BCF narrative plan template

This is an optional template for local areas to use to submit narrative plans for the Better Care Fund (BCF). These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover the headings and topics in this narrative template.

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

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

Cover

Health and Wellbeing Board(s)

Bristoll

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

How have you gone about involving these stakeholders?

The Bristol, North Somerset and South Gloucestershire (BNSSG) local authorities are partner organisations in the BNSSG Integrated Care System (ICS) – known as the Healthier Together Partnership. There is extensive and ongoing consultation and involvement of key partners, including VCSE organisations, in strategic planning and shorter-term plans for responding to system-wide operational pressures. The Healthier Together Partnership has an agreed governance infrastructure that encompasses planning, financial management, system performance and a wide range of transformation programmes in which stakeholders are actively involved.

Executive Summary

This should include:

- Priorities for 2021-22
- key changes since previous BCF plan

The BCF in 2021/22 continues to focus on reducing avoidable admissions and delays to discharge, as part of a shared longer-term strategic aim to make the community the default setting of care. The outline approach to achieving this was agreed and is described in the BNSSG Healthier Together Long Term Plan (2019-2024).

There is an agreed BNSSG joint vision for the Discharge to Assess approach: *Sharing the responsibility, risk and skills across organisations, leading to innovative and creative solutions; thereby achieving a seamless transfer for local residents from acute to community setting through the provision of integrated safe and effective assessment and support closer to home.* Implementation is via a BNSSG-wide model that has been developed over a number of years (outlined below).

A BNSSG business case was approved on 18th November 2021 by the Healthier Together Partnership to implement the Discharge to Assess model of care on a permanent basis. The approach to the BCF from April 2022 is being considered by the wider system, including LA partners, CCG & finance colleagues.

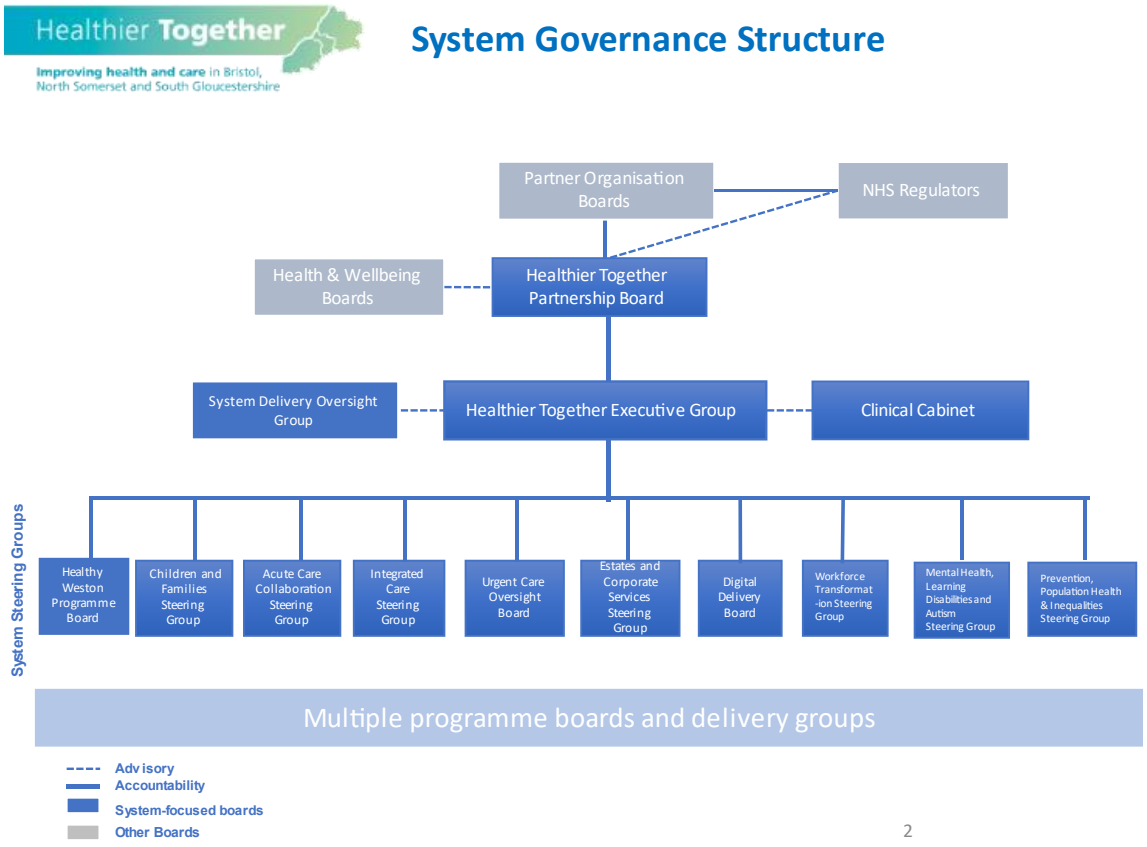
In addition to discharge, the BNSSG BCFs include a focus on support for mental health. Community Mental Health has been identified as the first area for which the new Integrated Care Partnerships (ICPs) will take on responsibility in April 2022. ICPs are a fundamental change to how health and care services will be delivered in the future. They will focus on delivering coordinated services at 'place' level. This will mean that the community will become the usual place of care for the majority of people's needs. While ICPs will be unique, they will all have to meet the same quality standards and a shared common purpose: to improve the health and care of the people they serve, integrate services for the benefit of the local population and reduce health inequalities. Six ICPs have been agreed for BNSSG: 3 within the Bristol City Council area; 2 within North Somerset and the South Gloucestershire ICP is co-terminus with the local authority footprint. The local authorities and voluntary sector are key partners in the ICPs; provider alliances to support the ICPs are currently under development. Discussions about the role of ICPs in the BCF are at an early stage.

No significant changes are proposed to the BCF in 2021/22.

Governance

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

The governance infrastructure for the Healthier Together Partnership is shown below. Work on much of the BCF implementation is now taken forward within this framework.



Discussions are underway for a proposed Discharge to Assess pooled budget from April 2022, and its relationship to the BCF, as part of the implementation of the BNSSG Discharge for Assess Business Case.

Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- Joint priorities for 2021-22
- Approaches to joint/collaborative commissioning
- Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.

Our shared ambition across the Healthier Together Partnership is to "build an integrated health and care system where the community becomes the default setting of care, 24/7, where high quality hospital services are used only when needed, and where people can maximise their health, independence and be active in their own wellbeing. We want to increase the number of years people in BNSSG live in good health; reduce inequality in health outcomes between social groups; and help to create communities that are healthy, safe and positive places to live. In redesigning our system, we also want to make it easier for staff to work productively together and develop a healthy and fulfilled workforce". We are pursuing a place-based approach to personalised care via the development of formal Integrated Care Partnerships (ICPs).

Healthier Together partners are working together to deliver this approach including via shared transformation programmes. These include:

- The Care Provider Programme which brings together Local authorities, Community Health, Primary Care, Care Providers, and CCG to support and develop our external provision. This has built on successful highly collaborative work during Covid 19 to support providers experiencing outbreaks. Work streams include a Strategic Commissioning Group, a tactical Care Provider Cell (support for individual providers, including IPC) and a joint planning group working on support for carers.
- Building Healthier Communities programme which is focused on building partnerships with VSCE organisations. Initiatives include coordinated VCSE support for discharge.
- A newly established Ageing Well programme, which is developing an integrated model of care for BNSSG, to be delivered via the ICPs to support people to remain as independent as possible in their own homes.

Joint commissioning and planning also takes place through other system bodies including a Learning Difficulties and Autism Board, (examples include work on a shared approach to Positive Behaviour Support) and there is an emphasis on joint planning and commissioning in the D2A space. There is also joint work in the Ageing Well space.

Given the diverse nature of the 3 local authority areas within the BNSSG ICS footprint, there is also work that is specific in each area. Support for families and carers is core to enabling many people to live as independently as possible, and carers provision is supported through our BCF. A revised Carers Strategy, coproduced with carers is being developed during 2021/2022 and services will be redesigned and/ or recommissioned to align in 2022/2023.

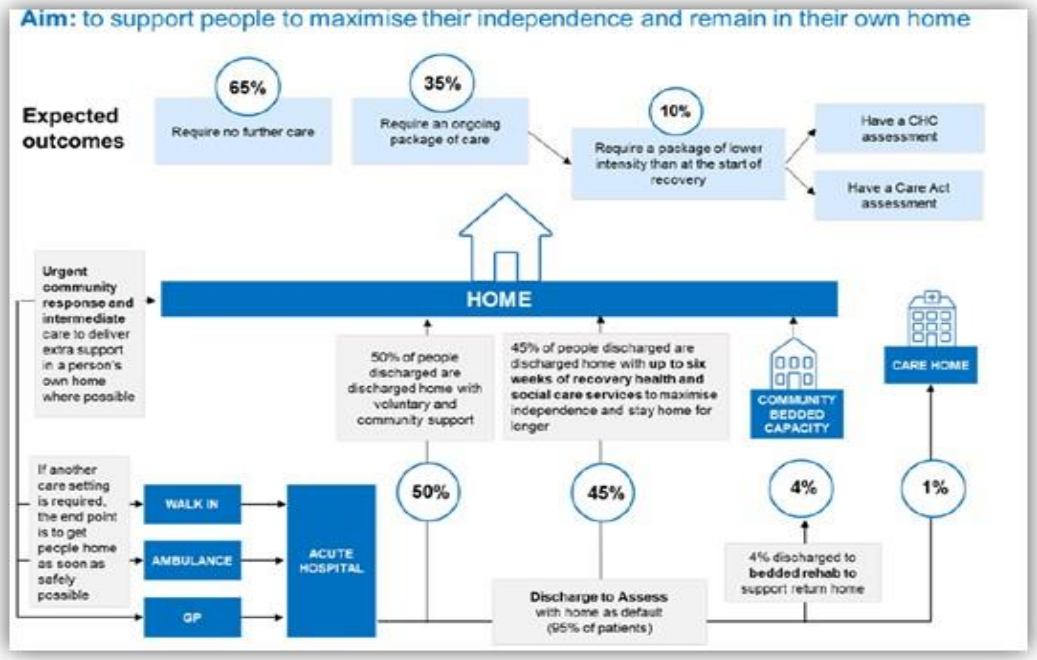
We are further developing our approach to reablement, in part to ensure an approach that support a more integrated approach, and has Technology Enabled Care and community based support at its heart.

Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

The D2A model is not new. Healthier Together partners have been working to deliver a rapid hospital discharge approach for years. The model is set out in the following diagram:



The D2A Business Case was approved on 18th November by the H&WB and we are now moving into the implementation phase. We will expect to achieve the following improvements in patient led outcomes within this model:

- Integrated, timely, personalised care
- Maximising Independence – The goal for everyone receiving support should be to maximise their long-term independence
- Although funded support will be available for up to six weeks, many people will benefit more from a shorter, intensive period aimed at enablement
- Reducing or eliminating longer term needs for care
- Home is best for 95% of older people leaving hospitals – for recovery and any further assessment of need
- Communication and information-sharing with the individual and their family/ careers and between those organisations, assessing, commissioning and providing care and support.
- Operating Strengths based assessment proportionate to the stage of recovery the individual has reached; involving the individual (and/ or others as appropriate); appropriate to the level of decision required; done at the right time and in the right place to get an accurate picture of what is needed. Describing the needs of the individual – not prescribing.

The model also aims to increase the proportion of discharges on Homefirst pathway, Increase in rehabilitation & reablement therapy staffing and shorter assessment times. In order to achieve these goals a clear partner implementation plan has been agreed.

We have been working together as a system to facilitate timely discharge from acute settings on the recognised discharge pathways to maximise independence and optimise the opportunity for people to return to their own homes.

We have also started to see a number of service users return home from P3, which is quite rare compared with other LAs.

We have also focused on improving flow within our P3 bed base by:

- Allowing assessment to take place outside of the acute setting – a period of convalescence / better environment = better outcomes
- Providing in-reach therapy in a P3 setting allowing for 'slower stream' rehab and rehab potential to be identified and optimised
- Providing wrap around support from other services such as dementia wellbeing
- Undertaking ECH pilots, which allows a better environment for people to be assessed outside of the bedded pathways in care homes, which leads to maximising independence ethos

Please refer to ***BCF Additional Information Document*** for more details about the approach we have taken to improve outcomes for people being discharged from hospital and how BCF funded activity supports safe, timely & effective discharge.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

- A range of teams have been brought together to deliver an integrated range of services funded through the Disabled Facilities Grant (DFG). These services include:
- An integrated Adult Care and Housing team covering the entire DFG and home adaptation process including the occupational health assessment, specification of works and commissioning of contractors for new home adaptations, ongoing repairs and servicing. This service is accessed through the Adult Care and Support, Care Direct contact centre;
- Using the flexibility in the Better Care guidance to fund the installation of minor adaptations using in house and commissioned services including support for the ICES contract.
- Increasing the speed and successful of the transfer of care from hospital to home through the hospital discharge hub. Commissioned housing services are a central part of the discharge Hub. They and the work done is funded through the DFG;
- Delivering the assessment and delivery of Technology Enabled Care (TEC) to enabled adults and children remain living independently at home for longer. TEC also enable flexible, hospital discharge support to achieve successful hospital discharge outcomes.
- Installing TEC in new Better Lives at Home facilities to facilitate independent living.
- The DFG has been used to fund a wider range of support to families and children through our commissioned Home Improvement agency. This service provides a range of health and social care advice and support to help families in housing need with a range of support to:
    - Access to appropriate health and social community services
    - Project management support and contract delivery of property repairs and improvements;
    - Voluntary support for hoarders to improve their health and wellbeing.

Equality and health inequalities.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan.
- How these inequalities are being addressed through the BCF plan and services funded through this.
- Inequality of outcomes related to the BCF national metrics.

An **Equality Impact Assessment** was developed to assess the impact of projects under the Out Of Hospital Programme to ensure that there is no direct or indirect discrimination against individuals with one or more protected characteristics and advance equality of opportunity and foster relationships between on group and another where possible, as outlined in the Equality Act 2020.

As previously described above, mental health and wellbeing is a priority consideration for our developing ICS and ICP. Our BCF continues to support specialised VCSE organisations that work with people with complex mental health needs.

The BCF joint funding ensures that people within Bristol with protected characteristics are supported in the most appropriate way to meet their specific needs. This includes disability specific support, but also support that is culturally appropriate, age-appropriate, sensitive to gender and religion etc. The range of work that is undertaken as a result of the BCF and joint working, means that a more holistic approach to people's lives can be taken, which in turn leads to preventative measures being put in place, which reduces pressure on health and care systems.

For example the support to informal and family carers means that people with disabilities from minority ethnic groups can receive support that is culturally appropriate, age-appropriate, sensitive to gender, religion and so on. It has also led to the development of a co-designed set of strategic principles for carers that underpin the future direction of support to carers across the City.

The impact of COVID has been particularly significant to people with protected characteristics, and the joint funding approach to the range of projects within the BCF mean that we can continue to target the greatest level of support to those with the greatest need, who have been disproportionately affected by the pandemic.