HM Government

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.

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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).

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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

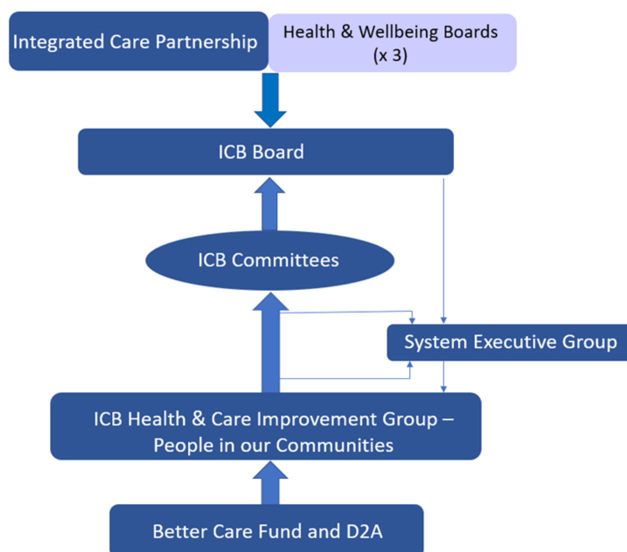
2. Governance

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 t

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

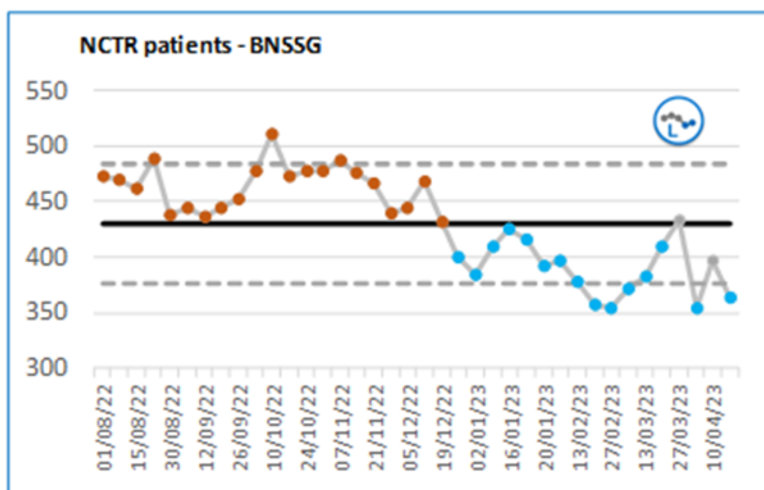
Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

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:

LGA Steering Group: evaluation criteria for D2A proposals

1. Outcomes impact

- Measure: number of people that go into P2/P3 beds or long term care
- Potential evidence: number of inappropriate outcomes driven by reason and how the solution will improve this

2. Operational impact

- Measure: acute bed days saved (plus reduced acute/community NC2R)
- Potential evidence: how a solution might affect length of stay and the number of bed days used, based on how many beds are currently lost to that specific problem

3. Financial impact

- Measure: net cost/benefit to the system
- Potential evidence: evaluation of investment needed and size and timeline of benefit delivery

4. Delivery feasibility

- Measure: ability to deliver by end 24/25 based on assumptions e.g. recruitment
- Potential evidence: delivery timeline and key assumptions relating to staffing or other factors

3

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.
20230323 NSC Servic

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.c

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)

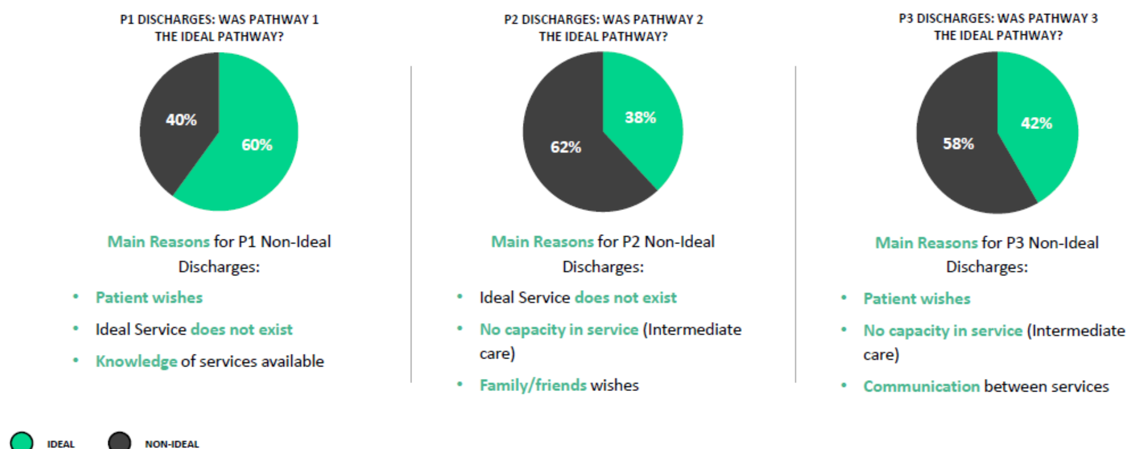
Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- 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 accreditation 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