We have piloted pod buildings for provision of ground floor facilities during 2022/23 but in each case, they have proved more expensive than traditional construction although in some instances could be a solution e.g., urgency, ground conditions. Funding (outside of the BCF) has been secured to recruit a new OT working with commissioning team to support new initiatives in housing and support an a**c**creditation and regulation of supported housing projects in North Somerset with a partnership agreement and accreditation scheme to be established.

The Winter discharge grant was used to commission a Wellbeing Flat, with Curo

it will deliver a service which will support customers experiencing mental health or emotional distress, but not those in crisis. The service will provide a minimum of 4 units of accommodation and a package of support delivered by a Senior Wellbeing Officer and 2 x Wellbeing Support Workers. This service is aimed at providing short term support to

avoid homelessness from hospital discharge or crisis avoidance to prevent admission.

DFG slippage in 2021/22 was also used to support our investment in TEC to support people to remain in their own homes, these initiatives have been described elsewhere.

14. Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

Yes

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

The discretionary powers available through the RRO has been extensively used in the form of a Housing Renewals Assistance Policy which provides:

- Funding for feasibility work including plans for major schemes
- Top-up funding (up to £20,000) above the maximum DFG
- Hospital discharge funding to facilitate safe return home
- Move-on assistance to support a move to more suitable accommodation
- Dementia Care Assistance – enhance comfort, safety and security of a home
- Emergency Work – imminent risk to safety or health

The budget for discretionary funding has increased to £200,000 in 2023/24; subject to further review linked to ongoing inflationary pressures.

Joint work recognises the importance of homes being warm and safe to maintain health. Initiatives to address this include:

- Low interest loans funded by the Council for home repairs that make a property warmer, safer, healthier of more suitable for the occupiers.
- Senior housing OT co-located with Private Sector Housing Team.
- Warmer Homes, Advice and Money scheme - partnership providing practical expertise to improve home energy efficiency, involves Handyvan Service, Citizens Advice and Centre for Sustainable Energy.

Structural changes have given the opportunity to strengthen ties between housing and adult care particularly commissioning, and the BCF has been used to develop specialist homeless provision for people with Mental Health, delivered by Curo for up to 14 days of support particularly to prevent admissions and support hospital discharge. Similarly in addition to the dedicated Occupational therapist working with the Private sector team an additional Occupational therapist is being recruited to work alongside commissioning and housing colleagues to look at initiatives to reduce housing barriers. On average our housing teams deal with about 4 hospital discharge housing related cases and with the Home from Hospital service involved in MDM meetings early identification issues is critical to resolution and LOS relating to housing related issues are low despite the housing challenges.

15. Equality and health inequalities

We will establish an Inequalities Oversight Group to review and support the work of the Health and Care Improvement Groups and other work in this area. This will incorporate supporting BCF activities to best meet the needs of people living in the 20% most deprived areas in BNSSG, in line with Core20PLUS5. The following information from the Joint Forward Plan applies to the use of the better care fund:

Our approach to reducing inequalities in access to, experience of and outcomes from services and other types of support includes:

1. Addressing the structural nature of inequalities - thinking about how decisions are made and who is involved in making those decisions.
2. Providing resources according to need – improving the way that we spend money so that we provide funding in a way that supports people who experience health inequalities to get what they need so that they can achieve what matters to them.
3. Exploring how we will achieve health equity in all policies and then implementing that approach.
4. Further actions developed and implemented over the course of the five years of this Joint Forward Plan.

The Integrated Care Board has agreed to fund a reserve of £3.2m for health inequalities. A plan will be developed and brought back to the Board for approval by the Chief Medical Officer who has executive responsibility for Health Inequalities.

Homeless populations are known to experience multiple health disadvantages, poorer health outcomes and barriers to receiving healthcare. An initial gap analysis of medical provision to the homeless population of Bristol, North Somerset and South Gloucestershire has identified inequity in the accessibility and delivery of services required to meet the clinical needs of homeless people. The re-commissioning of the Alternative Provider of Medical Services (APMS) contract for provision of Primary Medical Services to the homeless population offers an opportunity to work collaboratively with system partners to co-commission Medical and Local Authority services at a system level, supporting the provision of equitable, joined up, cohesive service provision to the homeless population of our system.

We will collaboratively commission services for the homeless population, facilitating;

- Equal service offer for the homeless population across our system
- Improved health outcomes
- Improved life expectancy
- Improved access to tailored services
- Streamlined, easily accessible pathways i.e. accommodation
- Reduced hospital length of stay
- Supported transition to receiving healthcare through mainstream services

Our six locality partnerships are embedding a population health management approach, helping them to identify specific groups of the population that are experiencing poorer than average health access, experience and/or outcomes. Supported by engagement and co-production, locality partnerships are determining more effective approaches to engage and support these population groups to improve their outcomes and reduce inequalities.

Please refer to Appendix 15 for further insight:

Appendix 15.
Population demograp

NSC's Corporate Plan vision is to be open, fair and green:

- Open: we will provide strong community leadership and work transparently with our residents, businesses and partners to deliver our ambition for North Somerset.
- Fair: we aim to reduce inequalities and promote fairness and opportunity for everyone.
- Green: we will lead our communities to protect and enhance our environment, tackle the climate emergency and drive sustainable development.

To help achieve this vision we have a number of aims and priorities including a priority to empower and care about people and within that to have:

- a commitment to protect the most vulnerable people in our communities.
- an approach which enables young people and adults to lead independent and fulfilling lives.
- a focus on tackling inequalities and improving outcomes.

Workstreams are identified to support these priorities, such as the Better Care Fund, and we monitor projects and key performance indicators aligned to these workstreams. Our current KCPI basket has over 180 live indicators and a number of these consider health inequalities including:

- healthy life expectancy an inequality in life expectancy at birth.
- mortality rates from causes considered preventable.
- positive outcomes for employment and stable accommodation for vulnerable cohorts.
- a number of measures from the Adult Social Care Outcomes Framework such as quality of life scores.

As part of our Medium-term Financial Planning we also undertake Equality Impact Assessments for any workstreams which will impact on our residents to ensure that there is no direct or indirect discrimination against individuals with one or more protected characteristics and advance equality of opportunity and foster relationships between one group and another where possible, as outlined in the Equality Act 2020.

Supporting the Corporate Plan are a number of other strategies including our Joint Health and Wellbeing Strategy and our Empowering Communities Strategy. These too identify workstreams which seek to improve outcomes across North Somerset and reduce gaps in inequalities to ensure that all our residents have the same life chances and positive outcomes.

Areas of focus in the Joint Health and Wellbeing Strategy:

- prevention - prevent people from becoming unwell or experiencing poor health and wellbeing
- early intervention - support people to identify and manage health and wellbeing problems as early as possible. Ensure sure support is in the right place to address those problems
- thriving communities - focus on the wider factors and influences on health, and work with partners to support communities to thrive

Areas of focus in our Empowering Communities Strategy:

- tackling inequalities and improving outcomes
- engage with and empower our communities
- collaborate with partners to deliver the best outcomes

We report regularly on the outcomes against our commitments.

Please refer to Appendix 16:

Appendix 16. Areas of focus.docx

Aging well: geographical inequalities

The Indices of Multiple Deprivation measures

deprivation across a number of 'domains' including 'income deprivation affecting older people (IDAOPI)' –the proportion of all those aged 60 or over who experience income deprivation. There are well researched links between income deprivation and poor health outcomes.

The map on this page shows this domain and the deciles of deprivation for North Somerset at Lower Super Output Area (LSOA*).

Decile 1 is the most deprived and decile 10 the least deprived.

The most deprived areas where outcomes are generally poorer for income deprivation affecting older people are within the South and East areas of Weston-super-Mare. Areas within Worle also show higher levels of deprivation and poorer outcomes.

Outside of Weston-super-Mare, Portishead East shows a high level of income deprivation affecting older people.

A key development in North Somerset to address our areas challenges is the formation of the North Somerset Together Virtual Hub building on the communities' response to the challenges of COVID.

Its purpose is to support residents and front-line workers to navigate the support systems, community assets and access social welfare support quickly with the aim of improving wellbeing and health.

- Help to reduce health inequalities by addressing the wider determinants of health, such as debt, poor housing, employment and physical inactivity.

- Increase people's active involvement with their local communities.
- Support the multi-professional team to provide access to the right service at the right time for their clients/patients.

North Somerset Together is a collaborative partnership between Citizens Advice North Somerset, North Somerset Together, Curo Housing Association, Alliance Homes, North Somerset Wellbeing Collective, North Somerset Council, Woodspring Locality Partnership, One Weston Locality Partnership and Sirona with Citizens Advice North Somerset acting as lead agency

- The service will take direct referrals from front line staff within health and community settings.
- The service will provide a one-stop connector service for a wide range of community related support with an emphasis on loneliness and isolation, and on the wider determinants of health, particularly low income, employment, learning, support, housing, debt, financial management and domestic abuse.
- NSC and LP''s are funding a two year pilot which is at the proof of concept stage with a phased roll out across PCN's in North Somerset.

Please refer to Appendix 17 for more information:

Appendix 17. North Somerset Together.pp

BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.
4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.
5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
7. Please ensure that all boxes on the checklist are green before submission.
8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:

- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:

- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

9. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
  - emergency admissions due to falls for the year for people aged 65 and over (count)
  - estimated local population (people aged 65 and over)
  - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.

2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

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.

Health and Wellbeing Board:	North Somerset
Completed by:	Gerald Hunt, Andy Newton
E-mail:	gerald.hunt@n-somerset.gov.uk, anewton1@nhs.net
Contact number:	01934634803, 07919558633
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes
If no please indicate when the HWB is expected to sign off the plan:	

	Role:	**Professional Title (e.g. Dr, Cllr, Prof)**	**First-name:**	**Surname:**	**E-mail:**
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair		Jenna	Ho Marris	jenna.homarris@n-somerset.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		David	Jarrett	david.jarrett2@nhs.net
	Additional ICB(s) contacts if relevant		Zanette	Pytel	zanettepytel@nhs.net
	Local Authority Chief Executive		Jo	Walker	jo.walker@n-somerset.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Hayley	Verrico	hayley.verrico@n-somerset.gov.uk
	Better Care Fund Lead Official		Andy	Newton	anewton1@nhs.net
	LA Section 151 Officer		Amy	Webb	amy.webb@n-somerset.gov.uk
*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 -->					

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: North Somerset

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£2,361,483	£2,361,483	£2,361,483	£2,361,483	£0
Minimum NHS Contribution	£18,475,154	£19,520,848	£18,475,154	£19,520,848	£0
iBCF	£6,985,854	£6,985,854	£6,985,854	£6,985,854	£0
Additional LA Contribution	£5,390,916	£5,390,916	£5,390,916	£5,390,916	£0
Additional ICB Contribution	£1,399,860	£1,425,057	£1,399,860	£1,425,057	£0
Local Authority Discharge Funding	£979,406	£1,625,810	£979,406	£1,625,810	£0
ICB Discharge Funding	£1,735,000	£2,058,500	£1,735,000	£2,058,500	£0
Total	**£37,327,673**	**£39,368,468**	**£37,327,673**	**£39,368,468**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£4,854,654	£5,129,428
Planned spend	£9,651,145	£10,197,400

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£8,094,784	£8,552,949
Planned spend	£8,095,626	£8,553,838

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	134.3	137.5	154.6	146.8

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,827.9	1,380.5
	Count	1009	762
	Population	52198	52198

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	94.8%	95.0%	94.9%	94.8%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	475	571

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	80.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Implementing the BCF policy objectives	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: North Somerset

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:
- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assesment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:
- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.
You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:
- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	Hospital demand was calculated using demand for P1-P3 has been calculated using last years hospital discharges. The LGA review identified that 58% of P3 patients were more appropriate for P2, 61% P2 would have been better on a P1 pathway and 40% of P1s should have been P0. The demand profile next year includes a shift towards these more ideal patient outcomes achieving 20% of the shift by the end of the year and will ensure that all patients are receiving the correct care by the end of 24/25. P0 Demand includes the patients who would previously have received P1 support as well as demand for Red Cross, Home from Hospital, Link Workers and DSGs.

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!

Select as many as you need

Trust Referral Source	Demand - Hospital Discharge												
	Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
NORTH BRISTOL NHS TRUST	Social support (including VCS) (pathway 0)	53	53	53	54	54	54	54	54	54	53	53	53
UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST		125	125	125	127	127	127	127	127	127	124	124	124
NORTH BRISTOL NHS TRUST	Reablement at home (pathway 1)	10	10	11	17	18	18	19	19	21	21	22	22
UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST		22	22	25	37	40	40	43	43	46	46	49	49
NORTH BRISTOL NHS TRUST	Rehabilitation at home (pathway 1)	40	42	40	40	40	39	39	38	39	39	37	38
UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST		89	92	89	90	90	87	87	85	87	87	82	87
NORTH BRISTOL NHS TRUST	Short term domiciliary care (pathway 1)												
UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST													
NORTH BRISTOL NHS TRUST	Reablement in a bedded setting (pathway 2)	1	1	2	2	2	2	2	2	2	2	2	2
UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST		4	4	5	5	5	5	6	6	6	6	7	7
NORTH BRISTOL NHS TRUST	Rehabilitation in a bedded setting (pathway 2)	9	9	9	9	9	9	9	9	9	8	8	9
UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST		25	26	25	26	26	25	26	25	26	26	24	26
NORTH BRISTOL NHS TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement	6	6	6	6	6	6	6	5	6	6	5	6
UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST	(pathway 3)	31	32	31	30	30	29	28	27	28	28	26	28
Totals	**Total:**	415	422	421	443	447	441	446	440	451	447	439	452

3.2 Demand - Community

Demand - Intermediate Care												
Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	10	10	10	10	10	10	10	10	10	10	10	10
Urgent Community Response	457	465	457	465	465	457	476	467	476	487	469	487
Reablement at home	57	57	57	57	69	69	69	69	69	69	69	69
Rehabilitation at home												
Reablement in a bedded settine												
Rehabilitation in a bedded settine												
Other short-term social care	13	14	13	14	14	13	14	13	14	14	13	14

3.3 Capacity - Hospital Discharge

	Capacity - Hospital Discharge													Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	175	175	175	175	175	175	175	175	175	171	171	171	20%	80%	
Reablement at Home	Monthly capacity. Number of new clients.	31	31	36	53	57	57	61	61	65	65	70	70		100%	
Rehabilitation at home	Monthly capacity. Number of new clients.	122	126	122	126	126	122	126	122	126	126	118	126	100%		
Short term domiciliary care	Monthly capacity. Number of new clients.															
Reablement in a bedded setting	Monthly capacity. Number of new clients.	5	5	6	6	7	7	8	8	8	8	9	9		100%	
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	28	29	28	29	29	28	32	31	32	38	36	38	100%		
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	18	19	18	19	19	18	19	18	19	19	18	19	100%		

3.4 Capacity - Community

	Capacity - Community													Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	9	9	9	9	9	9	9	9	9	9	9	9	100%		
Urgent Community Response	Monthly capacity. Number of new clients.	437	446	437	446	446	437	455	447	455	465	447	465	90%	10%	
Reablement at Home	Monthly capacity. Number of new clients.	57	57	57	57	69	69	69	69	69	69	69	69		100%	
Rehabilitation at home	Monthly capacity. Number of new clients.															
Reablement in a bedded settine	Monthly capacity. Number of new clients.															
Rehabilitation in a bedded settine	Monthly capacity. Number of new clients.															
Other short-term social care	Monthly capacity. Number of new clients.	13	14	13	14	14	13	14	13	14	14	13	14		100%	

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: North Somerset

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
North Somerset	£2,361,483	£2,361,483
DFG breakdown for two-tier areas only (where applicable)		
Total Minimum LA Contribution (exc iBCF)	**£2,361,483**	**£2,361,483**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
North Somerset	£979,406	£1,625,810

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS Bristol, North Somerset and South Gloucestershire ICB	£1,735,000	£2,058,500
Total ICB Discharge Fund Contribution	£1,735,000	£2,058,500

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
North Somerset	£6,985,854	£6,985,854
Total iBCF Contribution	**£6,985,854**	**£6,985,854**

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
North Somerset	£5,390,916	£5,390,916	total budget allocation covering s117, SPA and Aids &
Total Additional Local Authority Contribution	**£5,390,916**	**£5,390,916**	

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Bristol, North Somerset and South Gloucestershire ICB	£18,475,154	£19,520,848
Total NHS Minimum Contribution	**£18,475,154**	**£19,520,848**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
NHS Bristol, North Somerset and South Gloucestershire ICB	£1,399,860	£1,425,057	Additional Discharge Capacity
Total Additional NHS Contribution	**£1,399,860**	**£1,425,057**	

Total NHS Contribution	**£19,875,014**	**£20,945,905**

	2023-24	2024-25
Total BCF Pooled Budget	**£37,327,673**	**£39,368,468**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: North Somerset

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£2,361,483	£2,361,483	£0	£2,361,483	£2,361,483	£0
Minimum NHS Contribution	£18,475,154	£18,475,154	£0	£19,520,848	£19,520,848	£0
iBCF	£6,985,854	£6,985,854	£0	£6,985,854	£6,985,854	£0
Additional LA Contribution	£5,390,916	£5,390,916	£0	£5,390,916	£5,390,916	£0
Additional NHS Contribution	£1,399,860	£1,399,860	£0	£1,425,057	£1,425,057	£0
Local Authority Discharge Funding	£979,406	£979,406	£0	£1,625,810	£1,625,810	£0
ICB Discharge Funding	£1,735,000	£1,735,000		£2,058,500	£2,058,500	£0
Total	**£37,327,673**	**£37,327,673**	**£0**	**£39,368,468**	**£39,368,468**	**£0**

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 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£4,854,654	£9,651,145	£0	£5,129,428	£10,197,400	£0
Adult Social Care services spend from the minimum ICB allocations	£8,094,784	£8,095,626	£0	£8,552,949	£8,553,838	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No

>> Incomplete fields on row number(s):

60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91,

									Planned Expenditure						
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Expected outputs 2023-24**	**Expected outputs 2024-25**	**Units**	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding
1	Integrated Teams (running costs)	Enablers for Integration	Enablers for Integration	Workforce development					Community Health		LA			Local Authority	Minimum NHS Contribution
2	Connecting Care System	Enablers for Integration	Enablers for Integration	Data Integration					Community Health		LA			NHS	Minimum NHS Contribution
3	Project Manager Resource	Enablers for Integration	Enablers for Integration	Workforce development					Social Care		LA			Local Authority	Minimum NHS Contribution
4	NSC - Single Point of Access	Integrated Care Planning and Navigation	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	Minimum NHS Contribution

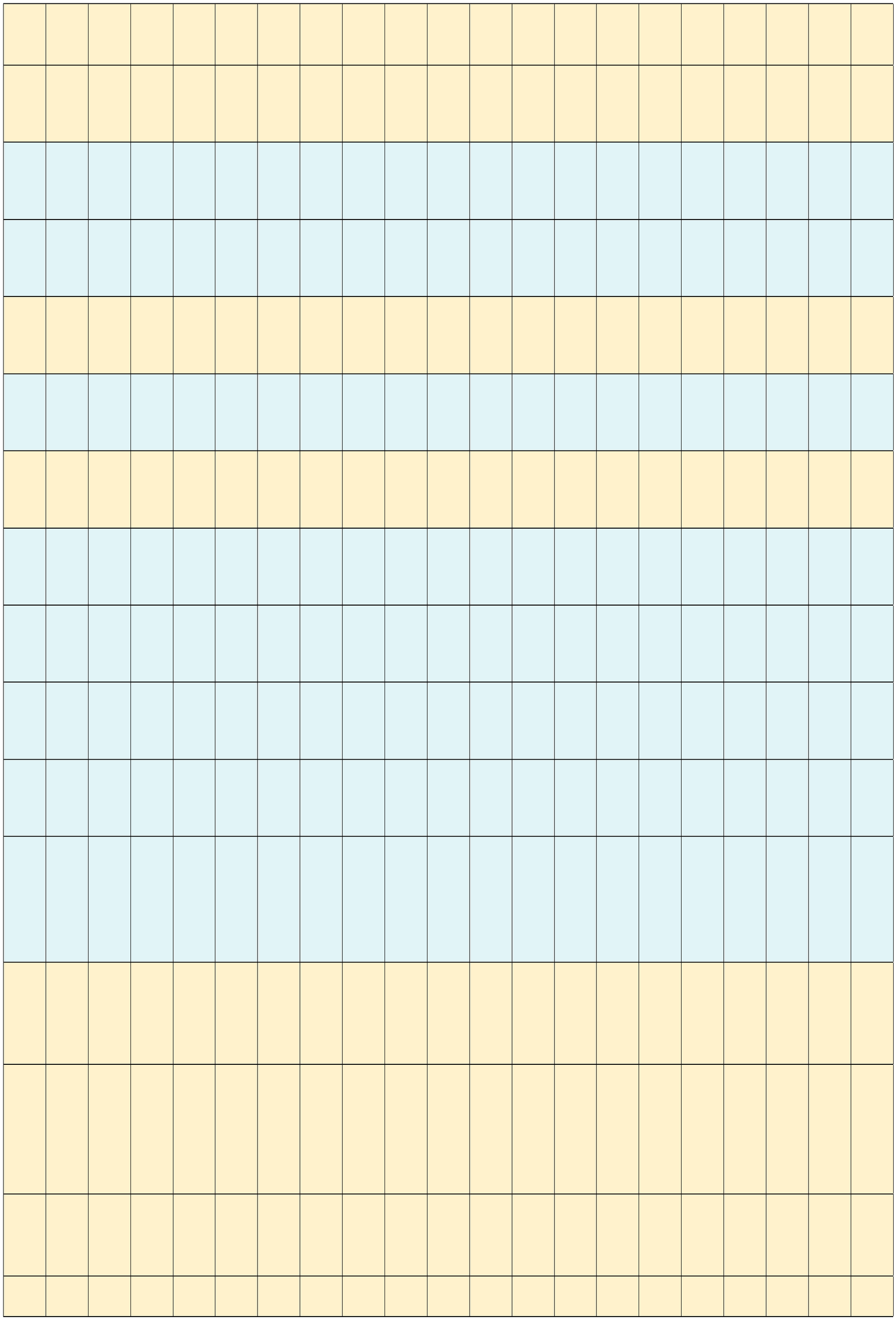
5	Frailty Service	Integrated Care Planning and Navigation	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
6	NSC - Impact of Social Care Reforms	Care Act Implementation Related Duties	Care Act Implementation Related Duties	Other	Transformation				Social Care		LA			Local Authority	Minimum NHS Contribution
7	AWP - Care Home Liaison	Community Based Schemes	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess					Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution
8	Training for Care Home providers	Prevention / Early Intervention	Prevention / Early Intervention	Other	Training				Community Health		LA			Local Authority	Minimum NHS Contribution
9	Brokerage Resource	Enablers for Integration	Enablers for Integration	Workforce development					Community Health		LA			Local Authority	Minimum NHS Contribution
10	Care co-ordination posts (x2)	Enablers for Integration	Enablers for Integration	Workforce development					Community Health		LA			Local Authority	Minimum NHS Contribution
11	Assistive technology co-ordinator post	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Assistive technologies including telecare		10	10	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution
12	Care Home Assistive Technology	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Community based equipment		5	5	Number of beneficiaries	Community Health		LA			Local Authority	Minimum NHS Contribution
13	Care Planning Capacity	Integrated Care Planning and Navigation	Integrated Care Planning and Navigation	Care navigation and planning					Community Health		LA			Local Authority	Minimum NHS Contribution
14	Case management for high cost packages	Integrated Care Planning and Navigation	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Community Health		LA			Local Authority	Minimum NHS Contribution
15	NSC - Impact of Social Care Reforms	Care Act Implementation Related Duties	Care Act Implementation Related Duties	Other	Transformation				Social Care		LA			Local Authority	Minimum NHS Contribution
16	Community Provider - Admission prevent	Community Based Schemes	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
17	NSC - Care Navigators & admin support	Integrated Care Planning and Navigation	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	Minimum NHS Contribution
18	Age UK - Somerset	Prevention / Early Intervention	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution
19	Voluntary Action North Somerset (VANS)	Prevention / Early Intervention	Prevention / Early Intervention	Risk Stratification					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution
20	Response 24 (Out of Hours response)	Assistive Technologies and Equipment	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	Minimum NHS Contribution
21	Community Meals Weekend Offer	Personalised Care at Home	Personalised Care at Home	Physical health/wellbeing					Social Care		LA			Local Authority	Minimum NHS Contribution
22	Carers Breaks Contribution	Carers Services	Carers Services	Respite services		50	50	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution
23	Proud to Care retention bonus for domiciliary	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care workforce development		100	100	Hours of care	Social Care		LA			Local Authority	Minimum NHS Contribution
24	Carers support - Mental Health (AWP)	Carers Services	Carers Services	Respite services		100	100	Beneficiaries	Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution
25	NSC - Reablement	Intermediate Care Services	Other						Social Care		LA			Local Authority	Minimum NHS Contribution

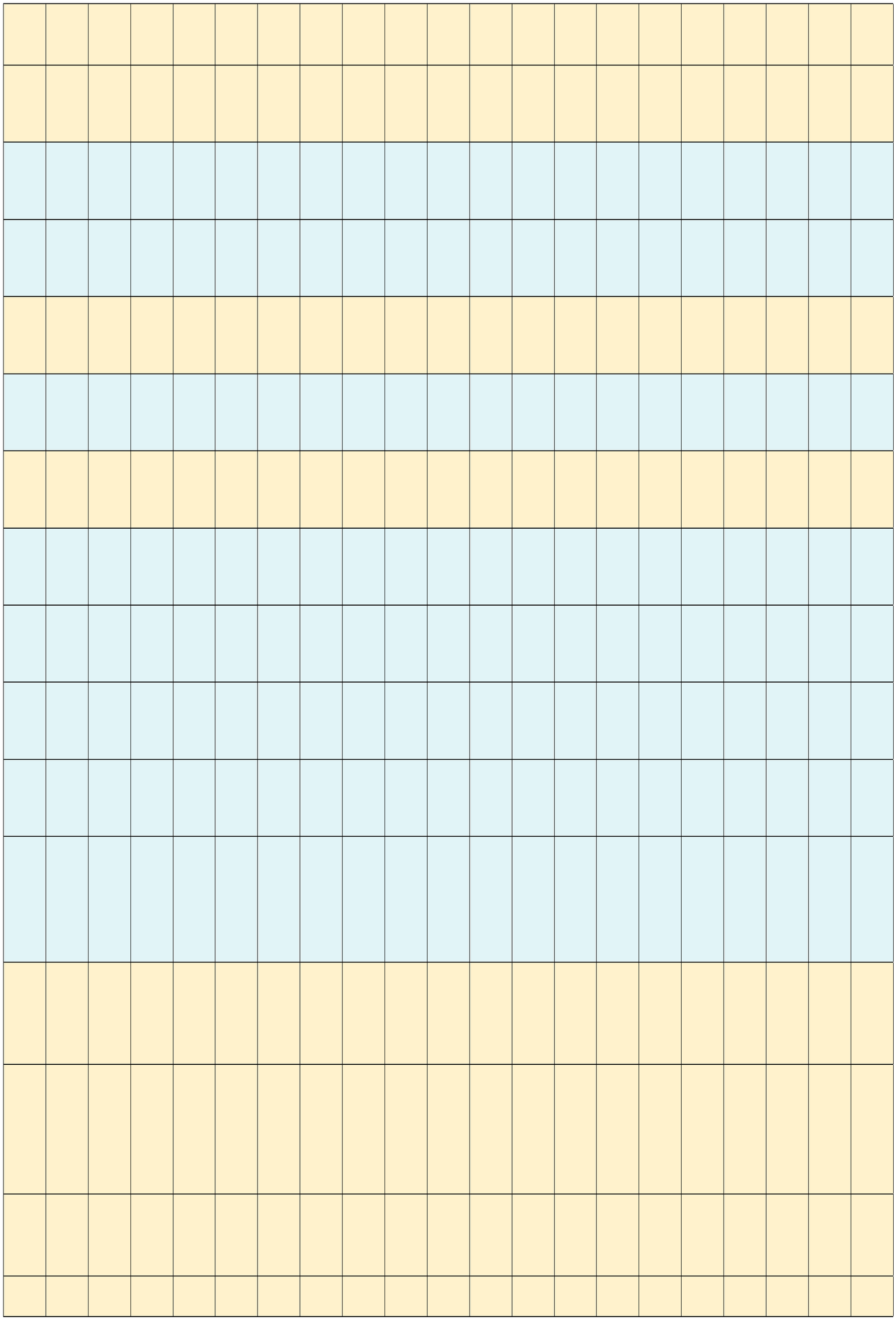
26	Community Provider - Reablement	Community Based Schemes	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
27	Community Equipment (posts)	Integrated Care Planning and Navigation	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	Minimum NHS Contribution
28	Community Equipment	Prevention / Early Intervention	Prevention / Early Intervention	Other	Community Equipment				Social Care		LA			Local Authority	Minimum NHS Contribution
29	Disabled Facilitaties Grant (DFG)	DFG Related Schemes	DFG Related Schemes	Adaptations, including statutory DFG grants		250	250	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG
30	Impact to social care reforms	Care Act Implementation Related Duties	Care Act Implementation Related Duties	Other	Transformation				Social Care		LA			Local Authority	Minimum NHS Contribution
31	Dementia Day Services	Community Based Schemes	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	Minimum NHS Contribution
32	Investment in services for Asperger's/Autism	Community Based Schemes	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	Minimum NHS Contribution
33	Contract Compliance Posts (core service)	Enablers for Integration	Enablers for Integration	Workforce development					Social Care		LA			Local Authority	Minimum NHS Contribution
34	Personality Post contribution	Enablers for Integration	Enablers for Integration	Workforce development					Community Health		NHS			NHS	Minimum NHS Contribution
35	North Somerset Wellbeing Therapies (ex-1 in	Enablers for Integration	Enablers for Integration	Workforce development					Community Health		NHS			Private Sector	Minimum NHS Contribution
36	Long term care including mental illness (s117)	Personalised Budgeting and Commissioning	Personalised Budgeting and Commissioning						Mental Health		NHS			Local Authority	Minimum NHS Contribution
37	Community Provider - Rehabilitation	Community Based Schemes	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
38	British Red Cross - Assisted Discharge Service	Community Based Schemes	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution
39	Discharge to Assess	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Community Health		NHS			Private Sector	Minimum NHS Contribution
40	NSC - Access and Hospital Support Team	Integrated Care Planning and Navigation	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			NHS Acute Provider	Minimum NHS Contribution
41	Hospital Discharge Co-ordinators and admin	Integrated Care Planning and Navigation	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			NHS Acute Provider	Minimum NHS Contribution
42	Hospital Discharge Manager	Integrated Care Planning and Navigation	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			NHS Acute Provider	Minimum NHS Contribution
43	Residential and nursing beds at Sycamore home,	Residential Placements	Residential Placements	Care home		10	15	Number of beds/Placements	Social Care		LA			Local Authority	Minimum NHS Contribution
44	Funding for new schemes to meet system pressures	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	Minimum NHS Contribution
45	Sirona Adult Community Services	Community Based Schemes	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
46	NSC - Impact of Social Care Reforms	Care Act Implementation Related Duties	Care Act Implementation Related Duties	Other	Transformation				Community Health		LA			Local Authority	Minimum NHS Contribution

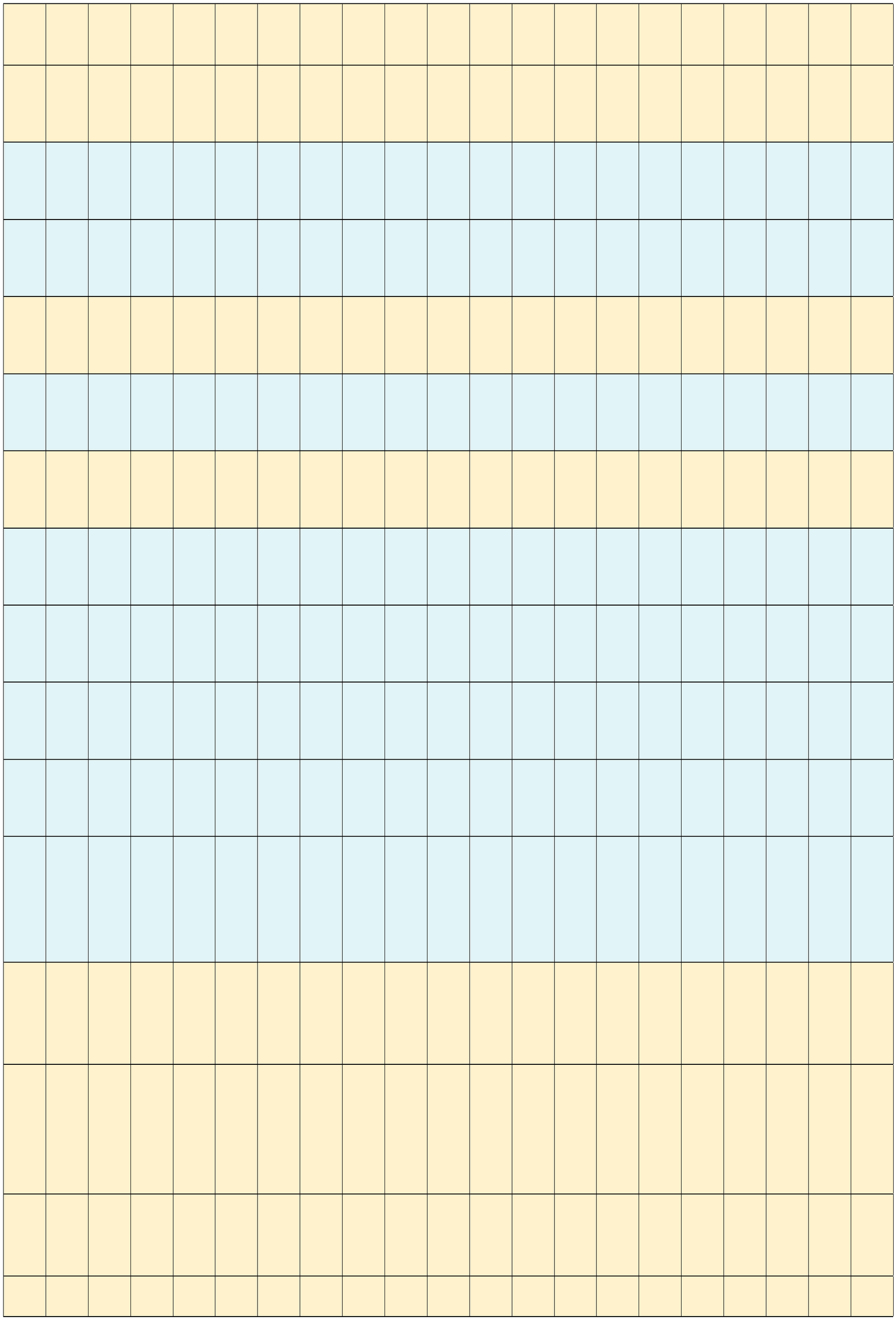
47	Proud to Care Retention Payment	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care workforce development		100	100	Hours of care	Social Care		LA			Local Authority	iBCF
48	Domiciliary Care Strategic Providers Capacity Building	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care workforce development		100	100	Hours of care	Social Care		LA			Local Authority	iBCF
49	Care Home BCF Innovation Grant - top up existing	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Community based equipment		10	10	Number of beneficiaries	Social Care		LA			Local Authority	iBCF
50	Stabilising Capacity - Care Home Sector	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes					Social Care		LA			Local Authority	iBCF
51	Within 24 hour fast track delivery of Carelink	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	iBCF
52	TEC - TO Support Care Sector	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Assistive technologies including telecare		5	5	Number of beneficiaries	Social Care		LA			Local Authority	iBCF
53	Supply of emergency radiators via	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Housing and related services					Social Care		LA			Local Authority	iBCF
54	Supply of furniture via Alliance, to support discharge	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Housing and related services					Social Care		LA			Local Authority	iBCF
55	Fund for Adaptations via Alliance, to suport	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Housing and related services					Social Care		LA			Local Authority	iBCF
56	In conjunction with VAN's map local community	Care Act Implementation Related Duties	Care Act Implementation Related Duties	Other	Transformation				Social Care		LA			Local Authority	iBCF
57	Premium payments to Care Home sector to	Residential Placements	Residential Placements	Care home		20	20	Number of beds/Placements	Social Care		LA			Local Authority	iBCF
58	Agency Social Work to address capacity issues	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	iBCF
59	Expansion of Home from Hospital service	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	iBCF
60	Proud to Care	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care workforce development		100	100	Hours of care	Social Care		LA			Local Authority	iBCF
61	Contribution to Care Home Fee	Residential Placements	Residential Placements	Care home		100	100	Number of beds/Placements	Social Care		LA			Local Authority	iBCF
62	Block purchase of capacity to support discharge	Residential Placements	Residential Placements	Care home		15	15	Number of beds/Placements	Social Care		LA			Local Authority	iBCF
63	Out of Hours assessment, Quality	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	iBCF
64	Dom Care Capacity incentives -	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	iBCF
65	Shared Lives Co-ordinator	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	iBCF
66	Fifteen Minute Premuims for Dom Care Providers	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	iBCF
67	Care Home Service Enhancements	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes					Social Care		LA			Local Authority	iBCF

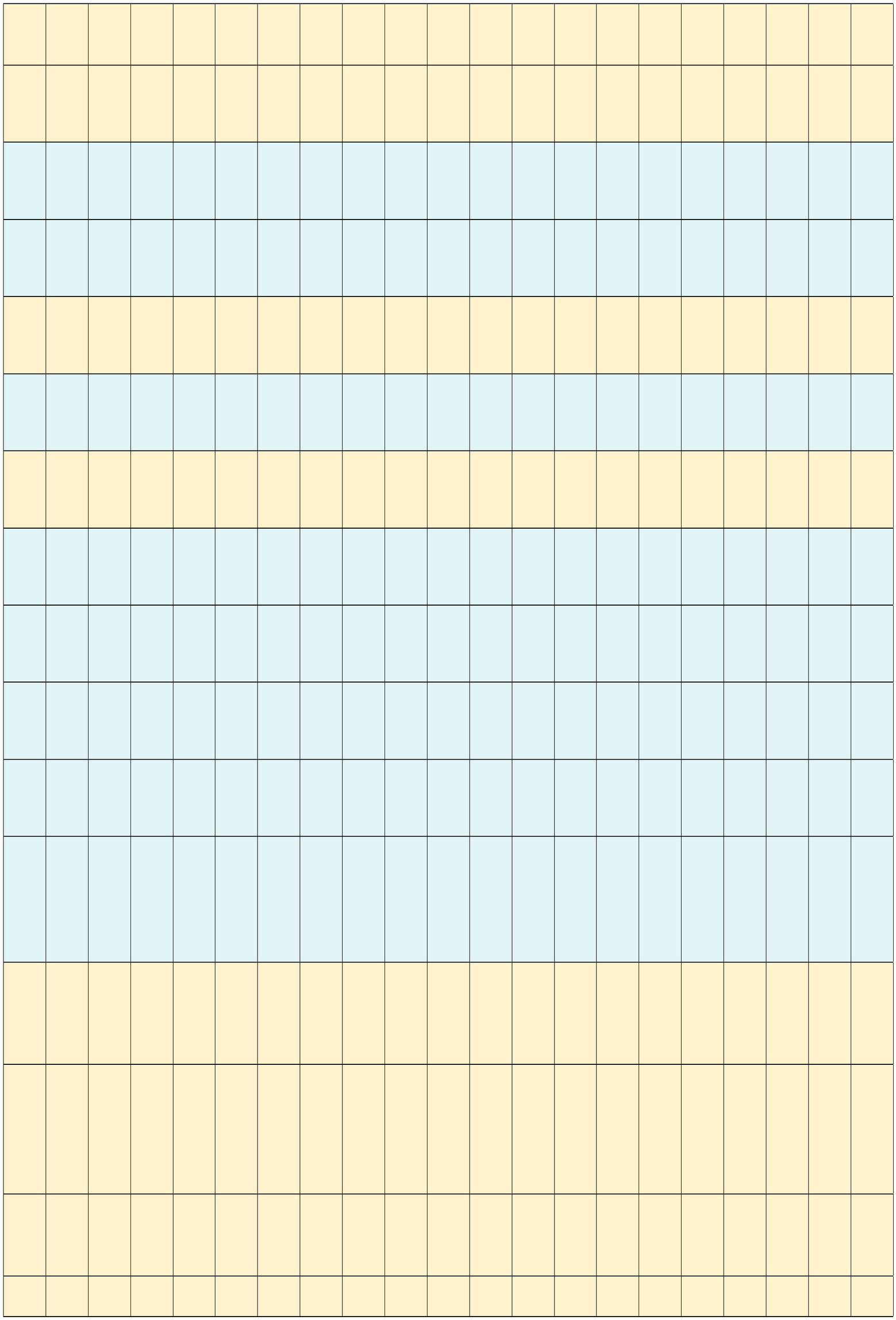
68	Delivery of Extra Care and Housing Support	Residential Placements	Housing Related Schemes						Social Care		LA			Local Authority	iBCF
69	Common processess relating to adult	Enablers for Integration	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	iBCF
70	Increase take up of assistive technology	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Assistive technologies including telecare		20	20	Number of beneficiaries	Social Care		LA			Local Authority	iBCF
71	Essential prevention and early intervention	Community Based Schemes	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	iBCF
72	Connecting Care developments/int ereface with	Enablers for Integration	Enablers for Integration	System IT Interoperability					Social Care		LA			Local Authority	iBCF
73	Stabilising the market	Residential Placements	Residential Placements	Care home		100	100	Number of beds/Placements	Social Care		LA			Local Authority	iBCF
74	Section 117	Enablers for Integration	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	iBCF
75	Discharge to Assess	Enhanced D2A pathways to support hospital discharge	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Social Care		NHS			Local Authority	Additional NHS Contribution
75	Joint Funded Packages (s117)	Integrated Care Planning and Navigation	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	Additional LA Contribution
76	Single Point of Access	Integrated Care Planning and Navigation	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	Additional LA Contribution
77	Community Equipment	Prevention / Early Intervention	Prevention / Early Intervention	Other	Transformation				Social Care		LA			Local Authority	Additional LA Contribution
78	Link Workers/Care Navigators	Integrated Care Planning and Navigation	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Local Authority Discharge
79	SW Assessment Capacity	Integrated Care Planning and Navigation	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge
80	Dementia Support at Home	Prevention / Early Intervention	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		20	20	Hours of care	Social Care		LA			Local Authority	Local Authority Discharge
81	Reablement in-reach	HICM for Managing Transfer of Care	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		25	25	Number of Placements	Social Care		LA			Local Authority	Local Authority Discharge
82	Falls Pathway/Rapid Response	Prevention / Early Intervention	Home Care or Domiciliary Care	Short term domiciliary care (without reablement input)		50	50	Packages	Community Health		LA			Local Authority	Local Authority Discharge
83	Night Sitting	HICM for Managing Transfer of Care	Personalised Care at Home	Physical health/wellbeing					Social Care		LA			Local Authority	Local Authority Discharge
84	Hospital Discharge	Transfer of Care Hubs - NBT	Prevention / Early Intervention	Risk Stratification					Acute		NHS			NHS Acute Provider	ICB Discharge Funding
85	Hospital Discharge	Transfer of Care Hubs - NBT	Prevention / Early Intervention	Risk Stratification					Acute		NHS			NHS Acute Provider	ICB Discharge Funding
86	Discharge Bed Capacity - Reablement	P2/P3 Bed Provision	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support admissions avoidance)		59	59	Number of Placements	Community Health		NHS			Private Sector	ICB Discharge Funding
87	Therapy Bed support	P2/P3 Bed Therapy Support	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		25	25	Number of Placements	Community Health		NHS			NHS Community Provider	ICB Discharge Funding

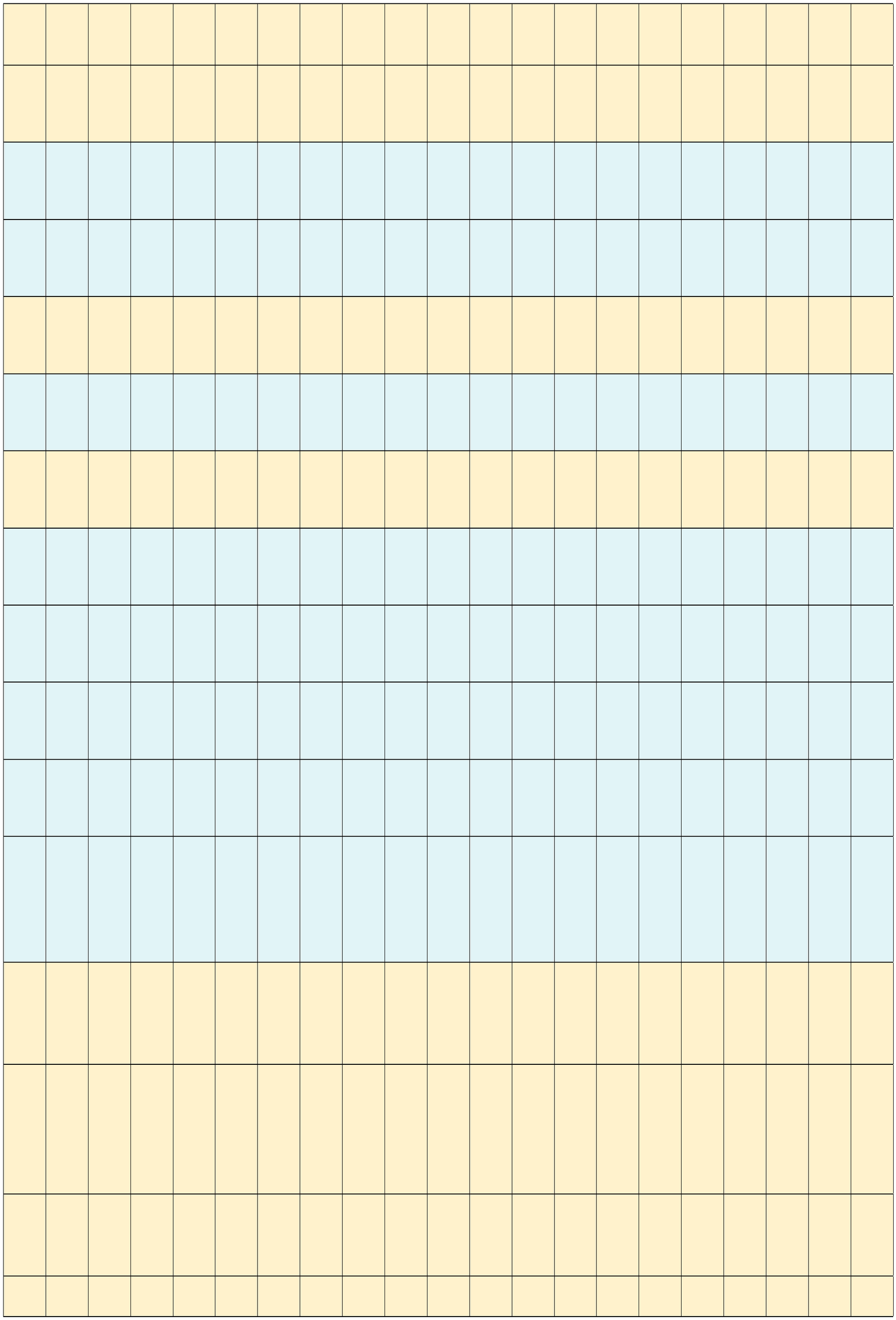
88	Rapid Response - Falls	NSC Rapid Response - Falls	Urgent Community Response						Social Care		LA			Local Authority	ICB Discharge Funding
89	Dementia Care Home Support	NSC Dementia Care home support	Urgent Community Response						Social Care		LA			Local Authority	ICB Discharge Funding
90	Capaciity Contingency	Winter Capacity Contingency	Urgent Community Response						Community Health		NHS			NHS Community Provider	ICB Discharge Funding
91	Care Market Incentives	Care Market Incentives	Urgent Community Response						Social Care		Joint	50.0%	50.0%	Private Sector	ICB Discharge Funding
92	MH Discharge Investment	MH Discharge Investment	Other						Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding

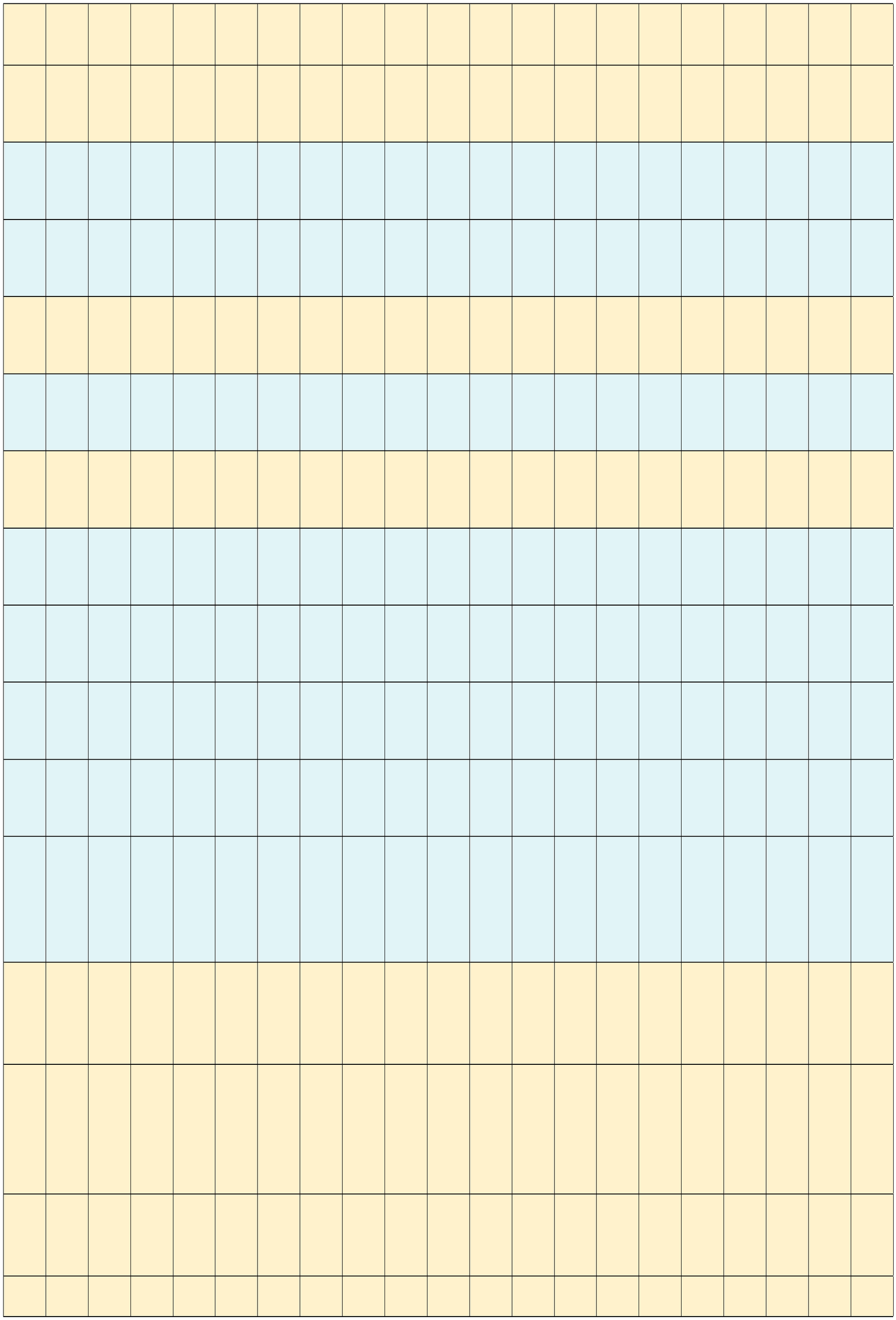


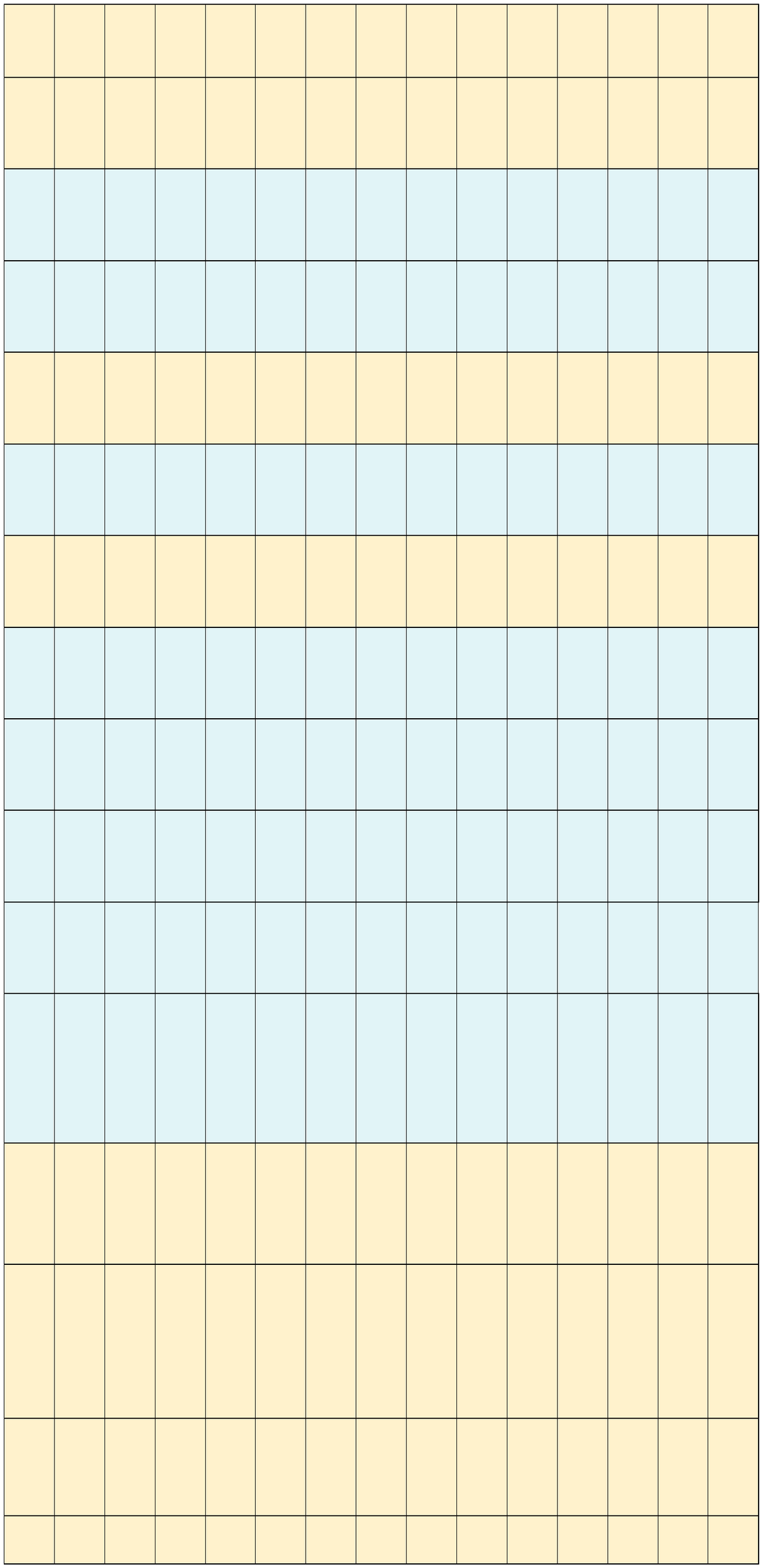












Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.

12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: North Somerset

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	147.1	151.4	166.3	120.0	The estimated impact of all admission avoidance schemes relating to ACS conditions has been calculated and applied to last years actuals to reflect the planned levels anticipated. This has been applied to each quarter to reflect seasonality.	BNSSG ICS is committed to ensuring that patients are not admitted to hospital unnecessarily and that effective community care is in place to ensure that patients can remain healthy at home. Schemes include Ageing Well Enhanced care home Pilots, Diabetes programme as well as enhancing the community Urgent care responce, enhancing virtual ward capacity and enhanced SDEC
	Number of Admissions	414	426	468	-		
	Population	215,574	215,574	215,574	215,574		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	134.31	137.51	154.57	146.75		

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,752.0	1,827.9	1,380.5	The estimated impact of North Somerset falls scheme has been calculated and applied to last years actuals to reflect the planned levels anticipated.	A shared priority across our two localities evidenced by population health management, was to improve the response to falls, enhance outcomes and experience for individuals who fall, and increase system efficiency. Currently, residents with care link pendants who fall receive a timely response from Access Your Care (AYC), an independent care provider
	Count	965	1009	762		
	Population	52,198	52198	52198		

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition

Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	93.6%	94.2%	93.8%	91.3%	The denominator was calculated using the acute bed modelled admission profile for the year and includes a reduction for planned admission avoidance activity. The numerator was calculated using the modelled profile for discharge to bedded intermediate care including reductions planned as outlined in opposite box, enabling to determine the planned numbers discharged home.	The BNSSG ICS is committed to ensuring our combined health and care resources are used to promote a Homefirst ethos, and has a suite of programmes from anticipatory care planning in the community, through to crisis response and facilitated discharge from Hospital. Following system wide research as part of the Better Care Fund support Programme in 2022, we know there is opportunity to reduce the number of times an interim bed
	Numerator	4,099	4,287	4,284	3,623		
	Denominator	4,379	4,553	4,565	3,970		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Quarter (%)	94.8%	95.0%	94.9%	94.8%		
	Numerator	3,878	3,950	3,828	3,697		
	Denominator	4,092	4,160	4,032	3,899		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	475.0	504.6	644.7	571.3	The target is based on making siginificant progress on the Home First priorities. 22/23 has seen a continued recovery in care home activity, following the dramatic drop in activity during COVID and estimates are well below pre COVID stats.	Primarily the Local Plan's action to enhance capacity in domicilary care and related prevention interventions relating to TEC, VCSE and accommodation shift ie Extra Care to deliver robust alternatives to bedded care.
	Numerator	247	270	345	310		
	Denominator	52,003	53,512	53,512	54,266		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	78.8%	81.3%	73.9%	80.0%	Despite the additional reablement capacity in place, the plan overestimated the capacity in the timeline and strict criteria of the count, this is adjusted for in this estimate which reflects a continued stretch. The lower estimate may have	The Local Plan outlines the additional reablement/bridging service capacity and investment in services aimed at maximising independence.
	Numerator	26	130	34	48		
	Denominator	33	160	46	60		

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan

NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4**	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan
Additional discharge funding	**PR5**	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* 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 workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans
NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan

Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Have stretching ambitions been agreed locally for all BCF metrics based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan

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Better Care Fund Plan 2023 -25

North Somerset Council

Gerald Hunt

Principal Head of Commissioning, Partnerships and Housing Solutions

24th August 2023

Health & Wellbeing Board

BCF Purpose

The BCF Programme underpins key priorities in the NHS Long-Term Plan by joining up services in the community and the government's Plan for Recovering Urgent and Emergency Care (UEC) Services, as well as supporting the delivery of Next Steps to Put People at the Heart of Care.

The BCF facilitates the smooth transition of people out of hospital, reduces the chances of re-admission and supports people to avoid long-term residential care.

The BCF is also a vehicle for wider joining-up of services across health and local government, such as support for unpaid carers, housing support and Public Health.

BCF Context

Since 2015, the BCF has been crucial in supporting people to live health, independent and dignified lies, through joining up health, social care and housing services seamlessly around the person. This vision is underpinned by two core objectives, to:

- Enable people to stay well, safe and independent at home for longer;
- Provide people with the right care, at the right place, at the right time.

The BCF achieves this by requiring Integrated Care Boards (ICBs) and local government to agree a joint plan, owned by the Health and Wellbeing Board (HWB), governed by an agreement under Section 75 of the NHS Act (2006). This continues to provide an important framework in bringing local NHS services and local government together to tackle pressures faced across the health and social care system and drive better outcomes for people.

BCF - Objectives

BCF Objectives and Priorities for 2023 to 2025

Objective 1: to enable people to stay well, safe and home for longer

The priorities for health and social care are to improve quality of life and reduce pressure on UEC, acute and social care services.

This will be achieved through various mechanisms, including:

- Collaborative working with the voluntary, housing and independent provider sectors;
- Investment in a range of preventative, community health and housing services;
- Supporting unpaid carers.

Objective 2: to provide people with the right care, at the right place, at the right time

The priorities for health and social care are to tackle immediate pressures in delayed discharges and demand for hospital attendances and admissions, bringing about sustained improvements in outcomes for people discharged from hospital, and wider system flow.

This will be achieved by embedding strong joint working between the NHS, local government and the voluntary, housing and independent provider sectors.

BCF National Conditions

BCF National Conditions

The Local Authority and ICB must agree a Plan for the HWB area that agrees:

- Agreement on use of mandatory BCF funding streams
- An assessment of capacity and demand for intermediate care services
- Ambitions on making progress against the national metrics.

The Plan must be signed off by the HWB.

BCF Plans should set a joined-up approach to integrated person-centred services including unpaid carers across local health, care, housing and wider public services. They should contain arrangements for joint commissioning and an agreed approach towards the 2 policy objectives as part of the HWB's area response to the two national policy conditions 2 and 3. This should confirm how the BCF will support this work, and how this will improve performance on the national metrics

Finance : Better Care Fund (BCF) 2023/24

BCF	2023/24 Allocation £'000
DFG	£2,361
Minimum NHS Contribution	£18,475
iBCF	£6,986
Additional LA Contribution	£5,391
Additional NHS Contribution	£1,400
Local Authority Discharge Funding	£979
ICB Discharge Funding	£1,735
Total	**£37,328**

Included in Minimum NHS contribution	£'000
Adult Social Care services spend from the minimum ICB allocations	£8,095

Discharge Fund Breakdowns 2023/24

LA Discharge Grant	£'000
Link Workers / Care Navigators	259
Dom care and reablement capacity	610
NSC Dementia care home support	110
Total	**979**

ICB Discharge allocation	£'000
Transfer of Care Hubs - NBT/NSC	120
Transfer of Care Hubs - UHBW/NSC	277
P2/P3 beds - Re-procurement	862
Procurement saving - spot vs Block	(490)
Capacity contingency (if procurement saving made)	250
Care market incentives (if procurement saving made)	240
P2/P3 beds - therapy support	156
NSC rapid falls response	230
NSC Dementia care home support	90
Total	**1,735**

Other discharge related spend

D2A Risk Pool - non-recurring	£'000
P1 bridging	448
P2/P3 beds - ongoing until Sept then stepped down	579
Transformation programme	240
TEC project - FYE	70
Discharge Support Grants	120
Total	**1,457**

Anticipatory Care (NHS)	£'000
NSC Dementia care home support	200
NSC rapid falls response	225
Total	**425**

BCF Plan : Headlines

- Performance - A Winter of two halves
- System v Locality
- LGA evaluation for BNSSG area – reduce LOS by 40%, reduce bed base by 40%
- Discharge Grant financial challenges , missed opportunity?
- Transfer of Care Hubs emerge
- Local Innovation – First Response service, Dementia Care , Advanced payment of pay awards, TEC
- Monitoring and governance

BCF Plan 2023/25

Questions?