SOMERSET County Council

Fit for my future. A HEALTHIER SOMERSET

NHS Somerset Clinical Commissioning Group

Somerset Better Care Fund 2021-22 – Narrative Template

Health and Wellbeing Board Area: Somerset

Our vision for Somerset

'In Somerset we want people to live healthy independent lives, supported by thriving communities with timely and easy access to high quality and efficient public services when they need them.'

'Somerset's vision remains focused on working together to improve and maintain the health and wellbeing of everyone who lives and works in Somerset. We can only do this if we continue to work together with our partners in the health and care system, our voluntary sector and with our patients, service users and the public. We know that bringing health and care together in a way that is sustainable, while also making improvements to how we deliver services is a priority and we will do this to help build stronger communities and services which support people to live happy, healthy lives' *(taken from the 2021.22 Somerset ICS Operational Plan)*

The focus on our populations' health and wellbeing, both from a preventative and reactive perspective, and the bringing together of key partners is fundamental and continues to be enabled by mechanisms like the Better Care Fund (BCF). This encourages public bodies to work together, to collaborate, to manage resources, to share expertise and integrate services where this is in the public interest. It also helps us look beyond the demands of today and take a more preventative approach, reducing demand and poor health in the future.

The Somerset BCF narrative for 2021.22 is set out below, using questions from the national template. It offers an overview of key aspects of our approach relevant to the unprecedented context in which health and care services are working and managing.

This should be read in conjunction with our BCF planning template which sets out our ambitions against the national metrics and details of each of the schemes that are funded through the BCF and contribute to our system goals.

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1. Please describe the 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?

Stabilisation - a key priority during and after the pandemic

The Somerset Better Care Fund (BCF) 2021.22 represents a stabilisation and roll-over of our previous plan. This has been very important in supporting local people and services to manage the ongoing challenges and our recovery from the COVID-19 pandemic. It has provided essential stability of services and collaborative working arrangements at such a pressurised, destabilising, and fearful time for local people.

Our 2021.22 BCF plans continues to meet the national conditions and continues to align with our local strategic priorities informed through the *Somerset Fit For My Future Programme (FFMF)* and the *Somerset Improving Lives Strategy.*

FFMF has involved an extensive period of engagement with local people, service users, patients, and stakeholder groups. It has encompassed hundreds of conversations and events and the contribution of many people and groups. Key bodies involved have included local NHS Trusts, Voluntary and Community partners, local patients, and people.

The strategic priorities arising from FFMF are summarised in the next section. They support and align with the national intentions for the Better Care Fund in promoting integrated, person-centred care and enabling people to live safety within their own homes or usual place of residence. Our plans continue to foster joint working between the NHS, local Councils, and other strategic partners.

Working in recovery and within a state of high system escalation

Across Somerset there is a vast programme of improvement work, collaboration, and integration underway. There are a huge number of highly committed people who have and continue to work tirelessly. This is despite the system managing extremely high, unprecedented levels of pressure which have resulted from: the COVID-19 pandemic, the vaccination and booster programmes, high levels of demand and backlog, workforce and staffing shortages, instability across a number of sectors and the impact of wider political, environmental and financial conditions. There are also major organisational changes in progress including the bringing together of our Councils, the merger of our Hospital Foundation Trusts and the establishment of the Integrated Care System. For these reasons it is important that we maintain our ambition for better, more personalised care and acknowledge that we are managing in exceptional circumstances ***and*** forging ahead with our improvement plans.

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2. Executive Summary and key priorities for the 2021.22 BCF plan

Please outlines the key priorities for 2021.22 and the key changes since the previous BCF plan.

Strategic priorities supportive by the BCF

The Somerset Fit For My Future Programme and its extensive engagement and involvement has culminated in a set of priority areas for development (see below). These support and complement 1) the intentions and spirit of the BCF, 2) the 2021-22 Somerset System Planning Priorities, 3) the Somerset Improving Lives Strategy (overseen by the Health and Wellbeing Board), and 4) the establishment of a Somerset Integrated Care Systems (ICS). The Fit for my Future vision is our single ICS vision and aims to:

1. Enable people to live healthy independent lives, to prevent the onset of avoidable illness and support active self-management. (This is also a key aim of the Improving Lives Strategy which seeks to see 'improved health and wellbeing and more people living healthy independent lives for longer'). 2. Ensure safe, sustainable, effective, high quality, person-centred support in the most appropriate setting. 3. Provide support in neighbourhood areas with an emphasis on self-management and prevention. 4. Value all people alike, addressing inequalities and giving equal priority to physical and mental health. 5. Improve outcomes for people through personalised, co-ordinated support.

Achieving our ICS vision will require us to focus on the following areas:

- ***Prevention –*** directing more resources and attention towards prevention and the underlying and wider drivers of health and wellbeing outcomes including the wider determinations of health: isolation, loneliness, relationships, housing, education, healthy lifestyle behaviours, employment. A focus on community development will be adopted to maximise resilience within individuals, families, and communities

- ***Tackling inequalities*** – tackling inequalities of outcomes, experience, and access by changing how services can be accessed, where they can be accessed, how they are delivered and who they are delivered by. This also includes greater targeting and tailoring of services to people and groups who are the most affected by health inequalities.

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- ***Person-centred approaches*** – ensuring that the person receiving help and care is at the centre. This requires that care, support, and treatment plans are codesigned with people and that they are delivered in a tailored way, reflecting what matters most to the person, their life, their strengths, and their aspirations. Achieving this will involve an ongoing focus and further cultural change

- ***Community based support –*** enabling more people to engage with support in their community (where the solutions to the wider determinants of health and wellbeing often lie). This includes our investment in Community and Village Agents, Social Prescribing Link Workers, and investment in Voluntary and Community Sector Enterprise (CVSE) partners. It also recognises that many very important community assets are not and do not need to involve statutory organisations

- **Multi-disciplinary working** – Enabling greater opportunities for local professionals to know each other, work collaboratively, share resources and information as part of local integrated community teams. This includes Primary Care Networks, Community Health and Care Teams, Social Prescribers, and local Voluntary and Community Sector partners

- **Support to enable people to remain or go back to their own home –** strengthening the support available to people to enable them to remain in their own homes or return home after a stay in hospital or a short term care placement. In Somerset this suite of services is known as Intermediate Care and includes Rapid Response, Home First, Community Nursing and Voluntary Sector Partner involvement

- ***Joined up strategic planning and commissioning*** – Somerset is in a good position to build on the strong tradition of joint working by strategic partners across Social Care and Health. Our ambition, where in the public interest, is to integrate and streamline the commissioning and provision of services further under strong and stable governance structures and public accountability

- ***Stability and security for system partners*** – to improve how we work with and invest in services provided by CVSE partners we are moving towards the use of more proportionate forms of contract and longer-term agreements. This is essential to provide greater stability for these crucial services, support and teams and enable the development on longer term, high trust strategic relationships.

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3. Governance

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

The governance of the Somerset Better Care Fund is being reviewed and updated in line with the development of the Somerset Integrated Care System (ICS). The overall approach is as follows:

1. Overall strategic leadership by the National Better Care Policy Team
2. Regional leadership and support by the Regional Better Care lead
3. Somerset Integrated Care System Board (Our local Executive accountability)
4. Maintaining a nominated lead Director for the Somerset BCF (Executive Sponsor)
5. Somerset Health and Wellbeing Board (Public scrutiny, democratic sign off and oversight, shaping and influence)
6. Somerset Better Care Commissioning Group (day to day oversight). Includes named BCF leads from Social Care, Public Health, District Councils, and the NHS)
7. The CCG's Finance and Performance Committee (in respect of the NHS's contribution and the outline of the plan)
8. The lead member for Adult Social Care and the LA cabinet for financial oversight and LA funding contribution
9. Peer Group: engagement with regional peers and via the national webinars
10. Links with other strategic groups in the formulation- of the Plan. This includes the Elective Care Programme Board, the Urgent and Emergency Care Board, the Intermediate Care Board, the People Board, and others
11. Engagement with a range of key partners, public and patient groups

The governance of the Somerset BCF is thorough and extensive, is linked with wider strategic plans and is embodied within the new ICS structure.

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4. Overall approach to integration

Please provide a 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.

Integration (bringing together and joining up)

For Somerset Integration and collaboration is a key priority. In simple terms, it refers to the bringing together and joining up of services and support, care processes, and ways of working which improve outcomes for local people and local services.

Integration relates to several important interdependent domains:

- ***The person:*** Integrating (joining up) care and support around what matters most to the person and their life situation and enabling people to engage with resources in their local community. We believe that integration and person-centred care are closely linked.
- ***Services:*** Integrating (joining up) health and care services where this will improve outcomes for local people and make better use of local resources
- ***Systems:*** The integration (joining up) of governance, commissioning, or provider functions where this brings about a more efficient and effective use of public money and better outcomes for local people.
- ***Culture and ways of working*** *(bringing together)**:*** The Somerset health and care community acknowledge that structural and process change needs to be accompanied by culture change. This is fostered by ensuring we are always listening to the people we service and making sure they are at the heart of our strategic plans and service development. This is also achieved by enabling teams to work together, to form trusting, psychologically safe joint working arrangements in which different perspectives can be considered and shared. It involves enabling culture change using IT, training, and support and most importantly through leading by example.

Excellent joint and collaborative commissioning

In Somerset we have a long tradition of joint and collaborative commissioning across Social Care, the NHS, and Public Health. This has been enabled by mechanisms like the Better Care Fund and our view that by working together we can achieve better outcomes for the people of Somerset.

We continue to develop joint and collaborative commissioning and have ambitions to take this further.

Our current portfolio of joined up commissioning extends across a wide spectrum of areas. This includes the following examples which are specifically supported either entirely or in part by the Better Care Fund:

Aspect of the system	Joint or collaborative commissioning
Support for carers	We have a jointly commissioned and jointly funded service dedicated to supporting carers
Community Support and social prescribing	Our commissioning of community-based support. For example, support by Village, Community and Hospital Agents and Social Prescribing Link Workers is joined up and involves close working with Social Care and the NHS. All strategic decisions and investment levels represent are jointly supported
Workforce development	The Somerset People Board oversee strategic workforce developments in the county. This is multi-partnership collaborative forum including local Trusts, Social Care, Councils, Primary Care training and education leads and VCSE partners. Using funding from the Board and the BCF has enabled us to develop 'Person-centred Care Conversations' training which has been accredited by the Institute of Public Care. This will now be offered to a wide range of staff and help promote and language and culture of person-centred, strength-based approaches.
Intermediate Care	This is a crucial multi-million-pound collaborative service which includes Rapid Response, Home First, District Nursing, Social Care, Community and Hospital Agents and VCSE partners. This extensive service is a keystone to our model of support for people to remain or go back home, preventing admission and enabling recovery following a stay in hospital
Community Equipment	We have a jointly funded and jointly commissioned Community Equipment Service which provides a wide range of equipment, aids and enables people to live independently at home
The Disabled Facilities Grant	We have a well-led collaborative approach to the use of the Disabled Facilities Grant. This involves the lead and other District Councils, the County Council, and the NHS.

Changes in 2021.22

The focus of our 2021.22 plan is to ensure system stability as we manage the impacts of COVID and other system pressures. This applies to the funding directly towards mainstream services (as has been the case for all years of the Somerset BCF) and funding directed towards relatively newer, more innovative schemes.

We have made improvements in how we set out the funding for our local BCF in 2021.22. This is to ensure that whole scheme costs are shown together and not

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particularly included in several planning lines. This gives a much clearer view of the true costs of schemes and the true extent of our investment in out of hospital, personalised care.

5. Supporting Discharge (national condition four)

Please outline 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?

Intermediate Care – the crucial bridge

In March 2020, at the onset of the Covid pandemic, the Somerset System agreed to implement a new model for Intermediate Care. This built on the Home First Model that had been operating in Somerset since 2016 and brought under one umbrella all intermediate care discharge support from hospital, as well as services to prevent admissions. At its foundation is a strong collective ambition across health and care organisations in Somerset; to maximise people's independence and support people to remain at home as far is possible.

Somerset's Model for Intermediate Care was developed following a review of Home First at the end of 2019. The onset of Covid-19 accelerated the implementation of this model and led to a rapid reorganisation of the discharge and diversion support in the system. Whilst several of the pathways and operating principles were already in place in the Somerset's Home First service, the revised model ensured that:

a) Supported discharge decision making was removed from the hospital wards and instead made by a multidisciplinary team within a discharge lounge.

b) Responsibility for managing the supported discharge pathways was separated from the acute discharge function and instead managed out in the community.

c) A central Somerset Hub for Coordinating Care was set up to provide a single point for coordinating and managing capacity across all the intermediate care options.

d) All community beds, including Home First Pathway beds, community hospital beds and interim beds, act as one bed base with a defined hierarchy of use and are coordinated and monitored from one place.

e) The previous Home First reablement pathway (Pathway 1) is converted to a discharge to assess model, introducing a period of assessment at home to determine ongoing reablement or support needs.

f) A Head of Intermediate Care was appointed to act as a senior responsible contact for discharge across the county and is a jointly managed post between Somerset Foundation Trust and Somerset County Council.

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In Somerset, Intermediate Care refers to services and support which sits in between hospital or residential care and the person's home (their place of ordinary residence). The service acts as a crucial bridge in supporting people to safely go back or remain in their homes with the right level of support. Our Intermediate Care model is an essential set of services and reflects around £25m of investment from the Better Care Fund. It includes a wide range of essential services:

- Single Points of Contact and case management in each locality
- A health and care joint Head of Intermediate Care post
- The Rapid Response Team
- The Discharge to Assess (D2A) Pathway 1 Team
- Specific reablement pathways in various supported bedded care settings (Care Homes and Community Hospitals) with on-site therapy support and training
- Community Reablement and Rehabilitation
- Social Care allocated workers outside of the acute setting
- Links with Community Nursing
- Access to Community, Village and Hospital Agents
- Strong links with Community Hospital Discharge Teams
- Access to Voluntary sector support for practical and social issues
- Urgent access to Community Equipment
- Links with micro and other support that people and their families can arrange directly for themselves

A focus on length of stay

We are aware that, in line with many other NHS trusts nationally, that length of stay and possible delays are a major source of concern. In Somerset, we have confidence that our Intermediate Care model is the right one as evidenced in previous winters. Current challenges in reducing length of stay include workforce shortages in domiciliary care, social care and the NHS which impact on flow and ultimately on length of stay. The Better Care Fund has been the major contributor to Intermediate Care growth as well as being a home for some of the additional funding. The BCF is fundamental to us managing down our length of stays following the pandemic. This includes us having more trusted assessors to cover weekends and out of hours, more voluntary sector capacity (returning to the wards) and short term contingency measures such as shared recruitment, shared bank staff and the purchasing of more interim bedded options. There are also a number of schemes under way with Local Authority colleagues around the wider domiciliary care provision, including incentive payments, provision of staff accommodation, new salaried location based teams and a new live bed sourcing team.

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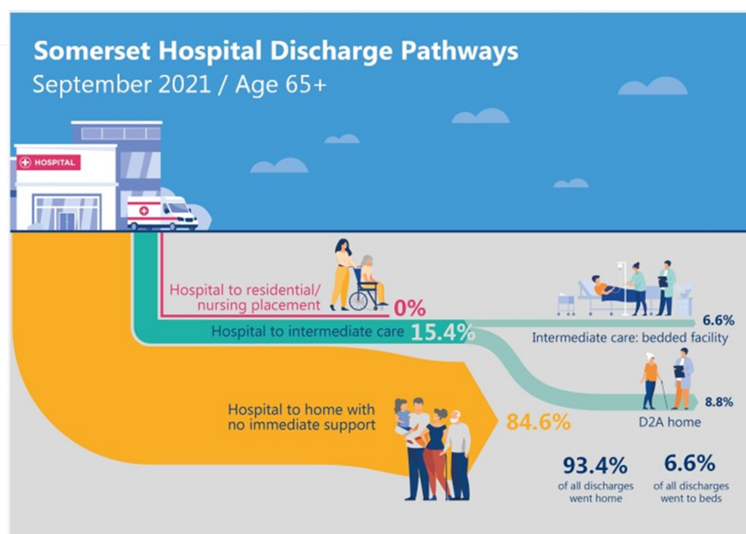
Each month in Somerset, the Intermediate Care Teams support over 50% of people to safely return home from intermediate care. This is only possible thanks to the dedication, commitment, expertise, and collaborative working by these teams.

The pictogram below illustrates the discharge pathways that are in place in Somerset which indicate that over 80% of patients are discharged directly home from hospital with no immediate support. This ensures that the remaining patients that do require support receive the most appropriate care and support for their needs.

Hospital Flow Diagram – September 2021



The % of people being discharged with no support during September was **84.6%**. This is a slight decrease from August's figure of 86.9%.

6. 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?

Somerset currently has a two-tier Local Authority structure and therefore the 4 District Councils have the statutory duty to manage the Disabled Facilities Grant (DFG). In doing so they ensure that home adaptations are made available to people who qualify and enable them to remain living in their own homes. They also ensure that existing housing stock (across all sectors) is of a standard which promotes health and wellbeing and enables independent living for those with a range of physical and mental health conditions.

In accordance with the BCF planning guidance, the DFG is passed to the District Councils to manage on behalf of the Somerset system. The nominated lead District Council oversees the use of the grant and coordinates applications, home adaptations and work across partners.

For Somerset, the DFG is deployed to achieve the following outcomes:

- Prevent or delay admission to hospital and/or residential or nursing care of individuals through a joint understanding of what is required, improved communications, timely and responsive processes.
- Prevent delayed transfer of care or facilitate discharge of individuals from hospital/residential care through building capacity and resilience within key staffing roles in health and housing as well as the suitably adapted stock required.
- Maintain older and disabled people's ability to live independently in their own home and community for as long as possible and promote their well-being, by providing choice and more control over their lives. Increasing assistive technology, recognition of the hoarding and mental health services provided.
- Reduce chances of a life changing health event by initiating prevention policies, activities, and adaptations. Understanding the types of prevention packages that there are, improve partnership working and community self-help.

In seeking to continually improve the use and impact of the Grant, the District Councils, in working with partners have introduced monthly multi-agency practice development meetings to look at complex blockages and learning. These are set to expand links through the DFG, for example into the community hospitals and focus on proactive actions such as influencing pre-operative meetings for people undergoing elective surgery to ensure that people's housing needs are fully considered. Communication between agencies including housing, health and social care has vastly improved as a result, and partners are recognising the benefits of working with district housing authorities more strategically.

There are many other initiatives developed in partnership between health, care, and housing services, some are listed below:

- A new stairlift loan facility to remove stairlifts from the DFG process
- A new Paediatrics Housing Options Occupational Therapists (OTs) to assist the OTs deployed to support adults
- A revised Private Sector Housing Renewal Policy which has much more emphasis on prevention. Prevention grant has been increased from £1,000 to £2,500 to reduce the number of clients going through the major adaptation route.
- Additional Trusted Assessors being trained across district housing services

As Somerset undergoes local government reorganisation, the links established via the BCF will be crucial to maintaining and expanding services across housing and support. The joint working in this space will ensure a smooth transition to one council and lead the way in integrating district and county functions.

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Linked to the DFG is the provision of community equipment. This long-standing service, also funded from within the BCF, offers, distributes, and collects a range of equipment which enables people to remain independent in their own homes. This ranges from complex equipment like ceiling hoists and lifting equipment to specialist mattresses, walking frames right through to smaller items like toilet seat raisers and shower rails.

The Somerset Councils and CCG are in the process of recommissioning a new Integrated Community Equipment and Wheelchair Service. This is a jointly funded service. We plan to further integrate the management of the DFG and new Community Equipment Service as we move into an Integrated Care System. This will include expansion of Independence Assessment Centres, staffed by Occupational therapist and housing officers, where clients can be appropriately assessed and try out adaptations and, if necessary, be means tested and approved for a DFG all at the same time.

As part of prevention policy there is a Memorandum of Understanding - Improving Health and Care Through the Home in Somerset. The MoU brings together Health, Care and Housing around five priorities. Complex Homeless and Rough Sleepers, Independent Living, the Gypsy, Roma and Traveller Community, Climate Change and Home Improvement Agency Services (Somerset Independence Plus). . Following adoption (Sept 2020), the MoU is building improved relationships and ways of working between councils (housing), the commissioners and providers of housing support services, and registered providers, in order to better meet the housing, health and care needs of vulnerable people across Somerset, and ensure that more of our existing housing stock (all sectors) is good for health, enabling independent living for those with a range of physical and mental health conditions. Working across partners we can increase the choice and quality of both accommodation and support to homeless/rough sleeper communities. This includes provision of accommodation and support to match specific needs (low, medium & high complexities; high risk offenders; victims who are homeless as a result of Domestic Violence, homeless people with wheelchair accessible needs etc) to have a much better opportunity to stabilise their lives and move quickly to independent living. Investment here also helps reduce expenditure on temporary accommodation, including Bed & Breakfast accommodation, which is totally unsuitable for homeless people with complex needs.

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7. 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.

Health Inequalities

The Somerset Health and Care System places significant importance on tackling unfairness, disadvantage, discrimination and observable avoidable differences in health and wellbeing outcomes for its population. This is evidenced throughout the Somerset Integrated Care System (2021/22) Priorities and Operational Planning, the setting up of a new Health Inequalities Group within our ICS structure, having in place nominated system leads and dedicated workstreams.

Health is closely linked to the conditions in which people are born, grow, live, work and age and inequities in power, money, and resources, the social determinants of health.

Significant differences can occur between the health experienced by some social groups when compared with others, these differences are inherently unfair. Such inequalities can be found between many types of community or social groups such as geographical areas, socio-economic status, ethnicity age, gender, and disability.

This is true for both morbidity and mortality; we aim to narrow the gap in health and social inequalities, ensuring that the health and wellbeing of the worst off in society is improved at a faster rate than those who are the most advantaged.

For these reasons, it has been, and remains extremely important that services and support funded from the Better Care Fund:

- is person-centred and truly tailored to the needs of the person and their life making services more responsive to the needs of disadvantaged populations
- addresses the wider determinants of health in the delivery of its work, dealing with the long-term underlying causes of ill health
- ensures access criteria are not restrictive
- directs resources to help people to connect with others and access support in their own community thereby engaging communities and individuals to ensure relevance and sustainability
- enables people to return or remain in their own home and be with their own family, friends, and community

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Somerset Better Care Fund 2021-22

In concluding the Better Care narrative for 2021.22 we would like to say a huge thank you to:

> All the local people who help make Somerset a safe and wonderful place to live.
>
> Organisations, groups, and people who strive towards improvement in the care and support we offer, through the building of trust, collaboration, integration, and a relentless focus on what matters to the person.
>
> Providers and staff working across health and social care for having managed and maintained support in exceptional circumstances over the last 18 months.
>
> To the Somerset Health and Wellbeing Board, Somerset Councils, Public Health and Somerset Clinical Commissioning Group for their leadership, their forward-thinking approach and their collaborative, joint culture.

It is because of you that our health and care system is there.

It is because of you that we strive to improve the health and wellbeing of all the people of Somerset.

Thank you

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