Somerset Health and Wellbeing Board

Monday 22 November 2021
11.00 am Luttrell Room - County Hall, Taunton

SUPPLEMENT TO THE AGENDA

To: The Members of the Somerset Health and Wellbeing Board

We are now able to enclose the following information which was unavailable when the agenda was published:

Item 3	Minutes from the meeting held on 27 September 2021 (Pages 3 - 10) The Board is asked to confirm that the minutes are accurate**.**

Item 8	Better Care Fund Report (Pages 11 - 80) To receive the report and presentation.

Item 9	Integrated Care Services - Verbal Update To receive the verbal update (document on HWBB / ICP Structure and Governance Update to follow)

Published on 19 November 2021

Democratic Services, County Hall, Taunton, TA1 4DY

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SOMERSET HEALTH AND WELLBEING BOARD

Minutes of a Meeting of the Somerset Health and Wellbeing Board held in the Luttrell Room, County Hall, Taunton, on Monday 27 September 2021 at 11.00 am

Present: Cllr C Paul (Chair), Cllr F Nicholson, Cllr D Huxtable (Virtual), Cllr L Vijeh, Cllr C Booth, Cllr J Keen, Cllr B Hamilton (Virtual), Trudi Grant, James Rimmer, Mel Lock, Julian Wooster, Cllr Mike Best, Sup. Dickon Turner

Other Members present: Cllr M Chilcott, Cllr A Kendall, Cllr A Bown, Cllr T Munt, Cllr H Prior-Sankey, Cllr Bill Revans, Cllr Heather Shearer, Cllr Christine Lawrence, Cllr M Keating

Apologies for absence: Dr Ed Ford, Mark Cooke, Cllr Ros Wyke

Declarations of Interest - Agenda Item 2

There were no new declarations.

Minutes from the meeting held on 15 July 2021 - Agenda Item 3

The minutes were agreed without alteration.

Public Question Time - Agenda Item 4

There were no public questions.

Recommendations to Approve from Last Meeting - Agenda Item 5

The Somerset Health and Wellbeing Board approved all recommendations carried forward from the previous, non-quorate meeting.

Community Adult Mental Health - Agenda Item 6

The Deputy Director of Commissioning-Mental Health, Autism and Learning Disabilities for the CCG and his team made the presentation, including slides and a video. He noted that the original presentation was going to cover a wide range of issues, including not just adults but also children, but the range was too great for one meeting. Therefore, in discussing adult mental health, they will be specifically

discussing the Open Mental Health initiative, which entails 11 providers, the NHS, the CCG, and the local authority all working together. He and his team will be modelling today the new way of working, which gained them Trailblazers status in September of 2019. Persons receiving support and their families are at the centre, but all partners collaborate before acting. Covid has presented a real challenge, but their collaboration has allowed them to achieve great things.

The next speaker was a representative of Second Step in Sedgemoor. She noted that Open Mental Health was created to get rid of barriers and ensure that they provided help from the right service to the persons in need. She emphasised that mental health does not occur alone; there are complex and multiple factors, so this initiative uses a holistic approach. She then went over the Key Principles of Open Mental Health, noting that it's a co-production model with experts at every stage of the process:

- Preventative engagement rather than reacting
- Open access – no wrong door, no shut door, always a door
- Co-production VCSE, statutory colleagues, and "experts by experience"
- All inclusive – no one is excluded based on criteria or diagnosis
- Warm introductions in, across, and between services
- Adopting a trauma-informed approach by all partners
- Flexible and responsive to needs of the individual, outcome-focused
- Whole-system approach with NHS and VCSE elements combined – all one team
- Building on community assets

Two representatives of Open Mental Health then spoke, advising that they are leaders called "experts by experience". They have been users of the services themselves and have been made to feel like equal partners with all the other professionals in Open Mental Health. They don't just check in with users afterwards; they are involved from the very beginning at the strategic level including co-planning, evaluation, meetings, design planning, etc. They have been proud to speak with other CCGs across Somerset about how Open Mental Health is working; for example, the warm transfers where someone from their group accompanies the service user to their first appointment with a different service and keeps in touch with this person throughout the provision of the whole range of services (housing, addiction services, etc.)

One representative then noted that, at Open Mental Health, she works on the design and delivery of training for those who work with hard-to-engage patients. She first spoke to the CCG about how to support new staff about engaging with person with mental health in a way that is empowering and without setting up barriers between themselves and new staff; and she reiterated the other representative's belief that they have been treated as equal partners from the beginning. They will deliver the training across Primary Care in Somerset; they have presented this designed training once so far and will continue to train volunteers and others. She is very proud to be involved with Open Mental Health, because as a user of the service herself, she feels that it is so important.

The Deputy Director of Commissioning then presented a video which showed service users speaking about their previous experiences (negative) and the new system, including services like the 'recovery college' to promote wellbeing, better access, expanded services like the 24/7 emotional support helpline, wrap-around support tailored to each service user, and far more people now being able to access services. The VCSE and NHS together are a great team to work with, and there is also collaboration with the police for safety support and de-escalation. People now know that local services are available and are part of a network where one can find services suitable for each individual in a streamlined process. All providers across Somerset are involved and now have more to offer people by sharing information and collaborating together.

The Second Step representative returned after the video to discuss the Open Mental Health VCSE Offer, which entails Locality Teams and Countywide Support-VCSE. Both sections include specialist workers, training, peer support, etc. She also discussed the access routes to Open Mental Health, which includes those listed below, noting that all clients transferred to Open Mental Health will have an initial contact made within three working days:

- 24/7 Mindline Helpline
- Email: support@openmentalhealth.org.uk
- GP transfer (GP or MH liaison nurse)
- Any team member at a locality hub
- Any network partner
- Introduction by social prescribing workers, housing teams, social care and pharmacists

The Service Director-Mental Health and Learning Disabilities of the Somerset Foundation Trust then discussed the key achievements of Open Mental Health, including:

- More people accessing support (3800 contacts per month on average)
- Low waiting times and a recovery rate significantly higher than the national average
- No patients placed out of area
- Ten peer support workers with a further five in training and four recruited
- Physical health support workers helping people with mental illness to improve physical wellbeing
- No waiting time for care coordinators in the majority of localities

She noted that Somerset's Open Mental Health model has been cited as an exemplar nationally, so there is much to be proud of.

The Committee then asked questions; the first enquired what were the links with family safeguarding teams? It was replied that this is being done differently through integrated Open Mental Health and its volunteer organisations, who can introduce users and their families to other services and partners. It was asked with respect to family safeguarding how Open Mental Health services are connected up specifically with children and their families; it was responded that the family safeguarding model is part of their own model and that the Commissioner at Open Mental Health will be part of family safeguarding.

The Chair thanked everyone involved for their presentation and apologised for the technical difficulties.

The Chair noted that the Somerset Health and Wellbeing Board received and discussed the presentation.

Somerset Integrated Care System (ICS) - Agenda Item 7

The Chief Executive of the NHS Somerset CCG made the presentation. He first thanked everyone who had spoken on Open Mental Health and their integrated care system and emphasised that Somerset ICS is all about everyone being in it together.

He then discussed the key functions of the proposed ICB (Integrated Care Board), noting on Slide 4 that the ICS will need such a board to focus on the health needs of the population, allocating resources to deliver the plan, establishing governance arrangements, etc. On Slide 6, there is a discussion of key functions of the ICP; it was noted that both the Health and Wellbeing Board and the ICS need to bring together health and care to support the population. The ICP board will bring together partners to deliver the actions required through joint working. The composition of the ICP is discussed on Slide 7; there will be input from Directors of Public Health through arrangements agreed by local authorities and the area ICS, clinical and professional experts, representatives of adult and children's social services, and representation from health and care services, the VCSE sector, and Healthwatch, as well as volunteer organisations. They are setting up the ICP Board to be operative in April 2022, with the Health and Wellbeing Board and the ICS working together across health and care services covering 13,000-14,000 persons. The board's overriding vision is to keep the population well.

SCC's Director of Adult Social Care then discussed how the ICS is working together regarding Intermediate Care, which manages the flow of persons into and out of hospitals. It attempts to keep people out of hospitals in the first place, but once they are hospitalised, it facilitates their discharge. It involves health and social care working with providers to get people back home and give them support, including social workers, OTs, and other who will go to a person's home and work with them there to achieve desired outcomes. For those person remaining in hospital or care,

intermediate care attempts to find beds in different facilities where these persons can be helped. This is a team effort that has received national recognition, but they don't have enough people delivering care presently, so they hope that many will come forward to work in the care system. The Chief Executive-Somerset CCG added that the aim is to find the way to help people live well in their own homes and communities.

The Strategy Specialist for Housing and Communities at Somerset West and Taunton Council then spoke about homelessness and Leading for System Change in Somerset, noting that Somerset is one of 7 local areas working with the NHS Leadership Academy to provide integrated services via the VCSE. There are 40 members and a range of partners involved, including Adults and Children Social Care, the CCG, the NHS, Public Health, the Somerset Foundation Trust, district councils, hospitals care providers, and GPs. There are two main topics involved: The first is place-based approaches, both rural and urban, which seek to effectively support local communities. This approach is very much tied to the coming unitary council. The second main topic is homelessness and the importance of providing care and housing, including dealing with complex homelessness/rough sleeping. They attempt to accomplish this through commissioning and early help, and he pointed out that the majority of the homeless have had childhood trauma, requiring the necessity to work with providers in stopping such trauma. To achieve this, they work closely with the Homelessness Reduction Board, as well as other boards. The next steps will entail the ICS engaging in New Ways of Working, which is a long process for which the national guidance has just been published. The good news is that Somerset's services are already joined up and working well, through a very large number of great providers. The legislation for New Ways of Working should go through Parliament in April of 2022.

There were no questions from the Committee; the Chair thanked the presenters for presenting their topics so well using good examples.

The Somerset Health and Wellbeing Board received and discussed the presentation.

Governance Arrangements for Health & Wellbeing in Somerset - Agenda Item 8

SCC's Director of Public Health spoke on the coming ICP and noted that this update carries on from earlier conversations regarding ICS, ICP and the Health and Wellbeing Board's role. Somerset has a tidy ICS system, better than in other places, with one central Health and Wellbeing Board in the county. The new legislation calls for Integrated Care Partnerships (ICPs), which are designed to cover large geographical areas with multiple authorities and boards. She pointed out that there is a degree of duplication between the ICS and the Health and Wellbeing Board, the benefit of which is Somerset's strong system narrative of the Improving Lives agenda, which needs to be kept in place. We need to keep the coming system simple and avoid complicating it; we have made great steps forward toward joining up work, commissioning, etc. It is

a requirement that there be an ICP, which is a statutory body, unlike the Health and Wellbeing Board, which is an organisation. There are similarities within the delegated responsibilities of both the proposed ICP and the Health and Wellbeing Board, such as addressing inequalities, improving health, etc. The Health and Wellbeing Board has had clear statutory responsibilities since 2013, but there will be a number of new duties and responsibilities coming with the ICP, where the focus will be more on services. The Health and Wellbeing Board and the local authority will have to have due regard for the ICP and vice versa. Statutory membership for the Health and Wellbeing Board has been proscribed by the Health and Care Act, whereas the ICP does not have this; the only requirements are members of local authority and the local NHS, with the recognition in the guidance that not all partners need to be included and the membership can be quite flexible. As far as governance, the Health and Wellbeing Board is a committee of the full Council and is a public meeting; the ICP will also be a public meeting, and it should be subject to scrutiny, but the guidance doesn't say. The Health and Wellbeing Board has not received delegated authority from the full Council; the ICP could delegate, but that has not been decided yet.

It was noted that there had been a discussion some time ago about the difference between a Health and Wellbeing Board system and a health and social care system, and the diagram they formulated may be needed to help design the HWB/ICP system, because the overlap of functions needs to be dealt with. With respect to the Improving Lives strategy and other related bodies/issues, she noted that some are statutory, and some boards have statutory responsibilities, so it needs to be determined how to place the ICP within that system. Health organisations that are involved include the Growth Board, Safeguarding, Housing, Education, Safer Somerset, Climate Change Agenda, Fit for My Future, Homelessness Reduction, and others. They all need to be brought together, with a stronger focus on neighbourhoods at the local level.

There will be no conclusions regarding the HWB/ICP issue today, but the aim is to provoke thought about it. It is important to note that Somerset MUST have both boards; they cannot merge them, according to the guidance. She proposed that the Health and Wellbeing Board members have an informal workshop to discuss the matter and bring forward proposals to be presented to full Council.

The Committee made comments and enquiries, asking if, although it is clear they cannot have only one combined board, can the two have common membership? It was also stated that there was a need to ensure that enough organisations were included for economic activities, such as Chambers of Commerce. The Director of Public Health agreed that both needed to be discussed, noting that Chambers of Commerce sit on the Growth Board, and that they have brought in links with the wider determinants of health. The Chief Executive-Somerset CCG offered that he and the Director of Public Health were aligned on this issue and noted that his Slide 7 discusses partnerships having coordination of members. However, the guidance on this is still working its way through Parliament. It was suggested that more people

could always be brought into each board and would include members from the NHS and health/social care.

The Somerset Health and Wellbeing Board received and discussed the presentation and decided to move forward with a workshop on this issue.

Somerset Health and Wellbeing Board Work Programme - Agenda Item 9

The Chair noted that members can always email the Deputy Director of Public Health with items for the work programme, but the board would now be looking at the current programme. It was questioned whether children's mental health would be discussed at the next meeting; it was responded that there were too many items scheduled for November 22nd, and another meeting was planned for October where it could take place, but the Service Manager for Democratic Services pointed out that October 8th will be a virtual meeting specifically to discuss the governance arrangements for HWB/ICP, followed by an extraordinary meeting on 10th November to decide the proposal for HWB/ICP that would be brought before the full Council. (Subsequent changes were made to the work programme, with children's mental health scheduled for the regular meeting on 22 November, along with a Healthwatch update, Better Care Fund, JSNA and APHR, and PNA (Pharmaceutical Needs Assessment.)

The Somerset Health and Wellbeing Board discussed and noted the Work Programme.

Any other urgent items of business - Agenda Item 10

It was observed that this meeting had been very difficult, with wifi problems and difficulties as far as hearing the speakers, which led to certain things being missed. The Chair agreed but noted that there had been no decisions to be made on the issues presented at this meeting. The Service Manager for Democratic Services apologised for the difficulties and stated that she will be discussing with relevant parties how these hybrid meetings could be better conducted in the future.

The meeting ended at 12:47 pm

CHAIR

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Better Care Fund 2021-22 Template

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2021-22. It will be pre-populated with the minimum CCG contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.

2. Please select whether any additional contributions to the BCF pool are being made from local authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be used to include any relevant carry-overs from the previous year.

3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.

4. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net

5. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Conditions 2 and 3 are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:

- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:

- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme

- This is a free text field to include a brief headline description of the scheme being planned.

4. Scheme Type and Sub Type:

- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important to our understanding of how BCF funding is being used and levels of investment against different priorities.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns.

7. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the CCG or Local authority
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2021-22:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2021-22 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's performance plans for each of the BCF metrics in 2021-22. The BCF requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for the last two quarters of 2021-22.
The previous measure of Non Elective Admissions is being replaced with a measure of Unplanned Admissions for Chronic Ambulatory Care Sensitive Conditions. Performance data on this indicator up to 2019-20, by local authority can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

A data pack showing breakdowns of data for new metrics (discharge and avoidable admissions) is available on the Better Care Exchange.

For each metric, systems should include a narrative that describes:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.

1. Unplanned admissions for chronic ambulatory sensitive conditions:
- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf

2. Length of Stay.
- Areas should agree ambitions for minimising the proportion of patients in acute hospital who have been an inpatient for 14 days or more and the number that have been an inpatient for 21 days or more. This metric should be expressed as a percentage of overall patients.
- The ambition should be set for the HWB area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the average percentage of inpatient beds occupied by patients with a length of stay of 14 days and over and 21 days and over for Q3 2021-22 and for Q4 2021-22 for people resident in the HWB.

- Plans should be agreed between CCGs, Local Authorities and Hospital Trusts and areas should ensure that ambitions agreed for 21 days or more are consistent across Local Trusts and BCF plans.

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay.

- The ambition should be set for the healthand wellbeing board area. The data for this metric is obtained from the Secondary Uses Service database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.

4. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2021-22 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.

2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2021-22 Template

2. Cover

Version 1.0

HM Government

NHS

Please Note:

- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".

- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Somerset
Completed by:	Andy Hill, Associated Director of Integrated Care
E-mail:	andrew.hill6@nhs.net
Contact number:	07732 673 197

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Deputy Director - Adult Social Care
Name:	Tim Baverstock

Has this plan been signed off by the HWB at the time of submission?	Delegated authority pending full HWB meeting	
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Mon 22/11/2021	<< Please enter using the format, DD/MM/YYYY Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair		Clare	Paul	CAPaul@somerset.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)		James	Rimmer	james.rimmer2@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers		No applicable - Single CCG in ICS	No applicable - Single CCG in ICS	james.rimmer2@nhs.net

	Local Authority Chief Executive		Pat	Flaherty	PFlaherty@somerset.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Mel	Lock	malock@somerset.gov.uk
	Better Care Fund Lead Official		Andy	Hill	andrew.hill6@nhs.net
	LA Section 151 Officer		Jason	Vaughan	JZVaughan@somerset.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->	Joint Lead Official (Adult Social Care)		Tim	Baverstock	tdbaverstock@somerset.gov.uk
	CCG Finance Lead		Scott	Sealey	scott.sealey1@nhs.net
	Somerset County Council Finance Lead		James	Sangster	JSangster@somerset.gov.uk

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Somerset

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£4,952,841	£4,952,841	£0
Minimum CCG Contribution	£43,187,394	£43,187,394	£0
iBCF	£22,685,408	£22,685,408	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£70,825,643**	**£70,825,643**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£12,272,633
Planned spend	£24,478,394

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£14,289,297
Planned spend	£18,709,000

Scheme Types

Assistive Technologies and Equipment	£0	(0.0%)
Care Act Implementation Related Duties	£0	(0.0%)

Carers Services	£204,000	(0.3%)
Community Based Schemes	£51,888,394	(73.3%)
DFG Related Schemes	£6,152,841	(8.7%)
Enablers for Integration	£0	(0.0%)
High Impact Change Model for Managing Transfer of	£0	(0.0%)
Home Care or Domiciliary Care	£10,300,408	(14.5%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£0	(0.0%)
Bed based intermediate Care Services	£2,280,000	(3.2%)
Reablement in a persons own home	£0	(0.0%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£0	(0.0%)
Residential Placements	£0	(0.0%)
Other	£0	(0.0%)
Total	**£70,825,643**	

Metrics >>

Avoidable admissions

	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	4,017.0	4,502.0

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	LOS 14+	8.9%	8.9%
	LOS 21+	5.0%	5.0%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	0.0%	90.0%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	296	316

Reablement

21-22 Plan

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	79.9%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Somerset

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Somerset	£4,952,841
DFG breakerdown for two-tier areas only (where applicable)	
Mendip	£1,009,598
Sedgemoor	£1,092,482
South Somerset	£1,405,418
Somerset West and Taunton	£1,445,343
Total Minimum LA Contribution (exc iBCF)	**£4,952,841**

iBCF Contribution	Contribution
Somerset	£22,685,408
Total iBCF Contribution	**£22,685,408**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

CCG Minimum Contribution	Contribution
NHS Somerset CCG	£43,187,394
Total Minimum CCG Contribution	**£43,187,394**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£43,187,394**	

	2021-22
Total BCF Pooled Budget	**£70,825,643**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Somerset

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£4,952,841	£4,952,841	£0
Minimum CCG Contribution	£43,187,394	£43,187,394	£0
iBCF	£22,685,408	£22,685,408	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£70,825,643**	**£70,825,643**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£12,272,633	£24,478,394	£0
Adult Social Care services spend from the minimum CCG allocations	£14,289,297	£18,709,000	£0

Checklist

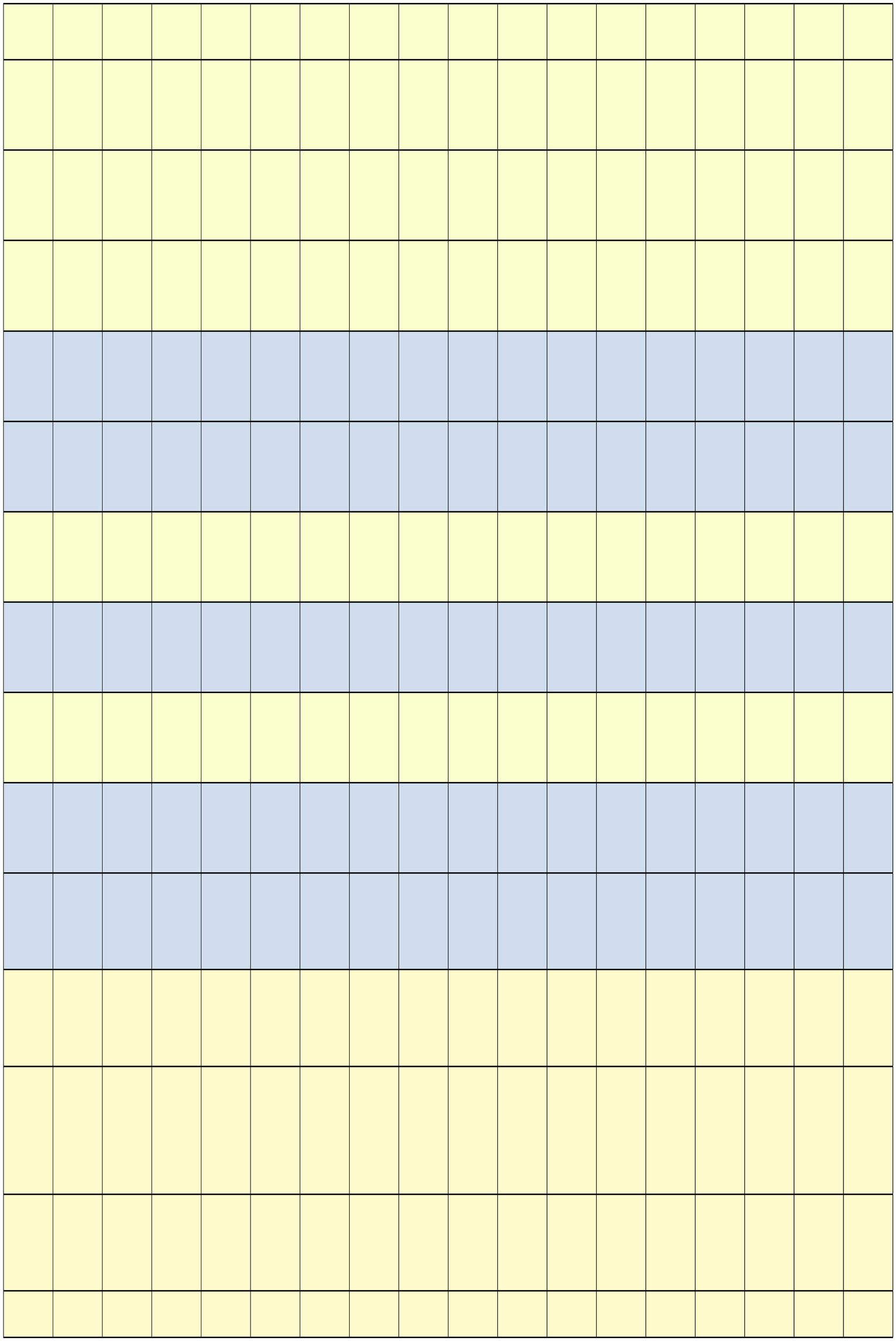
Column complete:

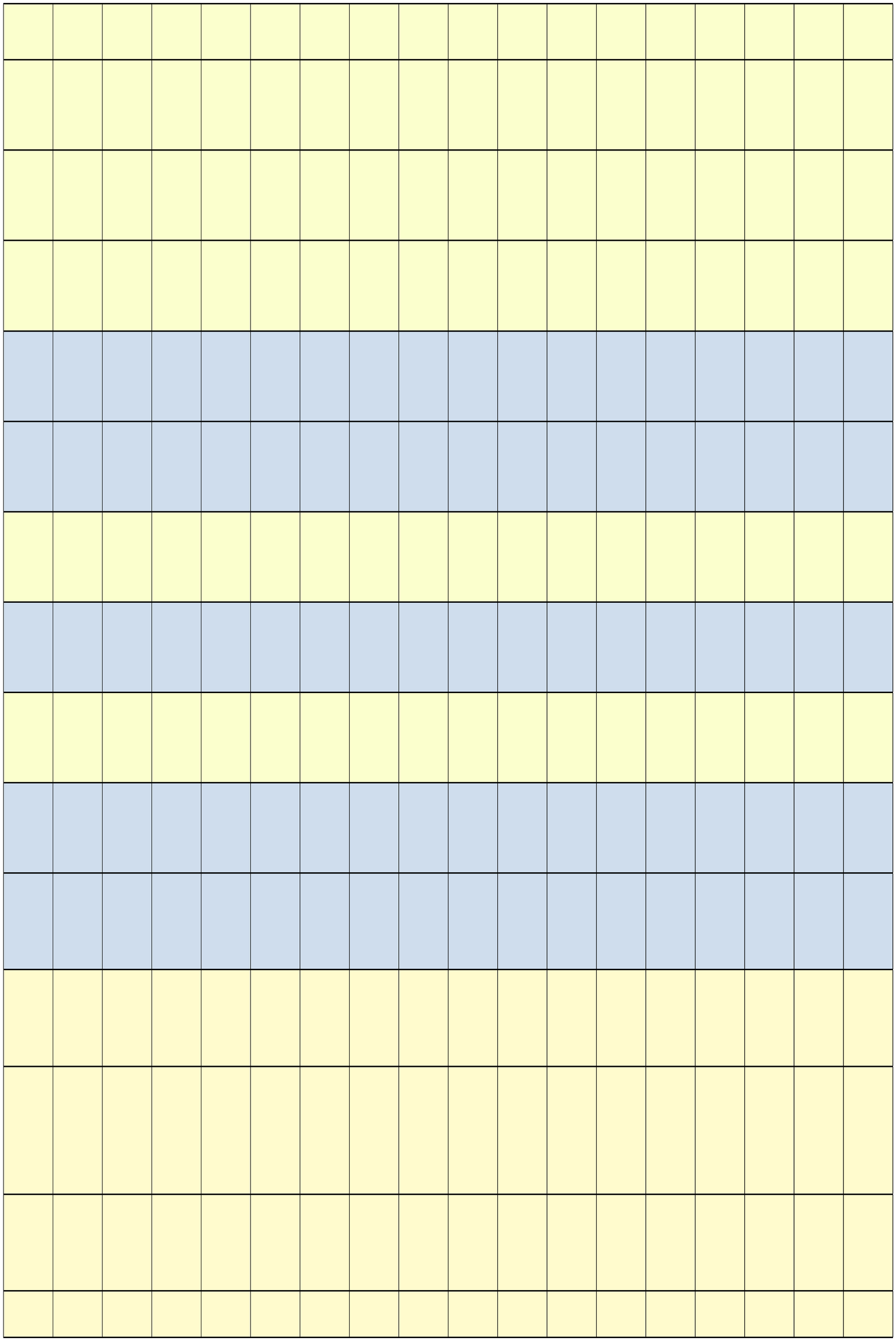
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

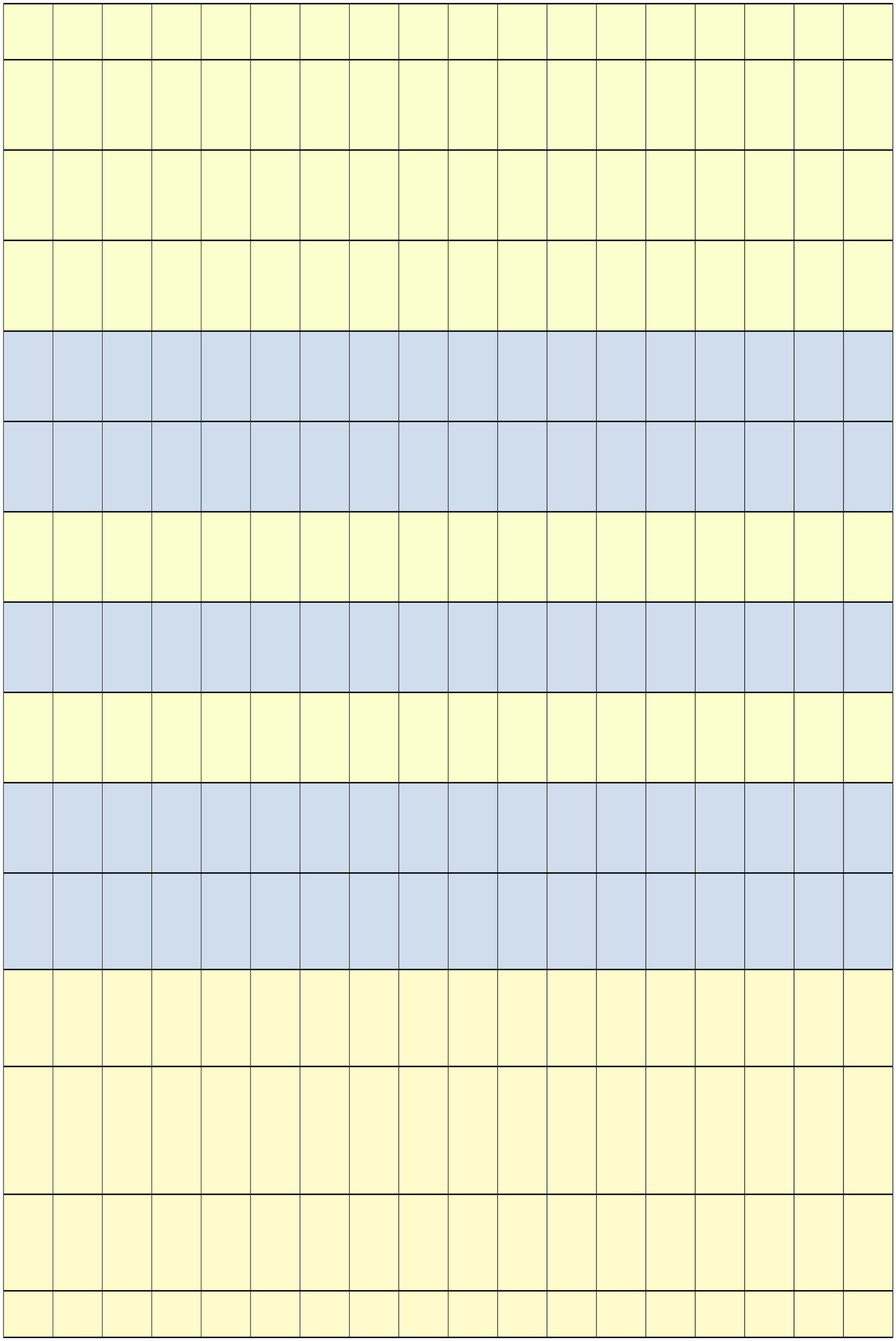
Sheet complete

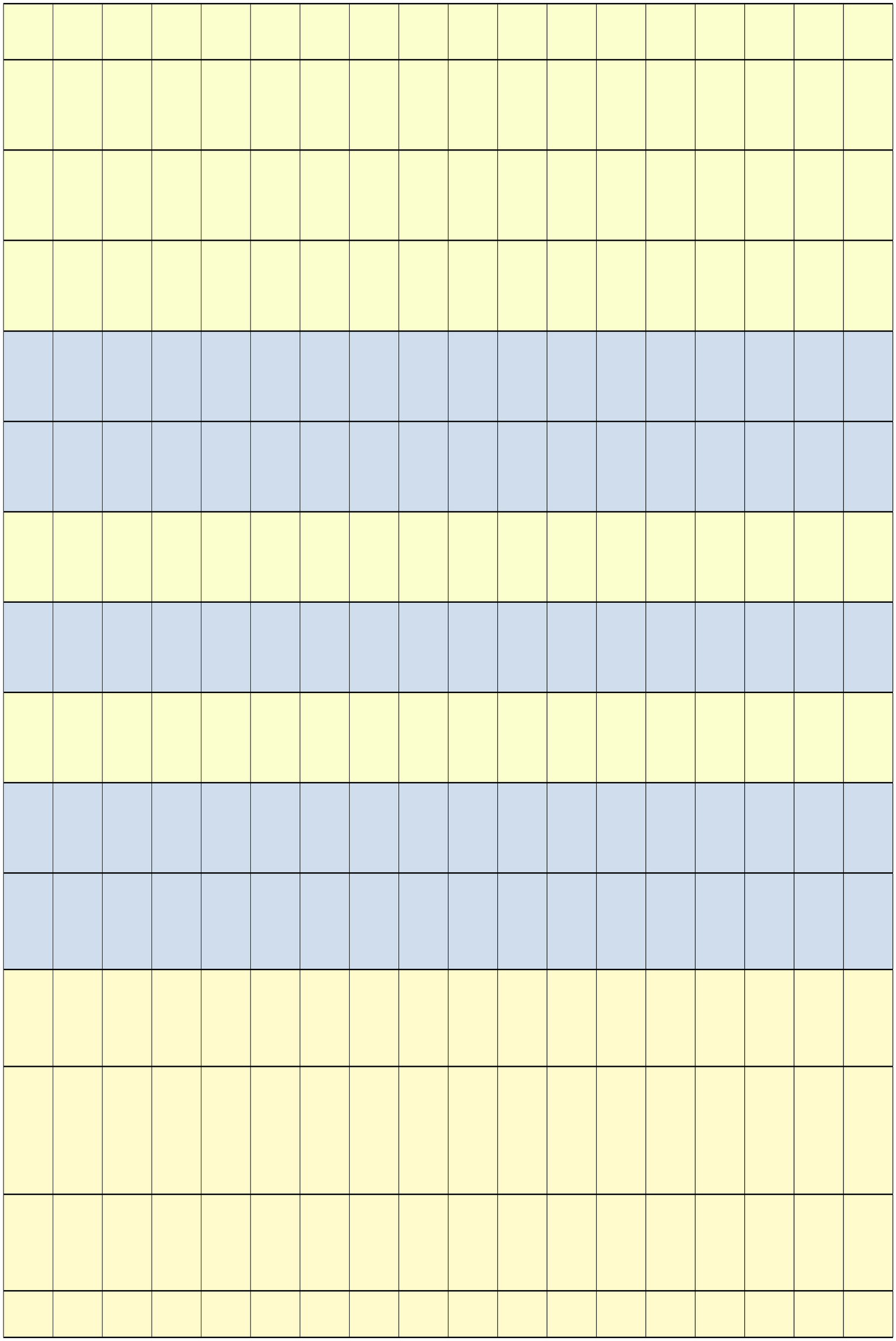
						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	DFG	Disabled Facilities Grant	DFG Related Schemes	Adaptations, including statutory DFG		Social Care		LA			Charity / Voluntary Sector	DFG	£4,952,841	Existing
2	Intermediate Care	Out of hospital care and support	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£21,162,000	Existing
2	Intermediate Care	Out of hospital care and support	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Private Sector	Minimum CCG Contribution	£3,442,000	Existing
2	Intermediate Care	Out of hospital care and support	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Social Care		LA			Charity / Voluntary Sector	iBCF	£5,299,000	Existing
2	Intermediate Care	Out of hospital care and support	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Social Care		LA			Local Authority	Minimum CCG Contribution	£4,602,000	Existing
3	NHS funded new models of care	Social Prescribing and related support	Community Based Schemes	Integrated neighbourhood services		Other	Community based support	CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£3,316,394	Existing
4	Community bed based care (short stays, hospital	Nursing home pressures, nursing home fees and interim beds	Bed based intermediate Care Services	Other	Mixed provision	Social Care		LA			Private Sector	Minimum CCG Contribution	£2,280,000	Existing

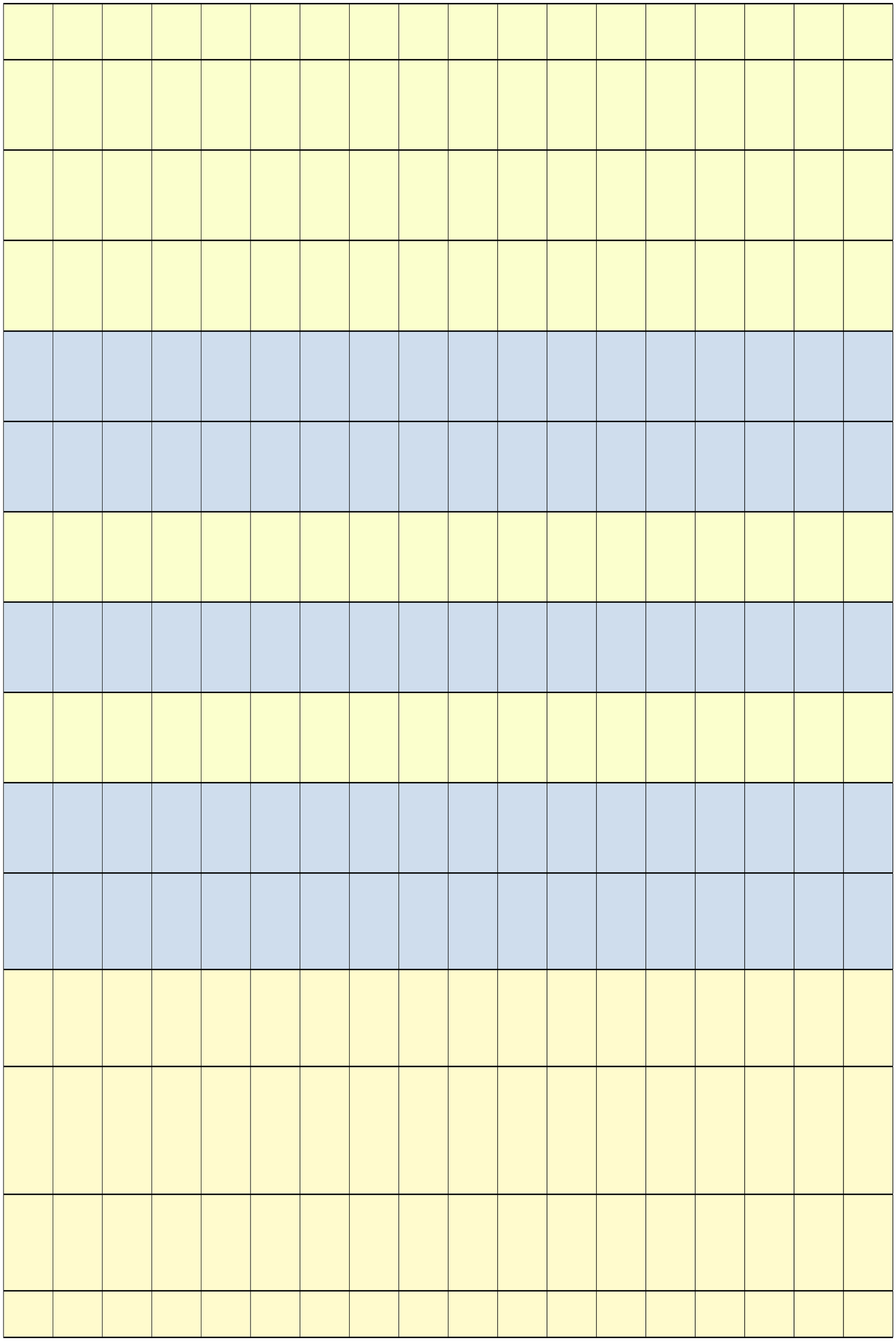
5	Community Equipment Service	NHS additional contribution to community equipment	DFG Related Schemes	Other	Community equip	Social Care		LA			Private Sector	Minimum CCG Contribution	£1,200,000	Existing
6	Support for carers	NHS contribution to the Carers Support Service	Carers Services	Other	Whole county ser	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£204,000	Existing
7	Adult Social Care	Funding to protect front line services, e.g. additional social workers	Community Based Schemes	Other	Social care	Social Care		LA			Local Authority	Minimum CCG Contribution	£5,913,000	Existing
7	Adult Social Care	Funding to protect front line services, e.g. additional social workers	Community Based Schemes	Other	Social care	Social Care		LA			Local Authority	iBCF	£10,647,000	Existing
8	Learning Disability Services	Maintaining and protecting Learning Disability Services	Community Based Schemes	Other	Learning Disability Services	Social Care		LA			Private Sector	Minimum CCG Contribution	£1,068,000	Existing
8	Learning Disability Services	Maintaining and protecting Learning Disability Services	Community Based Schemes	Other	Learning Disability Services	Social Care		LA			Private Sector	iBCF	£6,340,000	Existing
9	Market Support	Funding to support budget pressures in light of increasing number of	Home Care or Domiciliary Care	Domiciliary care workforce development		Social Care		LA			Private Sector	iBCF	£399,408	Existing

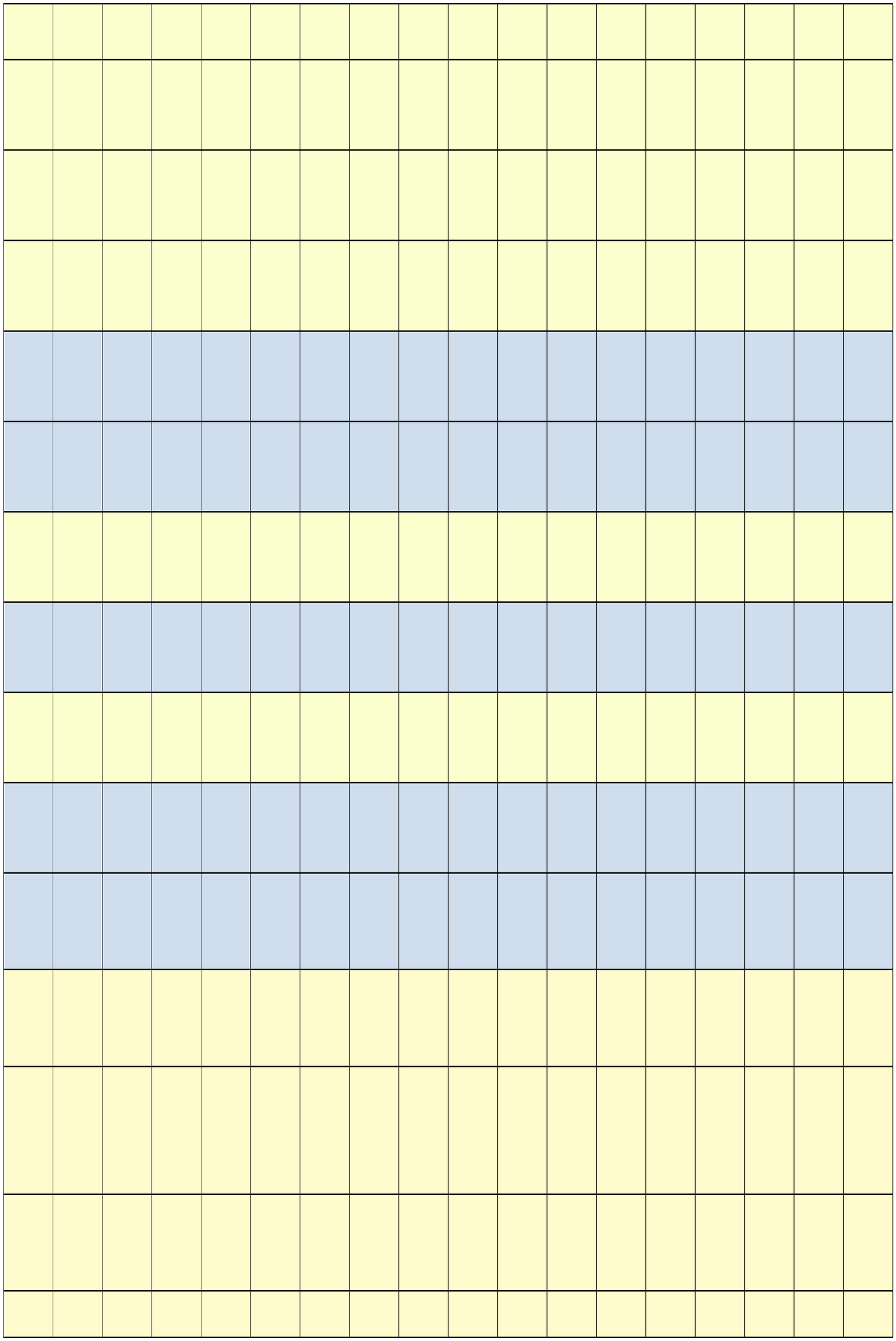


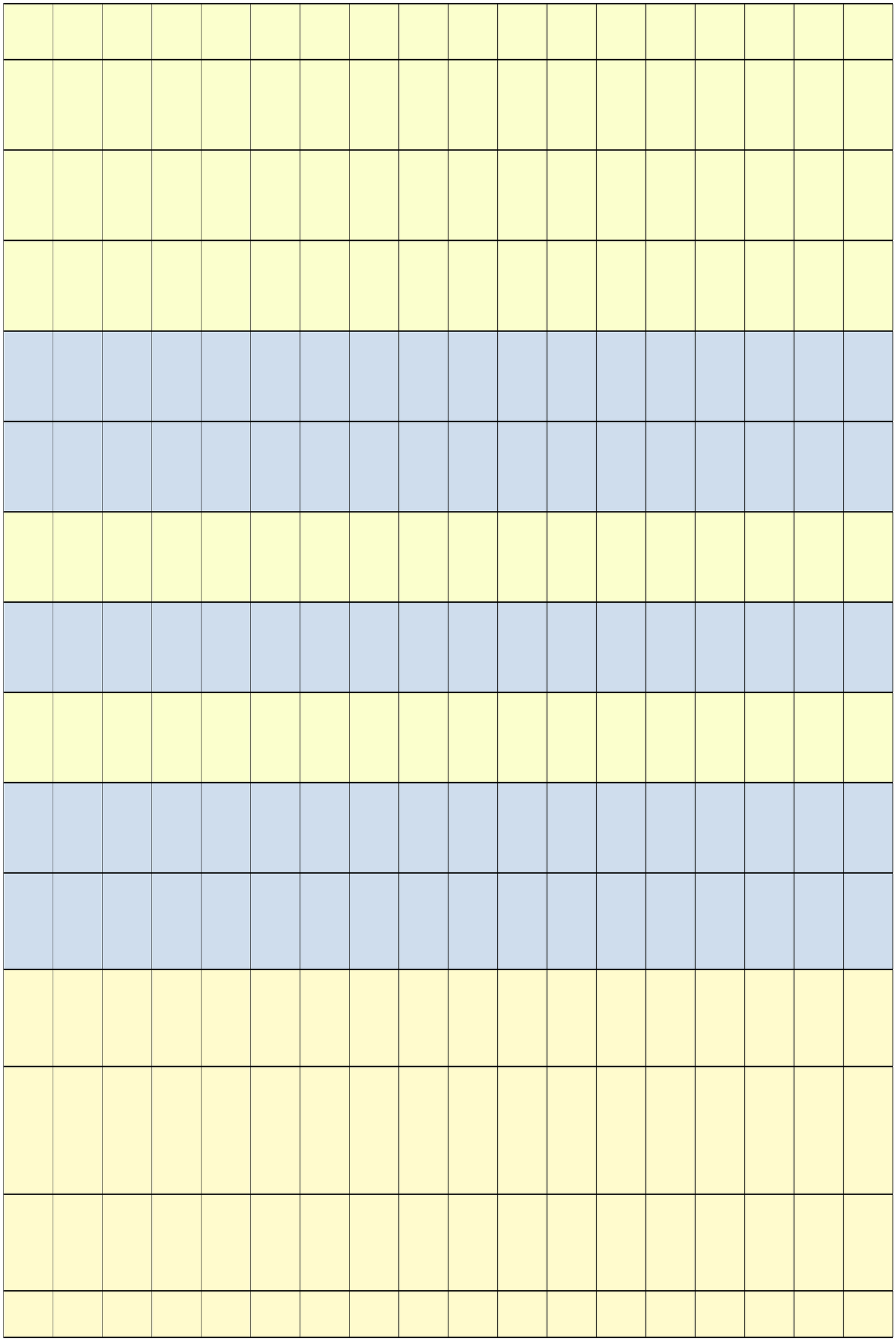


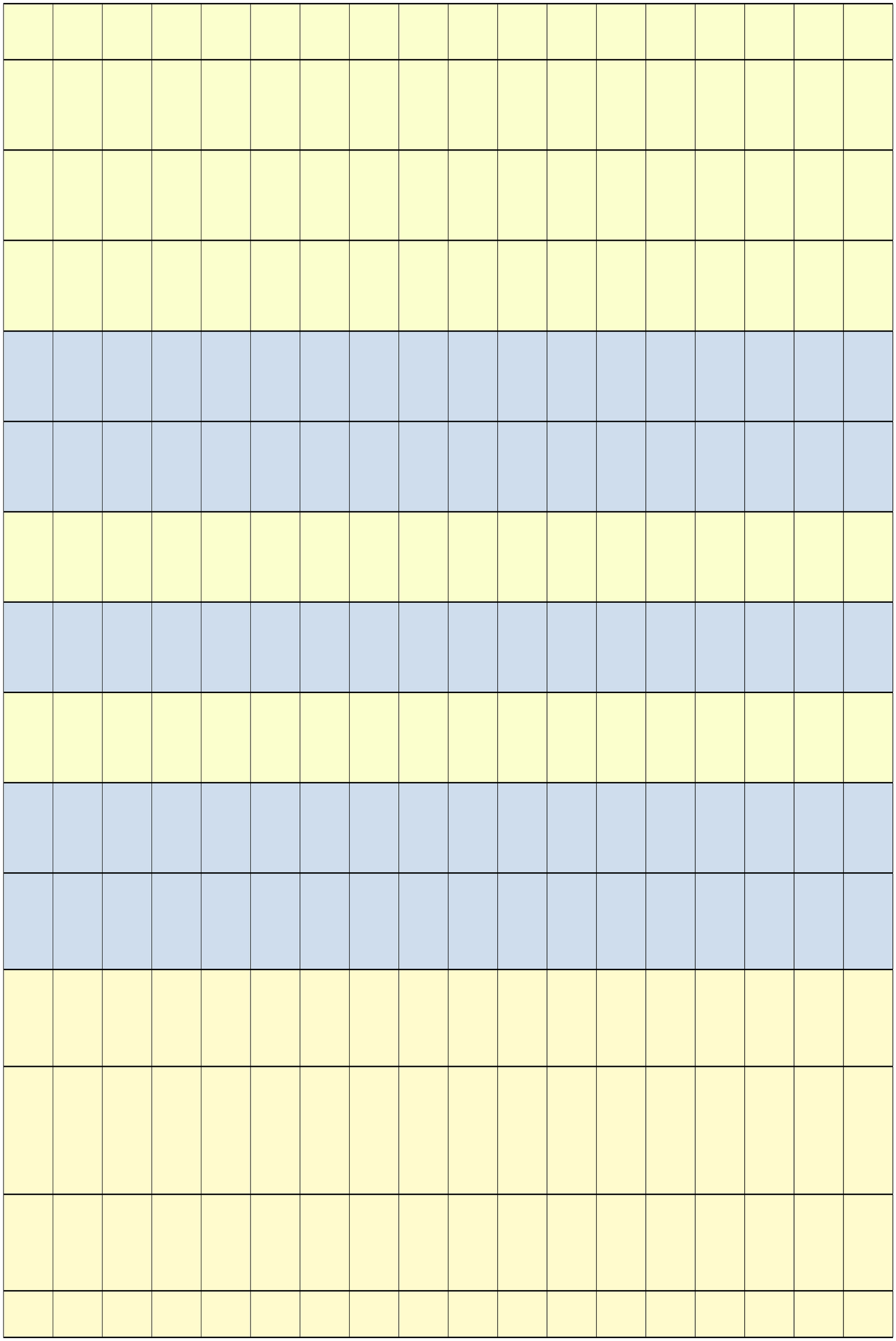


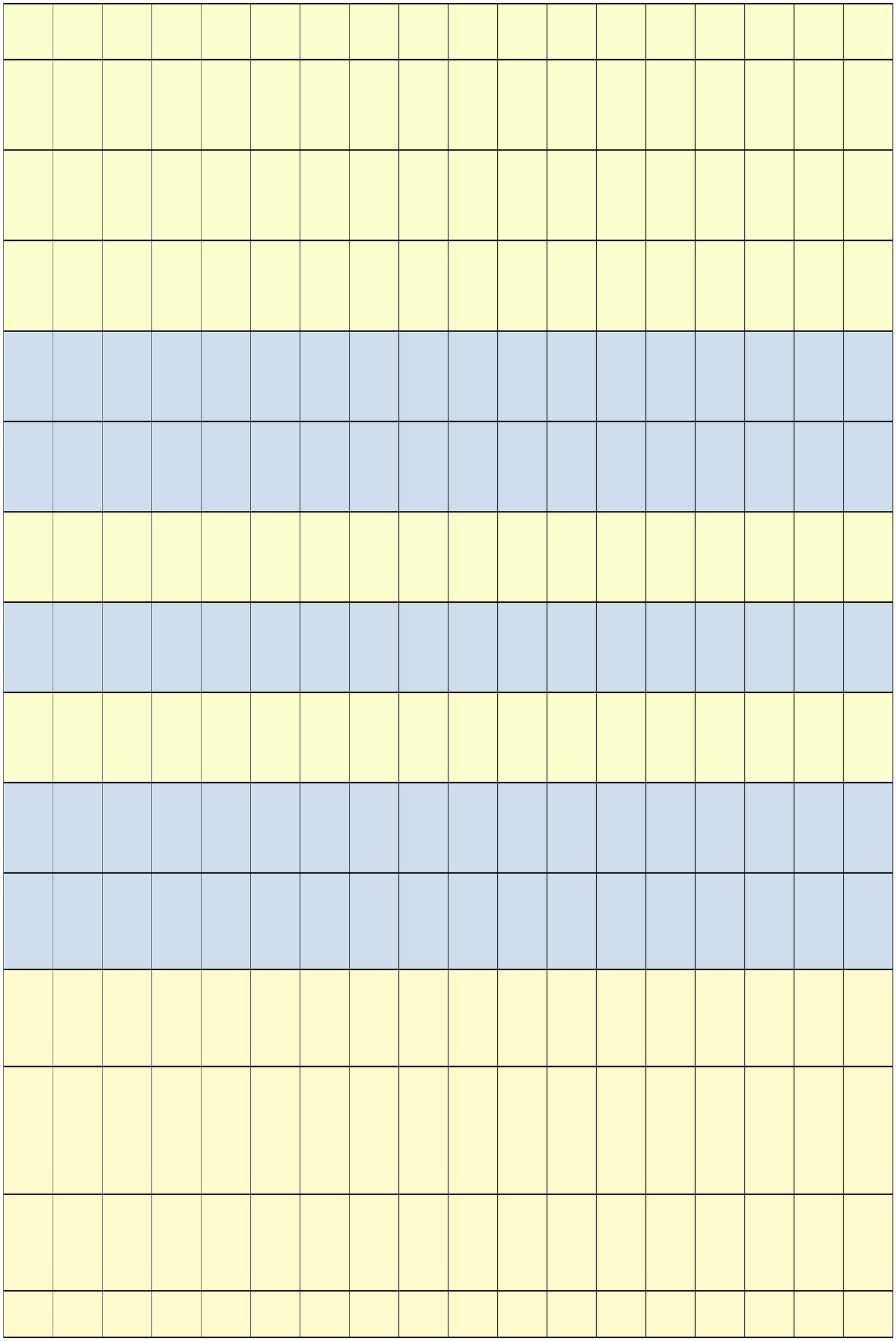


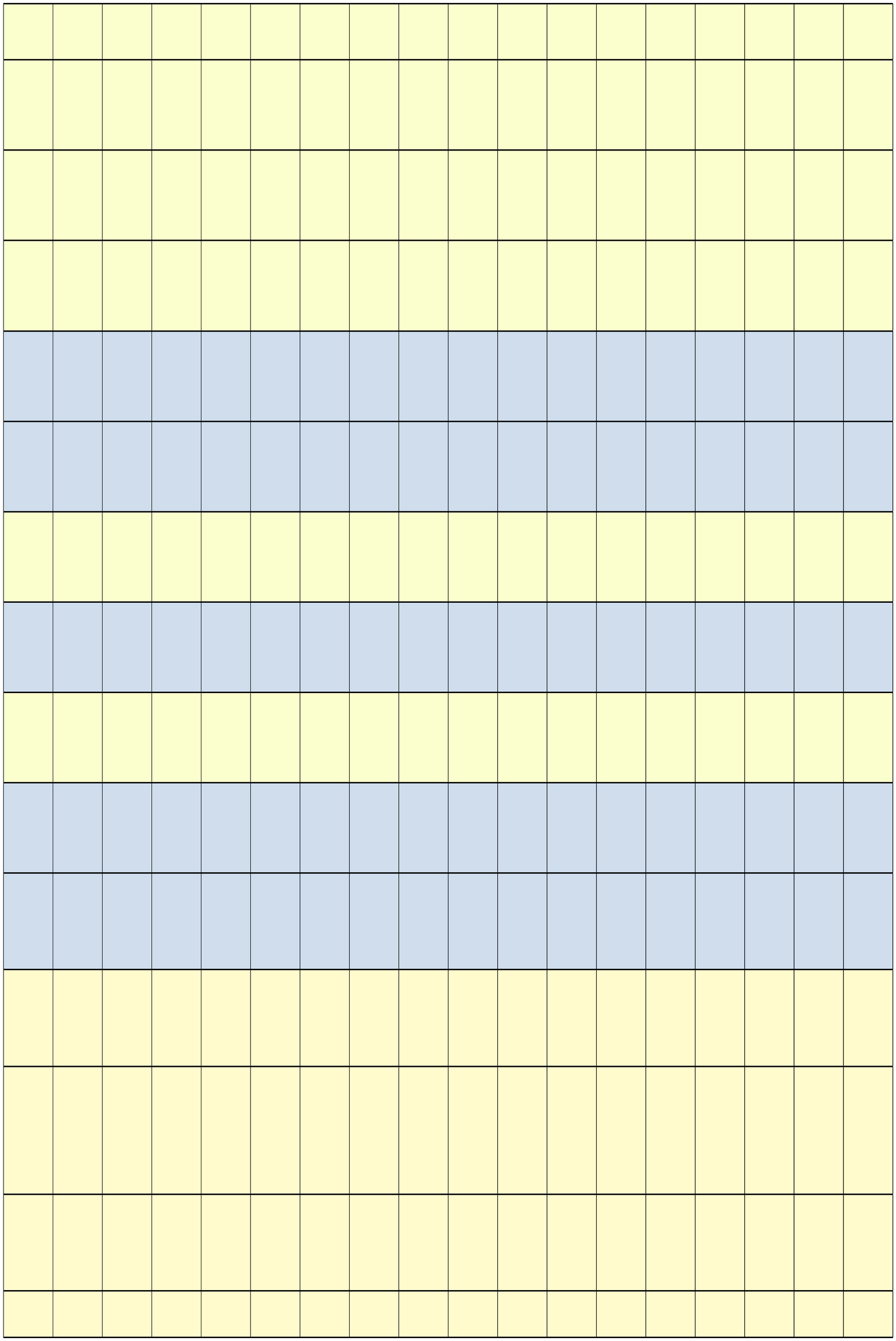


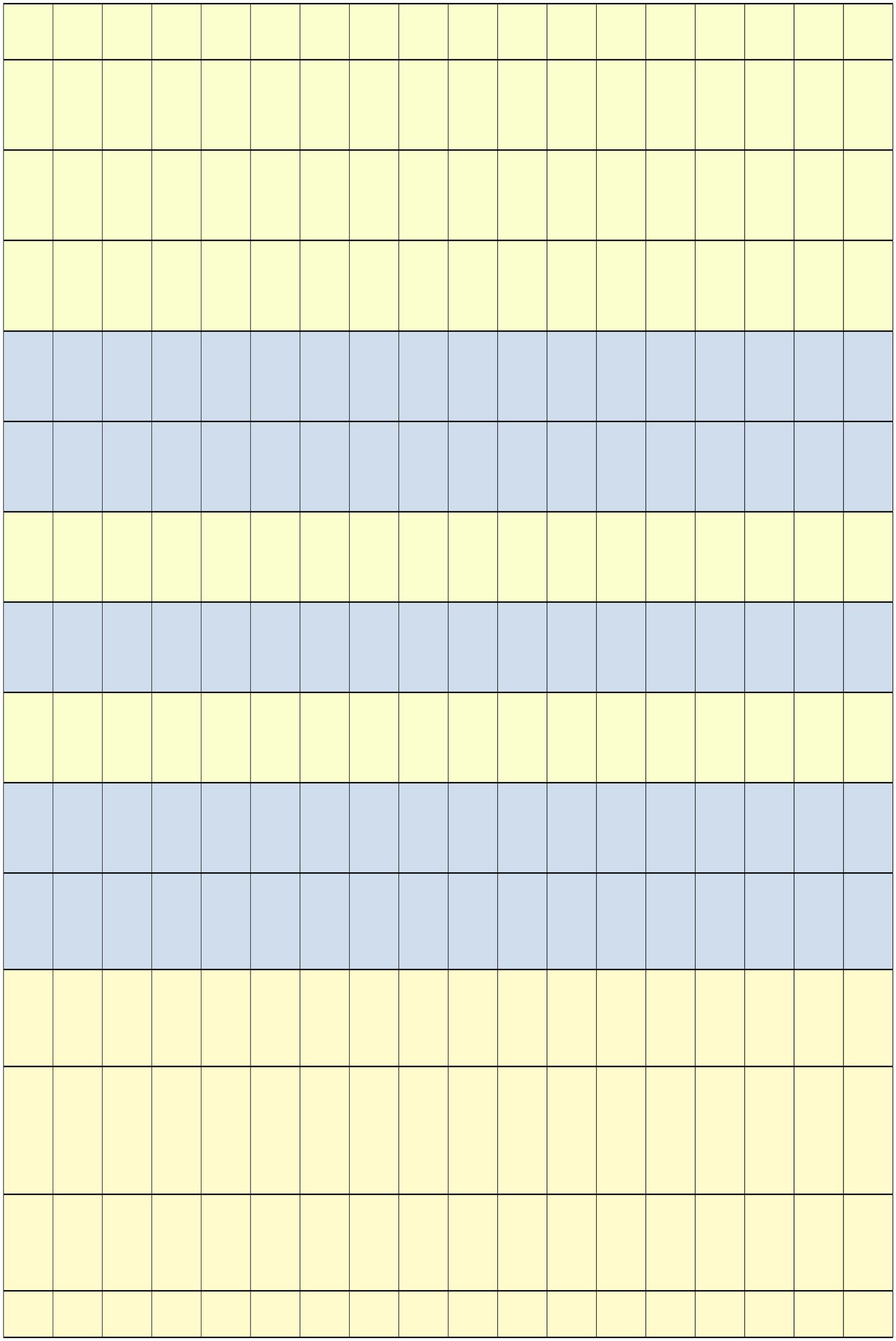


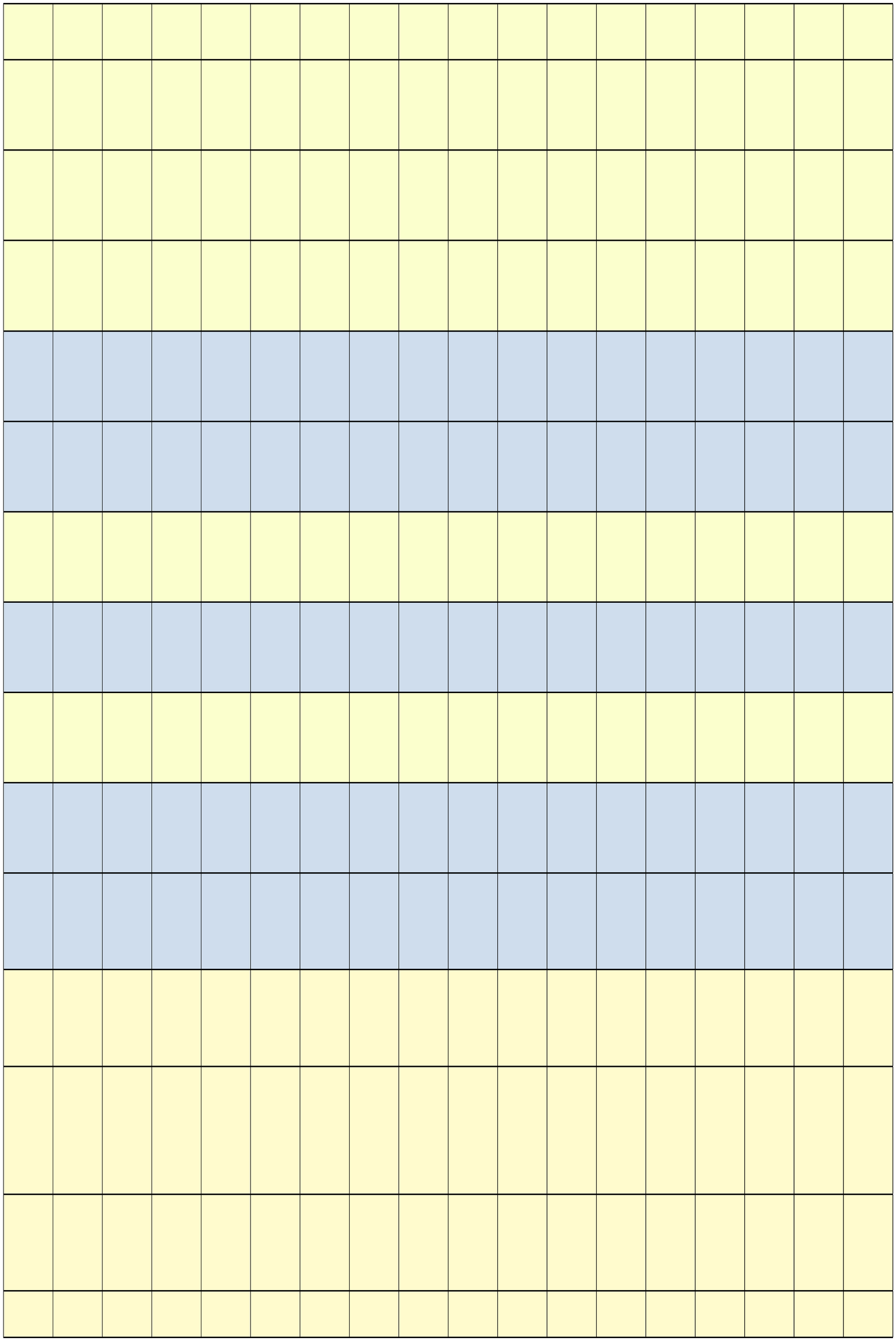












2021-22 Revised Scheme types

Number	Scheme type/ services
1	Assistive Technologies and Equipment
2	Care Act Implementation Related Duties
3	Carers Services
4	Community Based Schemes

5	DFG Related Schemes
6	Enablers for Integration

7	High Impact Change Model for Managing Transfer of Care
8	Home Care or Domiciliary Care
9	Housing Related Schemes

10	Integrated Care Planning and Navigation
11	Bed based intermediate Care Services

12	Reablement in a persons own home
13	Personalised Budgeting and Commissioning
14	Personalised Care at Home
15	Prevention / Early Intervention
16	Residential Placements

17	Other

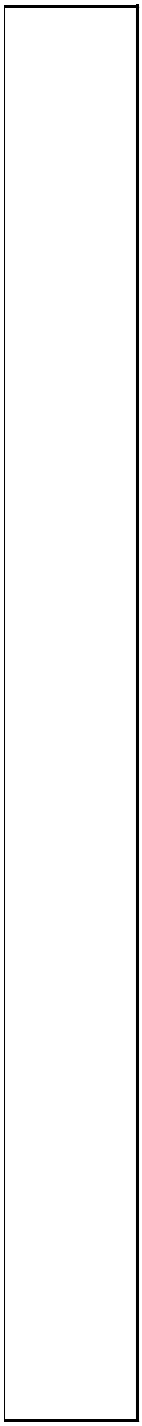
Sub type
1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other
1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other
1. Respite services 2. Other
1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other

1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other
1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other

1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other
1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other

1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other
1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other

1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other
1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other
1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other
1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other



Description
Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'

The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.

The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.

Provides support in your own home to improve your confidence and ability to live as independently as possible
Various person centred approaches to commissioning and budgeting, including direct payments.
Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.

Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Somerset

8.1 Avoidable admissions

		19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only		4,017.0	4,502.0	The overall number of emergency admissions for unplanned chronic ambulatory care sensitive conditions is increasing when comparing 21/22 to 20/21, and this is due to the level of admissions being significantly impacted by Covid during 20/21 so is not a fair comparison. When comparing the projected position in	**Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**

>> link to NHS Digital webpage

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments	
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	8.9%	8.9%	The number of patients exceeding 14 and 21 days has increased over the past 2 months due to the increased urgent care demand, increase acuity leading to a longer LOS and challenges in intermediate care provision delaying timely discharge and extending LOS. Whilst a number of schemes have been agreed across the system the detail of these are the specific impacts are still be wokred through. The 14 day baselines: 19/20 = 7.9%, 21/22 (Q3/4) = 8.9%. The 21 day baselines: 19/20 =	**Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**
	Proportion of inpatients resident for 21 days or more	5.0%	5.0%		

8.3 Discharge to normal place of residence

	21-22 Plan	Comments	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	90.0%	90% of all elective (excluding day case) and non-elective admissions are to the patients usual place of residence and this is expected to be maintained over the winter period with over 80% of patients discharged with no immediate support. There are a range of actions in place to support flow through the hospitals to facilitate timely	**Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	468	432	296	316	Residential placements: The Somerset BCF will ensure that we continue to minimise the number of people who require long term residential placements. This will be achieved by: stabilising and protecting adult social care, purchasing short term reablement interventions including residential and nursing homes reablement beds
	Numerator	653	604	420	460	
	Denominator	139,497	139,913	141,969	145,530	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.1%	81.8%	79.9%	The Somerset BCF supports people to remain in their own home through protecting and maintaining budgets which cover community rehabilitation and enablement, the extension of social prescribing which will ensure people link with and make better use of local resources and connect with local people. Importantly the Somerset
	Numerator	240	469	151	
	Denominator	282	573	189	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Somerset

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes			
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes			
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes			
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes			

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes			
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes			

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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.

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.

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.

- ***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.

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.

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

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.

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

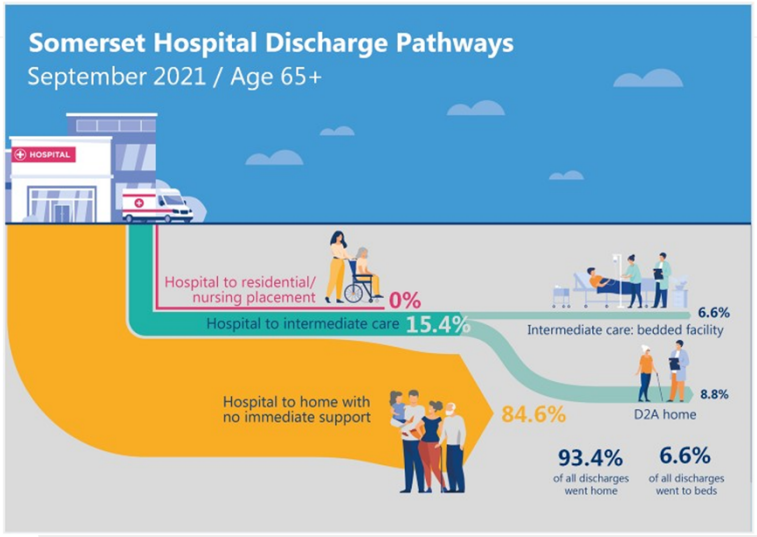
A focus on length of stay

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.

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%.

SOMERSET County Council | NHS Somerset NHS Foundation Trust | NHS Somerset Clinical Commissioning Group | Yeovil Hospital Healthcare

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.

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.

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

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

Somerset Health and Wellbeing Board
10 November 2021
Report for information

Somerset Health and Wellbeing Board and ICP governance arrangements

Lead Officer: Professor Trudi Grant, Director of Public Health
Author: Professor Trudi Grant, Director of Public Health, Julia Jones, Service Manager – Democratic Services, Jade Renville, Associate Director of Partnership and Integration Somerset Integrated Care System
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Summary:	This report updates on the work being carried out and the discussion and the outcomes following an informal workshop of the Health and Wellbeing Board regarding the future governance arrangements for Health and Wellbeing in Somerset.

Recommendations:	The Somerset Health and Wellbeing Board notes the ongoing work and intentions from the workshop regarding the future governance arrangements:
	• To support system discussions in terms of the next steps in developing the ICP
	• To establish a close working relationship with the Integrated Care Partnership following its establishment on 1 April 2022:
	  • To align work programmes, agendas, and have a common membership to avoid doubling discussions and workloads
	  • To hold meetings in common although each committee makes its own decision and records its own minutes
	Further work on this will be reported and brought back to future Health and Wellbeing Board meetings.

Reasons for recommendations:	To note the ongoing work for the future governance arrangements.
Links to The Improving Lives Strategy	As detailed in 2.1 of the report.
Financial, Legal, HR,	

Social value and partnership Implications:	Not applicable
Equalities Implications:	Not applicable
Risk Assessment:	Not applicable

1. Background info

1.1. Somerset is a low-complexity Integrated Care System with boundaries that are coterminous between health services and the new local authority arrangements.

The 2012 Health and Social Care Act brought in legislation for every upper tier local authority to have in place a Health and Wellbeing Board.

New legislation sees the introduction of Integrated Care Systems from 1 April 2022 which require the establishment of an Integrated Care Partnership (ICP), alongside an Integrated Care Board (ICB).

1.2. The purpose of Health and Wellbeing Board is to provide shared leadership for the local Health and Wellbeing System, to improve health and reduce inequalities. The Board has responsibility over all influences of health and wellbeing including health and care services as well as the wider determinants of health.

1.3. The Integrated Care Partnership is a statutory committee of the ICS, not a statutory body. As a statutory committee, ICPs will a) be required to be established in every system; b) have a minimum membership required in law (the ICB and Local Authorities); and c) will be tasked with producing an integrated care strategy for their areas. The ICP is expected to highlight where coordination is needed on health and care issues and challenge partners to deliver the action required. It will be established in April 2022.

1.4. ICPs can be flexible in their membership. The only members specified are the ICB and Local Authorities (LA) in an ICS area, who must come together to establish the ICP. Wider membership can be locally determined. In smaller systems, where the majority of ICS governance will be conducted at the system level, it has been confirmed that partners can agree to common membership of the ICP and the Health and Wellbeing Board and streamline arrangements for holding meetings. This may allow different sets of business to proceed in a more coordinated way.

2. Improving Lives Priorities and Outcomes

2.1. There is a strong local narrative in Somerset to 'Improve Lives'.

2.2. There is senior-level agreement in the local system that the Improving Lives Vision needs to be maintained over time, with an ever-increasing focus on

prevention and addressing health and social inequalities. There is a desire for the system to remain uncomplicated, efficient and more integrated as it develops, united with single purpose to Improve Lives in Somerset. 'Keep it Simple'.

3. Discussions and workshop outcomes

3.1. Recognising the requirement to establish the Somerset Integrated Care Partnership by 1 April 2022, a workshop was held on 8 October to discuss options in terms of its governance arrangements, and any opportunities for alignment with the Health and Wellbeing Board.

3.2. In doing so it was noted that the purpose and responsibilities between the ICP and the Health and Wellbeing Board were very similar and had duties covering certain issues such as the Joint Health and Wellbeing Strategy and the Joint Strategic Needs Assessment.

3.3. Membership requirements of the ICP were also flexible and covered very similar arrangements as the current membership of the Health and Wellbeing Board. The intention is for this to be adapted to suit local circumstances and to be complementary to one another.

3.4. Governance arrangements for the ICP were also close to those of the existing HWBB in that it would be a statutory committee, established locally and jointly by the relevant local authority and the ICB, evolve existing arrangements with mutually agreed TOR, membership, ways of operating and administrations and meetings should be held in public.

3.5. There was discussion on the current Health and Wellbeing system and how this looked and worked in the county and the need for a longer-term vision and joined up strategy to achieve the vision.

3.6. This was then followed by a discussion on the benefits and challenges of future possible governance options which covered the following: Having one meeting – split approach HWBB followed by ICP Committee (or vice versa) would be separate meetings in terms of governance; both Boards meet separately and then bring them together at defined periods; ICP Committee has responsibility for all and HWBB meets twice a year as a visionary board; and frequency of meetings.

3.7. There was a good debate on these matters and the consensus of the discussion was:

- Legally we are required to maintain separation of the ICP and HWBB, although there can be alignment, so there needs to be clarity about responsibilities, coordination, and avoiding duplication/overlap
- The structure needs to be simple in order that these entities can function efficiently/effectively and the public is not confused.

- The membership needs to be broad-reaching and from a variety of sectors but not overly large in number.
- The Improving Lives Strategy will play a part in the activities of both Boards, and the community should have input.

3.8. Discussions regarding the development of the ICP are ongoing across our system. In line with national guidance, the required next steps, and our progress to date, are:

1. Recognise that it is for the NHS and LAs – as the statutory partners in each ICS – to start the process jointly of creating an ICP in preparation for legislation (September 2021) (Addressed by the recommendations in this report)
2. Reach agreement between NHS and local authority leaders as to how the ICP will be established and a secretariat resourced, at least during the 2021/22 transition year (October 2022) (Under consideration)
3. Ensure that the statutory ICP partners come together as required to oversee ICP set up, including engagement with stakeholders (November 2022) (Ongoing discussions with stakeholders)
4. Appoint an ICP chair designate, taking account of national guidance on functions and ensuring there is a transparent and jointly supported decision-making process (February 2022)
5. Determine key questions to be resolved for that particular system including but not limited to the following (April 2022):

- What kind of chair would best galvanise the system behind its common aims and what is the process for appointment?
- Who might constitute an ICP committee that might galvanise the ICS and how should those individuals be chosen?
- What would be required to deliver an inclusive approach to engagement, in terms of methods, resourcing, and public reporting?
- To what extent can existing structures be used or adapted to create the ICP so as to build on what happens already?
- To what extent do existing ICS plans meet the requirement for a health and care strategy and how might they be refreshed?
- How might the ICP meet the ten principles described in NHSEI's ICS Design Framework to set the culture of the system?

4. Request of the Board and Board members

4.1. The Somerset Health and Wellbeing Board notes the ongoing work and intentions from the workshop regarding the future governance arrangements:

- To support system discussions in terms of the next steps in

developing the ICP

- To establish a close working relationship with the Integrated Care Partnership following its establishment on 1 April 2022:
  - To align work programmes, agendas, and have a common membership to avoid doubling discussions and workloads
  - To hold meetings in common although each committee makes its own decision and records its own minutes

Further work on this will be reported and brought back to future Health and Wellbeing Board meetings.

5. Background papers

5.1. Somerset Integrated Care System report and Governance Arrangements for Health and Wellbeing in Somerset presentation for the Somerset Health and Wellbeing Board agenda 27 September 2021

6. Report Sign-Off

6.1

	Seen by:	**Name**	**Date**
Report Sign off	Relevant Senior Manager / Lead Officer (Director Level)	Trudi Grant	Click or tap to enter a date.
	Cabinet Member / Portfolio Holder (if applicable)	Clare Paul	Click or tap to enter a date.
	Monitoring Officer (Somerset County Council)	Scott Wooldridge	Click or tap to enter a date.

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