Appendix 1 - Narrative on how the fund will be utilised to enhance and improve integrated working

Health and Wellbeing Board(s)

Buckinghamshire

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

How have you gone about involving these stakeholders?

Buckinghamshire has a joint (NHS Integrated Care Board and Council) Integrated Commissioning Executive Team (ICET). ICET is made up of Health and Social Care senior leaders including the ICB Executive Place Director, the Council's Service Director for Integrated Commissioning, the ICB Finance Place Lead and the Council's Head of Finance. ICET also has representation from clinical leads in Mental Health and LD, CYP, Integration and Primary Care as well as Public Health, Business Intelligence, and the lead commissioner for the Disabled Facilities Grant.

ICET holds the delegated responsibility for overseeing the BCF plan and through monthly meetings, leads the BCF development and planning.

In addition to this, Buckinghamshire uses the established integrated programmes and workstreams for all the key BCF areas to inform and influence BCF planning. Some examples include:

- Integrated Community Programme which has several workstreams directly related to BCF. Commissioners provide the link between these workstreams, such as admission avoidance and out of hospital, to the BCF planning through ICET.
- Within Discharge to Assess, commissioners, Home First representatives and hospital discharge representatives meet with D2A home care (monthly) and care home providers (weekly). The feedback and discussions feed into the Intermediate Care Programme which contributes to the BCF planning.
- A newly established Carers Board has representatives from all key stakeholders including health and social care leaders, carers and the VCS. This reports into the Buckinghamshire Council Transformation Board which contributes to BCF planning.

Information collected through routine contract and quality monitoring of BCF scheme providers and feedback from service users is shared via ICET and informs the BCF planning process.

Executive summary

This should include:

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

In Buckinghamshire, the BCF plan brings together several strategic priorities with operational workstreams to deliver these. The priorities for 21-22 focussed on five key areas for a 12-24-month period. These priorities were identified as areas that could yield significant benefits from a stronger partnership approach and included hospital discharge, admission avoidance, mental health, primary care community services and health inequalities with a focus on cardiovascular disease.

The work undertaken to deliver against the priorities the previous year has provided a firm foundation for an integrated system approach in Buckinghamshire and remain priority areas. Previously funded schemes continue to be funded for 22-23 and provide a focus on a strengths based approach to :

- support people to live well and age well,
- ensure people receive appropriate health and social care support, in the right place at the right time and
- support people to retain independence and remain in their own home environment for as long as possible.

The key changes for 22-23 which contribute to the delivery of the priorities are:

- Introduction of an Intermediate Care Programme of work with dedicated integrated transformation posts to develop a sustainable intermediate care offer for Buckinghamshire.
- Carers transformation programme of work for 22-24 including the establishment of a Carers Board to oversee and inform the transformation work to improve outcomes for carers.
- Dementia Needs Analysis has been completed in 22-23 which has identified six priority areas to improve the outcomes for people living with dementia and their families.

Governance

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

Buckinghamshire has joint governance arrangements in place for the BCF. The Health and Wellbeing Board (HWB) hold overall responsibility for the BCF plan but has delegated the responsibility for oversight of the plan and the pooled budget to the Integrated Commissioning Executive Team (ICET). ICET is made up of Health and Social Care senior leaders including the ICB executive place director, the Council's Service Director for Integrated Commissioning, The ICB Finance Place Lead and the Council's Head of Finance. ICET also has

representation from clinical leads in Mental Health and LD, CYP, Integration and Primary Care as well as Public Health, Business Intelligence, and the lead commissioner for the Disabled Facilities Grant.

The BCF Plan is agreed by the ICB Accountable Officer who has delegated authority from the ICB and by the Local Authority Corporate Director and DASS, Cabinet Member for Health and Wellbeing and the Local Authority Chief executive prior to final HWB sign off.

Following approval and submission of the BCF 2022-23 Plan the BCF Section 75 agreement will also be updated.

ICET also has delegated authority from the HWB to sign off the BCF quarterly returns submitted to NHSE.

The Governance arrangements are under review in light of the introduction of the ICB in July 22.

Overall BCF plan and approach to integration

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

- ***Joint priorities for 2022-23***
- ***Approaches to joint/collaborative commissioning***
- ***How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.***

The joint priorities are shaped by the Joint Local Health and Wellbeing Strategy and the Integrated Care Partnership and for 22-23 remain the same as 21-22 which were planned as 12-24 month priorities and were identified as areas that could yield significant benefits from an integrated approach. The priorities are:

1. hospital discharge
2. admission avoidance
3. mental health
4. primary care community services and
5. health inequalities with a focus on cardio-vascular disease.

Buckinghamshire has an Integrated Commissioning model and continues to build on this in 2022-23. There are formal s75 agreements including for Integrated Therapies, s117, Integrated Community Equipment, Continuing Health Care and BCF. Through the Integrated Commissioning Executive Team (ICET) meeting held monthly, there is shared oversight of commissioning plans to monitor joint priorities. The meetings provide a clear forum that can be used effectively for integrated decision making.

There are integrated approaches to broader commissioning functions such as the management of care sector quality with formal integrated Quality Surveillance Groups and an integrated Care Home Outbreak Risk Group. There are integrated workstreams for all the BCF priority areas including the Intermediate Care Programme, Integrated Community Transformation programme, Mental Health, Learning Disability and Autism Board.

The BCF in Buckinghamshire supports an integrated approach through funding schemes which collectively work as a system to keep people at home and as independent as possible. An integrated approach is taken to prevent the need for people to be admitted to hospital and to ensure those who are admitted are discharged in a timely way to receive the right care and support in the most appropriate way for them. This is delivered using integrated pathways for admission avoidance and hospital admission. During 22-23, the additional BCF funding will be used to support these areas of work to improve efficiencies and the outcomes of individuals within these pathways.

The BCF supports the intermediate care offer in Buckinghamshire including funding hospital discharge teams, hospital social work teams and service finding commissioning teams. These teams work together to identify need and find and implement the right care for people to prevent hospital admission or to support people out of hospital. The BCF is also used to fund the Home Independence Team via social care which provides a hospital discharge and community reablement service. The Rapid Response and Intermediate Care (RRIC) service is also funded via the BCF contribution to the Buckinghamshire Health Trust Community Services contract. RRIC provides Urgent Community Response (2 hour and 2 day response, Rehabilitation and intermediate care, improving function, clinical outcomes, maximising independence and preventing deterioration to remain at home, Community Physiotherapy, hospital discharge support through community physiotherapy or intermediate care on discharge.

In addition to the integrated discharge to assess and admission avoidance pathways that are currently in place, one of the key BCF funded integration workstreams for 22-23 is the development of a transfer of Care Hub (ToCH) which will see the co-location and integration of all the participating agencies and professionals within a single management arrangement. The hub is key to supporting effective hospital discharge from the point of admission through to ensuring that the person leaving hospital is on the correct pathway and can return home or to an appropriate placement, as soon and as safely possible.

Implementing the BCF Policy Objectives (national condition four)

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

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

Please use this section to outline, for each objective:

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

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

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

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

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

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

Adult Social Care is supported with BCF funding to deliver the Buckinghamshire Council Better Lives Programme which started in 2018 and is designed to deliver a change in approach to social care, moving from a traditional paternalistic approach to a strengths-based model of care. The programme seeks to enable more people to live longer, independent lives in their communities and ensure more high cost, high dependency care in residential and nursing homes is only used when absolutely needed.

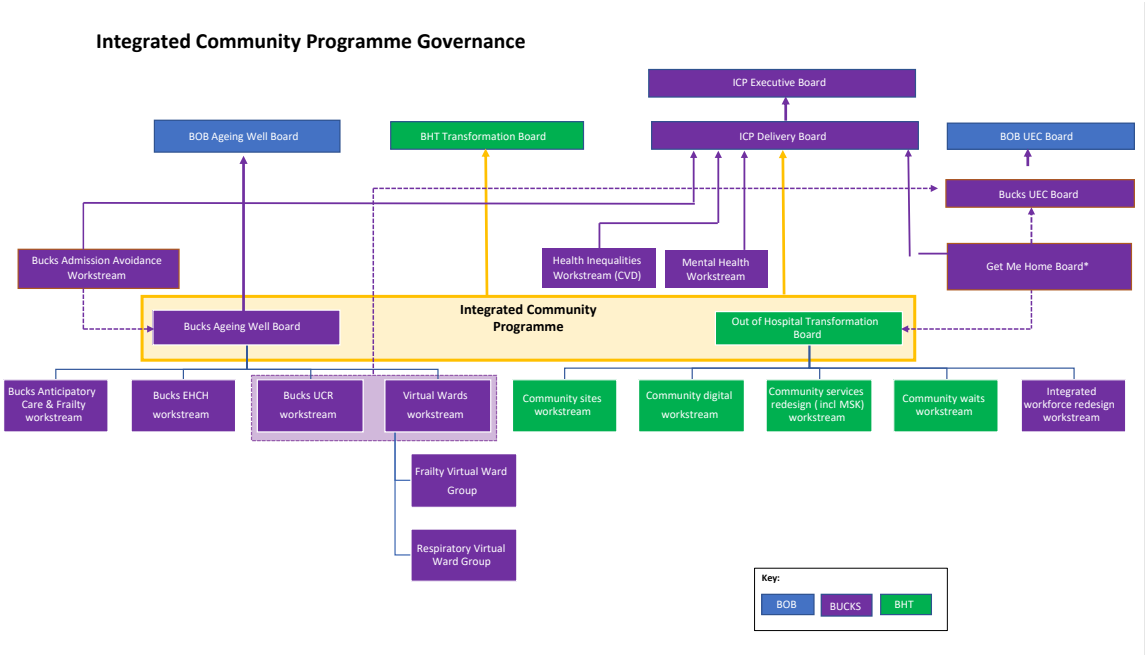
The programme has delivered a shared model of prevention, agreed by partners across Buckinghamshire. The Better Lives Programme aims to keep people healthy and in their own homes and communities for longer.

BCF funded schemes which support this include:

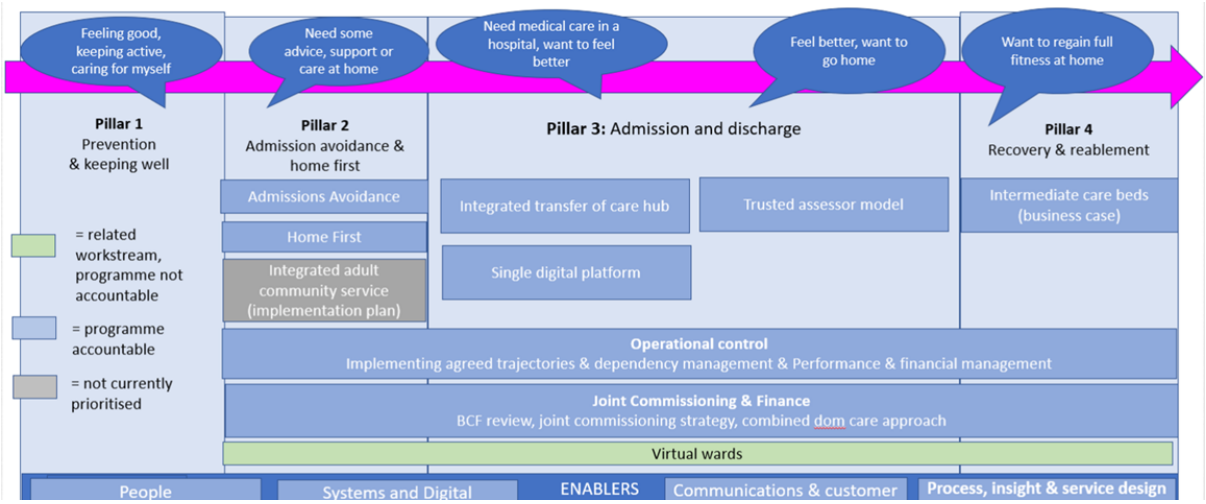
- Advocacy and DOLs – Liberty Protection Safeguards are being merged with the current contract to ensure a smoother transition for individuals
- Community Advocacy contract – will allow individuals outside of the statutory capacity to gain access to support and deal with challenging areas of their life. This is currently being developed and tailored to ensure it is manageable and deliverable
- Integrated Carers Service – improves the experience of carers and those that become carers for the first time in hospital. Post pandemic we are developing ways to provide the service safely and manage the rise in the number of carers being registered
- Community Engagement Contract with Healthwatch – gathering information through questionnaires and focus groups with communities to inform the future of specific areas of commissioning. Currently this is focused on the future of direct payments.
- Supported Living – provision of housing which enables people to live at independently whilst within a supported environment and helps them to sustain their tenancies
- Direct Payments – supporting service users to make choices over the care and support they receive

The Corporate Management Team for Buckinghamshire Council have approved a one council action plan for specialist accommodation which includes Adult Social Care accommodation. This is building on the work of an Adult Social Care accommodation steering group, with representation from housing, property, and planning. The action plan will integrate needs around Adult Social Care accommodation, into a more general housing and planning policies and the need for a joined up unitary approach has been approved by CMT. This strategic approach will support the overall objective to support people to remain independent and at home for longer and to ensure the right environment to receive the right care at the right time.

The BCF in Buckinghamshire is used to support the integrated community programme which provides an integrated approach to improving health outcomes, admission avoidance, and hospital discharge including implementing a Home First approach. Each of the workstreams involve system partners from the Council, the ICB, NHS provider Trusts and wider stakeholders such as care homes where relevant.



Building upon work that has been done in previous years, Buckinghamshire is committed to establishing a sustainable long-term intermediate care offer. A new Integrated Care Programme Board has been established and integrated posts to lead and support the delivery of the programme have been created and appointed to. The programme will use the findings from the High Impact Change Model (HICM) self-assessment to drive improvements in the system in Buckinghamshire. The findings in the most recent self-assessment identified that although there have been improvements in all of the key change areas, the assessment was primarily 'established' heading to 'mature'. The intermediate care programme is supporting the ambition within Buckinghamshire to move to 'exemplary' and the HICM self-assessment will continue to be used to assess progress. Some examples of where improvements have occurred are the implementation of the Enhanced Health in Care homes framework which is now overseen by both Health and Council named leads and progress has been made in all the care elements, including the support of the provision of an Urgent Community Response service to care homes.



Demand and Capacity Modelling

The requirement to submit a demand and capacity plan for the BCF for the first time has provided a challenge and an opportunity for the system partners to collectively discuss and agree how this can be approached and delivered. Data and information have been drawn from several sources across both Health and Social Care. There is a current workstream for 22-23 looking at the digital mechanisms for sharing information and data across key partner organisations. The development of streamlined approaches to recording and collecting data through the pathways will support future demand and capacity modelling. It has been determined that the planned trajectory can meet anticipated demand but only when presented in conjunction with associated risks and acknowledging the tension between capacity and flow. The current systems are meeting identified demand but could also be masking true demand, particularly at different points in the pathways. The experience of the individual is impacted by capacity and an increase in capacity could improve flow, decrease the length of stay (LOS) and improve the patient experience. Each area of the current system pathways operates at full or near full capacity and as such there is no room to absorb any unanticipated increase in demand and LOS in this circumstance is likely to be impacted significantly. There are several system workstreams to improve flow and create efficiencies to maximise the use of available capacity, but these will not be fully realised before the anticipated 22/23 winter surge.

Supporting unpaid carers.

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

Buckinghamshire has a Carers Transformation programme (2022 – 2024). During 22-23, an integrated Carers Board has been established which has senior leadership representation from Adult Social Care, Cabinet Members, ICB, Buckinghamshire Healthcare Trust, the voluntary and community sector (VCS) and Carers. The Board will use a co-production approach to oversee the carers transformation workstream to deliver improved outcomes for carers in Buckinghamshire. The Carers Board is accountable to the Adults & Health Transformation Board via Buckinghamshire Council, and the Health & Social Care (HASC) Board via Buckinghamshire Council Cabinet.

The BCF funds Carers Bucks, which is a VCS organisation, to provide a Carers Support Service. The service complements and reflects the wider health and wellbeing agenda of promoting a strengths-based approach, focusing on building resilience and wellbeing. The service works flexibly to provide a range of services across Buckinghamshire to meet the differing needs of carers aged from 5 years plus. The BCF funds the Young Adult and Adult elements of the service. The service works in partnership with health, social care services and the VCS to provide a holistic approach to supporting carers within Buckinghamshire.

In line with Care Act duties, Adult Social Care have a tiered system to identify support needs for carers with a focus on improving wellbeing, as well as supporting the Carer in their role. The conversations range from signposting or providing information and advice through to a full assessment leading to an agreed outcome-based care plan.

Buckinghamshire Council has well established Direct Payment options and carers breaks are funded through Direct Payments.

Carers Bucks support carers via primary health environments by developing their investors in GP award, working with surgeries across the County. The award requires that all staff within GP primary care settings are trained in recognising the needs of carers and that flexibility is offered where possible to promote carer wellbeing.

Carers Bucks had support staff located in the acute hospitals to support carers, with a particular focus on hospital discharge. This was suspended due to the pandemic but is currently under review as it was previously successful in identifying, engaging, and supporting carers. The involvement and support of carers is acknowledged as key contribution to improving efficiencies within the hospital discharge and admission avoidance pathways

Disabled Facilities Grant (DFG) and wider services

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

Adult Social Care has created an accommodation steering group to develop a one council approach and action plan to utilise the benefits of becoming a unitary authority. This group includes membership from wider Council departments including Housing, Planning and Property. The aim of this group and work is to maximise the potential to develop accommodation solutions that will meet the future needs of people with adult social care needs, aligning the strategic objectives of both housing and adult social care. Included in this is accommodation that can support delivery models that focus on maintaining independence and maintaining wellbeing. This work includes undertaking a detailed market analysis to inform future commissioning activity but also provide evidence to incorporate adult social care accommodation needs in the Local Plan. To support planning and property services to engage with this agenda, work is also being undertaken to develop design principles for different types of adult social care need. The one council action plan which will integrate needs around Adult Social Care accommodation, into a more general housing and planning policies.

Buckinghamshire had aimed to use becoming a unitary authority in April 2020 as an opportunity to review how DFG is delivered within the county. Prior to this, DFG was passported to the four former district councils. The pandemic limited progress but the review was an identified priority for 21-22. This was delayed further due to the Omicron surge and now remains a priority for 22-23. The policy is currently being reviewed and the way the policy is operationalised is also under review. Access to DFG currently still operates under multiple existing policies and is administered by the housing teams while the assessment of need is undertaken by OTs within Social Care. The funding is now retained by the single unitary council.

Through collaboration between Council departments (Adult Social Care, Children's Social Care and Housing), and in consultation with recipients of DFG, the Council intends to enhance the delivery of DFG to better meet the needs of its residents whilst aligning with the various strategies in place (and in development). This will include ensuring adults are supported to remain independent in their own homes for longer, ensuring children are given the best start in life and ensuring that people are living in homes that support them to have positive health and social care outcomes.

Opportunities include:

- Utilising the increased investment in recent years in a better and more equitable way
- Introducing a central point of administration (surveying, planning, admin of grant)

- Reducing 'handoffs' between social care and housing to improve client experience and speed up delivery
- Streamlining the policy to abolish the nuances between the former district councils' policies
- Reviewing the referral criterion to determine how we can make improvements to access
- Bringing DFG closer to the Integrated Community Equipment service to allow greater access
- Greater alignment of DFG with housing lists to enable mutual exchanges/swaps to take place where suitable properties for DFG adaptations can be identified
- Evolving discretionary use of the grant to further support hospital discharge

As well as capital funding to support permanent adaptations to homes, DFG is also currently used for some minor discretionary approaches that serve a preventative purpose. These are outlined below:

Deep Cleans – For individuals that self-neglect who are at risk of admission to hospital or cannot be discharged to their home without a deep clean taking place. Deeps cleans can also be undertaken to enable equipment installations or DFG adaptations to take place.

Healthy Homes on Prescription – Seeks to prevent hospital admissions and assist with managing timely discharge from hospital by funding essential works to address health and safety hazards in homes. This could range from installing and repairing heating and other minor repairs, to installing electrical points for medical equipment and widening doorways to accommodate wheelchairs.

DFG currently runs in parallel to the Integrated Community Equipment Service (ICES). The ICES service within Buckinghamshire is delivered by NRS through a joint funding arrangement between health and social care and encompasses several service elements including provision of simple and complex aids to daily living, minor adaptations, technology enabled care, continence products, long term wheelchair provision, sensory equipment and domestic lift maintenance. The service plays a key role in supporting discharge of people into their own homes, preventing avoidable admissions to hospital and maximising service user independence.

Supplementary OT support to Home First Pathway – NRS have been providing therapy input to the Home First Pathway through dedicated OT resource supplementary to the existing ICES contract. On discharge, a joint assessment between therapy and the home care provider takes place, identifying equipment needs, the appropriate package of care and the initial goals for the person. Utilising NRS for this also brings further opportunities to identify other needs e.g. assistive technology.

Equality and health inequalities

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

- ***Changes from previous BCF plan***
- ***How these inequalities are being addressed through the BCF plan and BCF funded services***
- ***Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered***
- ***Any actions moving forward that can contribute to reducing these differences in outcomes***

Buckinghamshire is currently developing a new Joint Local Health and Wellbeing Strategy. The strategy takes a life course approach of Start Well, Live Well, Age Well. The main evidence base for the strategy is the Joint Strategic Needs Assessment (JSNA) and the Health and Wellbeing Board draws on the JSNA to prioritise its work programme. Priorities have not yet been signed off but the themes of mental health, obesity and smoking with a particular focus on tackling health inequalities have been identified.

The Buckinghamshire Integrated Care Partnership has taken the CORE20PLUS5 approach to address health inequalities. Cardiovascular disease and smoking are current priorities and are included in the community transformation programme of work. There is a focus on smoking cessation as this is the number one cause of health inequalities in Buckinghamshire and has been identified within the CORE20PLS5 approach as having a positive impact on all five identified key clinical areas. THE BCF funds the NHS Integrated Community Services which delivers some of the workstreams addressing health inequalities. The workstream includes:

- Improving referrals and access to smoking cessation services
- Prioritising long term conditions reviews for cohorts of patients who smoke and are an ethnic minority
- Developing smoking cessation support for acute inpatients, maternity services, and mental health services
- Ensuring pathways and services are culturally appropriate
- Improving the cultural competence of the workforce
- Focusing on the most deprived practice areas including Aylesbury and High Wycombe

Mental illness is one of the Buckinghamshire BCF priorities. It is evidenced that people with SMI are more likely to die prematurely and individuals with SMI are 3 x more likely to smoke. BCF funding is used for Annual Health Checks for people with SMI to reduce the inequalities this cohort faces, in line with the CORE20PLUS5 approach. The work has increased the proportion of patients receiving all six elements of the physical health check.

Buckinghamshire JSNA has identified that the number of people being admitted to hospital due to a fall, is more prevalent in deprived areas, with a particular focus on the south of the county, as it has a higher figure than the overall average in England. The BCF funds a Falls Prevention service in Buckinghamshire via the NHS community contract and primarily works with older adults. This is being reviewed considering the UKHSA identification that the incidence of falls is likely to increase post-COVID due to deconditioning and periods of immobility during the pandemic. This will primarily have an impact on older adults and the opportunity to use this BCF scheme to further address this is being explored.

The JSNA shows rates for people with dementia in Buckinghamshire are estimated at 7,000 people aged 65+ having been diagnosed. A Dementia Needs Analysis has been carried out in 22-23 and this has identified that Buckinghamshire's low dementia diagnostic rate (56.9%, or 4,061 people diagnosed out of estimated prevalence of 7,142, as per NHS Digital report from March 2022) illustrates the underdiagnosis of people living with dementia in the area, which results in people not accessing the appropriate dementia support. It has been suggested that the gap is not within the current diagnostic pathways but instead around increasing awareness, reducing stigma, and encouraging people to come forward to be diagnosed. This is particularly key to care homes and social care teams when supporting frail people. In other words, by employing proactive behaviour in identifying dementia signs and supporting access to a diagnosis, not only the dementia diagnostic rate (DDR) would improve, but more people would access the appropriate dementia support. The Dementia workstream has identified six priority areas for 22-23 to improve the outcomes for people with Dementia. BCF funding supports this workstream.

During 22-23, there will be an assessment of the impact of the BCF on addressing inequalities and how the BCF is being used to reduce health inequalities. The timing of this will enable the inclusion of exploring the impact of COVID in relation to inequalities. It will also assess how each of the schemes is addressing inequalities, particularly for individuals with a protected characteristic. This has been agreed as a priority by ICET.