Bath & North East Somerset Council

Improving People's Lives

To: All Members of the Health and Wellbeing Board

Dear Member

Health and Wellbeing Board: Tuesday, 27th September, 2022

Please find attached a **SUPPLEMENTARY AGENDA DESPATCH** of late papers which were not available at the time the agenda was published. Please treat these papers as part of the agenda.

Papers have been included for the following items:

5. **URGENT BUSINESS AGREED BY THE CHAIR (Pages 3 - 28) – BETTER CARE FUND NARRATIVE PLAN 2022-2023**

Yours sincerely

Corrina Haskins
for Chief Executive

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Bath & North East Somerset Council

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

Bath and North East Somerset Better Care Fund 2022 - 2023 Narrative Plan

Health and Wellbeing Board: Bath and North East Somerset

Contents

1.0 Executive Summary

Bath and North East Somerset Council and the Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (BSW ICB) are proud to present the 2022/23 Better Care Fund plan.

This plan is built on the commitments and understanding set out in previous plans. In line with the formal establishment of the BSW ICB on 1st July 2022, we have been working in partnership to develop a plan for meeting the health needs of our local population and to arrange the provision of health and social care services through management of the pooled Better Care Fund Budget, and in line with the Better Care Fund national objectives.

The 2022/23 Better Care Fund Plan focusses on:

- The continued integration and development of the Your Care Your Way programme
- The commitments to improve system flow by utilising BCF funding to support key initiatives
- Reduction of patients categorised as having 'No Criteria to Reside' (NCTR) through BCF funding of projects mandated to make significant improvements.
- Strategic transitioning from our current position of helping people get out of hospital, to a more transformational model of admission avoidance and prevention.
- Winter planning
- The development of the BSW ICB to fully integrate ways of working and best practice
- The termination of the HCRG Care Group partnership contract (ending in 2023) and set up of new arrangements

The specific area of focus for 2022/23 is centred around mobilisation of a number of projects, all of which will be funded, or part funded by the Better Care Fund to improve urgent care and flow and reducing the volume of patients in hospitals and acute settings that have been categorised as having 'No Criteria to Reside' (NCTR). Data shows how the number of patients with NCTR has increased from approximately 52 people to high point of 83 people in July 2022, and the distribution of need has also changed from higher numbers of people on Pathway1 (P1), to significantly higher numbers or people now on Pathway2 (P2), with data now showing equal numbers of P2 and P1.

Currently, the maturity of data sources for BCF schemes is in need of review, to establish the extent to which key demographic information is collected consistently. Some of this may be addressed through local authority preparation for the Client Level Dataset and Assurance Framework, but the BCF data sources comprise a number of ancillary datasets which may not share common identifiers, so reading across schemes can be challenging. Data development work needs to take place before the focus can shift towards detailed analysis of BCF schemes, therefore. The recent publication of the Strategic Evidence Base for B&NES does help to frame the challenges around equalities and can inform further exploration of the issue in the context of BCF.

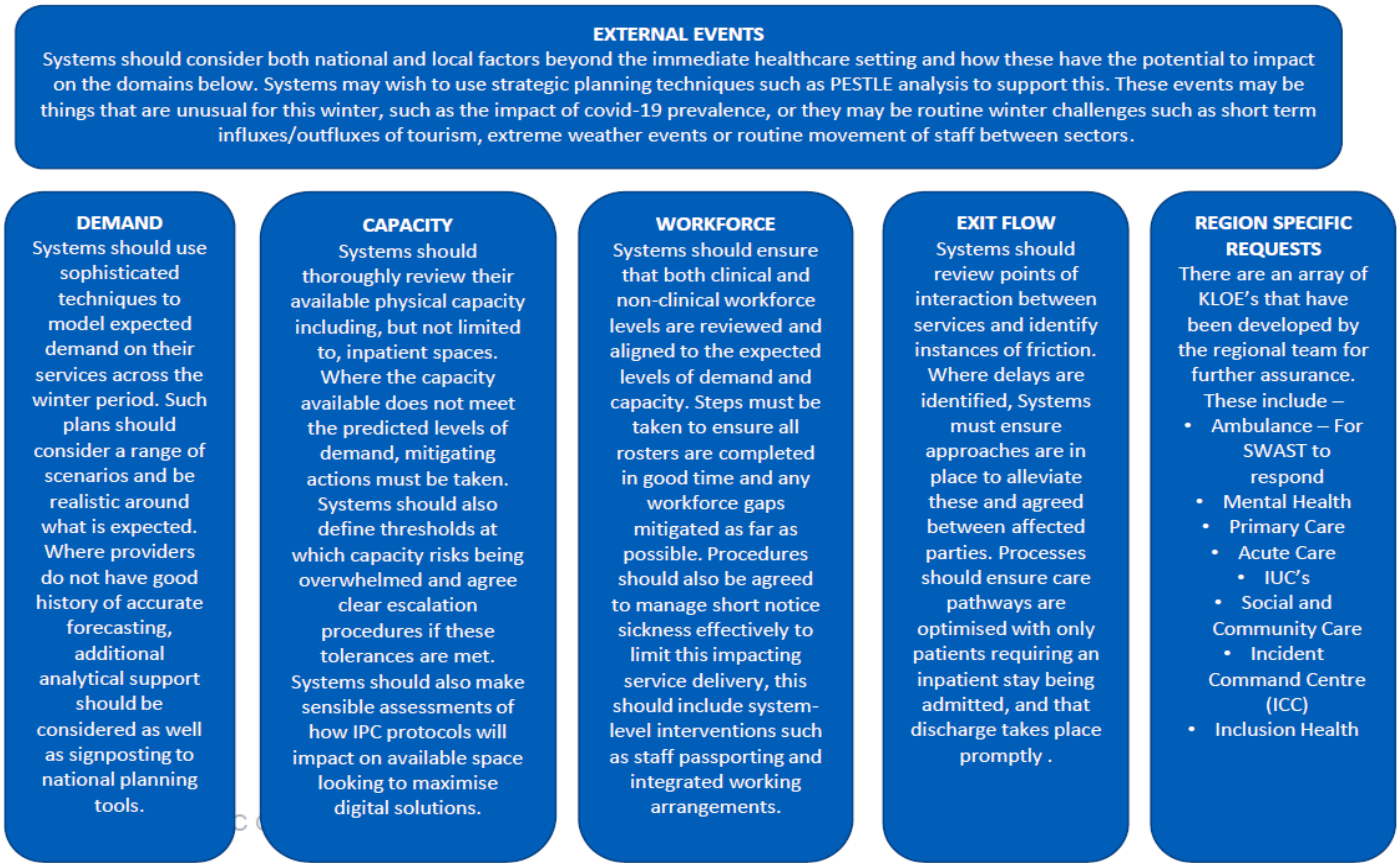
A number of projects have also received non-recurrent funding from the Better Care Fund to help to reduce system pressures and Improve flow through the health and social care system. This Better Care fund report provides further details on these projects.

This summary report also recognises that the first 3 national conditions for the Better Care Fund remain in line with 2021/22, and that the fund requires a minimum spend level from the NHS (BSW ICB). The NHS minimum contribution to the polled funding has increased by 5.66% in 2022/23, and the Improved Better Care Fund (iBCF) has also increased by 3%, and this report evidences continued development of the integration of the BSW ICB, particularly around the evolution of a

governance structure to coexist alongside the existing Health and Wellbeing Boards overarching Better Care Fund assurance.

The focus on urgent care and flow improvements is a continuation of last year's priorities and is also evident in the winter plan which has been carefully considered for 2022/23. The winter plan reflects the whole system approach to the delivery of services over the forthcoming winter period, with the aim of ensuring that seasonal infection demand will not compromise patient care, experience, and service standards.

Similar to previous years, to ensure that the BSW system has stability and preparedness for winter, the winter planning process has been achieved by embedding multiple lines of defence building upwards from provider level, assurance at system then regional and national level.



In 2017, Virgin Care were commissioned by Bath and North East Somerset Council and the then BaNES CCG to join-up services so that they work more closely together and to empower local people to be able to take control of their health - to get well and stay well. Virgin Care have since been acquired by HCRG Care Group, and further details of the contractual position with our primary care provider are outlined in section 5.0 further in this plan. This was driven by investing in technology to put all the information from health and care services into a single system. With access to all the information, clinicians could make informed decisions and treat people in a more effective and efficient way. This was part of a change of focus to support adults in the Bath and North East Somerset locality to live more independent lives, providing access to services supporting:

- Independent living to allow individuals a greater opportunity to continue living independently.
- Personal assistants to provide support to individuals who need some support and assistance with daily tasks to enable them to continue living in their own community and often remain living in their own home

- Adaptations to homes to provide additional safety and prolonged independence.

This Better Care Fund plan and winter pressures plan build on the progress made and lessons learnt locally from previous plans, and it also incorporates and supports the national strategic direction to deliver integrated services which recognise the need to deliver change across the whole health, care, and community system of services.

The use of the Better Care Fund and Improved Better Care Fund and the new schemes being implemented as a result of this investment are outlined in more detail later in the plan, building on this partnership, with a primary focus of improving flow out of the Royal United Hospital (RUH) and creating capacity in the Home Care market. Existing high-profile schemes also benefit from an updated scheme plan and financial dashboard to monitor their progress and provide additional scrutiny of performance.

ECIST have been actively engaged in our ICA to review the D2A/hospital discharge policy implementation which has set out a number of findings and recommendations which are being addressed to help reduce the number of patients who do not need to reside in hospital. ECIST have been working to identify opportunities and actions required to improve system flow and to scope the current practice and alignment to national Policy within the BaNES system. Following consultation and review, ECIST are working to develop a Joint Strategic Forum to look at principles and strategy of D2A while agreeing short term operational/tactical changes to support the system and executive lead to deal with the current pressures and develop a D2A plan for winter 2022/23. This is also supported by work led by the *Whole System*[1] around consistent data management which this year's data return should benefit from.

In March 2022, BSW launched a new 'Academy' for health and care staff in BSW, which is available for all health and care staff working in Bath and North East Somerset, Swindon, and Wiltshire (BSW). This has been provisioned through investment from the BSW partnership and through collaboration of partner organisations in BSW to promote career progression and opportunities for the workforce. Further collaboration with existing organisation and networks will further enhance the offering.

Founded on five pillars of leadership, learning, inclusion, innovation, and improvement each pillar works both independently on key priorities and collectively to deliver the aspirations of the academy.

1. Leadership – providing a united voice across BSW, which sets clear direction, enables cultural transformation, and listens to its workforce and communities.
2. Learning – increasing the quality, quantity and access of the learning and development opportunities on offer.
3. Inclusion – being clear about our ambition. Starting the conversation with our workforce and communities to define and address the unmet need.
4. Innovation – proactively supporting our partners to identify, adapt, implement, and evaluate innovations and share learning.
5. Improvement – building and spreading a consistent, continuous, improvement culture across BSW.

Tackling health inequalities is at the core of the BSW Academy and supports our members of staff that are leading on BCF projects and working on BCF priorities.

This narrative plan has been prepared by the Better Care Fund Commissioning Project Manager at Bath and North East Somerset Council and presented to and approved by the Integrated Care Alliance, which consists of representatives from the following areas:

- Bath and North East Somerset, Swindon, and Wiltshire Clinical Commissioning Group (BSW ICB)
- Bath and North East Somerset Council (B&NES Council)

The plan has been produced in collaboration with representatives across our primary care partner, HCRG, the Royal United Hospital, and third sector colleagues from Age UK and Dorothy House, as well as colleagues from the Integrated Care Board and various different council departments, including Adult Social Care, brokerage, patient safety and quality and various commissioning leads.

This plan will be presented to the Bath and North East Somerset Health and Wellbeing Board for approval on 27th September 2022.

2.0 Programme Governance

The Bath and North East Somerset Better Care Fund is governed by the following bodies:

- ***The B&NES, Swindon and Wiltshire Integrated Care Board (BSW ICB) and the sub group the Integrated Care Alliance (B&NES ICA):***
    - Replaces the Locality Commissioning Group (LCG) which was made up of a sub-committee of the BSW CCG Governing Body and a sub-group of the Council's Strategic Leadership Team and Cabinet meeting in common.
    - All Better Care Fund decisions were previously presented to the Locality Commissioning Group for initial review and approval to progress to the Health and Wellbeing Board.
    - The BSW ICB is new statutory organisation, in operation from 1st July 2022 that will develop a plan for meeting the health needs of the local population, manage the NHS budget allocated to the ICB and its ICA to arrange the provision of health services.
    - It will work collaboratively to improve outcomes in population health, provide better joined-up care, reduce health inequalities, and enhance productivity and value for money, while also helping the NHS support broader social and economic development.
    - The BSW ICB/A sits within the Bath and North East Somerset, Swindon and Wiltshire Integrated Care System, which will be known as 'BSW Together'.

- ***The Health and Wellbeing Board:***
    - Health and wellbeing boards are a formal committee of the local authority charged with promoting greater integration and partnership between bodies from the NHS, public health, and local government. They have a statutory duty, with clinical commissioning groups (CCGs), to produce a joint strategic needs assessment and a joint health and wellbeing strategy for their local population
    - All decisions that have been approved by the Locality Commissioning Group (LCG) are presented to the Health and Wellbeing Board for ratification of the LCG decision to approve. Any challenges from the board must be addressed ahead of final ratification.

All new applications for Better Care Fund funding are reviewed by our BCF working group and senior leadership teams against the Better Care Fund national conditions and local priorities to ensure that they meet the criteria for funding. They are also reviewed collaboratively with colleagues from the quality team through the submission of an equality and quality impact assessment before being

progressed through to the Alliance Delivery Operational Group (ADOG) who act as delegated authority for the BSW ICB for consideration and first line approval. Any funding application that receives approval from the ADOG will then be presented to the Health and Wellbeing Board for final ratification.

Upon final Health and Wellbeing Board approval, the scheme manager is notified of a successful funding application and advised of their reporting requirements. All schemes must provide regular reporting (quarterly) to the Bath and North East Somerset Better Care Fund Commissioning Project Manager to highlight key achievements, milestones, and metrics. This report outlines whether the scheme is performing as expected, and once all schemes have submitted reports, it presents a good holistic view of performance across all BCF schemes as an entire funding stream. Rate of return of the quarterly report has improved over the past 12 months, and we are now seeing reports from over 85% of our underlying BCF project schemes.

These quarterly checkpoints provide an opportunity to consider any potential project underspend and consult on any opportunities for redirection of funding. Some of the commissioned projects that are funded by the Better Care Fund are funding salaries, and due to the unstable nature of the jobs market, it has been incredibly difficult to recruit into some of these posts, meaning that on occasion, funding is not being fully utilised. The quarterly return provides an opportunity to consult with the project lead and agree timescales for recruitment, and where necessary, serve notice that the funding may be re-purposed in year if spend is not recorded within the agreed timescales.

2.1 Specific BCF Schemes Monitoring and Governance

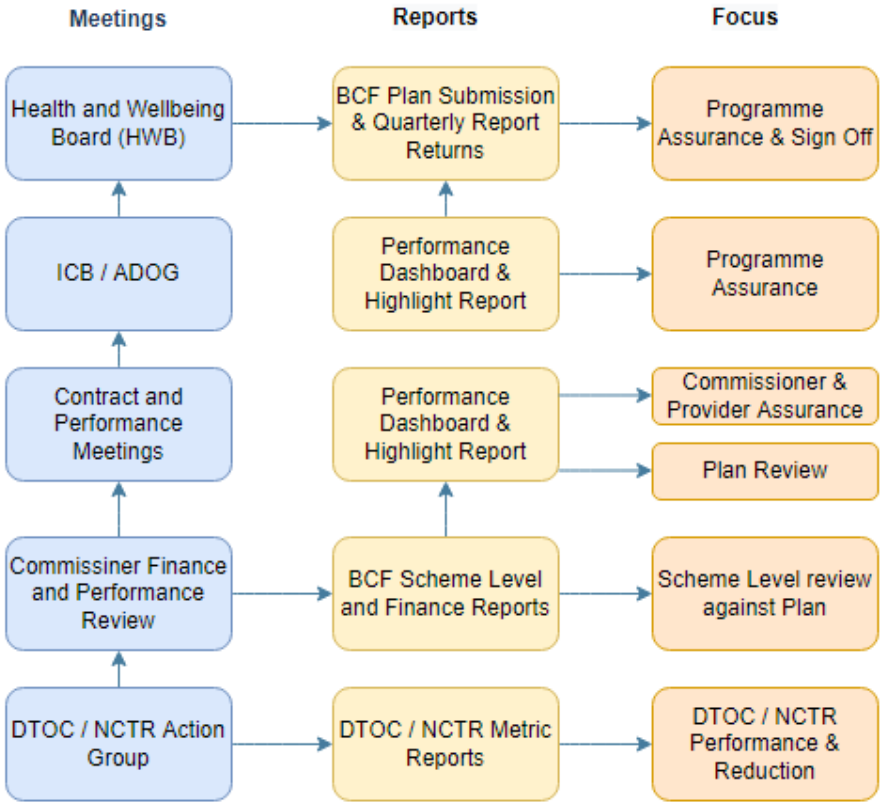
In terms of the specific schemes highlighted under the Better Care Fund plan 2022/23, monitoring will be undertaken within the Council, led by the Better Care Fund Commissioning Project Manager for the Better Care Fund, and supported by monthly performance dashboard and scheme level data. Many of the schemes that are supported by Better Care Fund funding are sending regular (typically monthly) data to supplement their quarterly report.

Delivery of the schemes and performance are addressed through Contract and Performance evaluations and meetings with providers, with the key provider being HCRG Care Group.

A set of tools have been created that allow holistic oversight of all of the underlying BCF funded projects for 2022/23, including the below dashboard that provides a monthly view of utilisation of all projects spend. This allows the commissioning BCF project manager to 'check and challenge' underspend regularly with project leads, and highlight spend challenges to senior management to allow consideration of fund redirection when significant underspend is likely.

	General Information			Finance		
	Scheme Ref	Source	Scheme Name	Total 2022/23 Alocation	Total Spend YTD	Utilisation
Block Contract	15	BCF	Community Services (Virgin)	£53,808,932	£13,452,233	25.0%
	7	BCF	Integrated Care and Support	£2,740,248	£685,062	25.0%
	8	BCF & iBCF	Protection of Social Care, Sleep in Cover & Fair Price of Care	£5,517,364	£1,379,341	25.0%
	12	BCF	BCF Strategic Support	£364,163	£73,083	20.1%
	13	ACT	Care Act Implementation	£1,390,250	£609,768	43.9%
	14a	DFG	Disabled Facilities Grant	£1,441,905	£360,476	25.0%
	16	Grant	Transformation Funding	£583,431	£145,858	25.0%
	100	NHS	BCF Risk Share Contingency	£667,946	£166,986	25.0%
	see below	Various	Measured Schemes	£4,116,903	£495,491	12.0%
	101	Grant	2022-23 Uncommited Funds	-£102,411	-£102,411	100.0%
				£70,631,141	£17,368,298	24.6%

Assurance of the overall delivery of the BCF will be monitored through the BSW ICB and Health and Wellbeing Board as outlined in section 2.0 Programme Governance. The below diagram highlights this structure:



3.0 Overall approach to integration

Integrated health and social care structures have been in place in B&NES since 2009, with commissioning arrangements implemented in that year and provider arrangements consolidated by the contract award for an integrated health and social care provider in 2011.

The commissioning arrangements were reviewed and redesigned in 2013 in response to the creation of the CCG and the reaffirmation of the commitment by both CCG and Council to joint working and to the integrated commissioning and provision of services.

The operation of joint working arrangements, including the operation of pooled funds and the exercise of functions by either body on behalf of the partner body, was previously overseen by the Locality Commissioning Group (LCG), which was constituted as a joint committee of the CCG and Council, however this is now overseen by the BSW ICB.

The governance and operational structures are underpinned by a Joint Working Framework, adopted by both the BSW ICB and the Council, which sets out the commitment, aims and practical supporting arrangements for joint working, and is underpinned by legal agreements as follows:

- S113 agreements allowing managers with joint responsibility employed by either body to perform functions for and be accountable to the other body within an agreed HR framework and within the Schemes of Delegation of each organisation.
- S75 and S10 pooled budget agreements to allow pooling of resources managed by joint commissioners to support integrated commissioning and provision.
- S256 agreements (both nationally required and local) to support expenditure on social care which has a benefit for health services.

The Locality Commissioning Group (LCG) instituted in April 2020 has been overtaken by the ICA meeting (ICAM) instituted in April 2022 which further strengthens the governance of our joint commissioning arrangements. The ICB's Constitution and the People and Communities governance structure are being designed to allow this.

The ICAM will have a formal governance and operational leadership role across health, social care, and public health commissioning in respect of strategic planning, performance management and decision-making.

Like other parts of the country, people in our area are living longer, but often with a number of long-term conditions which add complexity to their health and care needs. Many adults (and children) are dealing with mental health issues, sometimes alongside a long-term physical health condition.

We know there are people in hospital (in acute and mental health beds) and in nursing and residential homes across Bath and North East Somerset, Swindon, and Wiltshire (BSW) who would be better cared for in the community or at home.

All organisations providing health and care within BSW are struggling with a combination of rising demand, staffing vacancies, and increasing financial challenges.

These pressures are very real. Our nurses, doctors, social workers, therapists, and clinical support staff work incredibly hard to provide the very best care they can. Their hard work and dedication in caring for our family members, relatives and friends, day in and day out, all year round is inspirational.

But if we are to maintain safety and quality of care in the future, we have to change and we need to address the issues we currently face in a way that will improve outcomes for individuals, the communities we serve and our staff.

We believe the only way to do this is to build closer ties between all partner organisations across BSW and within the B&NES Integrated Care Alliance. We also need to support more people to manage their condition themselves and to improve our approach to our community-based care.

We are therefore committed to working towards the development of the ICA priorities in the coming year, meeting flow pressures and ensuring we support preventative and wellbeing measures in the community, and the shared contractual arrangements will be explored fully as the ICA continues to be developed.

4.0 National Conditions

4.1 National Condition One (Jointly Agreed Plan)

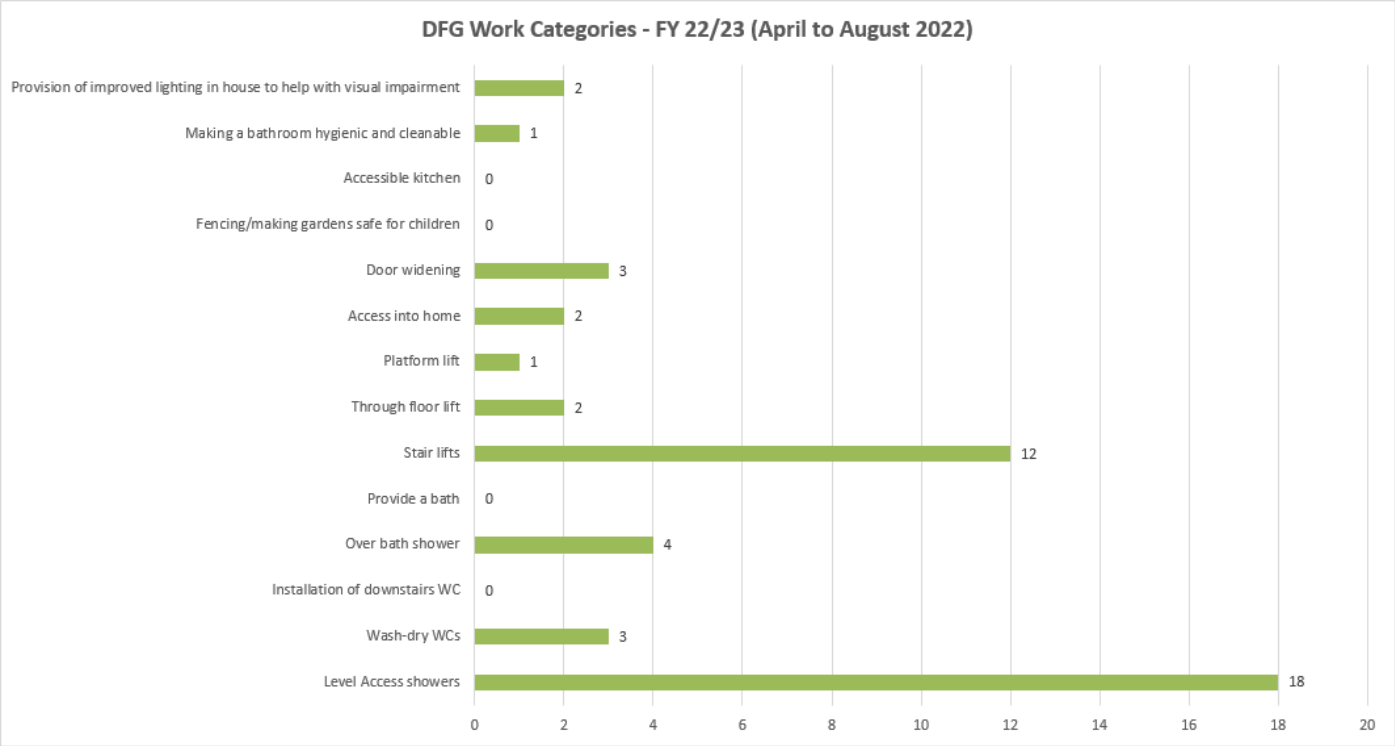
The Better Care Fund will be presented to the Health and Wellbeing Board for formal approval on 27th September 2022. The Board is co-Chaired by a Cabinet Member and the B&NES Locality Clinical Chair for the ICB who is a GP. In addition to the Council and CCG, Board members include key health and care providers, Education providers, public sector partners, a representative of the Voluntary, Community & Social Enterprise (VCSE) sector, Healthwatch and a representative of the housing provider sector.

The iBCF grant determination for the iBCF was issued in May 2022. Regarding the Winter Pressures Grant-this was brought into the BCF in 2019-20 as a discrete grant, which had to be pooled. In 2020-21, it was added into the iBCF grant, and not ringfenced.

4.2 Disabled Facilities Grant (DFG) and Assisted Technology

Bath and North East Somerset Council has been awarded £1,441,905 of Disabled Facilities Grant (DFG) funding in 2022/23, the same as in 2021/22, however this was uplifted by £171,116 last year, but there has been no indication of an uplift for 2022/23 at the time of writing this report.

The graph below shows the main uses for the Disabled Facilities Grant (DFG) in the first half of 2022/23.



Last year, a stronger working relationship was forged between the housing, health and care commissioners through regular liaison meetings which were established to evaluate the impact of DFGs and to strengthen the links between DFGs, Community Equipment services and Assistive Technology. 2022/23 sees a continuation of this enhanced relationship, which has helped to provide more regular oversight on the DFG usage and budget spend.

The main adaptations shown in the graph above will continue to be the key priorities for the DFG funding, alongside Assistive Technology in the form of capital investment.

The assisted technology scheme, funded by the DFG, continues to create an offering of assisted technology for social care packages within B&NES Council through engagement with an external

consultant (the required knowledge is currently not held within B&NES council), and by establishing a close working relationship with our prime care provider, HCRG Care Group, to ensure that technology offerings are complementary to the care homes

Early in 2022/23, a desktop review was completed with Amica 24 (now Community Housing, Technology Enabled Service). The aim of this review was to assess all domiciliary care packages of care that are paid for by the Council (social care funded), for adults aged over 65 years old, to see where technology could be implemented to reduce the amount of care provided by an individual or to prevent an increase of care needed in the future.

In total, 347 client care plans were assessed over 10 half day sessions. From the resulting recommendations we found that 86.2% (256 cases) may possibly benefit from technology solutions. Assuming there was no technology already in place then 256 cases would benefit from technology. Only 37 cases would not benefit from technology. 4 cases were not possible to understand if the client would benefit or not and would require a home assessment.

If the technology solutions were deployed, we would expect to see reduction in care in 18 of those cases. 7 of those cases we were unsure of the outcome possible. The remaining 259 cases we would expect to reduce the need for further care to be provided or reduce the time before additional care is provided. These cases would also deliver benefits from the value of the technology solution and the reassurance their support network receive from having these solutions in place.

This work was procured on a direct award basis as the work being completed and cost was only available from this provider. There was a second company who offered a review; however, it would have cost almost 10 times as much. In addition to the 347 reviews, there has been a request to extend this review to cover all adults of working age. This additional work will be managed by the specialist commissioning team, compared to the original piece that has been managed by the Older Peoples team.

We are now looking to progress through a tender process to further this piece of work, with the aim to deploy a technology service across the directorate with the outcome to reduce the hours of care used to replace the care hours. There is also a need to draft a technology strategy to set out how this work will be furthered and what the tech enabled care offering will be.

4.3 National Condition Two (Contribution to adult social care from the ICB)

In 2022/23, the Bath and North East Somerset Council oversight of the Better Care Fund plan aims to maintain a consistent level of protection of social care through distribution of the available funding. The use of this funding covers a range of schemes that will add stability to the local social and health care system, including continued investment into an integrated model of reablement.

The approach to planning for the Better Care Fund has been consistent with the Department of Health guidance for funding transfers to social care. Both organisations face increasing cost pressures and savings targets.

The local care market has seen a number of residential closures over the last few years and demand on primary, acute, and learning difficulties services continues to climb outside of demographic expectations. The schemes within the plan have therefore been identified to specifically address the

area of intermediate care services which supports the aim of the plan and will mitigate these key factors.

The protection of social care covers areas of adult social care spend which have an indirect impact on prevention such as provision of good quality, fit for purpose, accessible housing, support to the care market, and reablement pathway redesign.

4.4 National Condition Three (ICB commissioned out of hospital services)

The minimum allocation for CCG commissioned out-of-hospital services for 2022/23 is £3,314,067, an increase of £157,870 (+5.66%) on 2021/22.

The local risk share arrangement for 2021/22 has been rolled into the BCF plan and is reported under BCF Scheme number 100 (BCF Risk Share Contingency) and for 2022/23 is £667,946, an increase of £35,781 on 2021/22 (+5.35%).

It has been uplifted in line with NHSE inflation and has been retained by the ICB and forms part of the contract to pay the local acute provider if the non-elective reduction target is not met.

The 2022/23 plan has built on previous years and continues to invest in schemes which support reablement and step-down services such as “home from hospital”. The falls response service which has been live since 2017 is an integrated response specifically designed to reduce admissions to hospital and includes the assessment of further health and social needs at the time of response, and the service is proving to be a highly valuable contribution to admission prevention.

4.5 National Condition Four (Supporting Discharge)

Key initiatives in the Better Care Fund Plan relate to implementation of the High Impact Change Model for Managing Transfer of Care to support system-wide improvements in transfers of care.

The High Impact Change Model sets out eight high impact changes that can support local health and care systems to help reduce delayed transfers of care:

1. Early Discharge Planning.
2. Systems to Monitor Patient Flow.
3. Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary & community sector.
4. Home First/Discharge to Assess.
5. Seven-Day Service.
6. Trusted Assessors.
7. Focus on Choice.
8. Enhancing Health in Care Homes.

Home First (also known as discharge to assess) has been identified as a key priority to improve patient flow within B&NES and help the system regain stronger performance.

Home First is based upon the principle that it is aimed, where safe, for all patients to be discharged home where health and social care assessments can be undertaken in the most appropriate

environment for the patient to assess their long-term needs. If patients are unable to return home, then temporary options need to exist to allow assessments to be undertaken in an environment which will meet their current need.

The B&NES and Wiltshire systems have been particularly challenged through the covid pandemic and a number of **new** schemes are being prioritised to support flow. These include:

- Continued use of block bed bookings within our Community Resource Centres that are reserved for patients that are discharged from acute settings through the D2A provision.
- The ongoing development of an Intermediate Care Team (see section 6.1 for further details) to support patients progression through D2A
- A block provision of Pathway one intermediate beds to support discharge when home care is not available
- Over 1000 hours a week of block home care to support discharge into reablement and out of reablement once care objectives are achieved
- A Development of the Reablement service to support faster through put and shorter lengths of engagement
- Remapping of processes to ensure greater efficiency to provide service users in our D2A Care Home beds a better experience.
- A short-term programme to support hospital patients that are classed as having no criteria to reside and are discharged from hospital through to a care home setting, to ensure that they are given 'the perfect discharge' experience (see section 6.2, Collaborative System Review Group)

These schemes are supported by BCF and H2 funding and a number of these projects are further described in greater detail in section 6.0 below.

5.0 Termination of the HCRG Reablement Services Contract

The Governing Body of Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group (BSW CCG) and Bath & North East Somerset Council's cabinet agreed in May 2022 not to extend the contract for health and social care services operated by HCRG Care Group.

The seven-year contract, which covers the delivery of 51 health and social care services to residents, was initially awarded to Virgin Care Services Ltd and began in April 2017, with an option for the commissioners to extend the term by three years, taking it to 2026/27.

The BSW CCG Governing Body met on 11th November 2021 and agreed a recommendation for such a three-year extension of Virgin Care Services Ltd.'s joint commission for these services. As this is a joint contract, Bath & North East Somerset Council adopted similar recommendations on the same day.

On 1 December 2021, Virgin Care Services Limited notified BSW CCG and Bath & North East Somerset Council that the business it formed part of had been sold to T20 Pioneer Holdings Limited, which is in turn held by Twenty20 Capital Limited (via another company) (T20). T20 is a private equity investor. The commissioners were not aware of the potential sale of the provider, prior to making their recommendation a three-year contract extension.

Because the November decision to extend the contract was made on the assumption that the commissioners would continue to deal with the same provider, with the same intentions and risk profile, BSW CCG and the council paused formal confirmation and notification of the extension

decision and commissioned an independent review of the implications of these changes to local services.

The content of this independent review highlighted uncertainties arising from the change in ownership of Virgin Care, including ongoing contractual and financial risks, which have been carefully considered by BSW CCG Governing Body and Bath & North East Somerset Council cabinet at meetings held on 26 May. Both have agreed not to extend the contract which will now end on 31 March 2024.

The decision was reached after carefully considering of all of the options available to, and to allow high quality services to continue to be provided that meet the needs of our local communities and ensure we make the best use of public money (including the Better Care Fund).

This decision offers an opportunity to create a new, exciting, and integrated model for health and social care services for local people and allows BSW CCG and Bath and North East Somerset Council the opportunity to commission these services at scale. It will enable us to continue to work in a joined-up way to make sure everyone has access to the care and treatment that is right for them, live in communities that help them to lead healthier lives and have access to integrated local and specialised services. This decision gives us an opportunity to redesign community services to focus even more on prevention and ensure residents get the support and care that is right for them. This decision has also presented an opportunity to explore integrating adult social care staff and third sector commissioning back into the council and work will continue throughout 2022/23 to further improve outcomes for residents.

A progress report is due to be presented to cabinet in September 2022. The report will show how we are looking to use exploratory design and discussion in the programme of work. There are 3 distinct programmes that are designed to ensure that recommendations made to cabinet can be made about the delivery model for B&NES and to allow safe transition of services as of 1st April 2024:

1. Programme for Council Insourcing with a heavy focus on transfer of services and responsibility of the statutory function of adult social care services.

2. Public heath are working to review interdependencies and to review the future commissioning framework to meet the needs of public health services.

3. Programme for heath and community health to make a recommendation for how services need to be delivered across adults and Children's health services as of 1st April 2024.

The impact of the termination of the HCRG reablement services contract on the Better Care Fund will be better understood through the development and progression of these bodies of work, and further information can be shared with regional BCF leads and detailed in the 2023/24 Better Care Fund narrative plan document.

6.0 Projects to assist with Patient Flow

A number of schemes that aim to aid patient flow through health and social care services have been initiated and funded by the Better Care Fund in 2022/23, some of which are new schemes for this year, and some are renewals of existing schemes, but all are aimed at helping to improve healthcare patient flow through our local hospitals.

6.1 Intermediate Care Team

Intermediate care is broadly defined as “a range of integrated services to promote fast recovery from illness, prevent unnecessary acute hospital admission and premature admission to the long-term residential care, support timely discharge and maximise independent living”.

Support from the Better Care Fund was secured in 2021/22 to commission a multidisciplinary ‘Intermediate Care Team’ on a pilot basis to assess and support people within B&NES care homes that are occupying intermediate beds. The pilot has been extended until March 2023 (at which point it may be extended further) to allow for the continuation of this service to help to ensure a smooth transition following hospital discharge through the onward journey of care provision, until the service user has completed their reablement journey, or a long-term package placement or package of care is sourced.

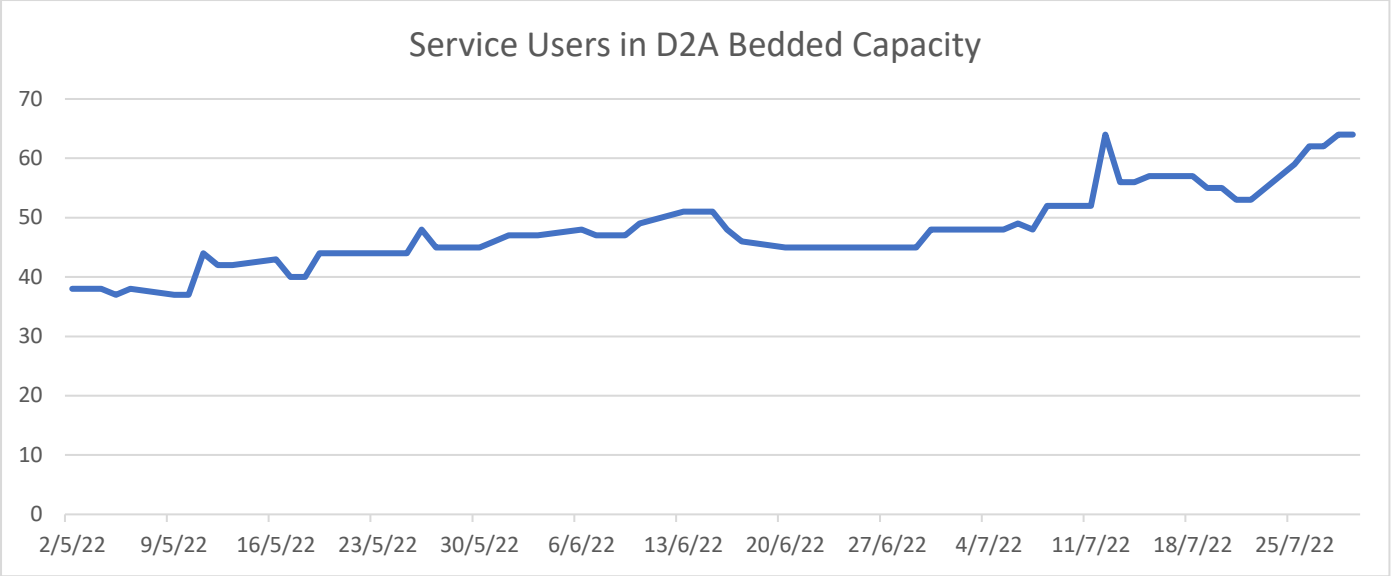
The team consists of a Physiotherapist, an Occupational Therapist and 2x Assistant Practitioners and recruitment is ongoing to source 2x Reablement Therapy Workers and an Activity Coordinator. Since the mobilisation of this team in September 2021, the team have been providing therapeutic support, and activity and case oversight of the cohort of service users in the Discharge to Assess bedded capacity, and through assessment and intervention have been able to:

- Increase the skills and abilities that support maximum independence for service users in the D2A bedded capacity.
- Provide reablement support and assistance to individuals on Pathway 1 and Pathway 2 to minimise their stay in D2A and to aid discharge on to their onward care pathway.
- Work proactively and in liaison with the Care Coordination Centre and multi-agency professionals to tackle, resolve, refer and take responsibility for all that needs to be done to get people home or on to their permanent future place of care. While in the beds the residents remain the responsibility of the Intermediate Care Team.
- To work together with the wider support and project teams to create caring and empowering experiences which enable people to move on to their permanent home

The team have been able to provide a greater level of support to allow patients that are discharged from acute settings into temporary beds in care homes within the locality, and to reduce the delays between admission and assessment, and to try to reduce the number of service users that are occupying these temporary beds.

The core objective has been and continued to be to ensure that nobody that is admitted into an intermediate bed remains there for longer than 42 days (6 weeks), and to ensure that they are progressed on to a pathway of care that is suitable for them at the earliest opportunity to aid their recovery.

Unfortunately, due to the unprecedented levels of people coming out of hospitals on through the Discharge to Assess pathway, over recent weeks, the number of service users occupying the D2A beds has increased significantly to levels that we have not seen before. Between mid May 2022 – July 2022, the number of people in B&NES D2A beds has increased from 38 to 64 (and continuing to increase), an increase of 59% in less than 12 weeks.



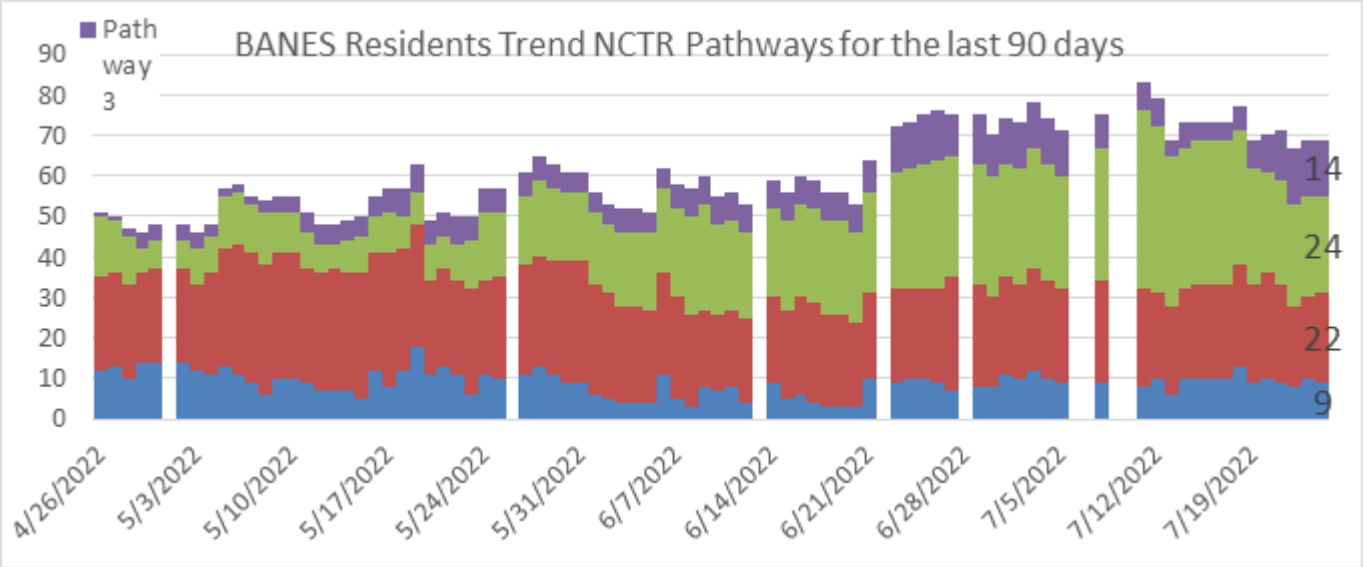
A robust project team has been supporting the provision of care across the wider D2A bedded capacity model, including the work that the Intermediate Care Team are doing, and regular project meetings have been established to work through case load and to identify areas of the health and social care system that are impacting on our ability to progress service users through the D2A experience as efficiently as possible. Regular reporting has been established and is shared with service leads to ensure that the right levels of support can be provided from a senior level through increased visibility of areas that are slowing progress.

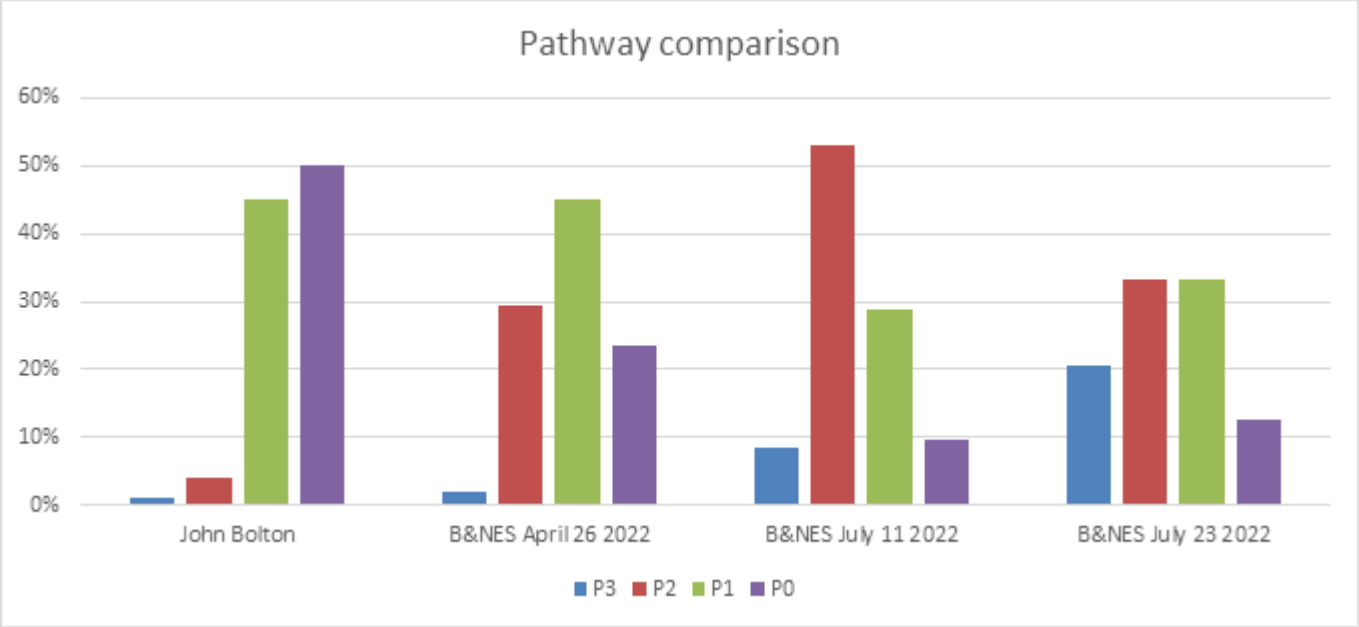
To assist with the increased levels of discharge that we are currently seeing, and to help to reduce the number of NCTR service users, a Pathways Escalation Team (PET) have been mobilised. The PET is outlined in further detail below but will work alongside the Intermediate Care Team to provide additional support to our service users in D2A bedded capacity (and who are receiving home care, see below).

6.2 Collaborative System Review Group

As Integrated Care Systems (ICS) have formed and developed systems to begin to 'live with Covid' there has been levels of unprecedented pressure on the health system. Data collection of 'non criteria to reside' (NCTR) within acute hospitals is showing extraordinary levels of pressure has received increased focus and scrutiny, and we are witnessing very high levels of delayed discharge which is negatively impacting on system flow. There is a system wide demand to reduce NCTR bed occupancy by 50%. At present (July 2022), BSW ICB and specifically B&NES ICB are not meeting the No Criteria to Reside (NCTR) target set by the UK Government. The number of people in hospitals that no longer meet the clinical criteria to remain there for inpatient care is exceeding the expected volume, particularly in relation to those people on Pathway 1 and 2.

Despite the mobilisation of a number of projects that should have been identified to help to reduce these numbers by moving people out of hospital that do not need to remain there, volumes have remained above the target rate that has been set, and this is predicted to remain due to on-going pressures presented by Covid-19 through the summer prior to anticipated winter pressures.





The charts above show how the number with NCTR has increased from Around 52 people to high point of 83 people in recent weeks.

The Pathways Escalation Team (PET) will be a joint enterprise between Bath and North East Somerset Council, HCRG Care Group, RUH and the BSW ICB, tasked with improving flow in out of the RUH Hospital in Bath by providing targeted support in areas where there are significant delays across all the Discharge Pathways. By releasing specialist knowledge from within the system, and working across boundaries, the Pathway Escalation Team (PET) will reduce the number of patients that do not have criteria to reside in hospital (people who no longer meet the clinical criteria to reside for inpatient care in hospital). The Pathway Escalation Team will identify inefficiencies within the existing system and process by having an overarching understanding of the whole system, rather than their specific field; particularly around where one service ends, and another starts.

6.3 Homeless Hospital Discharge Support

A proportion of the B&NES BCF funding id directed towards supporting homeless hospital discharge support. This year is year 2 of a provisional 2-year funding commitment that helps to fund 1.5 FTE workers at the RUH through an external partner, DHI (Developing Health and Independence) to prevent patients from being discharged from hospital in to homelessness or

rough sleeping. As experts in housing pathways and homelessness legislation, the team provides support and advocacy to broker discharge into suitable housing options. This prevents patients remaining in hospital for lengthy stays without clinical need. Linking patients with appropriate support for mental health and substance misuse needs reduces the likelihood of repeat-admissions.

The team work alongside colleagues from across the Royal United Hospital in Bath, supporting patients to manage challenging behaviour, to engage effectively with clinicians and to attend follow up appointments with relevant departments e.g., Liver Function and Hepatitis. Many patients have needs around substance misuse and mental health, and the team work closely with colleagues form the alcohol liaison service, DHI's treatment service and AWP mental health outreach teams. As regular attendees at the High Intensity User meeting the team uses their knowledge of community-based services to refer patients away from the hospital and into contact with appropriate community services.

The team provides regular training on the complexity of homelessness and in 2019-20 over 100 RUH colleagues including A&E staff, doctors and trainee nurses attended a course. The Homeless Hospital Discharge team is currently funded by via MHCLG's Rough Sleeping Initiative however this funding ends in March 2021 and has not yet been replaced.

Although our Curo Stepdown Provision (see section 6.4 Non-Recurrent Project Funding) does not directly provide support to those experiencing homelessness or are rough sleeping in the locality, the service outlined above provided by our partner DHI is helping to provide a high level of support to these individuals upon discharge to reduce repeat admissions and to provide links to the most suitable housing options to help reduce homelessness and rough sleeping in Bath and the surrounding areas.

6.4 Non-Recurrent Project Funding

At the start of the 2022/23 financial year, a small amount of BCF funding was identified as 'not committed' to support any existing project and was therefore available for use. In order to ensure that service areas had a fair opportunity to apply for this funding, a process was developed to allow recommendations to be made to the ICA and LCG (this was pre-BSW ICB).

Organisations across the B&NES health and social care sector were invited to apply for nonrecurrent project funding through submission of a high-level project plan. Applicants were advised to ensure that projects align to the Better Care Fund principles in order to meet initial application criteria.

27 projects totalling £8.9m were submitted and each project individually presented their application to the AODG panel across 3x separate 1-hour sessions. All AODG panel members and applicants were invited to rank applications in priority order by submitting a 'league table' style vote. Rankings were also correlated against the aforementioned 'No-Criteria to Reside' (NCTR) trajectory. Successful projects are detailed below:

- ***Home Care Provider D2A Block Contracts***
  A continuation of the block contracts, set up with three local providers, to supplement the reablement service provided by HCRG Care Group. Due to the difficulty in recruiting and retaining staff, HCRG required additional support to fulfil the reablement service, and at the time of the application for funding, B&NES had 775 hours of care provided by three providers in Bath and North East Somerset. This service has existed since December 2020 and had

agreed funding up until the end of 2022 Q1. The application for funding will allow the provision to be extended through 2022 Q2 – Q4.
This is deemed to be an essential service to support flow out of the hospitals into the reablement service. The aim will be to move this service back to HCRG once they have achieved sufficient recruitment, however this is unlikely to be completed before the end of the financial year.

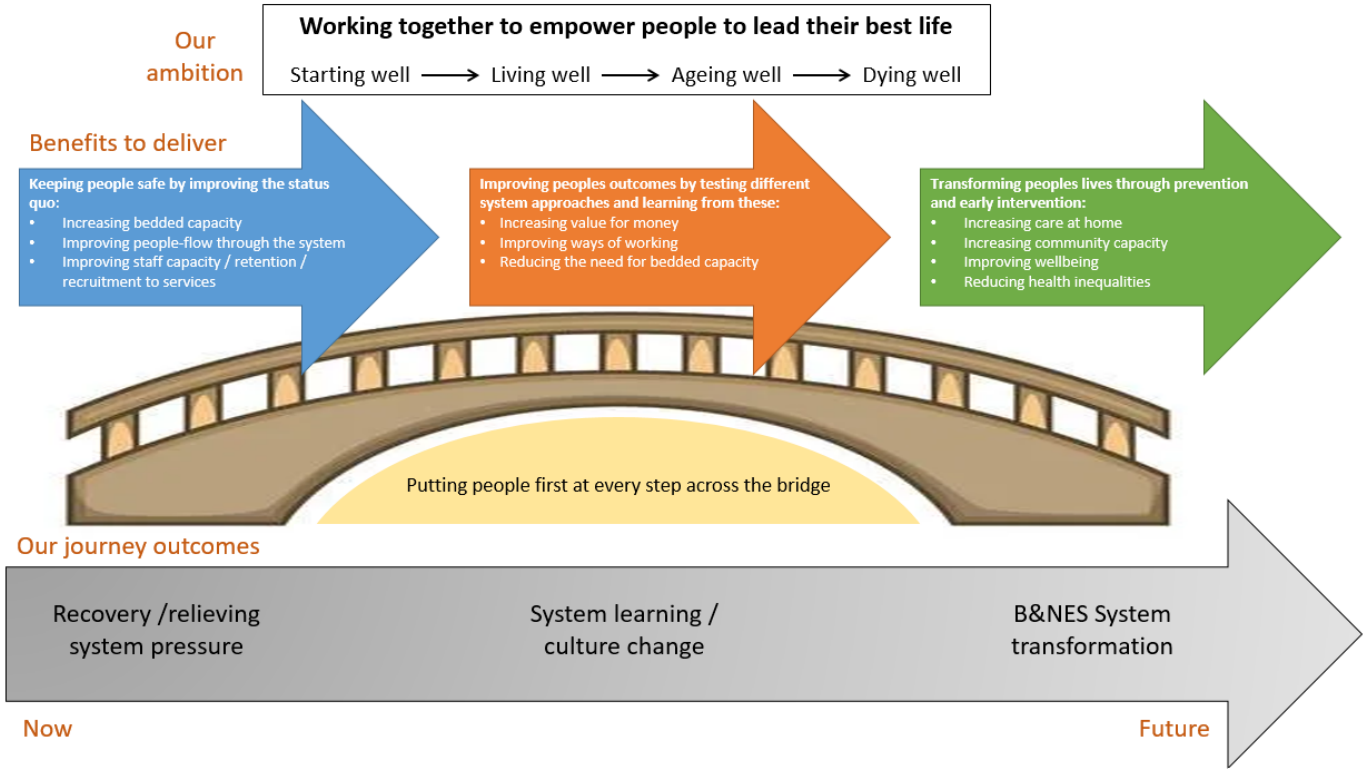
- ***Discharge to Assess Beds and GP Cover for Discharge to Assess beds in Care Homes***
Whilst most patients will be discharged from hospital to their homes, a very small proportion will need and benefit from short or long term residential, nursing home or hospice care as part of their journey along pathways 2 and 3. No-one should be discharged from hospital directly to a care home without the involvement of the local authority.
Pathway 0 and 1 (Home First) and the majority of pathway 2 is based upon the principle that the aim, where safe, is for all patients to be discharged home as soon as they no longer require care that can only be provided in an acute hospital setting. If patients are unable to return home, then P2 and P3 pathways should be followed and, there needs to be temporary bedded options to meet such needs and undertake assessments from health and social care.
This funding has been approved to support the provision of Pathway 2 and complex pathway 2. Reablement beds, are a bed-based provision offering support and care for patients who require further recovery, assessment and reablement of their long-term care needs with the support of 24-hour care or more than 30 dedicated care hours. This provision is specifically aimed at patients whose needs are unclear but are determined as likely requiring a home care package, residential or nursing Care. The recuperation and reablement will be provided by the Care home with the support of the Reablement service. The aim of which is to optimise independence and functioning and reduce long-term care needs.
This funding request will be for 30 SPOT contracted beds within B&NES care homes and 10 Block contracted beds at one of the B&NES owned and operated Community Resource Centres (CRC's).

- ***Extension of Stepdown Provision***
Stepdown is designed to support discharge from hospital for people with complex medical needs who no longer need to be in hospital but are unable to return home – it provides an interim placement until they are medically able to return home.

  It's a service that has been widely used successfully since 2011 and is different from traditional residential/nursing home beds as the service is set in a property akin to someone's home, which promotes independence. People are encouraged and supported to do things for themselves rather than having it done for them and ultimately resume a normal life within the community.
  Stepdown also helps to relieve pressure on the home care market, which we know is currently under immense pressure. Using stepdown as an option for people has shown that service users return home without a package of care or a reduced one and this supports the wider system.
  The extended Stepdown service has utilised an additional two of Curo's Sheltered units since the beginning of 2022 and provides an alternative to costly hospital or residential care for those being discharged and in need of rehabilitation, reducing the length of stay and the pressure on the system through limited access to beds.
  Over last 4 years the Stepdown service has saved 9464 NHS hospital bed days (including >900 mental health) which amounts in to over £2m saved in bed costs alone. Additional

preventative and enabling outcomes take social value to over £4m, including £298,745 in prevented readmissions.
This service delivers on the local BCF supporting the delivery locally of Theme 2 Improving the quality of people's lives, reduced rates of ill mental health.

Despite a rigorous voting process to determine which projects receive funding for 2022/23 (across a number of funding streams in addition to the Better Care Fund), the projects that were approved for funding support were all extensions of projects that were already operational. There is a recognition across B&NES Council and the BSW ICB that in order to move from a model that is helping people to get out of hospital, we need to support more transformation change to prevent people from having to go in to hospital. There are a range of projects that were submitted for funding consideration that did not get approved that will help us to transition towards this model, but due to limited available funding, they have not yet been mobilised. If additional funding can be secured as we progress through 2022/23, these transformational projects will help us to deliver more change through prevention and early intervention. The below diagram shows our ambition, benefits to deliver and journey outcomes that we hope to progress through:



7.0 Equality and Health Inequalities

A BSW Inequalities Strategy is currently being drafted, and this lays out plans to work in partnership to tackle inequalities across the life course to ensure that every resident of Bath, North East Somerset, Swindon and Wiltshire can live longer, healthier, happier lives. The plan outlines the following commitments to helping to achieve these objectives:

1. To make inequality everybody's business through awareness raising, training and engagement with partners and communities.

2. To tackle healthcare related inequalities by implementing the NHS Five Key Priorities:

- Restore service inclusively
- Mitigate against digital exclusion
- Ensure datasets are timely and complete
- Accelerate preventative programmes
- Leadership and accountability

3. Implementing the Core20PLUS5 programme. The programme focusses on the core 20% of most deprived areas PLUS communities at higher risk of inequality (e.g., those with black, Asian and minority ethnic backgrounds) focussing initially in five clinical areas:

1. CVD
2. Maternity
3. Respiratory
4. Cancer
5. Mental Health (including. children and young people)

Funding support is provided through the Better Care Fund towards the Mental Health Strategy that is aimed at supporting greater independence at home, supported living and specialist residential (mental health) to include Bath Mind, supported Independence, options for Living, St Mungo's and Arch Care as well as support for homeless and substance / alcohol misuse services. BCF funding is directed at a 2-year post to create a B&NES pathway of independent living for those with mental ill health, and to support the work of creating a partnership whole system solution in terms of mental health services.
The post will also support the creation of a B&NES local authority integrated, multi-disciplinary approach to support people of no fixed abode who also have mental ill health and substance and / or alcohol misuse issues through collaborative working with strategic partners and to influence bringing together any resources available to better support this group of people.
Although this funding will help to support one of the 5x clinical areas highlighted by the Core20PLUS5 programme, B&NES does recognise that there should be stronger integration with the other 4x clinical areas in future plans, particularly taking into consideration areas that can support system flow and out of hospital resilience, such as hypertension case finding or immunisations for those suffering COPD as part of the chronic respiratory approach. B&NES also recognise the need to better align with other BSW localities to support the wider system response to the system flow challenge, which will further enhance our response to the 5x clinical areas or the Core20Plus5 programme.

4. To focus on prevention, social, economic, and environmental factors.

The BSW Inequalities Strategy aims to provide a framework for system activity to reduce health inequalities. The strategy has been developed from key guidance and policy relating to reducing healthcare inequalities, as well as recognising the need for close partnership working with colleagues at a place level to address wider determinants of health. This strategy aims to address inequalities across the life course, to include pregnancy, children and young people, adults and into old age.

The B&NES oversight of the Better Care Fund integrates with this strategy by assessing each project that receives better care fund monetary support by conducting an EQIA Assessment (Equalities and Quality Impact Assessment). This assessment is designed to provide the project lead and the better care fund commissioning project manager with three key assessment templates that should be completed in the project scoping stage.

1.Quality Impact Assessment – This assessment helps the project lead to consider carefully, and to document and action any identified quality and safety concerns and start to consider any equality issues.

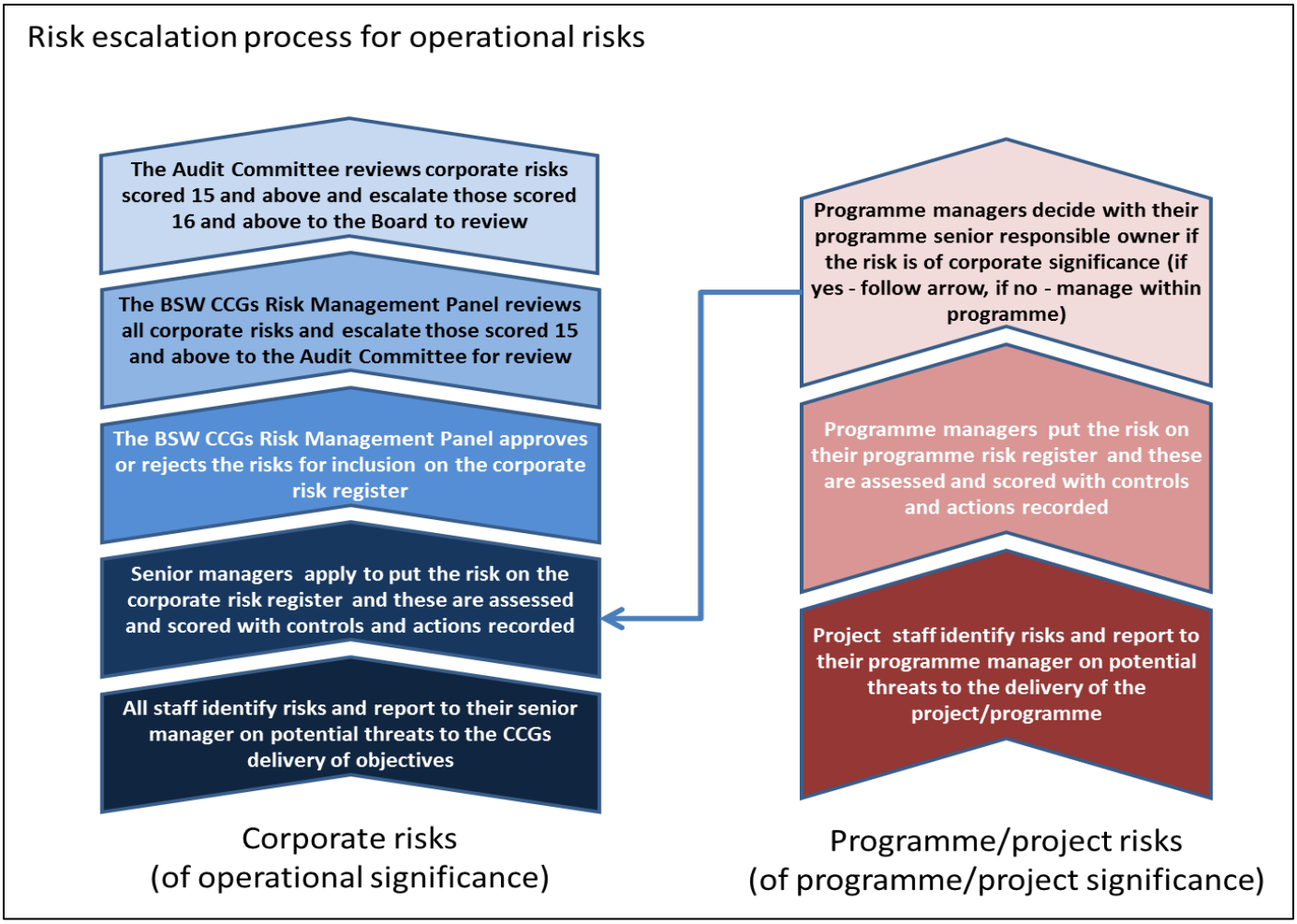
2. Equality Impact Assessment – An in-depth assessment to capture and document all equality and diversity assessments which must be completed for all significant changes to services, projects, or business planning.

3. Data Protection Impact Assessment – The project lead is asked to consider and document all Data Protection and GDPR requirements to reflect 'Privacy by Design'.

Each section is scored, and a total score is achieved by assessing the level of impact and the likelihood of each quality, equality and data protection issue identified, and then a total risk score is assigned to determine how each risk is managed and mitigated. Scoring is shown in the below table, along with action points for each score:

Programme or Project risks			
Level	**Ownership**	**Minimum authority**	**Action**
Low risk (1 to 8)	Senior Manager/ Programme Manager	Individuals	Individuals should manage low risks by maintaining routine procedures and taking proportionate action to implement any additional new control measures to reduce risk where possible. Risks must be entered onto the Programme/project risk register.
Moderate risk (9 to 15)	Senior Manager/ Programme Manager	Senior Managers	Senior Managers must prepare an action plan for high risks. Appropriate management assurance must evidence and control the risk and oversee the action plan to reduce the risk. Senior Managers must consider any developing implications of the risk and report to the Senior Responsible Owner if appropriate. Risks must be entered onto the Programme/project risk register.
High risk (16 to 25)	Senior Manager/ Programme Manager	Senior Managers	Management action is required to ensure immediate risk treatment, in line with the context of the risk. Senior Managers must consider any developing implications of the risk and report to the Senior Responsible Owner if appropriate. Risks must be entered onto the Programme/project risk register.

The following risk escalation process shows the course of action that each risk could take:



At this moment in time, B&NES acknowledge that due to the fast-moving pace of decisions for funding of 2022-2 projects that received new funding or extended funding of BCF monies, the EQIA tool is not being fully utilised as intended and that this exposes inequality risk. B&NS also recognises that as a local authority, we should be working with Public Health England to adopt the Health Equity Assessment Tool (HEAT) when reviewing new funding applications, in collaboration with the BSW ICA EQIA form to produce a combined assessment to drive continuous improvement in the work that we are doing to reduce health inequalities. This is an area that B&NES will look to improve upon as we progress through 2022-23 and beyond.

7.0 Other Priorities

7.1 Transformation of Community Services

The transformation of community services is a top priority within BSW with the following objectives:

• Building a comprehensive service model, with supporting infrastructure to support the BSW Care Model
• Supporting the resilience of core teams focused on delivering community-based care in people's homes
• Ensuring sufficient health and social care capacity to meet the demand for patient flow in a consistent and reliable manner

In a tactical context, we need to create the service capacity and resilience needed to provide responsive and effective community services and to support timely system flow. In a strategic context we need to drive forwards the delivery of our BSW Care Model and guide our recommissioning of community services needed across the locality over the next few years. Our approach to this recommissioning needs to address the expiry of our community service contracts in 2024 and will be undertaken in a manner that is consistent with the changes and opportunities introduced via the Health and Care Bill.

In order to drive forwards both our tactical and strategic changes, BSW will establish a system wide Community Services Transformation Programme. This programme will coordinate and oversee the various community services projects being undertaken across BSW, providing the support and resilience needed for successful implementation at scale. This approach will not seek to centralise all of the project activities, but rather to work with and coordinate resources in each of our three places to enable effective, and where appropriate, consistent delivery.

Our approach to transforming community services will be informed by our population health management analysis and our developing understanding of health inequalities across BSW.

7.2 Virtual Wards

Virtual Wards are intended to provide a safe and efficient alternative to the use of an NHS hospital bed, by supporting individuals to receive their care, assessment, monitoring, and treatment in the home or usual place of residence. Virtual wards can combine in-person care by a range of care staff supported by technology including a shared care record and remote monitoring.

Our virtual ward services will provide a range of interventions, tailored to the needs of individuals, to help prevent hospital admissions and to accelerate discharge from hospital.

Planning activity has focused on finalising an overarching agreed model of care, seeking to reduce reliance on individual schemes so that a sustainable and long-term solution is put in place. We have continued work to agree the system Community Transformation Programme scope and approach as a precursor for drawing up the detailed resourcing plans and timeline. We recognise that this programme needs to give shape and focus to an approach that encompasses virtual wards, solutions to non-criteria to reside challenges and the range of activities including our two-hour urgent community response that will support improvements in system flow as well as a shift towards earlier intervention and prevention. Wider system planning to ensure this work is done in a financially sustainable way, alongside driving forward elective recovery has meant that this process has taken slightly longer than anticipated. This will inform our BSW plan and trajectory to achieve the Long-Term Plan ambition of 400-500 virtual ward beds for our population.

The end-to-end pathway for the model we develop will be reviewed, ensuring there are exit strategies for people admitted to virtual wards so that flow is consistent. The Board will also support learning and sharing across our system, acting as other BSW Programme Boards in supporting the adoption of the BSW strategy and vision.

7.3 Two Hour Community Response

We are currently working om plans and actions to ensure that the provision of a 2 Hour Urgent Community Response is equitable across our system, with shared learning across our three placed-based, locality systems and more particularly advice and support from Wiltshire & Swindon colleagues to help accelerated progress in the B&NES locality. We are working with GPs and

SWAST to ensure that we have clear referral routes into the service. In addition, improved data capture through revised use of IT systems is also underway.

Currently, the Urgent Community Response (UCR) service accepts referrals from all services via the Care Coordination Centre (operated primarily by HCRG Care Group) and is available on the Directory of Services (DOS). B&NES, Swindon, and Wiltshire ICAs, with support of NHSE, are working together to access the ambulance services (SWAST) call stack to enable higher levels of referrals to the UCR so that greater admissions avoidance can be realised. UCR is currently accepting phone or electronic referrals from community, primary care, and acute settings, however, we still need to develop a process for electronic referrals from 111 without need for repeated information to be submitted.

The EoL community response teams respond within 2 hours within normal working hours, but Dorothy House is working up the out of hours response, ensuring EoL services align to the needs within the community.

7.4 Reducing Community Service Waiting Lists

The COVID pandemic and the related pause of some services has meant that community service waiting lists have increased in general across the locality, even though referral to treatment (RTT) targets for many services have been maintained. We do undertake regular triage of people waiting for treatment to ensure patient care is not compromised, and all patients deemed to be high risk are prioritised.

List validation activities are planned for all services prioritising those that are of particular concern regarding significant waits. Furthermore, in order to improve service effectiveness and productivity, localities will undertake a review of length of appointments and reduce time given (as appropriate) to encourage a greater through flow of people. This is also encouraged by using technology to support appointments with virtual calls for certain conditions.

Monitoring of lists is in place on an ongoing basis but there is more work to be done to join up monitoring and learning across the three localities. The aim would be to get to, and maintain, key targets by monitoring the following on a monthly basis:

- response times
- waiting list size
- PIFU utilisation
- digital/virtual appointment utilisation
- indicator for efficiency improvement (to be agreed).

8.0 Approval and Sign Off

This plan has been created in partnership with Bath and North East Somerset Council and the BSW ICB and will be formally signed off by the B&NES Alliance Delivery Operational Group (ADOG) as well as the BSW ICB and the Bath and North East Somerset Health and Wellbeing Board.

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