BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans but use of this template for doing so is optional. Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

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.

An example answers and top tips document is available on the Better Care Exchange to assist with filling out this template.

Cover

Health and Wellbeing Board(s)

Bristol

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

Across Bristol North Somerset and South Gloucestershire Integrated Care Board we have set up a Healthier Together programme and set up a system leadership and capacity to deliver the D2A programme to agreed timescale before March 23 :

We have an

- Executive sponsor for the system and individual organisational executive sponsor
- Senior system clinical executive representative on the D2A Board
- Co-leadership of all working groups across health and social care
- Enhanced programme capacity and project management support at a system level and in individual organisations
- Relaunched the Home First concept across BNSSG with a focus on senior system leadership and commitment to the programme as the top priority for the system in 22/23

How have you gone about involving these stakeholders?

The team which consists of partners across the ICB are developing accelerated targets for impact and timeline for delivering the D2A programme including:

- Insights work with frontline staff to understand in more detail the barriers to delivery and how these can be removed.
- Detailed demand and capacity modelling of Local Authority services to have a shared view of the changes needed across the full discharge to assess pathway
- Bring work taking place on technology enabled care (TEC) into the programme to redesign of P0 (home with VCSE support) and P1 (home with health and care support)
- Renewed focus on outcomes and evaluation

The programme is working closely with the LGA following their recent review identifying key areas to improve our pathways with particular focus on:

- Having a better understanding of people's experience of hospital discharge and their movement through the care pathways ensuring patients are on the correct pathway.
- Blending the reablement and rehabilitation pathway to a more blended model
- Utilising the Voluntary sector more to support P0
- Improving our data collection to understand our challenges across both health and social care including patient led outcomes – both in terms of qualitative feedback and what support they need following leaving Hospital on D2A pathways (e.g. in 3 months' time)
- We are working to develop a wider system understanding of the overall benefit of positive innovation in the way they support people in the community, through strengths based and asset-based approaches this and connect our innovation with pathway outcomes to help system partners support these approaches.

Executive summary

This should include:

- Priorities for 2022-23
- Key changes since previous BCF plan

The BCF in 2022/23 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.

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).

We are working together across acute hospitals, community health and social care and the Voluntary Community and Social Enterprise sector (VCSE) to get more people to the right place for their recovery, care and support needs, in the place they call home, as soon as clinically possible.

Too many people in our areas currently spend too long in both our Acute and Community hospital beds, which evidence shows leads to worsening physical and mental health. Compared with other parts of the country, more people in our area are discharged into community beds, rather than at home, further slowing their rehabilitation and recovery and leading to more people needing long term social care.

With current pressures, winter demands ahead, threat of further Covid-19 outbreaks and ongoing staff shortages, it's clear we must take action now – and do things differently in future. The challenges for health and care services mean urgent action is underway, through initiatives such as the 100 days challenge.

Working together, in new ways, can help tackle the immediate pressures facing staff and the people we care for throughout Bristol, North Somerset and South Gloucestershire (BNSSG). The work we do now will help us prepare for winter demand on the NHS and social care in 2022 and beyond, By reducing length of stay in hospital beds, we can improve flow throughout the system and delays in areas such as ambulance handovers, admission for other people needing hospital beds, and discharges. Together we will also develop long-term solutions which are sustainable for all partners, with joined-up pathways and care wherever possible outside hospital.

Please see here for more details on the **Home First Programme** – ***Appendix 1 Overview: Bristol, North Somerset & South Gloucestershire (BNSSG) Home First Discharge to Assess (D2A) Programme***

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) have taken on responsibility from April 2022. ICPs are a fundamental change to how health and care services will be delivered in the future. They focus on delivering coordinated services at 'place' level. This means 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.

Governance

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

The BCF for 2022/23 was reported to the Health and Wellbeing Board on 7th September by the Director for Adult Social Care. The paper set out the funds that make up the BCF and discussed this year's actions to reprofile the funding lines to make use of the allocations much clearer and to create whole funded service lines within the fund that allows us to easily see the joint commitments between the LA and the ICB to joint funded activity like intermediate care.

The BCF Plan is signed off by the Executive Director of Adults and the Section 151 finance officer at Bristol city Council.

The Healthier Together Partnership

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. The ICS became into being on 1 July 2022 and builds on the extensive system working already in place for both strategic planning and shorter-term plans for responding to system-wide operational pressures. The 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. It is likely that this infrastructure will evolve in response to the new BNSSG ICS strategy under development, and also as the six Locality Partnerships within BNSSG mature and extend their responsibilities.

The ICS is made up of an Integrated Care Partnership (ICP), and Integrated Care Board (ICB) and the six Locality Partnerships including the three Bristol City Localities, North, South and East and Central. Healthier Together Partnership (ICS) organisations include Avon & Wiltshire Mental Health Partnership NHS Trust, Bristol City Council, BNSSG ICB, North Bristol NHS Trust, North Somerset Council, One Care, Sirona Care and Health, South Gloucestershire Council, South Western Ambulance Service NHS Foundation Trust and University Hospitals Bristol and Weston NHS Trust. The ICP brings together a broad range of partners – including from the local voluntary sector and community groups, and is jointly chaired by our three constituent Health and Wellbeing Board chairs, on rotation.

System working to deliver Integrated Care

The BNSSG ICS has brought together three key BNSSG -wide change programmes into a Home First portfolio to deliver integrated care, which includes agreed ICS joint working on the related BCF objectives. The NICE definition of integrated care has been used to set the scope for this portfolio: "a multidisciplinary service that helps people to be as independent as possible. It provides support and rehabilitation to people at risk of hospital admission or who have been in hospital. It aims to ensure people transfer from hospital to the community in a timely way and to prevent unnecessary admissions to hospitals and residential care." The Home First portfolio has an agreed overarching aim to: work together to keep a person at home when they need extra support or get them back home as quickly as possible if they have to be displaced from their home environment. This might be unplanned and needed in response to the management of an existing condition or a change in the home circumstances (e.g. carer or housing related), as an alternative to admission, or to support an earlier discharge from hospital.

The Home First programmes are as follows:

1. **Ageing Well**
   The programme is currently working with the BNSSG Locality Partnerships on developing their offer in response to a Target Outcome and Quality Model for ageing well, including plans for anticipatory care implementation and the consistent delivery of the Enhanced Health in Care Homes Framework in care home settings. As part of the programme, 17 pilot schemes have been commissioned which range from advanced care planning to support for people with Dementia and their carers.

2. **Healthier Together@home**

This programme is developing virtual care and virtual wards pathways supported by a digital remote monitoring system, a clinical hub for overseeing care, specialist support for clinical pathways and workforce development.

- The virtual care pathways provide enhanced healthcare at home but not as an alternative to hospital. These include perioperative care, virtual consultations, and the monitoring of stable patients with chronic diseases and long term conditions.
- Virtual wards to enable patients to be treated at home as an alternative to hospital with remote monitoring and proactive management by a clinical hub. Acute respiratory infection virtual ward is in place. Work is underway on developing virtual wards including for supporting frailty conditions and heart failure.

3. Discharge to Assess

The BNSSG D2A programme has been refreshed and extensively revised. In addition to work on system performance and pathway redesign, the programme includes a focus on workforce development, deepening health and care integration, the use of technology-enabled care, and VCSE service provision to support a new Pathway).

Future direction of travel for the BCF

The BNSSG Local Authorities and the ICB have agreed to work towards a refocus of their respective BCF plans so that these become the key delivery vehicle in future for joint working at ICS, local authority and locality partnership level for intermediate care. It is some years now since the BNSSG BCF plans were revised and substantially updated, and the investments that have been made in 2022/23 in the Home First programmes, not least Discharge to Assess and Ageing Well, have provided an opportunity to review and revise these plans. Work is underway on developing a baseline of recurrent spend on intermediate care for the BNSSG ICS that encompasses both NHS and local authority funded services. This clarification of the baseline will support the future development of intermediate care services via the Home First portfolio of programmes. However, the review has not been completed in time to be reflected in the BCF plans for this financial year.

Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2022-23
- Approaches to joint/collaborative commissioning

- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.

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 ICB 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.

Ageing Well programme, which is developing an integrated model of care for BNSSG, being 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 ICB 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 has been developed and services have been redesigned or recommissioned accordingly.

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.

Bristol City Council are in discussions for more joint fully integrated services. We would like to progress the following:

a) Funding for a joint whole life Learning Disability and Autism team has been approved by the Learning Disability and Autism BNSSG board. The funding comes for 2 years for 6FTE (including a senior programme director and senior commissioner). The funding comes from transferring care funding to support patient with LD&A to step out from long stay hospitals back into a less restrictive community setting. The new project team will also focus on transitions where high cost packages and moved across from children to adults and where the care market is not well developed to provide the best specialist supported housing and the deliver outcomes that maximise a person's independence
b) We would like to move to a more integrated intermediate care offer that builds around a recurrent pooled budget under one joint commissioner and one lead provider (Sirona in our system). We would like to remodel BCF switching out some of the legacy spend and clarifying both the ICB's and BCC's full spend on intermediate care and to bring that spend together in a real way that can be managed and led by the Home First Programme that is signed up to by all BNSSG system partners. We feel this would lead to greater pace and clarity around transformation of D2A and admissions avoidance including alignment of the Council's reablement service and Sirona's rehab service, building on the initial success of a virtual wards model and putting these services on a more sustainable financial foundation.

Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

Please use this section to outline, for each objective:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care
- How BCF funded services will support delivery of the objective

Plans for supporting people to remain independent at home for longer should reference

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level.

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

- Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.
- Carry out collaborative commissioning of discharge services to support this.

Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

The D2A model is not new. Healthier Together partners have been working to deliver a rapid hospital discharge approach for years. 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 the Home First Overview Document (attached above) for more information about the approach we have taken to improve outcomes for people being discharged from hospital and how BCF funded activity supports safe, timely & effective discharges.

We have also commissioned a Discharge Support Grant pilot until 31st December 2022 to support earlier hospital discharges and prevent hospital admissions, which supports the personalised agenda. For more details, please see the *'supporting unpaid carers section'* below.

Supporting unpaid carers.

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

The Better Care Fund for Carers operates as a single pooled budget between Health and Social Care to meet our statutory Care Act duties in relation to unpaid carers. This pooled budget has been in place for a number of years and supports three core categories of work:

- **Integrated Carers Team (15%)**
  A specialist team, hosted within Adult Social Care, with a remit for undertaking carers assessments, acting as a point of advice / guidance to carers and professionals supporting carers, and offering strategic insight into issues and themes arising for carers across the system. The team also coordinate and support various local VCSE organisations to act as 'Trusted Assessors' to undertake light touch Care Act assessments / reviews for carers, with the ability to allocate low-level direct payments.
- **Direct payments to carers (55%)**
  A combination of one-off direct payments for carers and ongoing direct payments for carers are paid for via this budget. This funding, following assessment by the Integrated Carers Team, goes directly to carers, to enable them to continue in their caring role.
- **Contracted carers support services (30%)**
  There are jointly commissioned support services for carers in Bristol. These offer a range of interventions from local VCSE-led organisations, to help offer support to carers with the primary goal of preventing carer breakdown and enabling people to remain living at home. The specific services commissioned are:
    - Carers' telephone helpline
    - Short-term support to Carers
    - Short Breaks
    - Carers' Emergency Card Scheme
    - Carers' Support Groups co-ordinator
    - Health support services (including separate hospital-focused and Primary Care focused work)

Discharge Support Grant scheme is available to unpaid carers in BNSSG to support loved ones home from hospital

Families, friends or voluntary carers in Bristol, North Somerset and South Gloucestershire could be offered one-off payments of up to £1,200 to help their loved ones return home following a hospital stay or to avoid a hospital re(admission).

The pilot grant scheme aims to help improve 'flow' through local hospitals and free up beds for those who are medically unwell, by covering the minor costs associated with bringing a loved one home following their discharge.

It can be used to support the costs of childcare support, pet care, carers breaks or equipment. Funding can also pay for short-term personal care from a self-employed personal assistant to help with day-to-day activities or it may be possible for a family member or friend to be supported to provide care.

As part of the DSG agenda are reviewing our local offer to:

- Support an increase in the number of people who could be discharged from hospital, enabling them to recover in a more comfortable home environment and releasing the beds to others who need them
- Relieve pressure on commissioned community services by enabling people to design and fund new, personalised & bespoke solutions working with the discharged person's friends and family to identify the best options and coproduce good solutions for care and support
- Promote personalised agenda
- Proactively help grow a new workforce by empowering local people in their communities to provide support to people leaving hospital, which supports inclusive growth & climate change
- Promote 'describe' not 'prescribe' ethos by identifying specific needs
- Test new ways of working by employing self-employed PAs to provide personal care

Further information, about the grant is available on the Sirona care & health Partner2Care website.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, social 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 contribute to the funding 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 older residents and families in housing need with a range of support to:
    - Access to appropriate health and social community services
    - Provision of a handyperson service, providing trusted support to undertake small repairs and improvements
    - Operation of an assessment centre to increase efficiency of the DFG assessment process
    - 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 BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

An **Equality Impact Assessment** was developed to assess the impact of projects under the D2A 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.

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.

Appendix 1

Overview: Bristol, North Somerset and South Gloucestershire (BNSSG) Home First Discharge to Assess (D2A) Programme

We are working together across acute hospitals, community health and social care and the Voluntary Community and Social Enterprise sector (VCSE) to get more people to the right place for their recovery, care and support needs, in the place they call home, as soon as clinically possible.

Too many people in our areas currently spend too long in both our Acute and Community hospital beds, which evidence shows leads to worsening physical and mental health. Compared with other parts of the country, more people in our area are discharged into community beds, rather than at home, further slowing their rehabilitation and recovery and leading to more people needing long term social care.

With current pressures, winter demands ahead, threat of further Covid-19 outbreaks and ongoing staff shortages, it's clear we must take action now – and do things differently in future. The challenges for health and care services mean urgent action is underway, through initiatives such as the 100 days challenge.

Working together, in new ways, can help tackle the immediate pressures facing staff and the people we care for throughout Bristol, North Somerset and South Gloucestershire (BNSSG). The work we do now will help us prepare for winter demand on the NHS and social care in 2022 and beyond, By reducing length of stay in hospital beds, we can improve flow throughout the system and delays in areas such as ambulance handovers, admission for other people needing hospital beds, and discharges. Together we will also develop long-term solutions which are sustainable for all partners, with joined-up pathways and care wherever possible outside hospital.

The Home First D2A programme is focused on some key goals:

- Short-term actions: working at pace to make pathway and process improvements together that will have an impact this winter
- Long-term transformation: developing and implementing fully integrated pathways across health, social care, independent care providers including care home operators, and the VCSE so people can go home (or to another appropriate community setting) from hospital as soon as they no longer need acute care

We have set some key objectives and will publish progress. Our goals include:

Getting more people to the place they call home, sooner, once clinically ready to leave hospital beds:

- Truly integrated pathways across health and social care in the long-term with more clinical staff working in community roles and supporting both recovery and prevention of readmission to hospital
- Shared clinical decision-making (eg 'Trusted Assessor' model) with acute, community and social care colleagues, and VCSE providers involved earlier to assess and plan recovery and future care
- Technology equipping people to self-monitor and self-manage their conditions at home, helping us stay informed of their health, deliver interventions when needed, and prevent hospital attendances

Increased community care capacity:

- Recruiting new staff
- Moving more clinical expertise out of hospitals
- Trialling new approaches to developing the workforce, including rotations between hospital, community care and social care
- Increased and earlier collaboration between NHS and social care services at all levels, to ensure frontline social workers have the resources and time needed to deliver more integrated care pathways and individual care plans

Reducing waiting times and overall length of stay throughout the pathway

- Better flow through our acute and community hospital beds
- Earlier and ongoing timely assessment involving multi-disciplinary clinical and care teams
- Accurate, quicker, more consistent data to enable more informed joint decisions
- Consistent processes and discharge criteria so more people are discharged onto the best pathway for their recovery, at the place they call home, as soon as possible

How will we do this?
Effective partnership working is vital. The Home First D2A programme brings us all together, with workstreams, task and finish groups and joint governance and operational forums involving colleagues from every partner organisation.

Short-term actions

Getting more people to the place they call home, sooner, once clinically ready to leave hospital beds

- Rapid operational improvements and using consistent processes across health and care services
- New care navigator roles in acute hospitals helping plan for discharge on the wards
- Support more people to live at home with specialist clinical support through a Frailty Virtual Wards pilot, so people can be discharged home directly from acute hospital beds, and stepped-down sooner from community beds

Increased community care capacity

- Recruitment marketing campaigns for Rehabilitation Support Workers (RSWs) and therapists
- Innovative new rotation schemes, particularly RSWs and Band 5/6 therapists, widening experience and bringing more clinical capacity into care at home
- More integrated working between NHS providers and social care. More staff working in community settings with the time and resources to make best use of their clinical, professional and care planning skills, delivering personalised pathways and preventing readmission to hospitals

Reducing waiting times and overall length of stay throughout the pathway

- Operational improvements and consistency throughout Acute and Community hospital flow - focus on consistent delivery of standard operating processes and removing barriers for staff
- Collect and monitor more accurate, consistent data across all partners at all stages of pathways
    - Audit of people in Pathway Three community beds (hospital and commissioned from independent providers) to assess whether they are in the right place for their recovery
    - Audit of people in Pathway Two beds to see whether they are in the best place for their care
- Improving acute-community care working: new Community Transfer of Care Document process to ensure accurate shared clinical information is available first time, enabling quicker discharge onto the right pathway and saving staff time

How will we know how we're doing?
We will measure our impact and share progress in key areas for improvement:

- Reduced length of stay and waiting times for discharge in Acute beds
- Reduced time spent on Pathway One, so people can live well independently, sooner
- Fewer people transferred to community beds (Pathways Two and Three) and a higher proportion onto Pathway One. Our long-term goal is for 70% of people to be discharged from Acute hospital beds onto Pathway One; and 10% to each of Pathways Two and Three
- In future, fewer community beds needed overall as more people can go home to recover
- Increase in number of people discharged to support at home via Frailty Virtual Wards
- Introduce more specialist pathways including cognitive impairment, end of life care, and community support, so people can be discharged from Pathway Three beds sooner
- Increased community care capacity and workforce; so we can discharge more people home on individual patient-centred Pathway One care plans, and give staff more time for assessment and delivering rehabilitation, recovery and ongoing care outside hospital

- Increased community care capacity and workforce; so we can discharge more people home on individual patient-centred Pathway One care plans, and give staff more time for assessment and delivering rehabilitation, recovery and ongoing care outside hospital
- Reduced overall hospital LOS, reduced readmissions, and more people enjoying independent living with increased self-monitoring and self-management of their conditions

How are we doing? August 2022 impact

- Audit of Pathway Three beds complete; action plans being developed to reduce people in these including fewer spot purchases
- TOCD Document: operational processes, data quality and joint working to increase people referred onto Pathway One and reduce proportion of Pathway Two and Three referrals
- Overall Pathway One overall length of stay in our Trusts' Acute beds reduced by 11% (2.6 days) from April to end of June 2022
- The NHS '100 day challenge' is underway with a focus on improving flow across the system

Long-term Transformation

As well as the rapid work to make a difference for people now, we are planning for system-wide new integrated care models for the future. Collaboration and expertise from our social care, third sector, NHS trust and community health and care colleagues, the third and independent sectors is driving the planning, with support from specialist external organisations.

- Full redesign of all pathways: based on evidence and best practice, with health and social care truly integrated, and specialist pathways in place for people with complex needs

- VCSE support mapping: The VCSE task and finish group is undertaking research to comprehensively map the support provided at all stages of the D2A database by VCSE organisations in each Local Authority area. This will help identify the full provision currently provided, ensure all referral information and options are available consistently to partner health and care services, and people and their families/carers. It will help identify any gaps and opportunities to improve system flow by working in even greater partnerships with VCSE providers

- Digital transformation: the task and finish group is assessing and preparing pilots of new technology-enabled care solutions to:
    - give people new easy-to-use tools to assess their health, proactively manage their conditions, and access intervention and support when they need it
    - reduce clinical and social care interventions in people's homes, and prevent hospital readmissions
    - provide health and care professionals with timely data for effective remote monitoring - reducing community and hospital appointments and enabling proactive intervention and prevention
    - improve people's independence, self-management of conditions and quality of life

- Co-design: purposeful engagement, with social care, NHS, VCSE and independent providers staff, people we care for, and others such as housing providers, to help identify and co-produce solutions

- LGA (Local Government Association) support bringing senior leaders and frontline staff together to:
    - Co-design future transformation and implementation plans, including a fully-integrated Pathway One care model
    - Identify opportunities for consistent operating processes, and where local variation based on population health is essential, to consistently deliver outstanding person-centred care

- Ethical Healthcare Consulting: research and insight from colleagues across organisations to help understand how we can give people the time, tools and support to collaborate in new ways