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 2023 - 2025 Narrative Plan

Health and Wellbeing Board: Bath and North East Somerset

Contents

1.0 Cover

Health and Wellbeing Board (s):
Bath and North East Somerset
Bodies involved strategically and operationally in preparing the plan: (Including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils:
Representatives from the following organisations have either directly input or been consulted on the content of this plan. - Bath and North East Somerset Council - Bath, Swindon and Wiltshire Integrated Care Board (BSW ICB) - Bath, Swindon and Wiltshire Integrated Care Alliance (BSW ICA) - Bath and North East Somerset Health and Wellbeing Board - HCRG Care Group - Royal United Hospital Bath - Avon and Wiltshire Partnership - 3SG The plan has been presented to a number of different governance forums that have wider representation from Acute Trusts, health and social care providers and voluntary community sector organisations who have been consulted on through input at these forums. The Bath and North East Somerset Council Chief Executive has been consulted on the contents of this plan. This plan will be presented to The Bath and North East Somerset Health and Wellbeing Board (HWB) at its next meeting on 20th June 2023, and the plan will be shared with the Chair of the Board in advance to allow an opportunity for direct input ahead of the board meeting. This 2023-25 Better Care Fund Narrative Plan builds on the priorities that have been previously agreed and overseen by the Bath and North East Somerset Health and Wellbeing Board and the BaNES Integrated Care Alliance outlines the progress that Bath and North East Somerset has made since the 2022-23 plan was written and approved.
How have you gone about involving these stakeholders?
The plans have either been discussed directly with the stakeholders, allowing them an opportunity to input, or presented at both formal and informal forums with wide stakeholder representation, consulting with a range of provider representatives. All existing schemes that are funded through the Better Care Fund are reported on and shared frequently, as part of performance monitoring and reporting to the Health and Well Being Board, the BaNES Integrated Care Alliance and ICB Programme Boards as appropriate (for example the Urgent Care and Flow Board). Our stakeholders are informed of any evolving Better Care Fund guidance through the Health and Wellbeing board meetings and Integrated Care Alliance to gain support for existing and new schemes.

2.0 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 Bath and North East Somerset Integrated Care Alliance (B&NES ICA):***
    - The ICA encompasses the Locality Commissioning Group (LCG). This arrangement replaces the LCG in 2022 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. They are now presented to the ICA and LCG who meet in common under the same agenda.
    - The BSW ICB as a new statutory organisation, has been in operation from 1st July 2022 responsible for meeting the health needs of the local population, managing the NHS budget allocated to the ICB and its ICA to arrange the provision of health services.
    - BSW ICB and B&NES ICA 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 is now known as 'BSW Together'.
    - All decisions taken to the Health and Wellbeing Board now go first to the ICA Board, this facilitates integration with both Council and ICS planning and that of the wider stakeholders.

- ***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 Integrated Care Boards 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 Integrated Care Board are presented to the Health and Wellbeing Board for ratification of the ICB decision to approve. Any challenges from the board must be addressed ahead of final ratification.

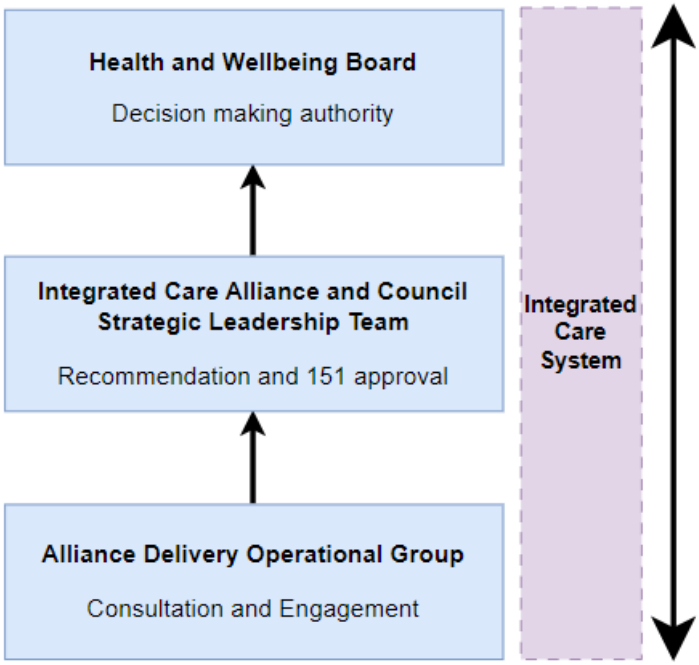
All new applications for Better Care Fund funding are reviewed by our BCF working group and senior leadership teams against the Better Care Fund national conditions and local priorities to ensure that they meet the criteria for funding. They are also reviewed collaboratively with colleagues from the quality team through the submission of an equality and quality impact assessment before being progressed through to the Alliance Delivery Operational Group (ADOG) who as act the steering group for the BANES ICA, their views are taken into consideration, and they give the first line recommendation. Any funding application that is recommended by ADOG will then be presented to the ICA and then the Health and Wellbeing Board for decision making.

The Alliance Delivery Operational Group (ADOG) also acts as an engagement and coproduction mechanism with the VCSE alliance in Bath and North East Somerset – the forum is represented by a range of partners across the VCSE and social care providers, as well as DFG and housing colleagues allowing for a broad range of discussion and input from key partners across the locality.

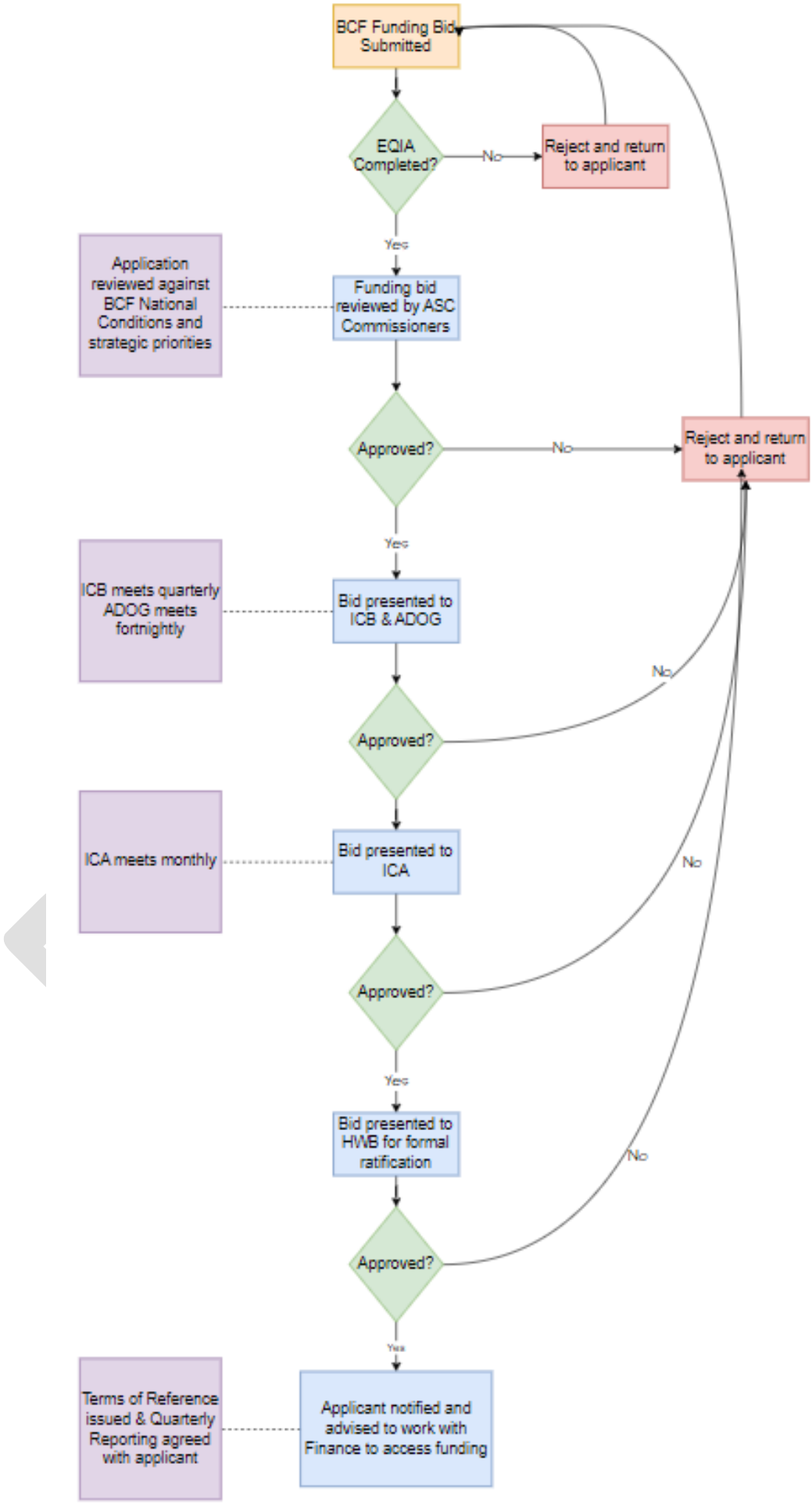
Upon final Health and Wellbeing Board approval, the scheme manager is notified of a successful funding application and advised of their reporting requirements. All schemes must provide regular reporting (quarterly) to the Bath and North East Somerset Better Care Fund Commissioning Project Manager to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

These quarterly checkpoints provide an opportunity to consider any potential project underspend and consult on any opportunities for redirection of funding. The quarterly return provides an opportunity to consult with the project lead and agree timescales for recruitment and planning and, where necessary, serve notice that the funding may be re-purposed in year if spend is not recorded within the agreed timescales.

The below infographic shows the relationship between the Alliance Delivery Operational Group, Integrated Care Alliance and the Health and Wellbeing Board, all of which are joined up in the overall Integrated Care Strategy.



The following process flow shows the Better Care Fund application journey from the point of application submission for a new Better Care Fund funding request through to approval by Health and Wellbeing Board, and highlights the review points that the application passes through (ICA/ICB & ADOG). Last year we took projects through as individual items, however this year a process was set out under a series of themes having reviewed current schemes under BCF priorities and those of the Council, ICA and Health and Wellbeing Board including reference to the Localities Inequalities Strategy. This is explored further in section 5.


BCF Funding Bid Submitted
EQIA Completed?
No
Reject and return to applicant
Yes
Application reviewed against BCF National Conditions and strategic priorities
Funding bid reviewed by ASC Commissioners
Approved?
No
Reject and return to applicant
Yes
ICB meets quarterly ADOG meets fortnightly
Bid presented to ICB & ADOG
No
Approved?
ICA meets monthly
Bid presented to ICA
No
Approved?
Yes
Bid presented to HWB for formal ratification
No
Approved?
Yes
Terms of Reference issued & Quarterly Reporting agreed with applicant
Applicant notified and advised to work with Finance to access funding

3.0 Executive Summary

This Bath and North East Somerset Council and Bath, Swindon and Wiltshire Integrated Care Board Better Care Fund Plan for 2023-25 seeks to deliver against the National Conditions of the Better Care Fund, including the Policy Objectives as set out in the Better Care Fund planning requirements that were published on 4th April 2023.

This document is to be read in conjunction with the Better Care Fund excel return templates as together, they provide confidence and assurance that Bath and North East Somerset Council and Bath and North East Somerset Integrated Care Alliance have:

- Jointly completed and agreed this Narrative Plan and Planning Templates
- Ensured that the NHS contribution to adult social care is being maintained in line with the uplift to NHS minimum contribution.
- Invested in NHS out of hospital services
- Implemented Better Care Fund policy objectives.

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 core objectives to *Enable people to stay well, safe and independent at home for longer,* and to *provide the right care in the right place at the right time*.

The 2023/25 Better Care Fund Plan focusses on:

- Improving discharge
- Reducing the pressure on urgent and emergency care and social care
- Supporting intermediate care
- Supporting unpaid carers
- Supporting housing adaptations
- Supporting the development of an ICA wide Technology Enabled Care Strategy and delivering the strategy at locality level.
- Supporting the transition of children to adults' services and support.

We have also changed our approach this year to reflect some key developments, including:

- The BCF 2yr commitment/plan
- The growing focus on discharge and Urgent care response directly through BCF and associated grants including ASC DG and Market Sustainability funds
- The Transformation of the Community Health and social care contractual arrangements (It's not a reablement service it's a community health service)
- The development of our thinking through our interpretation of the HICM model in the Home is Best Programme
- The significant progress we have made in the last 12 months on NCTR which has been supported by the HICM/Home is Best and the funding from BCF and the ASC DG.

A significant area of focus for 2023-25 will be to mobilise a number of projects, all of which will be funded by the Better Care Fund in full, or part funded by the Better Care Fund alongside other funding streams to improve discharge rates from acute settings in to intermediate care, therefore reducing the number of people in hospital settings with no-criteria to reside (NCTR) and improving elective care statistics. However, it is important to recognise that this is a huge challenge and will require the strength of co-production between a significant number of system partners to achieve

the desired results. Self-reflection will be integral to delivering the required outcomes through use of the High Impact Change Model (HICM) to address areas of development and self-improvement. The focus on urgent care and flow improvements within the HICM is a continuation of last year's priorities and is also evident in the winter plan which has been carefully considered for 2022/23. B&NES locality has made significant progress in 2022/3 reducing the number of people waiting to leave acute settings and this has been achieved by using BCF integrated funds alongside other non-recurrent funds to support discharge and intermediate care.

The coming two-year plan in B&NES will be influenced by the decision that was taken by the Council Cabinet and then CCG in May 2022 to not extend the Community Services contract for health and social care services with HCRG Care Group. This will present challenges through 2023-25 around contractual obligations of the prime contract (work carried out directly by HCRG Care Group) and the sub-contract schedule (work outsourced through the contract by HCRG Care Group to other community partners). Further details are presented on the impact of this decision and how we will work jointly on this, later in this narrative plan.

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.

It is also worth noting that at the time of writing this narrative plan, there are some uncertainties as decisions are still being made about the Transformation of the Community Health and social care contractual arrangements, which may particularly influence our plans for 2024/5 onwards (i.e., there are things we may need to be flexible and respond to)

It is also worth considering that the development of the Community Well-being Hub and the Technology strategy are our two stand out investments over the coming 2 years. Ensuing there is a clear balance to the discharge agenda about, prevention, admission avoidance, community resilience and neighbourhood working.

This programme working with BCF funded programmes has particularly galvanised system thinking around working together to consolidate and develop the workforce rather than each organisation competing for workforce.

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. The Inequalities strategy will be refreshed this year to reflect Core20PLUS5 and other locally determined priorities.

The BCF plan will be built upon the Health and Wellbeing strategy which has been renewed in 2023 and the Integrated Care Strategy published this year, alongside organisational plans from across the ICA system.

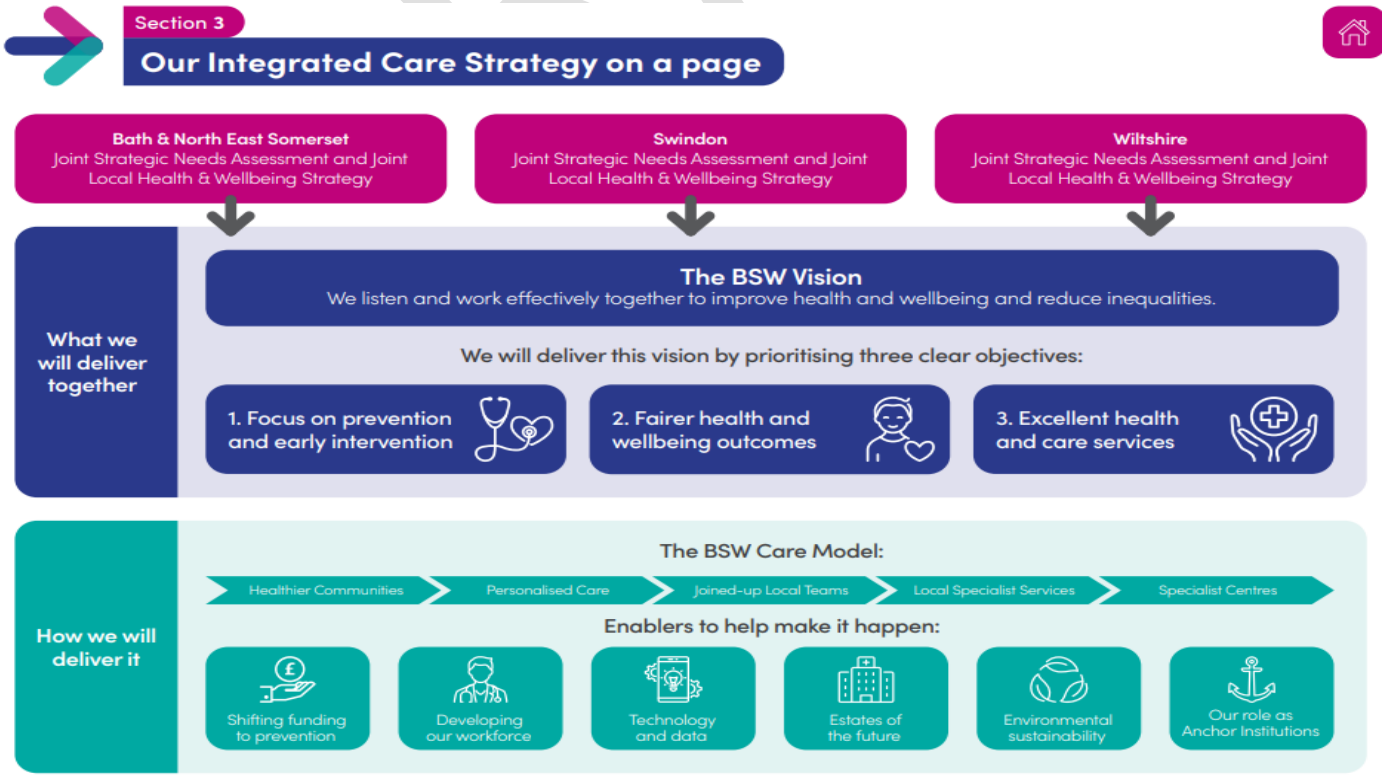
Bath and North East Somerset, Swindon and Wiltshire Integration

The 2023-25 Better Care Fund Narrative Plan outlines how the local authorities across Bath and North East Somerset, Swindon and Wiltshire, the NHS, the private sector, voluntary, community and social enterprise (VCSE) organisations and other partners can improve integrated working to help people in BSW to live healthier for longer through a range of jointly commissioned, co-produced services. Each place is developing their own Better Care Fund Narrative Plan to address needs set out in their joint strategic needs assessment, however Bath and North East Somerset, Swindon and Wiltshire have formed a strong, collaborative partnership and work closely together, drawing on the arrangements that are possible within the Integrated Care Board.

This B&NES BCF plan will be presented to the Bath and North East Somerset Health and Wellbeing Board for approval on 20th June 2023.

4.0 National Condition One

The Bath and North East Somerset, Swindon and Wiltshire Integrated Care System (BSW Together) have produced a 5-year strategy (2023 – 2028) setting out our ambition as partners in health, social care, voluntary and other sectors to support the people of BSW to live happier and healthier for longer. This is being adopted through the Health and Wellbeing board to create one narrative. A summary of the strategy is shown below:



The strategy sets out a number of ambitious objectives:

Focus on prevention and early intervention

We have a shared commitment across Bath and North East Somerset to ensure that people are able to stay healthier for longer – it unites all partners across BSW and is a key part of our rationale for how we work together.

Prevention and intervention is the most effective way to improve healthy life expectancy by creating the right conditions, communities and environments for children and adults to remain healthy, regardless of where they live in BSW. This will help to ensure individuals are able to live independently and are less reliant on health and care services. Our integrated care partnership will hold partners to account on whether we are putting prevention of physical and mental ill health at the heart of everything we do, and we will achieve this by focusing on the following key areas:

- **Focusing funding and resources on prevention rather than treatment**
  To improve the health and wellbeing of our residents, especially those living with disadvantages, we must seize the opportunity to focus our funding on activities that help to prevent people falling into ill health and wellbeing to begin with.

- **Intervening before ill-health occurs (primary prevention)**
  Through a focus on primary prevention, we aim to help enable individuals to prevent disease, injury or ill-health before it occurs. This is done by preventing exposures to hazards that cause disease or injury, helping people to avoid unhealthy or unsafe behaviours that can lead to disease or injury, and increasing resistance to disease or injury.

- **Identifying ill-health early (secondary prevention)**
  While we will focus on primary prevention to keep people healthier and happier, we also have an opportunity to ensure we detect ill-health as soon as possible. A focus on secondary prevention will be key for detecting and treating disease prior to the appearance of any symptoms.

- **Slowing or stopping disease progression (tertiary prevention)**
  We will provide comprehensive support to our residents who have an ongoing illness or injury that has lasting effects to help prevent their situation worsening.

Fairer health and wellbeing outcomes (adopting CORE20PLUS5)

The strategy that as part of our commitment to deliver fairer health outcomes we will reduce health inequalities across BSW. Health inequalities are defined as the systematic differences in health between groups of people. Differences in life expectancy, and health life expectancy, are one of the key measures of health inequality. A new approach to provision of services is needed to ensure that the services offered across BSW are delivered proportionately on the basis of need, with a scale and intensity that is proportionate to the level of disadvantage.

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement, and our commitment is to implement a CORE20PLUS5 approach across BSW

B&NES is proposing to adopt the Health Equity Assessment Tool (HEAT) to review the equality impacts for all our BCF funded programmes. We are planning a review of all our BCF funded programmes over the next two years, which will include reviewing leads for each programme and supporting them to undertake HEAT training. We will ensure that each programme has a HEAT assessment, which will form part of a suite of documentation which will also include robust logic models to clarify the logic between the actions we are taking and the outcomes we aim to improve. In addition to this, part of the HEAT assessment will include recommending metrics for the measurement framework (or segmenting existing metrics) which will demonstrate if BCF-funded schemes are closing the gaps on health inequalities. We will ensure that all relevant colleagues are supported to receive the HEAT assessment training where required, and complete the assessments, with BSW Academy and ICA support.

We also aim to adapt these to prompt users to focus on the BSW Inequalities Strategy of Swindon's "plus" groups, both for adults and for CYP. For example, drawing on both Core20Plus5 and CYP Core20Plus5.

Excellent health and care services

Over the coming years we will strive to deliver the 'Triple Aim' in how we provide services: better health and wellbeing, better quality of care, and financially sustainable and efficient services, and we aim to do this by focusing on:

- **Personalised Care**
  Personalised care is based on 'what matters' to people and their individual strengths and needs. In BSW, we have put it at the heart of our Care Model, and we will apply it to everything that we do in the future.

- **Joined-up local teams (Integrated Neighbourhood Teams)**
  Joined up local teams will be designed to serve communities in natural neighbourhoods across BSW. Forming these teams is an important element in developing sustainable health and care services. In BaNES this will involve using an asset-based approach and a population health management approach to meeting the broader needs of our communities, to focus on prevention, and to address wider determinants of health.

- **Responsive local specialist services**
  We will aim to deliver services as effectively close to people's homes as possible, ensuring they are responsive to individuals' needs.

- **High quality specialist centres**
  Our hospitals and other specialist facilities play a critical role in the provision of services to individuals with urgent, long-term, and elective health care needs. Through the work of our Acute Hospitals Alliance (AHA), which involves the organisations that run the Great Western Hospital in Swindon, the Royal United Hospital in Bath and Salisbury District Hospital colleagues are working together to improve the way services are delivered.

- **Mental health and parity of esteem**
  We know that mental health conditions have been rising across BSW, with mental health worsening due to factors such as the Covid-19 pandemic and cost of living crisis. We also know that many individuals have struggled to access the support they need when they need it. We will therefore put improving mental health and the principle of 'parity of esteem' at the heart of our efforts to improve health and care services over the coming years.

  BSW Integrated Care plan highlights 4 key areas for activity linked to the Long term Plan of:

- Emotional Wellbeing and Mental health
- Focus on prevention and to reduce out of area placements
- Case management and early third sector support and intervention and prevention
- Third sector support to work with people in own homes.

These objectives highlight our joint working priorities over the coming years (2023-2028) and demonstrates our approach to collaborative working, embedding integrated, person centred health and social care into the services that we commission.

4.1 National Condition Two

Enabling People to stay well, safe, and independent at home for longer

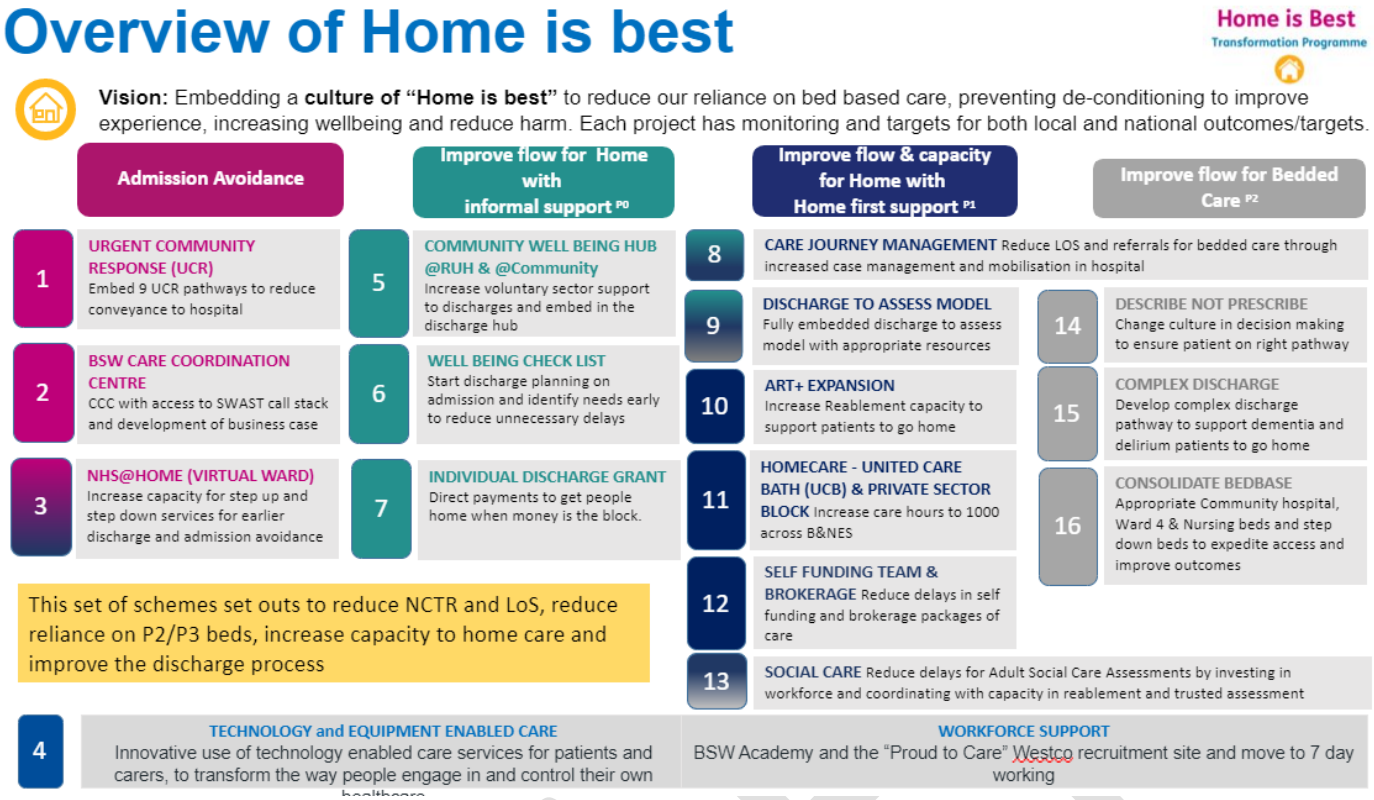
Bath and North East Somerset have commissioned a number of initiatives to enable people to stay well, safe and independent at home for longer, and many of these initiatives sit underneath the 'Home is Best' programme. The programme is the ICA's approach to outworking the strategic objectives above.

Home is Best Programme

The Home is Best programme has been initiated to ensure that we are embedding a culture of "Home is best" to reduce our reliance on bed-based care, preventing de-conditioning to improve experience, increasing wellbeing and reduce harm by focussing on the following areas of activity:

- Deliver and develop an efficient system of flow
- Meet national targets and guidance in relation to urgent care and flow
- Monitor and oversee key changes
- Act as a coordination point for the operation of the ICA supporting flow, discharge, urgent community response, virtual wards, intermediate and community recovery services

This jointly commissioned programme is broken down into a number of different work-streams as illustrated below:



The Home is best programme has a wide range of activities some but not all of which are funded via BCF. Some of the programmes are described below:

Social Work

Funding to support getting the social care voice in the Care Coordination Centre. Social workers will be in the hospitals to support hospital discharges by recruitment of additional social work capacity via HCRG CG. This will support the decision-making process and reduce the backlog of care act assessments in order to accelerate/enable reduced length of stay, more discharges from D2A/intermediate beds and reduce reliance on bedded capacity, moving to the home is best model. Care Journey Coordinators.

These are new roles (hosted by HCRG CG) that will provide dedicated resource to support people through their discharge journey from hospital into the community by supporting people back home. This role will form part of the RUH and HCRG discharge team supporting people across Bath and North East Somerset. The role holders will work under the supervision of the Care Coordination Centre Lead and will work closely with the hospital discharge team and Community HCRG Care Group services alongside both social care and voluntary providers to oversee short term care by ensuring that what should happen to a service user as part of their care journey does actually happen to them whilst in reablement to support with their journey home and reduce their overall length of stay.

Urgent and Interim Plan

Development of a method of being able to move people with care needs on from reablement and away from hospital until they have had their care act assessment, providing oversight and case management as an interim mechanism whilst assisting urgent care response and admission avoidance.

Technology Enabled Care in Bath and North East Somerset

Bath and North East Somerset recognise the importance of integrating technology in to our longer terms strategy to enable people to stay well, safe and independent at home for longer and through use of the Better Care Fund will be devising a 3-year strategy to devise a more effective technology enabled care provision. We understand that technology-enabled care can keep older adults safe and connected, help them manage their health and wellness, and provide support that enables them to stay independent at home for longer. We will be exploring areas such as:

- Remote Monitoring: With the help of sensors, cameras, and wearable devices, healthcare professionals can remotely monitor the health of people who need support to live independently. This includes tracking their vital signs, detecting falls and informing their family or caregivers about any concerning trends, making it possible for them to intervene in time.
- Communication and social interaction: Communication apps and other social media technologies can help older people stay connected with their families and friends, reducing feelings of isolation and loneliness.
- Medication and health reminders: Smartphones, voice-activated assistants, and other technologies can remind people to take their medication on time, monitor vital signs, and track health data.
- Home Automation: Technology can automate various functions of the home, such as the lighting and heating systems. This can help seniors stay safe and comfortable while reducing energy costs.

Through the development and integration of an integrated technology enabled care strategy, we strongly believe that we can improve the wellbeing of individuals and ensure that they remain independent at home for a longer period of time, contributing to our wider admission avoidance and prevention goals.

Night Care

A service which will deliver care to service users overnight, meaning that they can return home rather than requiring a care home placement. This aims to reduce overall usage of care home beds, thereby increasing utilising of domiciliary care capacity and lowering overall costs. Each “team” of two care workers will cost approximately £2,500 to £3,000 and will aim to service between 6 and 10 service users per night, however the cost of care homes is so great that by providing care to at least 6 service users in their own home, we will “break even” thanks to the avoidance of using a care home placement. Service will be available to service users in all funding streams – initially reablement, with the hoping of reducing overnight needs with the help of technology and equipment. If service users also require long-term care needs, this can be provided through the block in a chargeable social care package. This service will also mitigate the need for “Waking Night” packages which can cost in excess of £1,400 per week per service user. The service will commence as a six-month pilot with one provider, who will provide 2 “teams”. We will closely monitor utilisation and if demand increases, we can expand the service significantly to 5+ teams. If additional teams are required than the chosen agency can provide, we can commission further providers to support.

Domiciliary Care – Large Packages

Providers will be commissioned to deliver large packages of reabling care in the locality, where support is required for 12+ hours per day. This is part of the complex pathway where a high level of support is required for several weeks, but then quickly reduces down once they are settled in their home. They will then be discharged from the complex pathway and new clients enter the service. We have had four providers show interest thus far, and can expect anywhere from 2-4 care workers

per provider, meaning we could have up to 16 care workers available to provide large packages of reablement care.

This will be done as a six-month pilot initially but has the potential to grow depending on the demand required in the Complex Pathway. Initial estimates put the cost at around £1,600 per care worker per week, however the aim is that after several weeks, their needs have significantly reduced and their long-term package will be much smaller had they not had the initial support, or gone into a care home instead, thus improving outcomes and independence for B&NES residents. It will ensure that wherever possible people can follow a Pathway one discharge rather than Pathway two even if they have high care needs in line with the John Bolton modelling[1].

As an example, £1,600 for two weeks followed by a £500 four visit package, is much cheaper in the long run compared to an ongoing £900 per week care home package. This is supporting the protection of adult social care ensuring that care costs and options are commensurate and proportional to need.

Other Initiatives which support National Condition 2

Falls Rapid Response Team

The Bath and North East Somerset Better Care Fund continues to support the Falls Rapid Response Team as it has done since 2017, providing an urgent response to fallers within the locality. Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and over have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falls are estimated to cost the NHS more than £2.3 billion per year, and the service aims to deliver against the following objectives from the NHS Outcomes Framework:

- Preventing People from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people to recover from episodes of ill-health following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

The commissioned Falls Rapid Response team (using the Rapid Response Care, supporting SWAST) respond to people who have experienced a fall and the service offers a rapid response pick-up, comprehensive assessment, and intervention via referrals to community services. The primary aims of this service are:

- To avoid A&E attendance and hospital admissions
- Reduce the risk of further falls that could result in more serious injury or admission to hospital.
- Support independence and safety at home by assessing patients in their usual environment.
- Ensure seamless care with urgent care and community resources.
- Upskill SWASFT clinicians, Occupational Therapists, Physiotherapists and support the promotion of the falls pathway.

Support to unpaid Carers

The Carers Centre in B&NES is funded through the Better Care Fund via the contractual payment to HCRG Care Group. This service supports young carers aged 5 – 16 years and adult carers aged

[1] https://www.local.gov.uk/publications/developing-capacity-and-demand-model-out-hospital-care

17+. Currently, the youngest carer that this service is supporting is 5 years old, and the oldest carer receiving support is 93.

The Carers Centre provides a range of support services to support unpaid carers to ensure that:

- Unpaid carers have improved physical health and emotional wellbeing
- Unpaid carers are better able to manage the impact of caring
- Unpaid carers are better able to have a life alongside caring
- People living in Bath and North East Somerset understand the needs of local unpaid carers.

At the end of Q3 2022-23 (the latest available data at the time of writing this narrative plan), 495 out of the annual target of 700new carers have been integrated in to the service, and 96% of carers are contacted within 3 days of the referral. The majority of new carers accessing support are caring for those with Dementia/cognitive , physical needs and children with disabilities/care needs are the top 3 cared for person's needs.

Support is provided through a number of different methods, including:

- Providing information, advice, support, and wellbeing activities that directly benefit carers in Bath and North East Somerset
- Working with professionals; including schools to raise awareness if Young Carers and how to support them.
- Raising public awareness and understanding of the needs of carers in Bath and North East Somerset
- Digital transformation – virtual carers centre available 24/7

The service is available through the following channels:

- **Support: Young Carers Service** (Statutory Needs Assessments / 1-1 support / facilitating counselling when needed.)
- **Adult Carers Service** (Helpline – 1-1 information advice and support. Support planning / Emergency planning / Employment Support/ facilitate counselling when needed) Help carers apply for grants.
- **Recognition and Value** (**Adults:** Dementia Challenge - supporting carers during the hospital discharge process / Professional and community relationship development.
- **Wellbeing Services** Carers Cafes / Trips / Coping with Caring Courses/
- **Young Carers:** Group activities/ trips / residential / Workforce development – provide training / Schools conference/ learning experiences)
- **Participation** Give Carers a Voice internally and externally in the wider health care system. **(Adults:** Carers Voice / **Young Carers:** Creative Voices) In an example of excellent co-production, Young Carers, The Carers Centre, and BANES Council produced the BANES Young Carers Strategy
- **Digital Transformation:** Communications: Caretime magazine, Chill young carers newsletter and professionals e-news / Campaigns focussing on the issues that matter to unpaid carers. Supported national Carers campaigns to raise awareness of key issues / digital innovation e.g., Website and CRM Development which enables online referrals, with the capability to integrated with wider digital developments, e.g., Integrated Care Records / Digital infrastructure support – Information advice and support + wellbeing activities accessible 24/7

Minor Adaptations Service

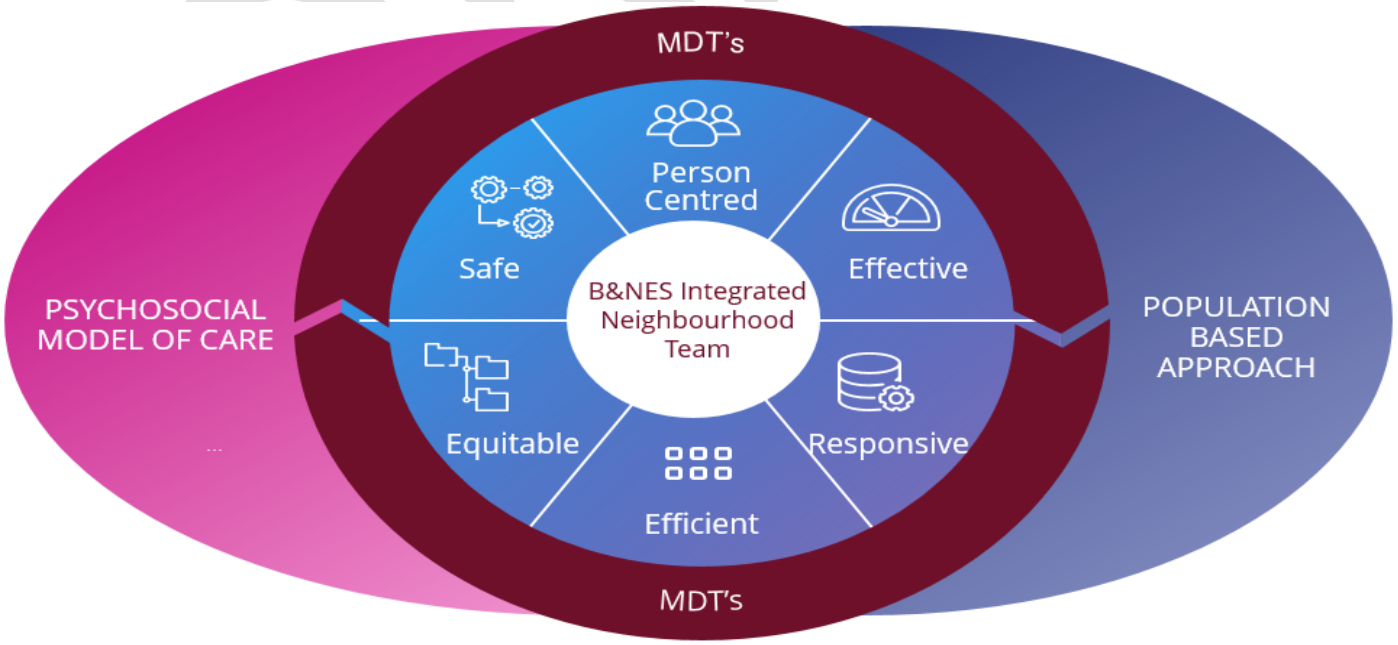
Minor Adaptations are adaptations to the fabric of an individual's dwelling that aid independence and mobility and include items such as grab rails, stair rails and key-safes. Such provision is covered by the Care Act 2014, with a specific requirement to ensure individuals can access such adaptations free of charge (up to a maximum cost of £1,000).

The service has been provided by We Care Home Improvements (WECHI) since 2016, however the contract is expiring, and a detailed options appraisal will be prepared and presented in June 2023. This will explore procurement versus in house provision. It is of note that approximately 90% of individuals who require minor adaptations are already in receipt of community equipment and therefore in house provision via alignment with the community equipment service could offer improved service user experience, economies of scale, efficiencies, and value for money.

Integrated Neighbourhood Teams

We have recently developed a Bath and North East Somerset Task and Finish Group for Integrated Neighbourhood Teams, which is attended by a range of partners and reports to the Bath and Northeast Somerset Integrated Care Alliance. Over the course of the next twelve months, this task and finish group will:

- Co-create a blueprint for the BaNES collaborative approach and Integrated Neighbourhood team model. This will include mapping of our current resources and community assets. Understand any gaps in resourcing.
- Create an INT Maturity Matrix and associated outcome measures to enable teams to develop INT ways of working (by July 2023).
- Collaborate with Community Frailty 12-month pilot to trial INT approach to working with two PCNs in B&NES (by May 2023)
- Identify at least 4 other teams and services - working with different scales of geography, population need, range of providers - to test the Maturity Matrix and outcome measures (Between August and October 2023)



- Evolve the BaNES INT T&F Group into a Steering Group to oversee and assure the progress against agreed programme timescales (by September 2023) .

Demand and Capacity for Intermediate Care to support people in the community

Demand and capacity estimates are still under development. The plan will be based upon the modelling carried out at a system level for 22/23 planning.

How BCF Funded Activity will support National Condition 2

Unplanned admissions to hospital for chronic ambulatory care sensitive conditions

We know that unplanned admissions to hospital are not only costly, but also unpleasant experiences for the individual, and that through continued investment we may be able to influence the number of unplanned visits to hospital for chronic ambulatory care sensitive conditions.

Overall, rates of emergency admissions are highest for falls, non-specific chest pan and non-specific abdominal pain, and we are seeing rising cases of emergency admissions for falls, cellulitis, urinary tract infections, COPD and acute mental health crisis, but decreased for angina and non-specific chest pain.

We are continuing to invest in our Falls Response service through BCF investment, providing an urgent response to fallers within the locality. Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and over have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falls are estimated to cost the NHS more than £2.3 billion per year, and the service aims to deliver against the following objectives from the NHS Outcomes Framework:

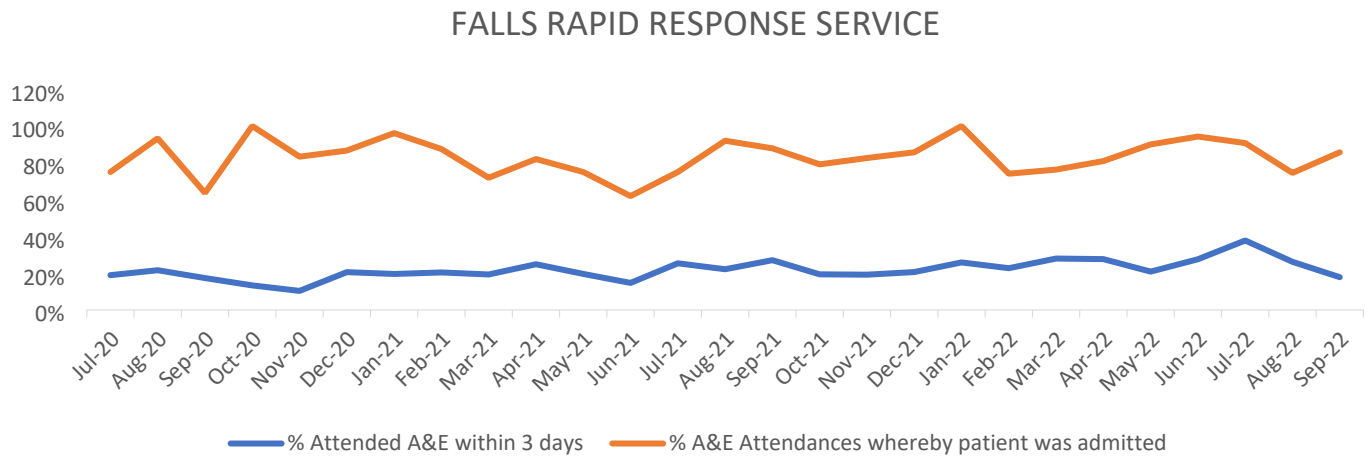
- Preventing People from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people to recover from episodes of ill-health following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

The activities described in this plan have been having a positive effect on overall admissions and continuation of the home is best programme and the movement of our NHS@home/Virtual wards and Urgent and Emergency Care response should deliver greater change as we go through the next 2 years.

Emergency hospital admissions following a fall for people aged 65+

The Bath and North East Somerset Better Care Fund will again provide funding support to the Falls Rapid Response Team, which is described in detail in the section above.

The following graph illustrates the total number of Falls Car Contacts by A&E Attendances within 3 days of contact between July 2020 and September 2022 (this is the latest data point available at the time of writing this Narrative Plan), and shows that on average, 22% of patients that have been attended to by the Falls Rapid Response Service do present at A&E within 3 days of an intervention, and of those that do present to A&E within 3 days, on average 83% of individuals are actually admitted to hospital.



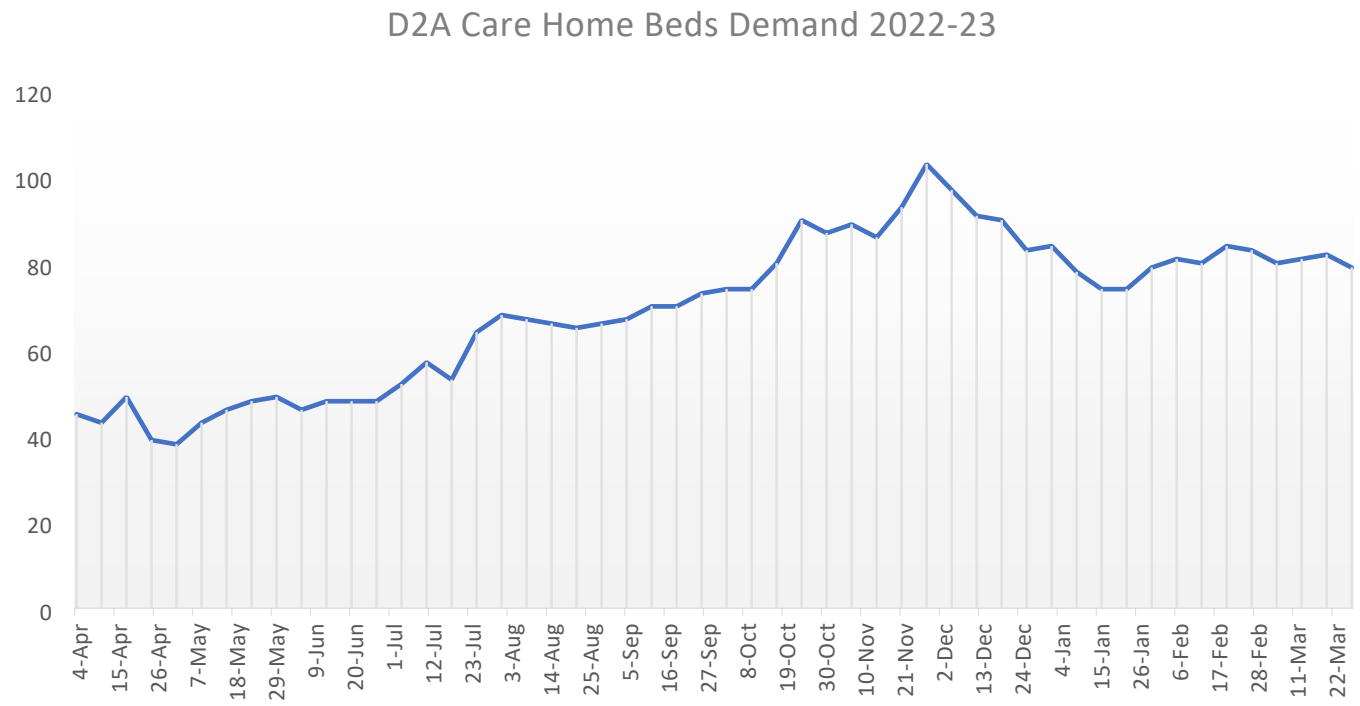
Continued BCF investment through 2023-25 will allow the service to operate alongside SWAST to provide valuable support and rapid response to the Bath and North East Somerset community.

People aged 65+ whose long-term support needs were met by admission to residential and nursing homes

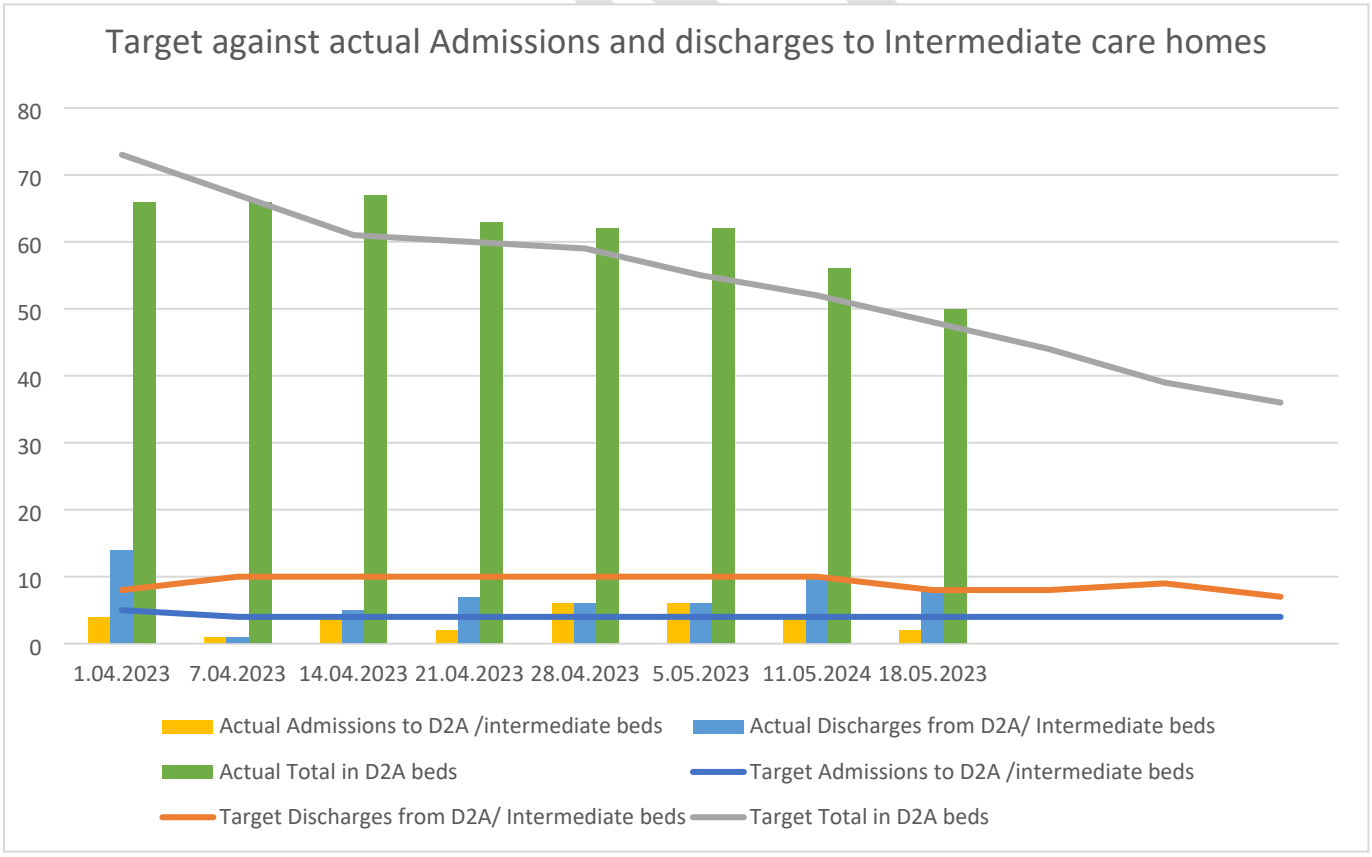
The Adult Social Care Discharge Grant will continue to fund 40 Discharge to Assess Care Home Beds across Bath and North East Somerset through 2023-24 and potentially beyond. These beds provide a valuable discharge route from hospital to allow ongoing assessments to be conducted outside of acute settings, and help us to reduce hospital pressures, ease flow and reduce our No-Criteria to Reside volumes.

2022-23 presented many capacity and demand challenges in our D2A Care Home Beds, as we only budgeted for 40 D2A care home beds but in reality saw an average of 69 beds in use per week which caused significant financial challenges – we had initially set aside £1.56m of funding (£730k from the iBCF) to finance these beds, but due to demand had to use an additional £1.22m from the 2022-23 Adult Social Care Discharge Grant to cover fees through to year end.

The below graph outlines the demand for D2A Care Home beds through 2022-23, peaking in late November when 103 beds were in use, reducing steadily across the remainder of the year and ending in March 2023 with 79 beds in use.



A recovery plan has been invoked which intends to cap admissions in to D2A beds where possible to 4 per week, whilst discharging approximately 10 service users per week out of D2A care home beds.



The intended net result of this plan is to reduce the total number of occupied beds to 40 as quickly as possible, however as shown in the above chart, with slower than anticipated discharges and higher than forecast admissions, progress has been limited at the time of writing this narrative plan but will remain a key area of focus as we progress through Q1 and beyond. Our data projects that

this should over time have an impact on long term beds, but at a significantly slower rate over the planning period, but none the less creating a positive impact on those discharged to their usual place of residence and reduced residential admission in comparison to peaks in this last year.

4.2 National Condition Three

Providing the right care in the right place at the right time

Bath and North East Somerset strongly believes that ensuring that the right care is delivered in the right place at the right time will vastly improve outcomes for our service users. We will ensure that we meet this objective by executing the following processes where and when possible:

Assessment and Planning: Before providing care to a service user, we will carry out an assessment of their needs and design a care plan that meets those needs. This will help to ensure that the services provided are specific to the individual's needs.

Regular Reassessments: Needs can change over time based on the health status and life changes of service users. Regular reassessments enable healthcare professionals and providers to review care plans continually, identify changes that may have occurred, and adjust services accordingly.

Communication: Communication among different healthcare professionals, providers, and service users is essential to ensure appropriate care delivered. Therefore, ensuring that there is effective communication among care providers, family members, and service users is essential to plan and delivering the right care to the right place and time.

Educate Service Users: Service users must know what services are available and how to access them. Therefore, educating service users about the care they require, where to find the services that meet their needs, and the importance of getting care at the right place and time is crucial.

Use of Technology: Incorporating technology in care service delivery can help provide care that is timely, safe, and effective. Technology, such as telemedicine, can help bridge the gap between service users who are far away from healthcare providers.

This continues to underpinned by the BSW Long Term Plan which is due for renewal in 2024 and will be supported by the ICA integrated strategy. Key themes run through all our BCF activity from this plan including the support to reducing inequalities and developing community based mental health support from use of !!! to workforce and HBPoS provision. https://democracy.bathnes.gov.uk/documents/s60016/NHS%20Long%20Term%20Plan.pdf . This has been supported by the renewed JSNA which has informed decision making this year. https://beta.bathnes.gov.uk/sites/default/files/jsna/Strategic%20Evidence%20Base%20Main%20Doc%20Published%2020220630_0.pdf

How we will embed a home first approach ensuring that more people are discharged to their usual place of residence

As outlined in the previous section under National Condition 2, we will endeavour to adopt the Home is Best approach for all service users where possible

How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds

We will look to invest funding from the Adult Social Care Discharge Grant into a number of initiatives that support discharge from hospital

Community Wellbeing Support

Continued investment into the Bath and North East Somerset Community Wellbeing Hub that supports health and wellbeing needs of our residents by offering a range of services such as:

- Debt, money advice and benefits support
- Short term financial help in a crisis
- Housing advice
- Access to low-cost food
- Practical support to improve your mental health
- Finding employment
- Advice on employment issues
- Keeping active and healthy
- Achieving a healthy weight for the whole family
- Improving your cooking skills on a budget
- Managing type 2 Diabetes
- Stopping smoking
- Practical and emotional support to help you build confidence, independence and connecting people to their local community.

We have used adult social care discharge funding to support the 'Community Wellbeing Hub' programme - by connecting with people on Pathway 1 to ensure that they have all of the wrap around support which when not in place can delay a discharge. Working with a number of partners to deliver a co-ordinated approach to accessing community services within hospital settings through things such as Self-Service Kiosks to allow service users and their families to connect to local services and support once they return home from hospital, and by increasing the number of Community Wellbeing Hub connectors and volunteers @ RUH to support people and their families to access community support needed on return home from hospital. This scheme brings together existing voluntary sector commissioned services based at the RUH, initiatives such as the HELP packs, as well as access to a wider network of support to offer a 'one stop shop' of community services.

Evidence shows that it is better for people, and more cost effective, where clinically appropriate, to spend a short a time as possible in hospital, and to avoid going into hospital when healthcare can be delivered safely in the home environment.
The Community Wellbeing Hub uses a person-centred approach to access a wide range of services, so that services can be wrapped around the individual.

The project supports clinical and non-clinical staff to access a range of community services that will enable people to be discharged home to be as quick as possible, helping to reduce readmissions and providing a better choice for individuals and their families.

By installing a number of Self-Service Machines within various hospital settings, we will allow users to search for targeted services within their community and connect service users and their families to local services and support to assist with their return home from hospital.

Hospital Discharge Support Grant

We will extend our 2023-24 offering of small amounts of financial assistance through one off payments (up to £1k per service user) to expedite their discharge from hospital. This can be used for services such as boiler repairs to ensure a warm house following discharge home, a taxi home from hospital where friends and family are unable to support, public transport costs for friends and family who may otherwise decline a care home placement for a relative due to travel implications. This scheme successfully supported 11 patients between January – March 2023 and saved an estimated 113 bed days in total.

Active Recovery Team

Further funding support for the Active Recovery Team who deliver integrated working between clinicians, social workers and community providers by working in partnership with the system to get people home from hospital with bespoke, wrap around support for recovery and reablement.

2000 Hours of Community Homecare

See sections above outlining the Night Care and Domiciliary Large Packages

Backlog of Care Act Assessments

Delays conducting service users care act assessments following discharge from hospital continues to be a major driver to increased length of stay in a Discharge to Assess Care Home bed. Investment through the Adult Social Care Discharge Grant will allow us to recruit additional social workers to address the backlog of care act assessments which is likely to accelerate a number of discharges out of D2A and help us to reduce the number of service users to align with our budgeted 40 beds as outlined under National Condition 2 here

Care Journey Coordinators

These new roles will provide dedicated resource to support people through their discharge journey from hospital into the community by supporting people back home. This role will form part of the RUH and HCRG discharge team supporting people across Bath and North East Somerset.

Curo Stepdown Beds

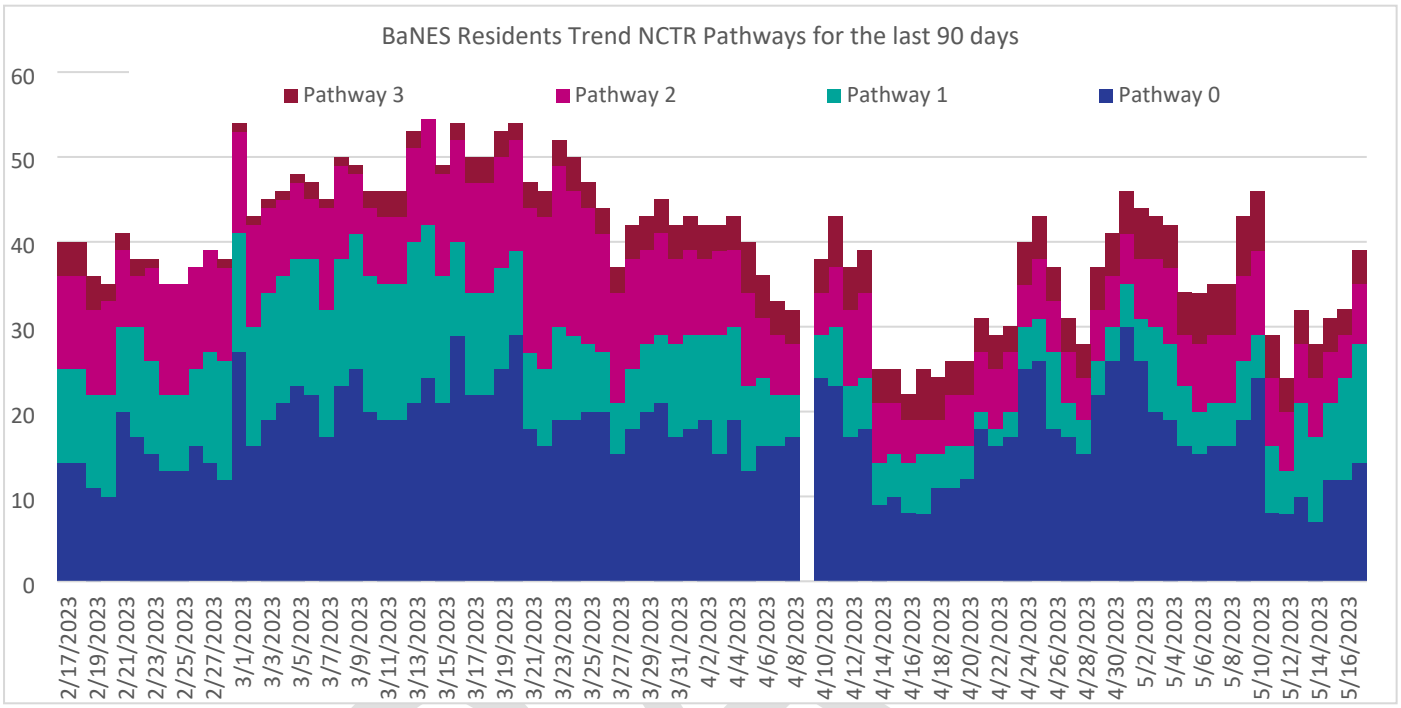
Stepdown is designed to support discharge from hospital for people with complex medical needs who no longer need to be in hospital but are unable to return home. Stepdown provides an interim placement until they are medically able to return home and we will continue to use funding from the Adult Social Care Discharge Grant to cover the cost of 2x additional stepdown beds through 2023-24.

Implementing the ministerial priority to tackle immediate pressures in delayed discharges

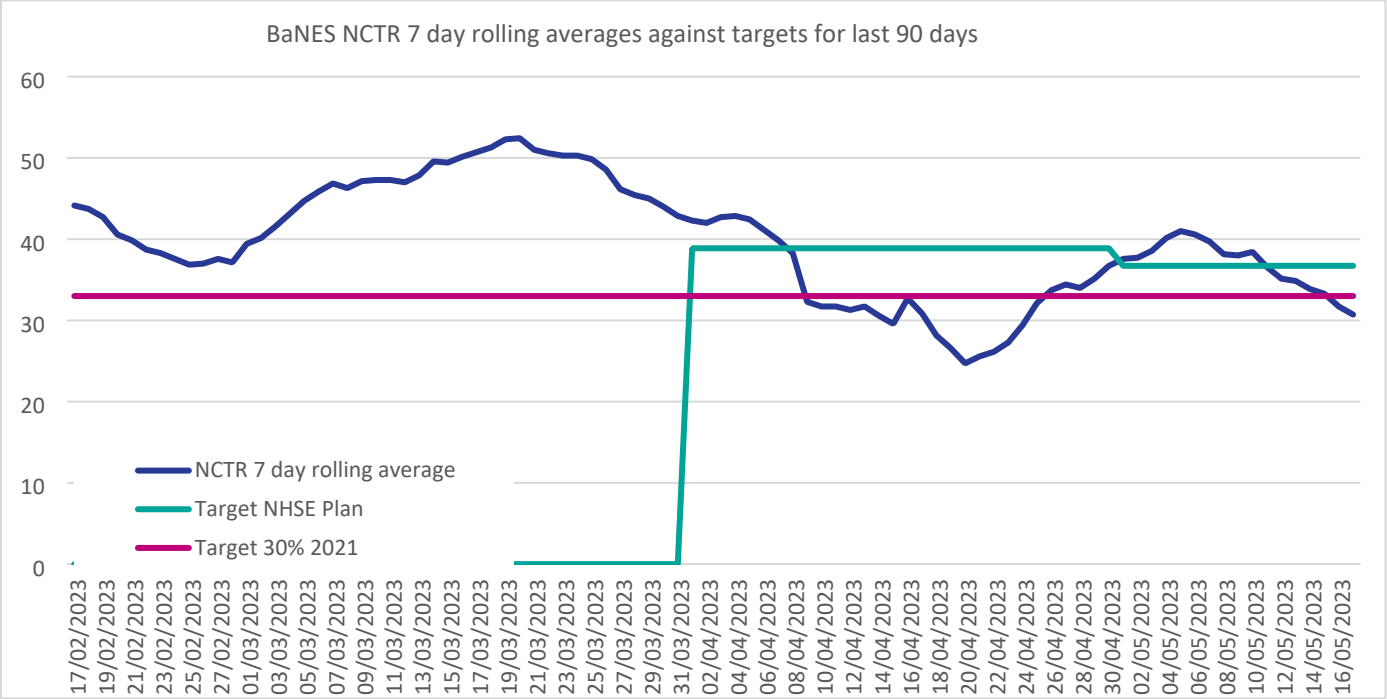
No Criteria to Reside

Patients that are categorised as having ‘No Criteria to Reside’ (NCTR) are patients that no longer need hospital care and reducing the volume of NCTR patients in our hospitals has been a significant challenge over the last 12 months or so and has received increased levels of focus and scrutiny. We have witnessed very high levels of delayed discharge, and this has a negative impact on system flow.

The following graph however evidences an improving picture in our main hospital in Bath and North East Somerset, the Royal United Hospital (RUH). In the 90 days that preceded the drafting of this narrative plan, the data shows the peak of B&NES residents classified as NCTR at just over 60. As we moved through January, through February and in to March, the volumes do drop off, hitting our lowest point for some time in early April to just above 30 (a 50% reduction). This illustrates the improving position and highlights the impact of some of the schemes that have been funded either directly through the Better Care Fund, or more recently via the Adult Social Care Discharge Fund.



The graph below consolidates the improvement that we are seeing in the number of NCTR patients in comparison to the improvement targets set by the government. The dark blue line shows the 7-day average for No Criteria to Reside patients. There are peaks and troughs across December, and January, but through February and March in particular, the volume starts to reduce significantly, and is currently very close to the 30% reduction against the benchmark, which is a very encouraging statistic. So we are seeing an improving picture within hospital around the volume of patients considered to have no criteria to reside, and some of this will be a direct impact of the Adult Social Care Discharge Funding through services such as the Hospital Discharge Support service, and the investment in developing our assistive technology offering and Community Wellbeing Hub support service



This has been achieved by implementing the home is best programme of initiatives working together as the council, ICB, Acute, community and primary health providers

Rationale for demand and capacity estimates for intermediate care to support discharge from hospital

Demand and capacity estimates are still under development. The plan will be based upon the modelling carried out at a system level for 22/23 planning.

How BCF funded activity will support delivery of National Condition 3 and how these services will impact on the 'Discharge to usual place of residence' metric

The schemes described in section 4.2 outline the BCF funded activity that will support delivery of National Condition 3. Modelling for the 'Discharge to usual place of residence' metric is still in progress, so details of impacts are not known at this stage. However, the plan will be based on the principle of increasing the proportion of people discharged to their usual place of residence and early indications as noted above would suggest an optimistic profile for the coming year due to sustained investment in the Home is Best Programme.

Implementing the High Impact Change Model for managing transfers of care

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 nine high impact changes that can support local health and care systems to help reduce delayed transfers of care:

1. Early Discharge Planning
   Continuing to support early discharge planning by involving the right people in strategic discussions and integrated commissioning.
2. Monitoring & responding to system demand and capacity

A suite of data analytic tools are monitored to allow us to react to system demand and ensuring we have sufficient capacity through continued investment in our most in demand services.

3. Multi-disciplinary working
   Strong collaborative MDTs are installed throughout the B&NES health and care system to ensure there is a range of knowledge and experience wrapped around care journey coordination and discharge programmes.
4. Home first Discharge to Assess (D2A)
   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.
5. Flexible working patterns
   Many of our health and social care practitioners and teams operate to a seven-day working, weekend working and extended hours schedule to ensure we see an improved flow of people through the system. In addition, we have an ICS 7 day working task and finish group.
6. Trusted Assessment
   The Better Care Fund contributes to the salaries of 3 FTE Trusted Assessors that carry out a holistic strengths-based assessment to ensure that people can be discharged in a safe and timely way. Following a supportive review from ESIST we are also taking forward further investment in trusted assessment across the D2A journey supported by our Care Journey coordinators
7. Engagement and Choice
   We recognise that early engagement with people is vital in allowing them to make informed decisions about their care. BCF funds will be directed in 2023/5 towards renewed investment in engagement particularly now that the covid has become less of a risk in face to face engagement
8. Improved discharge to care homes
   As previously mentioned, we are continuing to focus on reducing length of stay in D2A care home beds to further support the discharge process and reduce volumes of NCTR patients to ease hospital pressures and improve independent wellbeing goals
9. Housing and related services
   Our main BCF related housing services are financed through the Disabled Facilities Grant, whereby we offer a range of housing adaptations to maximise independence to support people to remain at home or to be discharged home following a hospital admission.- The development of the housing strategy will support this.

This is essentially the outworking of our Home is Best programme which is using the HICM to outwork and prioritise objectives.

How funding is being used to ensure that duties under the Care Act are being delivered

Better Care Fund investment is being used in a variety of ways to ensure that Care Act related duties are being delivered:

Health and social care integration: The Better Care Fund will be used to support the integration of health and social care services to ensure that patients receive the care they need in a coordinated and timely manner through integrated commissioning of services, delivering the right care in the right place at the right time.

Care planning: We will use Better Care Fund money to support the development of care planning for individuals, ensuring that their care needs are identified and met at the earliest opportunity, with full service user engagement where possible and that they receive the appropriate services and support.

Care coordination: The Better Care Fund will be used to support the coordination of care services for individuals, including the provision of care journey coordinators who will help individuals to access the services they need and through community wellbeing hub interventions who will connect service users and their relatives to a range of community services that can assist with a range of discharge and ongoing care support services.

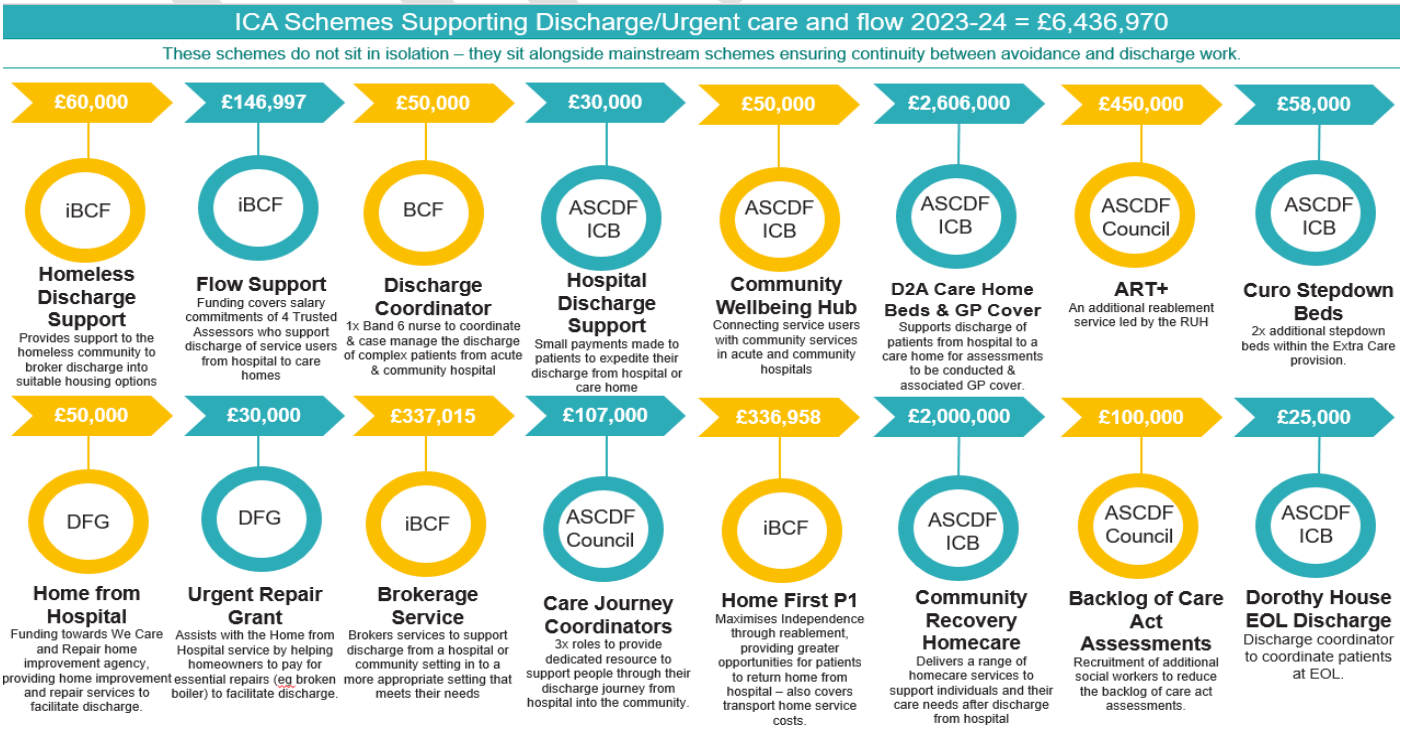
Training and development: Bath and North East Somerset will use funding to support the ongoing training and development of health and social care staff, particularly via our ongoing BSW commitment to the Skills for Care Partnership. This partnership leads on a number of duties including bidding for Skills for Care funding and advising providers on the minimum standards of training which staff are required to have in order to do their job effectively under the Care Act whilst improving outcomes for people who use our services.

How BCF plans and BCF funded services are supporting Unpaid Carers

Please refer to the Support for Unpaid Carers section for details on how this objective has been met.

5.0 2023 – 25 Strategic Priorities

To determine what our strategic priorities for the 2-year plan should be, a comprehensive gap analysis was conducted of our existing financial BCF commitments against a number of measures to help determine where uncommitted funding should be directed. This has been built upon revised data made available through the JSNA and the ongoing Long Term Plan for BSW.



The infographic highlights the volume of schemes that we are currently supporting through either BCF, iBCF or Adult Social Care Discharge Funding that directly influence discharge from hospital, equating to £6.4m of investment.

We also reviewed the existing BCF & iBCF commitments against the categories that are defined by the national BCF programme in the 2023-25 Planning Template to illustrate our investment gaps. For areas which scored poorly in this exercise were areas such as Assistive Technology & Equipment, Carers Services, Home Care & Dom Care, Residential Placements and Workforce Recruitment & Retention the board is looking towards greater investment.

We then did a similar analysis by reviewing our existing BCF and iBCF commitments against our local strategic priorities in 2023-24, This includes the Inequalities strategy, the Council's Adult Social Care directorate plan, the Health and Wellbeing Strategy and the ICB Integrated Care Strategy and Implementation Plan.

This analysis shows investment gaps in Digital and Technology Enabled Care, Engagement and User Voice, Carers Support, Transitions from Children's to Adults Services (including Learning Disabilities and Autism), Workforce & Retention and Transformation of Community Services. Therefore, the Health and Wellbeing Board is looking to investments in the following areas.

Potential area for investment	Detail
Admission avoidance and neighbourhood development focusing on the role of the **Community Wellbeing Hub**	The wellbeing Hub have set out a Development strategy/business plan showing how they can support stronger communities to improve independence and wellbeing by drawing together the resource, commitment and engagement of the third sector. This provision meets goals within all 4 corporate plans and BCF targets supporting the development of neighbourhood strategies, resilience, admission avoidance and prevention
Young people **with learning disabilities, autism &/or mental health transitioning** into adult care	Council and health budgets are under significant pressure to meet the growing costs of young people with high levels needs moving from children's to adult services. The care costs of one young person can be as much as £1m per annum and the BCF might be a good resource to support adult social care needs as described for iBCF.
Provision of resource to support **Technology** development in care linked to the neighbourhood teams strategy	Technology is an emerging area highlighted for investment at both a local and national level. Working alongside applications to the Adult Social Care Technology Fund and through the development of a system Technology Strategy for adult social care, this is an opportunity to culturally and strategically move forward an agenda for supporting prevention and enabling people to remain in their communities for longer with greater independence at affordable costs as part of our Neighbourhood strategy.

Contingency supporting **Transformation** and re-contracting of Community health and social care provision	The transformation of the community health and social care services is now well underway with further decisions to be made in October 2023. It is acknowledged that the process of transformation may need additional resources to support new approaches to provision. This is a contingency figure to create capacity across areas that meet BCF targets.

At the time of writing this report, it is proposed that schemes will now be co-developed that fit in to these strategic priorities that can best make use of this funding commitment.

6.0 Disabled Facilities Grant (DFG) and wider services

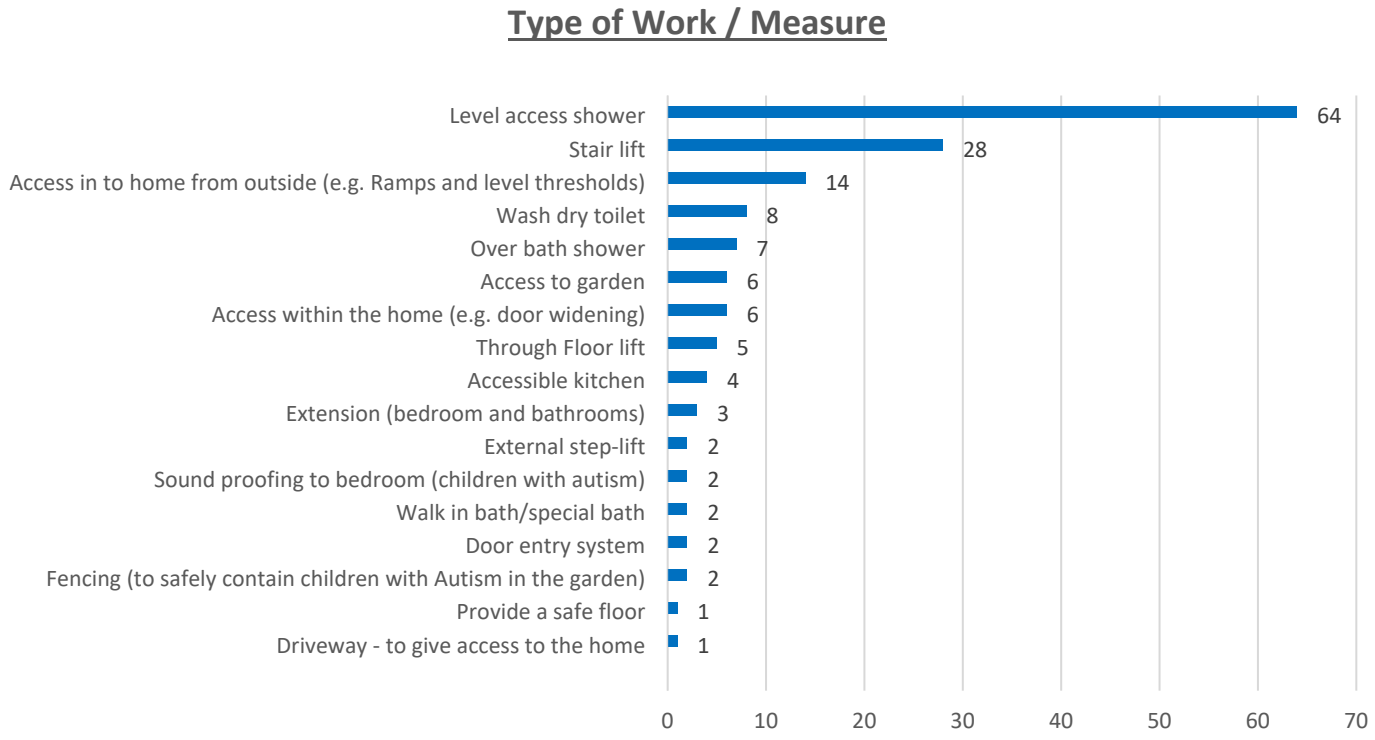
The below table shows the actual DFGs delivered under the Housing Grants, Construction and Regeneration Act 1996.

Works completed with DFG funding 2022 - 23	
No. of DFGs completed	151
No. of measures (some DFGs fund multiple measures under one grant)	157

Total spend on Grants from DFG Budget (12%)	£1,163,966
Spend on staff salary	£148,603
Total	**£1,212,569**

Number of DFG to tenants of Registered Provider homes:	87

Type of work/measure	**Number**
Level access shower	64
Over bath shower	7
Stair lift	28
Access within the home (e.g., door widening)	6
Access in to home from outside (e.g., Ramps and level thresholds)	14
Access to garden	6
Fencing (to safely contain children with Autism in the garden)	2
Driveway - to give access to the home	1
Door entry system	2
Wash dry toilet	8
Accessible kitchen	4
Walk in bath/special bath	2
Extension (bedroom and bathrooms)	3
Provide a safe floor	1
Sound proofing to bedroom (children with autism)	2
Through Floor lift	5
External step-lift	2
Total	**157**



Over the last year, applicants have been waiting about a year from when Housing Services received their referral from OT Services until we were able to begin working on their case.

Housing Services currently have approximately 107 cases waiting for their input. This figure has dropped from about 130 over the last year or so since the COVID pandemic.

The time taken for Housing to complete a case has reduced from ***85 weeks*** at the end of the pandemic to ***62 weeks currently*** with the number of completed cases rising closer to what was achieved before the pandemic.

The Council's Commissioned Home Improvement Agency (HIA) (We Care Home Improvements) takes on complex cases and manages them for the applicant. Helping them to submit complex applications when works are complicated and/or there is a need permission such as for Building control and planning consent. Last year our HIA also took on 40 non complex cases to help reduce the back log of cases and which we plan to repeat this year 23/24.

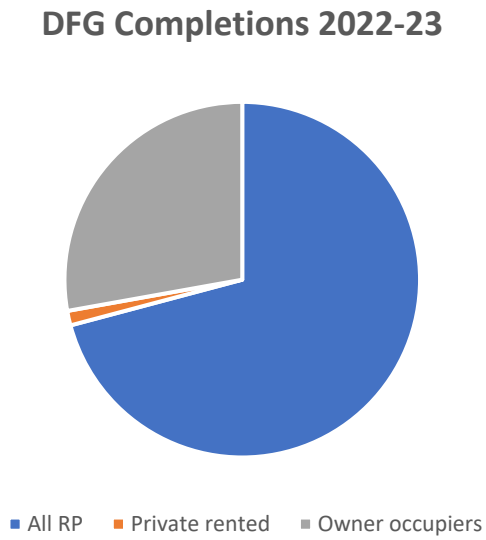
Over the next 2 years we anticipate utilising our staff resources to deliver 50 additional DFGs per year to remove the waiting list to pre pandemic levels. Our aim is to one gain be able to visit applicants within a month or so of their case being received from the Occupational Therapy Team by the DFG team in Housing. The budget for staff and grant funded works in 2023/ 24 is to be confirmed as part of the submission to the Health and Wellbeing Board. However the fund is under significant pressure as the cost of living rises and significant cuts will need to be made in 2024/5 if further funds are not found.

2-year forecast

Year	DFG grants administered /Anticipated	Project total cost
2022-23	151	£1,212,569.00
2023-24	201	£1,712,569.00
2024-25	210	£1,812,569.00

DFG's by tenure

Tenure	DFG completions 2022/23
All RP	107 (86 in Curo Homes)
Private rented	2
Owner occupiers	42
Total	**151**



We are currently in the process of setting out a Housing strategy beginning with working age adults. The current assessment suggests

Developing the strategy - What we need going forward – Type of provision

- Most people require access to long term homes that are affordable, accessible, offer security of tenure and are close to public transport and community facilities. As well as improving access to mainstream social housing via Homesearch, we require additional units of supported living including:
  - own front door 1 bed flats to include Assistive Tech. in supported living schemes with an area for tenants to socialise and staff sleep -in room/office on-suite (Housing Lin models).
  - Hub & spoke type accommodation. Single storey - one front door, robust build, sensory informed environments to suit individual needs, including Assistive Tech
- We are still placing young people in specialist residential colleges (Bath College residential project should address this)
- Some people require short term 'step down' accommodation from hospital, or 'step up'/crisis prevention from the community:
  - 1-3 years short term step down accommodation, studio accommodation with ensuite but shared kitchen/lounge spaces (license arrangements)
  - Small blocks of flats with a couple of 1 -2 bed bungalows on one site which would allow flexible support across the scheme
- Some people may prefer to live in a Shared Lives placement and we should aim to grow this scheme locally as well.
- Increased no. of Supported Lodgings placements – to include provision for UASC

Developing the strategy - What we need going forward – System change

- Ensuring visibility in Local Plan – the housing requirements of older people and working age adults with care/support needs to be reflected in B&NES' Local Plan
  - Developing Supplementary Planning Documents which can provide more detail of the types, location, design etc of housing required by older people and working age adults with care/support needs.
- Better demand data & improved system for gathering intelligence re what people need/want
- Earlier transition assessments/first Care Act assessments (often don't take place until the YP is 18)
- Improved information re housing options for people with care and support needs, and care leavers – including info/support re Shared Ownership/HOLD etc – to help people 'help themselves'
- Depending on findings of pending review of Homesearch allocations to assess fair access, potential to amend policy – e.g. higher banding (Band A) for Care Leavers and people with care and support needs or quotas for these groups
- Review of the HCRG housing related sub contracts – possible remodelling/recommissioning to improve diversity (e.g. currently Curo provides all the YP services & we do not have specialist floating support for YP) & ensure they are able to accept/meet more complex needs
- A move from spot purchasing to block contracting/framework to facilitate best use of local provision via centralised brokerage/placement matching function
- Explore opportunities for joining up Shared Lives and Supported Lodgings Schemes – to achieve economies of scale and improve efficiency
- Consider quotas for younger people with C&S needs in existing Extra Care Schemes

The plan will be developed in 2023/4 working alongside the DFG plans as part of the ongoing response to the growing needs of working age and older adults in B&NES.

7.0 Equality and Health Inequalities

The Bath and North East Somerset 2022-23 Better Care Fund Plan detailed the Bath, Swindon and Wiltshire Integrated Care Boards Inequalities Strategy 2021-2024 – a plan 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. This plan was published in May 2022.

To recap, 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:
   a. Restore service inclusively
   b. Mitigate against digital exclusion
   c. Ensure datasets are timely and complete
   d. Accelerate preventative programmes
   e. 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:
   a. CVD
   b. Maternity
   b) Respiratory
   c) Cancer
   d) Mental Health (including. children and young people)

Recent publication by NHSE of guidance on inequality and the Core 20 Plus 5 approach for children and young people has recently been published. The BSW Inequality Strategy is being updated in light of this. The focus is largely on clinical areas for particularly patient groups within young people.

The strategy is in the process of a refresh, which will incorporate recently published NHS guidance on reducing inequality, along with an implementation plan for Phase 1 of the strategy. This strategy sets out the following three phases of work:

1. To make inequality everybody's business through engagement and awareness raising
2. To tackle healthcare related inequalities
3. To focus on prevention, social, economic and environmental factor – also known as 'wider determinants'

Reporting against the plan commenced in February 2023, and progress updates are being presented regularly to the Bath, Swindon and Wiltshire Population Health Board, and significant updates are being shared with the Health and Wellbeing Board.

The Public Sector Equality Duty places a responsibility on local organisations to eliminate discrimination, advance quality of opportunity and foster good relations for people with protected characteristics. Work to understand and tackle inequities in access to preventative or treatment services and inequalities in health and social outcomes supports achievement of this duty.

Bath and North East Somerset, Swindon and Wiltshire has a combined population of around 923,000 people (BSW System Intelligence Report, 2021). Life expectancy across the three areas varies from 73 years to 91 years according to sex and geographical location. In BANES and Wiltshire, and nationally, the social gradient in life expectancy is steeper for males. In Swindon, however, the social gradient in life expectancy is steeper for females. There are further variations in life expectancy between neighbourhoods in BSW. For example, a female in Bathavon South, BANES, can expect to live for 91 years, whereas a male from Trowbridge Central, Wiltshire, can expect to live for 73 years (BSW Partnership, 2021).

Ethnicity also has a large and complex effect on health. In England, inequality is experienced when comparing ethnic minority groups and those from white ethnic groups, and between different ethnic minority groups (Robertson et al., 2021). There are approximately 100,000 people from Black and Minority Ethnic (BME) communities living in BSW (ONS, 2017). Swindon has significantly more residents from a black and ethnic minority group: 10.2% in Swindon, compared to 5.4% in BANES and 3.4% in Wiltshire (ONS, 2011). In BANES and Wiltshire, 'All other white' group is the largest ethnic group after 'White British', whereas in Swindon it is 'Asian/Asian British'.

8.0 Termination of the HCRG Community Services Contract

HCRG Care Group (previously Virgin Care Services Ltd – VCSL) deliver the Integrated Health and Social Care contract in B&NES as a prime provider. This contract is jointly commissioned between the Council and Bath and North East Somerset Integrated Care Board (BSWICB – previously BSW Clinical Commissioning Group) with the Council as lead commissioner.

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

Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group (BSWCCG now referred to as BSWICB) Governing Body and B&NES cabinet both met on 11th November 2021 and agreed the joint recommendation for the contract to be extended for the three-year term with Virgin Care Service Limited.

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

Because the November 2021 decision to extend the contract term was made on the basis that commissioners would continue to contract with the same provider ownership, the same commissioning intentions and risk profile, BSWCCG and the council undertook a period of due diligence through an independent review of the implications of the change of ownership to services being delivered to B&NES residents and undertook a new options appraisal process.

It was agreed with HCRG Care Group to extend the contractual period for commissioners to notify of the extension decision from March 2022 (year 5) to June 2022 (year 6) allowing commissioners time to undertake the due diligence and independent review, to revisit the November 2021 extension decision.

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 took the decision in May 2022 to not extend the contract with HCRG Care Group for the delivery of the Integrated Health and Social Care contract in B&NES and therefore the B&NES contract with HCRG Care Group will end 31st March 2024.

The decision was reached after careful consideration of all of the options available to commissioners which was informed by the due diligence review that highlighted uncertainties arising from the change in ownership of Virgin Care Services Limited, including ongoing contractual and financial risks.

In September 2022 the progress update report to B&NES cabinet outlined the approach both commissioning organisations agreed to commence three programmes of work to deliver a new operating model for health, adult social care, public health and community partners as part of Community Services Transformation. The programmes focus on high quality services that continue to meet the needs of our local communities whilst ensuring commissioners make the best use of public money (including the Better Care Fund.

The three Community Services Transformation programmes are:

Programme One: ASC Redesign and Community Partners for consideration of a new operating model for statutory adult social care services and future strategic commissioning intentions of services delivered by community partners

Programme Two: Public Health for a review of the future commissioning framework of Public Health grant funded services

Programme Three: Integrated Community Based Care for the future design of children's and adults' community health across BSW

The Community Services Transformation Programme offers the opportunity to create a new, exciting, and integrated model for health and social care services for local people and allows BSW ICB and Bath and North East Somerset Council the opportunity to commission these services at scale:

- Enables commissioners 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
- To redesign community services to focus even more on prevention and ensure residents get the support and care that is right for them
- To explore adult social care statutory services and third sector commissioning of community partners to transfer back into the council

On 10th November 2022 B&NES cabinet took the decision to transfer back to the Council two adult social care services, currently directly delivered by HCRG Care Group, following the presentation of a Strategic Outline Business Case. The services include Adult Social Work and Adults with Learning Disabilities and their Families. Good progress is being made by the project team to ensure the safe transition of services and transfer of staff back to the Council as of 1st April 2024. Robust governance is in place for Programme One combined with ongoing progress updates and assurance to Council SLT, Corporate Trade Union Group and Corporate Risk Management Group.

The extent and complexity of Programme Three for Integrated Community Based Care, combined with delays in securing specialist resourcing within this programme towards the end of 2022 has resulted in significant slippage to the original planned timelines. As a result, the ICB is not in a position to deliver all the required planning and procurement actions to achieve the original ambition for a new operating model for community health services (children's and adults) as of April 2024. It is therefore proposed that the timeline is extended to April 2025 for Programme Three.

The Integrated Care Board (ICB) has decided that, to ensure the safe transfer of adults and children's community health services and to allow sufficient time to undertake a full-service review and redesign, they will be recommending to secure a series of contracts for community services from early 2024 until the end of March 2025. This will cover all age health services across the Bath and North East Somerset, Swindon and Wiltshire (BSW) areas and take effect from 1st April 2024 to 31st March 2025 (BSW current providers include HCRG Care Group (B&NES & Wiltshire); Great Western Hospital; Wiltshire Health and Care; and Oxford Health)

For B&NES this now offers the opportunity to align with ICB timelines for the interim provision and future redesign of Public Health services and services delivered by Community Partners currently delivered by HCRG Care Group until the contract ceases on 31st March 2024. Under a new interim contract arrangement, with the ICB as lead commissioner for one year, this would enable full alignment of interdependent Public Health and ICB Children's and Adult's Health and Care services. The recommended interim contract arrangement for B&NES upholds the non-extension decision taken on 26th May 2022 by B&NES Cabinet and the Clinical Commissioning Group (CCG) Governing Body (now the ICB) to not exercise the option to extend the contract between B&NES Council, ICB and HCRG Care Group as this contract terminates on 31st March 2024.

Inclusion in the recommended interim contract arrangement is proposed for Public Health Services and services delivered by Community Partners. The inclusion of community partners ensures that

they are treated equitably and there is no misalignment in the reprovision of providers across BSW during this period. Under the recommended contract arrangement, the ICB would be the lead commissioner for sub-contracted services as well as Public Health services. The transfer of the directly delivered services of Adult Social Care (ASC) is unaffected and will be transferred to the Council as of 1st April 2024. The Reablement service is part of Programme Three and commissioners are reviewing the current service specification in readiness for the inclusion in the Direct Award.

The intention is for the ICB to conclude negotiations around contracts for 2024-25 as rapidly as possible to ensure they can be presented for approval to the ICB Board in July 2023.

It is intended that in Autumn 2023 Outline Business Cases will be reported to B&NES cabinet for decisions to be reached on the future strategic commissioning of services delivered by Community Partners and Public Health services in B&NES as of April 2025 as part of the wider Community Services Transformation programme.

The impact of the changing contractual arrangements for services in the Better Care Fund is reviewed across Programmes One, Two and Three, each with detailed analysis of the level of contribution of Better Care Fund for services directly delivered by HCRG Care Group and funding contributions to services delivered by Community Partners. Better Care Fund pooled budget arrangements will continue between BSWICB and B&NES Council for the period of the Direct Award from 1st April 2024 and 31st March 2025 and will continue to be reviewed and considered as part of the longer-term operating model for services as of April 2025.

9.0 Approval and Sign Off

This plan has been created in partnership with a number of different system partners (as detailed in section 1.0) and will be formally signed off by the BSW Integrated Care Board and the Bath and North East Somerset Health and Wellbeing Board at the board meeting on 20th June 2023.