**Appendix 1**

# Better Care Fund 2021/22

# Southwark

## Narrative template – November 2021

## 1. Executive Summary

The Better Care Fund (BCF) is a pooled budget held between the council and CCG that funds a range of core community based health and adult social care services. It was originally formed in 2015/16 by consolidating a range of existing funding streams for health and social care. It is a mandatory pooled budget to which the CCG and Council are required to make stipulated minimum contributions, with minimum ringfenced minimum amounts to be spent on social care and health. The value of the BCF for 2021/22 is £44.175m, which includes 5.4% growth.

The BCF plan is required to meet the requirements set out in national BCF planning guidance, which include a strong focus on the integration of services to improve outcomes, by supporting people to live in their own home, avoiding admission to hospital and care homes and ensuring hospital discharge is timely and effective. The plan is agreed by the Health and Wellbeing Board and subject to NHSE assurance.

The current BCF is based on the 2019/20 plan agreed by the Health and Wellbeing Board in November 2019. Due to COVID-19 the national BCF planning process was suspended for 2020/21 and budgets were rolled forward from the previous year. For 2021/22, in the absence of national planning guidance at the start of the year, it was also agreed to roll forward existing budgets, with some minor adjustments, and agreements were made on the use of annual growth to address cost pressures and fund new schemes.

On September 30th national BCF planning guidance for 2021/22 was issued with a requirement to submit formal plans by 16th November. The planning requirements are similar to those for 2019/20 and do not necessitate any change to our budget plans. However there is a change in emphasis relating to 3 new key metrics on which stretching targets are to be set for the current year. These are: reducing long length of stay in hospital; increasing the proportion of people discharged from hospital to their normal place of residence and reducing avoidable admissions to hospital, all in relation to people who live in Southwark. This replaces the previous focus on the target for reducing delayed transfers of care which is no longer collected due to changes in discharge arrangements during the COVID-19 pandemic. These requirements are currently being processed, however it is recognised that producing a plan this late in the year after resource decisions have been committed will have limited impact on

these measures in 2021/22. As a system we will be looking to develop and bed in any new arrangements in relation to these targets for the 2022/23 plan.

## 2. Key changes to the Southwark BCF priorities for 2021/22

The high-level priorities for the BCF are unchanged from previous plans that have been rolled forward into 2021/22. These are to develop person centred integrated care that will:

- Support timely and effective transfers of care from hospital
- Prevent avoidable admissions to hospital and care homes
- Support people to live independently and safely in their own home
- Provide community support that prevents or delays people from needing higher levels of support

More specifically for the current year, there are key system priorities that the BCF supports:

- The Partnership Southwark[1] Recovery Plan sets out priorities to deliver borough-wide recovery from the impact of COVID-19 and improve outcomes for the population, addressing inequalities that have been highlighted and exacerbated during the pandemic. The BCF is an enabler for the recovery plan and BCF funded services are key elements of the adult population-based transformation programmes delivered within the partnership: Live Well (working age adults), Age Well (older people and frailty) and Care Well (people in care and residential settings).
- The Recovery Plan includes a focus on building on progress made in partnership working during the pandemic, such as strengthened discharge to assess arrangement and ensuring the learning from this is locked into service redesign and delivery.
- Strengthening system resilience, with a particular focus on responding to the additional winter pressures arising from flu, COVID-19 and the backlog of elective care. Supporting the provider sector to maintain sufficient capacity to maintain patient flow, in particular the care home sector and domiciliary care which is facing increasing recruitment and retention challenges is key within this.
- Developing our partnership commissioning and other joint working arrangements through Partnership Southwark to support the development of the place based system that will formally come into being when the ICS is established in April 2022.
- Responding to the new focus on reducing length of stay in hospital and reducing avoidable admissions metrics.

[1] Partnership Southwark is Southwark's place-based Local Care Partnership within the Our Healthier South East London Integrated Care System (SEL ICS). The partnership brings together acute, mental health and community trusts, primary care networks, the voluntary and community sector, the CCG and the Council to transform the way services are planned, designed and delivered in the borough.

## 3. Use of the growth in the CCG minimum contribution to the BCF

The growth in CCG minimum contribution to the BCF pool for 2020/21 was £1.289m (5.4%), in line with overall growth in NHS resources, bringing the total to £25.166m. Whilst this is obviously welcome the majority of this must be focussed on addressing inflationary costs pressures rather than for new schemes. It is proposed to invest this growth as follows:

| **2021/22 BCF Growth items** | **£'000** |
|---|---|
| Funding for social care placement inflationary cost pressures* | £750 |
| Community Equipment (ICES) inflation* | £222 |
| Community health services budgets absorbed into BCF | £93 |
| Behaviour Support Scheme (Learning Disabilities and Autism): | £100 |
| Funding for Carers of people with dementia | £100 |
| Self- management (diabetes) | £20 |
| Enhanced Intervention Service adjustment | £4 |
| **Total BCF growth** | £1,289 |

*In addition, £197k funding was redirected from existing schemes to ICES costs and £88k to placements inflation from discontinued schemes.

There was no growth in council contribution in 2020/21, reflecting the unchanged value of the council Improved BCF grant and Disabled Facilities Grant (DFG) that feed directly into the BCF minimum.

The of BCF total funding by source is shown in the table below.

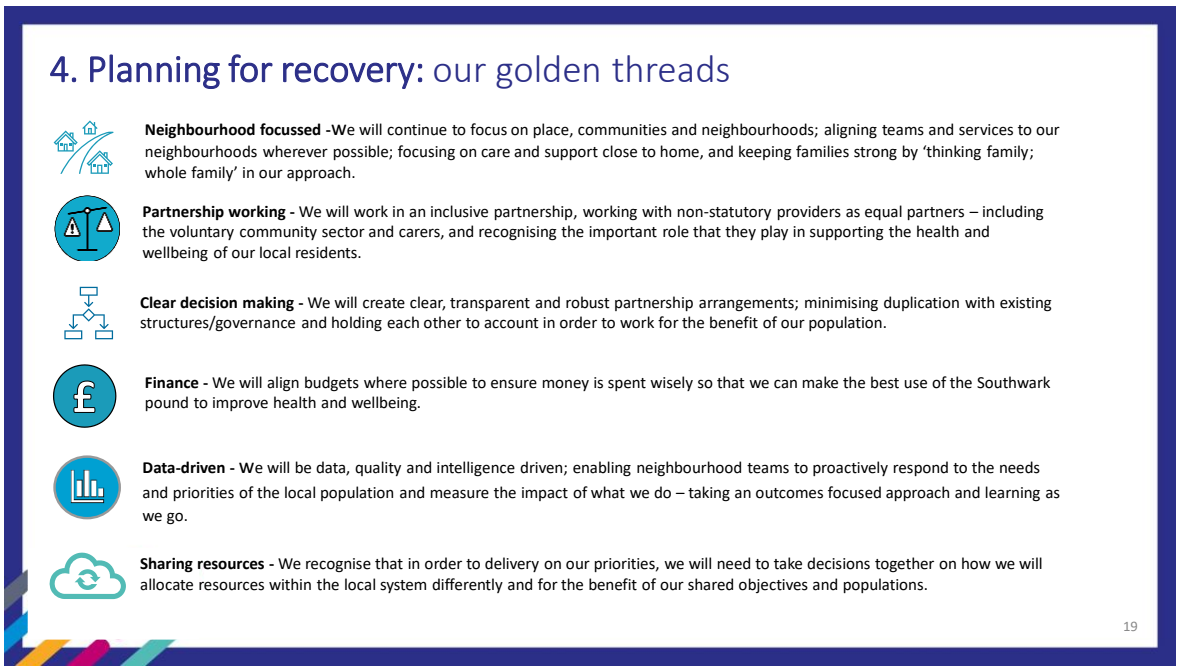
| **Total BCF Funding Sources 2021/22** | **Income** |
|---|---|
| DFG | £1,686,144 |
| Minimum CCG Contribution | £25,166,490 |
| iBCF | £17,322,581 |
| **Total** | **£44,175,215** |

## 4. Overall approach to integration

The overall approach to integration in Southwark is driven through our local care partnership, Partnership Southwark. The partnership was formed in May 2019 and brings together a range of health and care organisations with a view to working together with non-statutory providers and service users/carers in our communities. The overarching aim is to better join up services and tackle the causes of inequality and improve the health and wellbeing of Southwark residents. Partnership Southwark's Recovery Plan, which was signed off by the Partnership and Health and Wellbeing Board in September 2020, built on the work of the partnership pre-pandemic. It sought to use the experience of the first wave to reframe the partnership's work programme with a stronger focus on targeted approaches to addressing inequalities and a quadruple aim of:

| | |
|---|---|
| Improving population health outcomes and reducing inequalities | Enhancing people's experience of care services and reducing unwarranted variation |
| Securing a financially sustainable health and care economy | Enabling compassionate care and supporting the health and wellbeing of our staff |

Aside from short term recovery of services from COVID-19, the plan seeks to refocus our whole system efforts on tackling the health and wellbeing inequalities that were highlighted and exacerbated by the impact of COVID-19 on the population. The plan identifies 4 key population-based workstreams: **Start Well, Live Well, Age Well, Care Well** underpinned by key golden threads:



For the full Southwark Borough Recovery Plan visit **https://selondonccg.nhs.uk/in-your-area/southwark/working-with-you-on-our-plans/**

## 5. Approaches to joint/collaborative commissioning

The Partnership Commissioning Team was restructured in 2020 with new teams responsible for delivering joint programmes to improve outcomes for the population: older people and adults with complex needs; children and young people; and healthy populations. The team is jointly funded with a substantial contribution from the BCF. The primary care commissioning team is part of the overall structure although not jointly funded.

With the onset of the COVID-19 pandemic in 2020 there was little opportunity to build and bed in the new teams, with staff being extensively redeployed to work on COVID-19 related issues, particularly during the acute pressures of wave 1, but also beyond that, including the vaccination programme. As such a key priority for 2021/22 has been to establish the teams and their programmes and develop capacity to move to a new business as usual following COVID-19.

Building a consensus on the approach to integrated commissioning has been a key organisational development priority, supported by the bi-monthly Commissioning Strategy and Integration Board which has held workshops and discussions supported by external partners. This includes planning progress against agreed "road map" milestones on an integration maturity matrix and the development of integration demonstrator projects.

Partnership Southwark has agreed an approach to joint commissioning for improved population outcomes referred to as the Bridges to Health and Wellbeing model that was developed following extensive engagement. Whilst it was decided not to take a prescriptive approach to applying the methodology to all programmes, the model provides guiding principles for all integrated workstreams:

**Key principles of the Bridges to Health and Wellbeing Approach**

| | |
|---|---|
| **1** | **Organising the population into coherent groups –** grouping the population according to similar patterns of health and care need (i.e. 'population segments') and associated relevant outcomes is a sound basis for developing a population based approach |
| **2** | **Agreeing outcomes for population groups** - the development of an agreed outcomes framework for each population group/ segment, like the approach used for the frailty, dementia and end of life segment, provides partners with a common focus |
| **3** | **Whole system approach to deliver the outcomes -** population health and wellbeing outcomes can only be fully achieved by all partners working together as a single Southwark system. |
| **4** | **The integrated service models need to be holistic and person focused** – health, care and universal services focussed on working together on the whole need of a person or population rather than service focused. Co-production of new service models with the public and the use of personalised outcomes for individuals in their multi-disciplinary plans is a key element of this. |
| **5** | **Prevention -** we need to shift resources to prevention if outcomes are to improve. This will mean sharing the costs, risks and rewards of investment in prevention opportunities we have identified. |

| | |
|---|---|
| 6 | **Providers and commissioners will need to work together in new ways -** with formal and informal alliances where necessary to deliver outcomes on which they are jointly accountable. This will include high levels of collaboration, trust, and data and intelligence sharing. |
| 7 | **Workstreams to be aligned to outcomes frameworks –** we need a structured approach to incorporating the delivery of improved outcomes into the way services are developed. This covers not just existing and proposed Partnership Southwark workstreams, but any relevant workstreams and "business as usual" services. |
| 8 | **Evidence based and driven by shared data –** The new integrated service models need to be based on in depth needs analysis using shared data on individuals and populations, mapping of existing services, gaps and opportunities, knowledge of best practice etc. |
| 9 | **Aligning resources and commissioning -** We need to consider all resources available for populations to improve outcomes and consider the best way of configuring them that is the best use of the "Southwark £". |
| 10 | **Commissioning for outcomes and contractual changes -** There will inevitably be a need over time for the approach to contractual specifications and payment mechanisms to shift to reflect the focus on outcomes – however the need for these to be evolutionary rather than revolutionary is recognised, with clear mechanisms in place to address system risks |

### Developing the neighbourhood model in Southwark

A key aim of the integration strategy is to develop local networks of care that can provide person focussed co-ordinated care to those in need of support. This is summarised in the extract from the Recovery Plan:


## Example of integration in BCF funded services – Intermediate Care Southwark

A successful example of improved integrated working in Southwark that illustrates our approach is the integration of Enhanced Rapid Response, Supported Discharge, Reablement including the ASC reablement care provider contract and the urgent social work response (all BCF funded). This has been successfully integrated forming a single joint team, Intermediate Care Southwark, which provides a simplified and co-ordinated urgent response system, and is bedding in further in the current year with plans for further integration between community health and social care being developed. The approach has been provider led with commissioner involvement on the board. It involved creating a new team under a single manager with 178 employees and an annual budget of £5.5m. A key benefit has been the rationalisation and simplification of numerous complex referral processes into a streamlined approach. The programme of change was intensive including separate workstreams for; shared leadership & management; creating the pathway, workflows & teams; developing the workforce, working culture & staff engagement; shared performance management; premises and IT. The learning from this process has been captured and disseminated, including through a workshop for joint commissioners, and taken on board in the Partnership Southwark change management approach.

During the pandemic the focus of the team had by necessity to focus more on supporting hospital discharge and avoiding admissions to hospital. During the current year further development of the model is underway, with the @home (acute hospital at home) a part of the integrated model.

## 6. Supporting Discharge (national condition four)

The BCF budget for 2021/22 funds a wide range of schemes that directly and indirectly supports the objective of facilitating timely and effective discharge from hospital and reducing long lengths of stay in hospital.

Schemes explicitly identified as schemes under hospital discharge theme include hospital discharge teams (including weekend teams), reablement and intermediate care, discharge to assess, and the housing worker within the discharge team as set out below.

| **Scheme** | **2021/22** |
|---|---|
| **Theme 1: Hospital Discharge –** I get the support I need to leave hospital and settle back at home | |
| Hospital discharge | £1,790,453 |
| Reablement | £1,936,738 |
| Neuro rehab team | £195,529 |
| Discharge to Assess | £260,000 |
| Night Owls - overnight intensive homecare | £224,000 |
| Housing worker – discharge team | £50,000 |
| Care Act assessment and care management | £300,000 |
| Intermediate Care | £1,137,563 |
| **Sub-total – hospital discharge** | **£5,894,283** |

However, a much wider range of BCF schemes play a key indirect role in supporting discharge as set out below. This includes substantial budgets for social care home care packages and care home placements without which discharge from hospital would be impossible in many cases.

| **Schemes with a strong indirect link to supporting discharge** | £ |
|---|---|
| Community Health Enhanced Rapid Response /@home | £4,644,157 |
| Home care quality improvement | £1,900,000 |
| Placement costs - inflation home care and care homes | £1,718,954 |
| Disabled Facilities Grant | £1,686,144 |
| Residential Care | £2,010,610 |
| Community equipment: | £978,6891 |
| Mental Health Reablement | £151,632 |
| Mental Health discharge worker | £50,000 |
| Mental Health Placement Broker | £50,000 |
| **Improved Better Care Fund grant (iBCF)** | |
| Sustaining quality in home care | £10,327,850 |
| Re-ablement and intermediate care including step down accommodation | £999,749 |
| Improving and investing in local nursing care | £4,174,334 |

| | |
|---|---|
| Residential care for older people | £400,000 |
| Nursing care for older People | £300,000 |
| Home care for older people | £870,648 |
| **Total** | £30,262,767 |

## Review of discharge arrangements

Building on the learning and success of enhanced discharge arrangements put in place for COVID-19 is a key priority for the system. Southwark is contributing to a review across South East London which is seeking to understand the discharge models that have developed, and how they can be sustained in the context of changing discharge funding arrangements. The review includes a self-assessment of maturity of local systems, incorporating the criteria of the High Impact Change Model for reducing delayed transfers, and seeks to highlight best practice and reduce unwarranted variation in the service offer.

## Discharge to assess – development of step-down accommodation capacity

Whilst discharge to the patient's own home is the preferred outcome it is often the case that older people are too frail and need to be discharged to a temporary care home placement for assessment. Due to capacity constraints, suitable placements are frequently difficult to obtain, and patients end up waiting too long in hospital. To help address this Southwark has commissioned 16 discharge to assess beds in a local nursing home with a service model that is specifically geared to support positive outcomes from the discharge to assess process, starting in the second half of the year.

## Commissioning additional nursing care home capacity

Southwark has made significant progress in establishing a block contract with a local nursing home and increasing capacity within the sector, as well as attracting a new provider into the borough which in the longer term will reduce discharge delays.

## Further integration of Intermediate Care Southwark

Building on the previous success of the integration of council reablement services and community health rapid response services, the model has been expanded to incorporate @home services (acute care at home). The service now offers medical input alongside the therapy, nursing, and support worker offer.

### Housing advice worker placed with discharge teams

The BCF continues to fund this new post which helps discharge team navigate the housing system to help tackle delays associated with Housing. This has been recognised as an example of good practice.

# 7. New discharge metrics in the BCF – performance and plans

A significant change to the BCF this year is the replacement of the previous target on reducing delayed transfers of care as measured by the number of bed days lost for patients remaining in hospital after the discharge decision. This indictor was suspended following the introduction of COVID-19 discharge arrangements and replaced with a trust specific target to discharge all patients on the same day as the discharge decision.

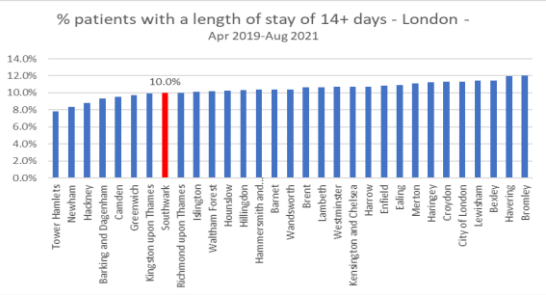
The new metrics, on which we are asked to set stretching targets, are set out below together with information on the baselines, benchmarking and proposed targets.

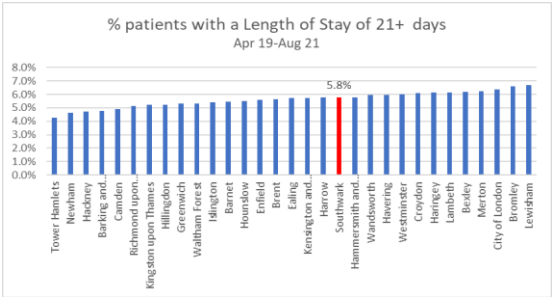
In terms of target setting for the remainder of this year, a key contextual factor is the potential for unusually high winter pressures on system capacity that could have an adverse impact. For example, a combination of Seasonal flu, COVID-19 and the backlog of elective care, combined with worsening capacity issues in social care provider services arising from recruitment and retention challenges could impact significantly on patient flow. Taking this into account it is considered that maintaining current performance over the winter is an appropriate and challenging target. This approach has been discussed and agreed with the partnership, which includes our trusts.

## a) Reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days

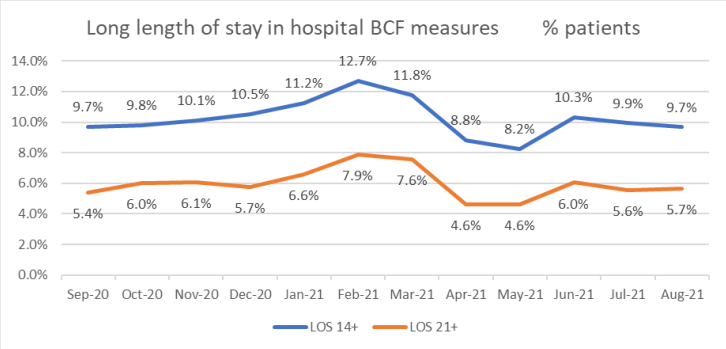
This measure has previously only been reported at trust level, rather than for borough residents who are inpatients in any trust.

The benchmarking data suggests that Southwark is in the mainstream on these measures for London.



**Trend**




The trend data provided shows that although there is some monthly variation there was a peak in February, which coincided with a period of intense acute pressures in wave 2.

In terms of setting a target it is considered that maintaining current performance could be very challenging given the anticipated capacity pressures on community-based services over the winter. However, the proposed expansion in capacity of discharge to assess beds is expected to help offset some of the increase in demand, as is the additional winter funding being released into the system outside this plan. We are aiming for an improvement on the forecast position, reflecting our ambition for improvement. Our ability to achieve this will be dependent on the level of system pressures arising over the winter, particularly in relation to flu and COVID-19. The forecast based on historical data (provided by NHSE) and our aspiration for improvement on that forecast is as set out below:

| | Q3 forecast | Q3 target | Q4 forecast | Q4 Plan |
|---|---|---|---|---|
| Proportion of inpatients resident for 14 days or more | 10.6% | 10.0% | 12.0% | 11.5% |
| Proportion of inpatients resident for 21 days or more | 6.5% | 6.0% | 7.5% | 5.5% |

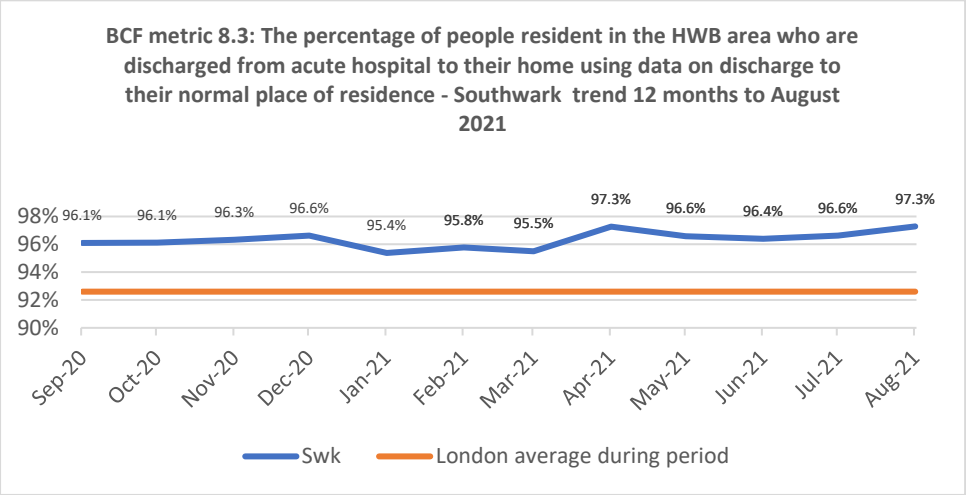
*note: section amended 3/12/21

This target aligns with national standards the trusts have been asked to work to (no more than 12% patients with length of stay 21 days+).

It should be noted that, as part of our current agreed approach on discharge with trusts, any Southwark patient who falls into a long length of stay category at a local trust who is medically fit for discharge, but delayed because of a lack of community provision, is already subject to daily board round review. In addition, both trusts hold bi-weekly meetings with senior discharge staff detailing the long length of stay patients to ensure active case management is progressing to discharge these cases.

**b) Improving the proportion of people discharged to their usual place of residence**

The data provided for the target base line shows that Southwark is already a very high performer on this measure. It is considered that current performance is optimal and will be a challenge to maintain, so the target has been set at the average of recent performance at 95.9%.



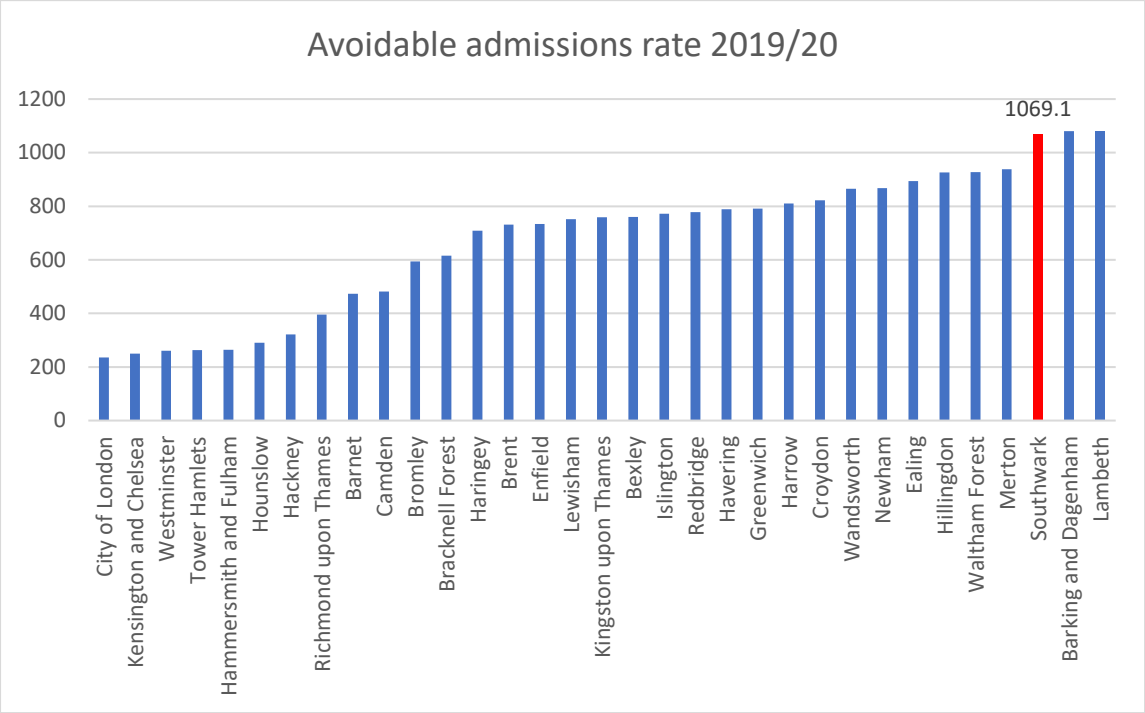

## c) Reducing avoidable admissions to hospital – new BCF metric

Previously the BCF had a target based on the rate of all non-elective admissions to hospital, which was widely regarded as a blunt measure of the success of the BCF, hence the move to an "avoidable" admissions measure. The measure used is admissions for a number of ambulatory care sensitive conditions which it is considered have the potential to be avoided through strong proactive health and care in the community.

The BCF funds a wide variety of services that all have a role in helping reduce the risk of admission to hospital amongst those in receipt of care and support in the community. Enhanced rapid response community health services and @home (£4.7m) have a very specific focus on this objective, and many more contribute to this outcome, for example home care, self-management, enhanced primary care access, telecare and community equipment.

The neighbourhood model of integrated care being developed under Partnership Southwark through its Age Well programme is based on providing person focussed co-ordinated care for people identified as being at risk of admission to hospital, in particular those with multiple long-term conditions.

## Baseline data and benchmarking




The data provided by NHSE for Southwark patients relates to 2019/20, with no more recent data being available. It indicates that Southwark is very high for London which is clearly a matter of concern. However much more analysis is required to understand how this data was produced and what it means. The SELCCG analytics team have run a report on the indicator and founds rates to be much lower than that provided by NHSE, and Southwark are not significantly above neighbouring boroughs in South East London. Further information has therefore been requested on the new measure in order to be able to set a more meaningful target.

However, aside from the technical issues with this new measure, the objectives for Q3 and Q4 are still to minimise avoidable admissions, and a suitable trajectory would be to maintain current performance over the anticipated challenging winter period. This will be developed when the data is better understood.

Overall, a shift in BCF focus from hospital discharge to preventing hospital admission is welcome. It is proposed that Partnership Southwark will convene a multi-stakeholder task and finish group to assess opportunities for improvement in reducing avoidable admissions. This will include a system self-assessment against the new High Impact Change Framework for reducing non-elective admissions.

## Note: Existing targets (social care measures)

The main template sets out targets on existing social care measures in relation to reablement outcomes and permanent admissions to care homes. The targets set are based on the mid-year position on these measures and aim to maintain current performance over the winter.

## 8. Equality and health inequalities.

The Partnership Southwark Recovery Plan sets out the wide range of inequalities in outcomes experienced by Southwark's population which were highlighted and exacerbated by the differential impact of COVID-19 on communities. Addressing inequalities is at the heart of the partnership's 4 key population-based programmes. The BCF funding is a key enabler of the adult's focused live well, age well and care well workstreams, funding a significant range of community based health and care services that are working together to deliver the objectives of the plan.

The Partnership is committed to a data driven population health approach to addressing inequalities. It draws on intelligence and recommendations from the Covid 19 JSNA and the guiding principles of the health inequalities framework both of which have been shaped and informed by a range of stakeholders from within the partnership.


### Contribution to Equalities Act requirements

The BCF funds services that provide a range of essential personalised support for people with health and social care needs. This has important benefits for people with protected characteristics under the Equalities Act, many of whom are reliant on these services, in particular older people, people with disabilities and people with mental health problems. Other beneficiaries of BCF investment are the homecare workforce who have been paid the London living wage since April 2018 as a result of BCF investment in our ethical home care policy. This workforce is mainly made up of women and those from the black and minority ethnic communities.

### Example: Behavioural Support

Although most growth in the BCF in the current year is necessarily focussed on meeting rising costs of existing services, a new Behavioural Support scheme has been funded for 2021/22 for £100k. This supports younger people with learning disabilities and challenging behaviour to remain in the community through the provision of enhanced psychological support, avoiding placement breakdown and the need to enter more restrictive placements including secure inpatient settings. This is a group

with poor health and wellbeing outcomes that the BCF scheme will help address by enabling a more preventative “all ages” approach to the issues.

## 9. Disabled Facilities Grant (DFG):

The DFG service is based within Southwark Council's Private Sector Housing & Adaptations Team and delivered through the Home Improvement Agency (HIA). Although formally part of the BCF pooled budget it is funded by a ring-fenced grant paid to the council for the discharge of its statutory duties to administer a DFG scheme. The DFG supports people with disabilities who are owner occupiers (who may be asset rich and cash poor) and tenants of private rented/housing association housing by funding physical adaptations to their homes that enable them to remain long term in their own home in the community, avoiding admissions to hospital and care homes. As well as major adaptations the DFG also funds a handyperson service which works closely with the hospital discharge teams to enable people to return home from hospital when their house needs minor repairs. Under the Regulatory Reform Order flexibilities Southwark also provide a range of small repairs grants and loans to help vulnerable people carry out repairs and improvements to their homes.

The Disabled Facilities Grant has a budget of £1.686m for 2021/22. This represents an increase of 13% on the 2019/20 baseline. Growth has been focussed on securing an increase in senior occupational therapist capacity to reduce delays and increase the number of people accessing DFG's.

93% of the DFG funding is used for housing adaptations, 3.75% funds the dedicated OT post, whilst 3.25% is used for a handyperson service and repair grants, supporting hospital discharge.

For 2021/22 the focus for DFG is very much about recovery of services following the pandemic, thereby contributing to the Partnership Southwark Recovery Plan. COVID-19 has had a substantial impact on all DFG services. For the majority of last year (2020-21) the only cases that could progress were those with emergency type works such as installing very urgent adaptations (stairlifts, level access showers, specialist toilets) for people with life limiting conditions or assessed as very urgent by the Occupational Therapy Team. As from April 2021, the HIA and Handyperson resumed their full services. To assist recovery, changes were made to the process to reduce any unnecessary delays. The financial means test for DFG applications has been temporarily waived, the DFG application form revised/simplified and discussions with contractors/builders have taken place to ensure they could provide a safe environment when carrying out building works. The overall delivery process has also been reviewed and improvements implemented.

Due to the high demand for DFG's and the impact of the pandemic the HIA had to put in place a waiting list. There are currently 100 cases on the list. The HIA have put in place a programme to help reduce the waiting list cases and progress these as soon as possible.

Other specific areas of improvement:

- The DFG service works closely with Adults Social Care Occupational Therapy (OT) team to ensure plans for adaptations are agreed within 5 days. There are plans to employ a Senior Occupational Therapist to work alongside the Housing

team to help increase the number of OT assessments completed, improve communication/queries with adaptations on site and build stronger links with ASC and Health colleagues.

- The DFG scheme has been promoted with GP Practice Managers across Southwark.
- A fast track system has been put in place to ensure cases assessed as urgent or end of life are prioritised.
- The Housing team have been trained in falls prevention and provide advice, support and practical help when visiting older, frail and vulnerable people to help prevent the risk of falls and potential hospitalisation

The case studies below illustrate how DFGs can benefit service users:

**Ms. E**

Ms E (36) has Devics disease; a neurological condition which leads to loss of eyesight and eventual paralysis. Ms E had been in the National Neurological in hospital for over a year and could not be discharged until her housing association flat was adapted to enable her to be cared for. Recently constructed, the flat had basic disability standard features (wider doors, level access) but the landlord did not have funding for specialist adaptations. The HIA Counsellor visited MS E at the hospital, completed grant forms and liaised with the HIA Surveyor and landlord so the Occupational Therapist's recommended adaptations of a level access shower and automated door openers could be fitted. A Disabled Facilities Grant was applied for, HIA oversaw the works and MS E returned home from hospital for the first time in over a year.

**Mrs M**

Mrs M (86) very frail with a heart condition, COPD and arthritis. She lives alone in a Housing Association property. The HIA applied for a Disabled Facilities Grant for a Closomat (assisted personal cleaning) toilet and a level access shower. The HIA oversaw the works on site. Mrs M telephoned the HIA recently to say her confidence and dignity have been restored. In addition to her quality of life being improved, she has reduced her care package from 2X carers, six days a week to three days a week.

**Mr & Mrs F**

Mr F (82) has chronic and unstable diabetes resulting in his suffering falls and blackouts. Mrs F (80) is also unwell but is Mr F's main carer, also caring for their disabled adult son. They are private tenants living in the same flat for 50 years. They were referred to the HIA by their son-in-law. We applied for a DFG, sought permission from the Landlord and supervised all work on site. Mr F now has handrails to help him from his front door to the gate, a level access shower and central heating, which provides a more stable temperature than the gas fires that previously heated the property. The HIA Counsellor applied for Council Tax Benefit, Housing Benefit and Attendance Allowance for Mr F. resulting in a significant increase in household income. Without this intervention it is certain that all three of the residents would have had to go into care.

## Wider joint working with housing, health and social care

The Partnership Southwark neighbourhood model identifies a wide range of statutory and voluntary services that have a role in helping people improve their outcomes. Housing is key within this - and is an especially important partner in Southwark given the high levels of social housing, particularly amongst older people.

Housing services are engaged in Partnership Southwark's population-based programmes where housing issues are relevant to a particular workstream/project and the Partnership Southwark programme team are a core member of the Housing and Social Care Partnership Board.

The Health and Wellbeing Strategy for Southwark is currently being refreshed with the close involvement of housing, health and social care. This will be a key strategy for the ICS when it is formally established in 2022/23.

Specific examples of joint working include:

- The BCF provides additional resources to have a housing advice officer working within the hospital discharge teams with the objective of addressing housing related delays as effectively as possible. This has been a considerable success and rolled out as an example of good practice.
- There is a strong link between housing, adults social care and health with regards to the BCF funded telecare services which the Housing department provides. For example, the telecare service provides pendant alarms, enabling a response to people who have fallen to be provided that reduces avoidable ambulance call-outs. This includes the use of emergency lifting cushions where necessary to assist the faller.
- The ICES equipment issued also helps people live in their home with more minor adaptations (e.g. bath rails) that complement the major adaptions offer
- The ongoing development of joint commissioning arrangements for supported housing and supported living arrangements for adults with complex needs, and extra care facilities for older people as an alternative to care homes.
- Close working between the council and health on the refugee and asylum seekers agenda
- During the pandemic there were many examples of proactive integrated working between health, housing and social care which we wish to build on. For example, in relation to homeless hotels and the vaccination programme in hostels.

## 10. Bodies involved in preparing the plan

The BCF Planning Group has overseen the development of this plan, including representatives from the council and CCG. In terms of engagement, it should be noted that:

- The Borough Based Board has been briefed on the situation with regards to BCF planning for 2021/22. The board includes representatives from public health, adults and children's social care, CCG, primary care clinical leads and elected members.
- The BCF plan is an enabler for the wider integration strategy set out in the Partnership Southwark Recovery Plan. This plan was generated with close involvement of a range of stakeholders within the partnership across the council, NHS (including acute and mental health trusts) and voluntary sector, and was signed off by the Partnership and the Health and Wellbeing Board in September 2020.
- A range of stakeholders are involved in the Start Well, Live Well, Age Well and Care Well workstreams overseen by the Partnership Southwark Strategic Board, which will be formally accountable to the Integrated Care Board within the SEL ICS from April 2022.
- The Partnership Southwark Leadership team have been briefed on the planning process and invited to comments.
- Housing are directly involved in the BCF plan, the recovery plan and related workstreams.
- Acute trusts have been asked to comment on the proposed targets on length of stay.
- The BCF plan for 2017/19 on which the current plan is largely based was informed by detailed discussion at a multi-agency workshop facilitated with the support of the regional Better Care support team.
- The Bridges to Health and Wellbeing model underpinning the Southwark approach to commissioning for population outcomes was discussed and developed at a large stakeholder event in 2019, and subsequent workshops to develop outcomes frameworks.

## 11. Governance arrangement for the BCF

The BCF is agreed between the council and the CCG (having been first agreed through each organisations own respective governance processes) prior to approval by the Health and Wellbeing Board. It is also subject to approval through a national BCF assurance process before being formally agreed.

The pooled budget arrangements are governed by a Section 75 agreement between the council and the CCG which sets out shared responsibilities to implement the planned spending as agreed.

The BCF is subject to quarterly and year end reporting to NHSE, reviewed internally and agreed by the council and CCG before submission.

In Southwark the BCF Planning Group has been set up to oversee the high-level monitoring of the BCF on behalf of the Health and Wellbeing Board and to agree any changes to the use of funding. This group includes the Director of Adult Social Care, the council's Director of Commissioning for Children's and Adults and the Borough Director of the CCG.

Each scheme in the BCF is assigned a lead organisation responsible for the expenditure on that budget. This budget is managed within the governance arrangements of the lead organisation.

**Fig 1: Governance Arrangements for BCF**