Bath & North East Somerset Council

NHS
Bath and North East Somerset, Swindon and Wiltshire
Clinical Commissioning Group

# Bath and North East Somerset Better Care Fund 2021 - 2022 Narrative Plan

Health and Wellbeing Board: Bath and North East Somerset

# Contents

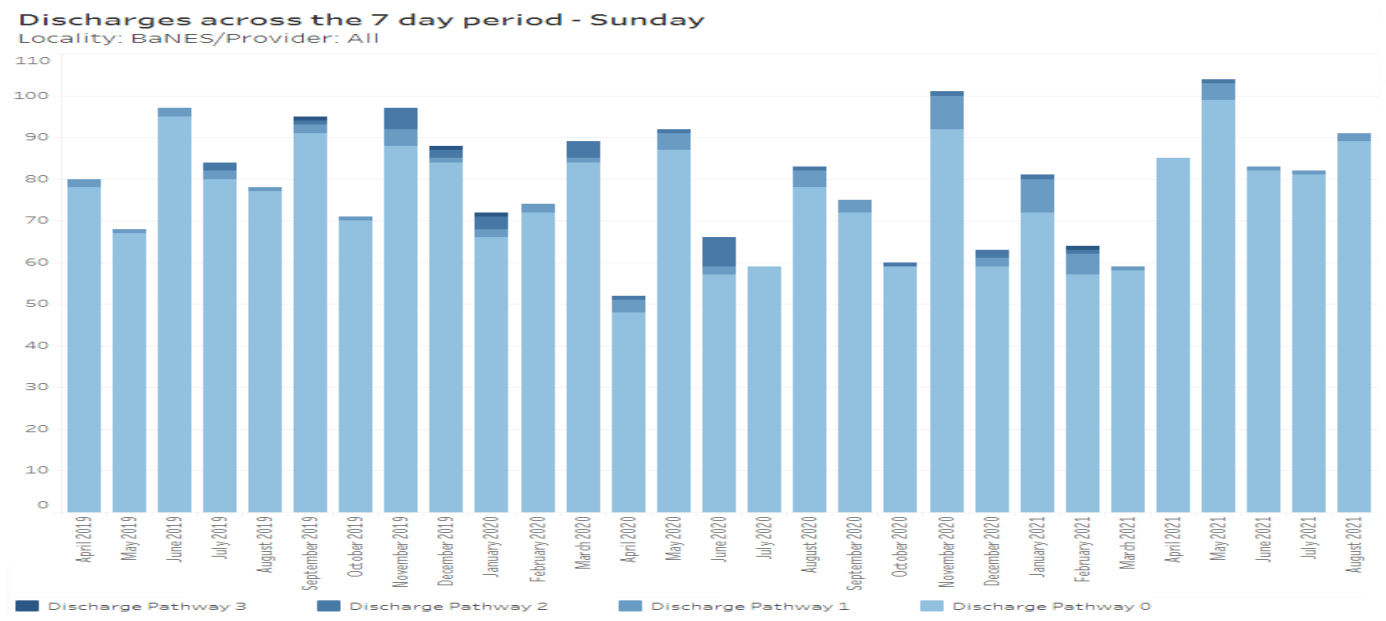
# 1.0 Executive Summary

Bath and North East Somerset Council and Bath and North East Somerset, Swindon & Wiltshire Clinical Commissioning Group (BSW) are proud to present the 2021/22 Better Care Fund plan.

This plan is built on the commitments and understanding set out in previous plans. Prior to the establishment of the Integrated Care system, we are not intending to set out new targets or goals, but will be building on our targets and aspirations around:

- Covid recovery
- Winter planning
- The development of the ICS/ICA in B&NES
- The on-going delivery of the B&NES Council Business plan as laid out in appendix one.

The specific focus is on urgent care and flow improvements in this year's plan, and a number of BCF funded projects have been commissioned this year to focus on this area, and the below really helps to illustrate the picture in this area since March 2021 and demonstrates that with continued focus, an upward trajectory could be maintained:




The continued focus on urgent care and flow improvements, is also evident in the winter plan has been carefully considered for 2021/22 and reflects a 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. This plan is owned by all members of the BSW Urgent Care and Flow Board and was presented and accepted at the 14th October 21 meeting in conjunction with our initial self-RAG assessment against the final national key lines of enquiry (KLOEs) that were published on 5th October 21, with final winter plan was approved at the BSW Oversight and Delivery Board on 22nd October 21. The plan pays particular attention to the following key lines of enquiry:

**EXTERNAL EVENTS**

Systems should consider both national and local factors beyond the immediate healthcare setting and how these have the potential to impact on the domains below. Systems may wish to use strategic planning techniques such as PESTLE analysis to support this. These events may be things that are unusual for this winter, such as the impact of covid-19 prevalence, or they may be routine winter challenges such as short term influxes/outfluxes of tourism, extreme weather events or routine movement of staff between sectors.

**DEMAND**

Systems should use sophisticated techniques to model expected demand on their services across the winter period. Such plans should consider a range of scenarios and be realistic around what is expected. Where providers do not have good history of accurate forecasting, additional analytical support should be considered as well as signposting to national planning tools.

**CAPACITY**

Systems should thoroughly review their available physical capacity including, but not limited to, inpatient spaces. Where the capacity available does not meet the predicted levels of demand, mitigating actions must be taken. Systems should also define thresholds at which capacity risks being overwhelmed and agree clear escalation procedures if these tolerances are met. Systems should also make sensible assessments of how IPC protocols will impact on available space looking to maximise digital solutions.

**WORKFORCE**

Systems should ensure that both clinical and non-clinical workforce levels are reviewed and aligned to the expected levels of demand and capacity. Steps must be taken to ensure all rosters are completed in good time and any workforce gaps mitigated as far as possible. Procedures should also be agreed to manage short notice sickness effectively to limit this impacting service delivery, this should include system-level interventions such as staff passporting and integrated working arrangements.

**EXIT FLOW**

Systems should review points of interaction between services and identify instances of friction. Where delays are identified, Systems must ensure approaches are in place to alleviate these and agreed between affected parties. Processes should ensure care pathways are optimised with only patients requiring an inpatient stay being admitted, and that discharge takes place promptly .

**REGION SPECIFIC REQUESTS**

There are an array of KLOE's that have been developed by the regional team for further assurance. These include –

- Ambulance – For SWAST to respond
- Mental Health
- Primary Care
- Acute Care
- IUC's
- Social and Community Care
- Incident Command Centre (ICC)
- Inclusion Health

The below table summarises the BSW Acute net bed position including the quantified winter initiative schemes with the aim to mitigate the modelled bed gap from the demand and capacity model outputs using Scenario 2 - which is based on **19/20 demand, 95% bed occupancy and escalation beds open.**

| BSW | Sep | Oct | Nov | Dec | Jan | Feb |
|---|---|---|---|---|---|---|
| Scenario 2 Acute Bed Gap- Pre-Covid (19/20) 95% Occupancy. Escalation open | -57 | -113 | -126 | -131 | -141 | -82 |

| Bed Impact of System Locality Initiatives | Sep | Oct | Nov | Dec | Jan | Feb |
|---|---|---|---|---|---|---|
| *Admission Demand Management* | 74 | 79 | 108 | 104 | 104 | 113 |
| *Internal Acute Provider Efficiency* | 0 | 3 | 7 | 12 | 14 | 14 |
| *Increasing Discharges/Flow* | 44 | 72 | 77 | 80 | 80 | 76 |
| Local Initiatives Grand Total (bed gap mitigated) | 118 | 154 | 192 | 197 | 198 | 204 |
| Net Acute Bed Position (scenario 2) | 61 | 41 | 66 | 66 | 57 | 122 |

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. 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 2021/22. This is also supported by a BSW Action Card initiative to support consistent messages and expectations across the system.

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 Locality Commissioning Group, which consists of representatives from the following areas:

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

This plan was approved by the Locality Commissioning Group on 4th November 2021 and will be presented to the Bath and North East Somerset Health and Wellbeing Board on 30th November for formal ratification.

In April 2020 the B&NES CCG merged with Swindon and Wiltshire CCGs to form BSW CCG and therefore we are beginning to align Better Care Fund planning with our colleagues at Swindon and Wiltshire councils, and conversations have started to ensure we move into a more collaborative approach to better care fund reporting and management. This has been particularly beneficial as we both Wiltshire and B&NES Council are discharging from the same hospital.

# 2.0 Programme Governance

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

- The Locality Commissioning Group (LCG)
    - Is 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 are presented to the Locality Commissioning Group for initial review and approval to progress to the Health and Wellbeing Board.

- 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 the Locality Commissioning Group and finally Health and Wellbeing Board.

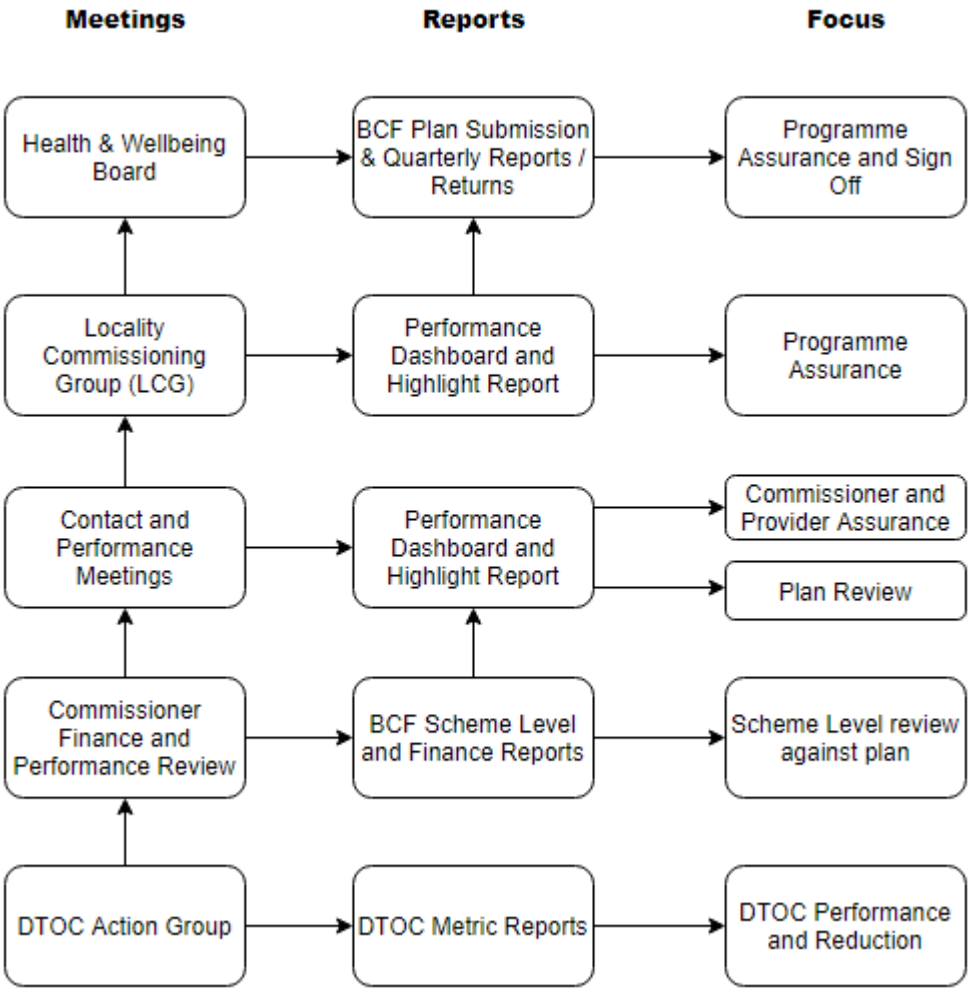
Upon final Health and Wellbeing Board approval, the scheme manager is notified of a successful funding application and advised of their reporting requirements. All schemes must provide regular reporting (quarterly) to the Bath and North East Somerset Better Care Fund Commissioning Project Manager to 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.

## 2.1 Specific BCF Schemes Monitoring and Governance

In terms of the specific schemes highlighted under the Better Care Fund plan 2021-22, monitoring will be undertaken within the CCG and 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. Additional reporting tools are under development and these will aim to further enhance the visibility and performance of all of the underlying B&NES BCF schemes.

Delivery of the schemes and performance will be addressed through Contract and Performance meetings with providers, with the key provider being Virgin Care.

Assurance of the overall delivery of the BCF will be monitored through the Locality Commissioning Group and Health and Wellbeing Board. 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, is overseen by the Locality Commissioning Group (LCG), which is constituted as a joint committee of the CCG and Council.

The governance and operational structures are underpinned by a Joint Working Framework, adopted by both the CCG 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 Joint Commissioning Committee (in place since October 2014) has been overtaken by the Locality Commissioning Group (LCG) instituted in April 2020 which further strengthens the governance of our joint commissioning arrangements. The CCG's Constitution and the People and Communities governance structure have been amended to allow this.

The LCG has 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.

The LCG is made up of a sub-committee of the CCG Governing Body and as well as a sub-group of the council's strategic leadership team and cabinet. As part of the new governance arrangements within the BSW Integrated Care System which will be on a statutory footing, subject to the health and care bill passing through Parliament, the place-based partnership arrangements for B&NES Integrated Care Alliance are likely to see the LCG transition into a Joint Committee with a partnership convenor (chair) and an executive lead appointment by the NHS Integrated Care Board and the local authority.

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 was signed off by the Health and Wellbeing Board on 6th September 2017. The Board is co-Chaired by a Cabinet Member and the B&NES Locality Clinical Chair for the CCG 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.

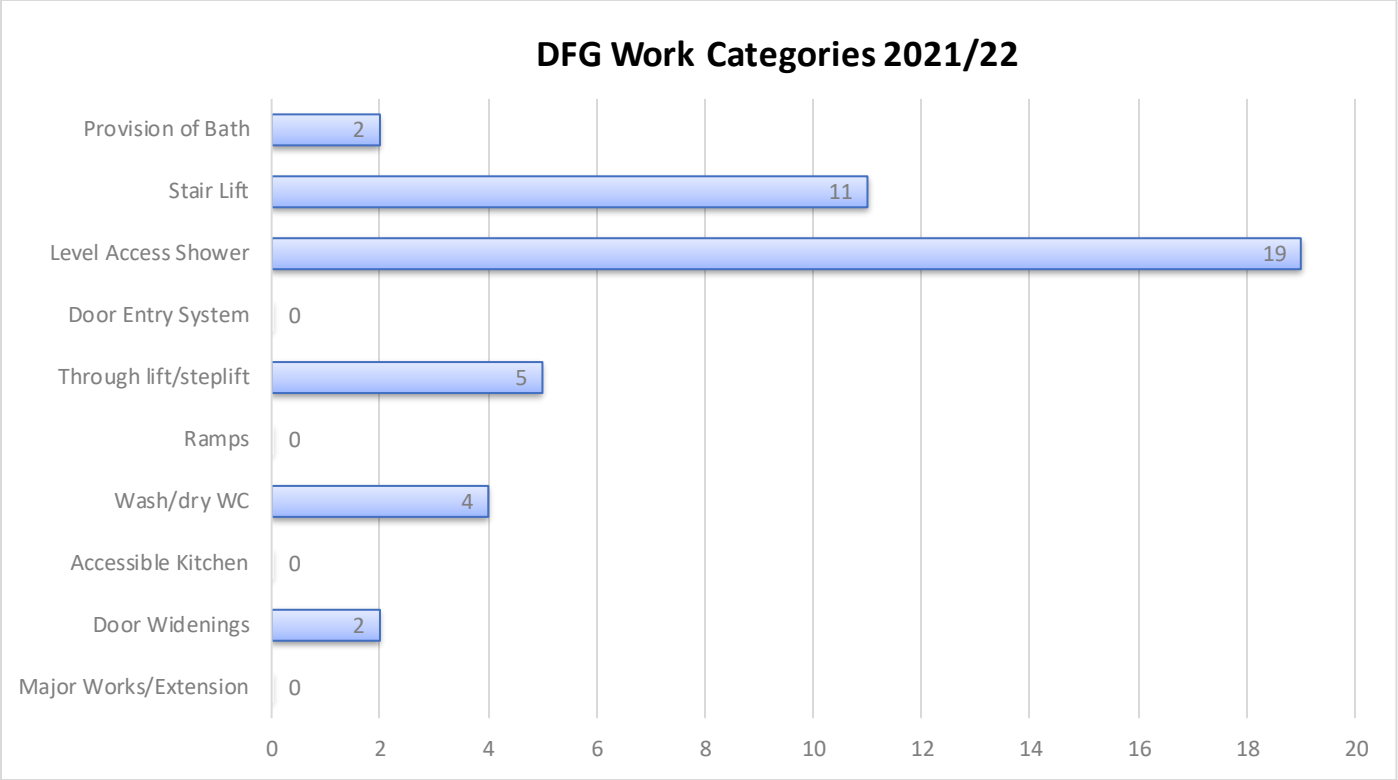
The iBCF grant determination for the iBCF was issued in May 2021. Since 2020-21, funding that was previously paid as a separate grant for managing winter pressures has been included as part of the iBCF grant but is not ringfenced for use in winter.

## 4.2 Disabled Facilities Grant (DFG) and wider services

Bath and North East Somerset Council was awarded £1,270,789 of Disabled Facilities Grant (DFG) funding in 2021/22, the same as in 2020/21 which was uplifted by £171,116 in December 2020.

The DFG allocation for the 2021/22 period has increased by 13.46% on the starting allocation for 2020/21.

The graph below shows the main uses for the Disabled Facilities Grant (DFG) in the first half of 2021/22.




This year's Better Care Fund Plan aims to see closer working between housing, health and care commissioners and regular liaison meetings have been established to evaluate the impact of DFGs and to strengthen the links between DFGs, Community Equipment services and Assistive Technology.

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, is helping 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 Virgin Care to ensure that technology offerings are complementary to the care homes

With a successful implementation of assisted technology into the home care packages we would expect to see:

1. return on investment (ROI) - this project has an invest to save element.

2. improved wellbeing for service users.

3. increased independence for service users.

4. service users being able to stay in their own home.

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

The 2021-22 BCF plan aims to maintain a consistent level of protection of social care with the BCF 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. In addition, H2 planning has been jointly developed by the CCG, Council, RUH and Virgin Care (our prime provider).

## 4.4 National Condition Three (CCG commissioned out of hospital services)

The minimum allocation for CCG commissioned out-of-hospital services for 2021/22 is £3,136,539, an increase of £157,870 (+5.03%) on 2020/21.

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 2021/22 is £632,165, an increase of £31,818 on 2020/21 (+5.3%).

It has been uplifted in line with NHSE inflation (105.3%). It has been retained by the CCG and forms part of the contract to pay the local acute provider if the non-elective reduction target is not met.

The 2021/22 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. The service is proving to be a highly valuable contribution to admission prevention:

| Data for 2020/21 (Pending new data for 2021/22) | Total |
|---|---|
| Average number of contacts per month | 129 |
| Average Face to Face visits per month | 113 |
| Average Telephone contacts per month | 31 |
| Attendances at A&E within 3 days of visit | 0 |
| Emergency Dept avoidance average per month | 114 |
| Community equipment issued after visit (avg per month) | 24 |

## 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:

- 2 New Block contracts for D2A beds
- An intermediate care/reablement team to support all D2A beds
- 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

These schemes are supported by BCF and H2 funding and a number are described in greater detail below.

## 5.0 COVID-19 Recovery Support from BCF

A number of schemes that aim to aid recovery in adult health and social care services following the outbreak of the COVID-19 pandemic have been initiated and funded by the Better Care Fund.

## 5.1 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 has been secured to commission a multidisciplinary 'Intermediate Care Team' to assess and support people within B&NES care homes that are occupying intermediate beds.

The team consists of a Physiotherapist, an Occupational Therapist and 2x Assistant Practitioners and will be expanded to also include 2x Care Coordinators and a Senior Administrator. The team will provide therapeutic support, activity and case oversight and will aim:

- To increase skills and abilities that support maximum independence
- To enable people to have a maximum stay of 42 days with an average of significantly shorter than this.
- To 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, Home, and intermediate team, to create caring and empowering experiences which enable people to move on to their permanent home

The team will aim 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.

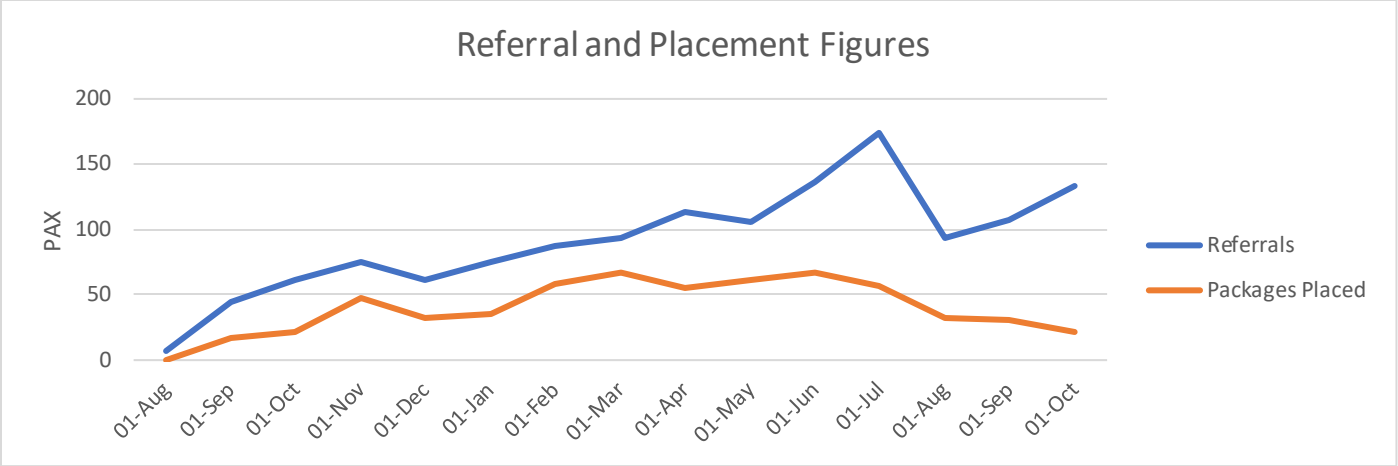
The core objective is to ensure that nobody that is admitted into an intermediate bed remains there for longer than 42 days (6 weeks), and to ensure that they are progressed on to a pathway of care that is suitable for them at the earliest opportunity to aid their recovery.

The team is initially operating on a 6-month pilot phase with monitoring of KPI's that will govern the performance and success of the team, and will also use patient feedback, largely based on the three conversations model to ensure that service users have an opportunity to express their views on the level of care and service that they have received from the care home and the intermediate care team.

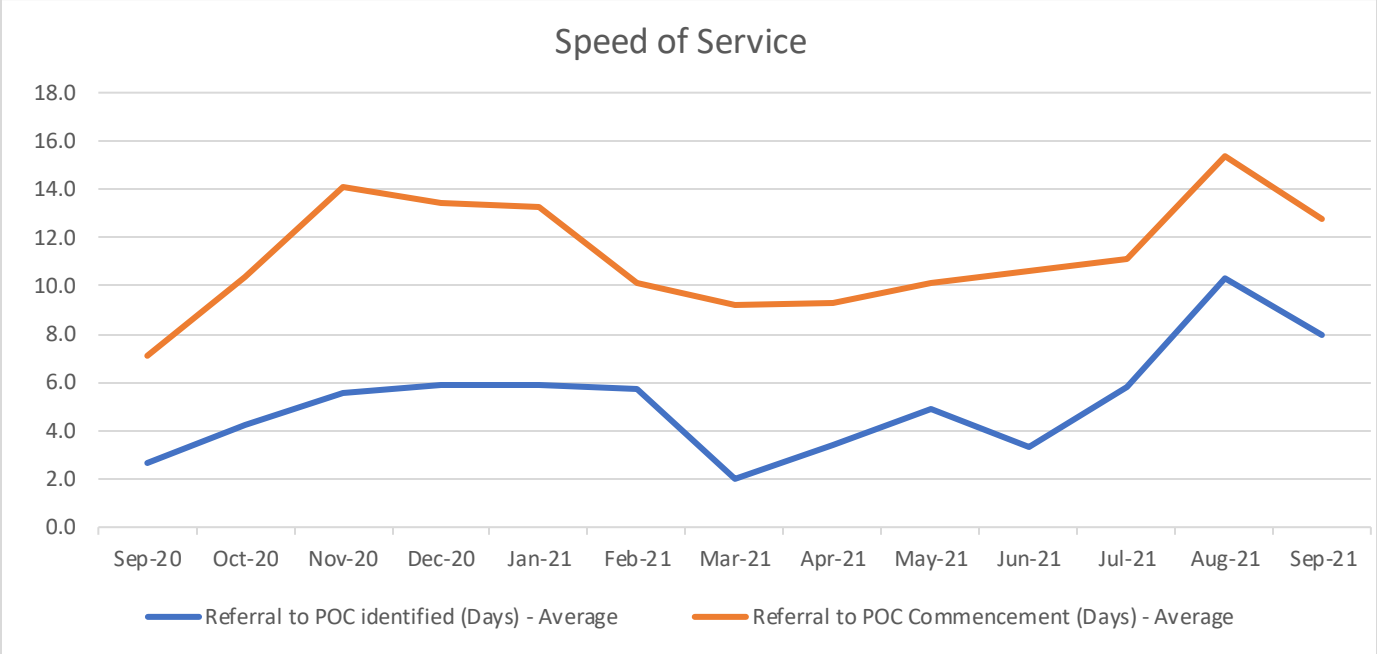
## 5.2 Care Home Beds with Royal United Hospital Bath

Due to the extraordinary pressures on the B&NES health and social care system the provision of intermediate care beds to support patients being discharged on pathway 1 and pathway 2 has been implemented.

Capacity issues that exist in the system are unfortunately impacting on the seed of service that brokerage is able to offer at this present time, and whilst the volume of referrals to brokerage have continued to rise throughout the 2021/22 period, the number of packages placed have remained fairly low in comparison:




This problem is compounded by the lack of available beds that exist within the B&NES locality, and both referral to identification of package of care and referral to commencement of package of care both peaked recently in August 2021 at 10.31 days (12-month average is 5.2 days) and 15.37 days (12-month average is 12.29 days):




As a balance to this we have invested in supporting people in care homes where there has been some marginal capacity. These new services capitalise on a previous arrangement with Virgin Care where a home was used to provide a temporary provision instead of community hospital. The use of the established Active Recovery Team Plus, ('ART+') service will collaborate to ensure timely discharge form this service back to home or place of residence.

This new arrangement seeks to strengthen relationships in the system and build on the work of the RUH's ART+ and Hospital at Home to further support flow. This is a pilot and will be closely monitored to review impact, outcomes and value for individuals benefitting from this provision and demonstrate clinical need and increasing outcomes for this patient group.

The RUH discharge team will have responsibility for deciding which service users are transferred to RUH Intermediate Care Block Beds following the Admission Criteria for RUH iBeds and will liaise directly with the care home provider to gain authorisation to enable this transfer to occur. There are currently significant risks that without system support for solutions the current P1 and P2 patient delays, the RUH Operational performance, Patient experience and Patient outcomes will be detrimentally impacted upon in winter 2021/22. Currently, there can be up to 70+ patients with non-criteria to Reside in acute RUH beds awaiting provision in the wider system. They average a wait of 5.9 days for Banes services P1 and 7.9 days for P2, during which they are at significant risk of poorer clinical outcomes, decreased patient experience and significant clinical risk of deconditioning and comorbidities and for the System, creating a significant acute bed and capacity loss to the RUH.

RUH will establish ART+ for P1 going forward and expand the ART+ service into 10 intermediate beds in Westin Care Home for Pathway 2 patients from the RUH in what will be known as RUH iBeds. For patients who require short-term recovery care prior to a move to; ART+ Pathway 1 service and move home, or direct discharge home P0. The initial proposal of expansion will run for 7 months from September 2021 until the end of the 2021/22 financial year.

## 5.3 Complex Discharge and Health Assessment Support

There is currently a significant gap in the specifications for community health services whereby no health service is specifically commissioned to provide a health needs assessment for determining joint funding. In addition, for those patients whose needs are not Social Care and who do not meet Continuing Health Care funding criteria but do need specialist health resource, there is currently no case management support.

This includes people who are receiving a package of care from Social Care and may require joint funding from Health to support their health needs.

Better Care Fund funding has been secured to allow recruitment into a band 6 Complex Care Coordinator role that should help to:

- Coordinate complex discharges for people who are discharged from specialist units or have requirements outside of the general Discharge to Assess Pathway.
- To provide a person-centred approach and ensure that people with complex health needs receive a high-quality service that meets their needs.
- plan discharges for these complex people much earlier due to the relationships built up with the specialist units and discharges from the Specialist units will be timelier which is cost effective for the CCG budget
- Provide more appropriate discharge destinations with follow on support to ensure that care is appropriate.
- Remove steps, processes, disagreements, and delays in the discharge process which consume valuable resources and do not add value for the patient.
- Reduce the risk associated with vulnerable patients remaining in a hospital environment or being admitted (during and post COVID period).

The Complex Health coordinator can support the Discharge to Assess model by arranging the discharge and coordinating the assessments required during the 6-week period for people with

complex health needs. These people could not be managed through the usual pathways of Reablement or Discharge to Assess Beds.

- When people are discharged from the specialist units, they do require a significant amount of discharge planning due to the complexity of their needs. It has been really beneficial to have one person coordinating and case managing as they do not align with the standard Discharge to Assess Pathways of Reablement or Discharge to Assess Beds.
- The Complex Health coordinator can ensure that these people receive the correct level of care and are moved onto the correct funding pathway as soon as possible. This will result in a cost saving for the CCG and Local Authority.
- Complex assessments take place within an environment familiar to the patient, it is 'context specific' and the patient's immediate and longer-term needs can be more appropriately evaluated.
- In some cases, issues which may have been developing for some time which precipitated an acute admission can be assessed and plans put in place while the patient is still able to be at home (so reducing admissions).

- Reduction in length of stay.

The main objective of this Better Care fund supported scheme is to reduce the overall length of stay, accelerate the freeing up of hospital beds reducing medical outliers, increase patient flow through various streams and improve the application of 'Joint Working'.

## 5.4 Occupational Therapy Support for DFG's

Following the Covid pandemic, there are a number of Occupational Therapy assessments waiting for extended periods of time for assessment for Disabled Facilities Grant (DFG) or larger items of equipment. The Occupational Therapists that are currently in post expressed concerns that the increased volume of moving and handling assessments that have been caused due to an increased number of people being supported at home, are leading to those waiting for assessment having to wait even longer as the moving and handling assessments are prioritised as urgent.

A new Occupational Therapist role has been created and funded by the Better Care Fund for the next 2 years to help to alleviate some of the pressure on the existing Occupational Therapists and to try to reduce delays to people waiting for assessment in the hope that it will lead to:

- An increased Number of Disabled Facilities Grant assessments completed per month
- An increased volume of completed assessments provided to Housing Colleagues.
- The creation of a new process to review the demand and supply on Social Care Occupational Therapist resources - closer working links with Housing, Curo etc

This role is required as there has been an increase in demand for manual handling assessments which take priority over other assessments. This role would only focus on the adaptations/DFG assessments, leading to a reduction in the time and number waiting and developing an improved process for the management of these assessments going forward.

## 5.5 Dynamic Home Care

Four carers that have been sourced from a Live-in Care Agency, along with a care coordinator, and are living in accommodation that is being rented by the care provider and charged back to Bath and North East Somerset Council and financed by Better Care fund money.

This provider would normally provide live-in care but are currently providing domiciliary care to service users who have completed their reablement. The hope is that this will ease pressures and increase flow from reablement.

## 5.6 Block Care Hours

Better Care Fund money is helping to fund a block contract of 200 hours per week for a care provider to provide 4 carers, totalling 50 hours per week.

The carers will come to Bath and stay in local accommodation, and they will provide a total of 200 hours of care a week to assist people on packages of care that are waiting to come out of reablement, with the core objective to ease some of the pressures that are currently on the reablement team and to increase flow through the system.

## 5.7 Trusted Assessor

Trusted assessors undertake pre-admission assessments for care homes and form the main link between care homes and hospitals. Better Care Fund money has been secured to fund the posts of 2x Trusted Assessors whose primary objective is to:

- Conduct Trusted Assessments (TA) on behalf of the Royal United Hospital Discharge to Assess (D2A) social work team/CITT referrals (Mental health patients) – These are Often complex patients requiring timely case coordination to facilitate discharge from the Royal United Hospital to nursing home/home/stepdown
- Conduct Trusted Assessments for the community hospitals (Paulton and Sulis)
- Conduct Trusted Assessments for the Priority 1 waiters in the community hospitals who are waiting for a package of care.
- Conduct Trusted Assessments for the Royal United Hospital intermediate beds for patients going into Westin Care Home.
- Conduct Trusted Assessments for residents being readmitted back into their care home after a period of hospitalisation.
- Conduct Trusted Assessments for some end-of-life patients.
- Support the B&NES Care Homes Commissioner with regular telephone calls to care homes within the locality to ensure KPI's are monitored and measured.
- Attend regular Multi-Disciplinary Team meetings community hospitals to facilitate flow and review patients to ensure they meet the Discharge to Assess criteria, or if further work can be done to facilitate a timely discharge
- Engage in regular flow calls to discuss reablement and community hospitals to discuss patient flow.

## 6.0 Equality and Health Inequalities

Bath and North East Somerset Council and the BSW CCG are developing plans and approaches to tackle equality and diversity in everything we do, whether that's commissioning services, employing people, developing policies, communicating with, or engaging local people in our work to ensure the right choices and decisions are made.

BSW ICS has a population of around 940,000 people and covers a wide geography containing rural and urban, affluent, and more deprived areas. We are committed to eliminating all forms of discrimination and providing equality of opportunity for everyone. We recognise and value the diversity of our communities and believe that equality is pivotal to the commissioning of modern, high quality health services.

The below set of principles have been drafted that outline the BSW strategy for equality and health inequalities:

1.We work to improve the health of our population through prevention of illness, early intervention and promoting independence through all stages of life

2.We are leading a determined drive to reduce health inequalities in all our communities

3.We work as one system without boundaries with parity of esteem between services

4.We make the best use of our combined available resources to deliver high quality care

5.We use shared evidence, listening and learning in order to design care around the individuals we serve.

6.We treat people at home or as close to home as possible.

7.We nurture a flexible and ambitious workforce

8.We maximise the use of digital technology to improve care and access to care while supporting those with limited access to technology

9.We make decisions as close as possible to those people they affect.

10.We are a learning system in everything we do.

## 7.0 Approval and Sign Off

This plan has been created in partnership with Bath and North East Somerset Council and the BSW CCG and formally signed off by the Bath and North East Somerset Locality Commissioning Group (LCG) as well as the Bath and North East Somerset Health and Wellbeing Board.

## 8.0 Appendix One

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Better Care Fund Pla