BCF narrative plan template

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

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

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s).

Sefton Health and Wellbeing Board

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

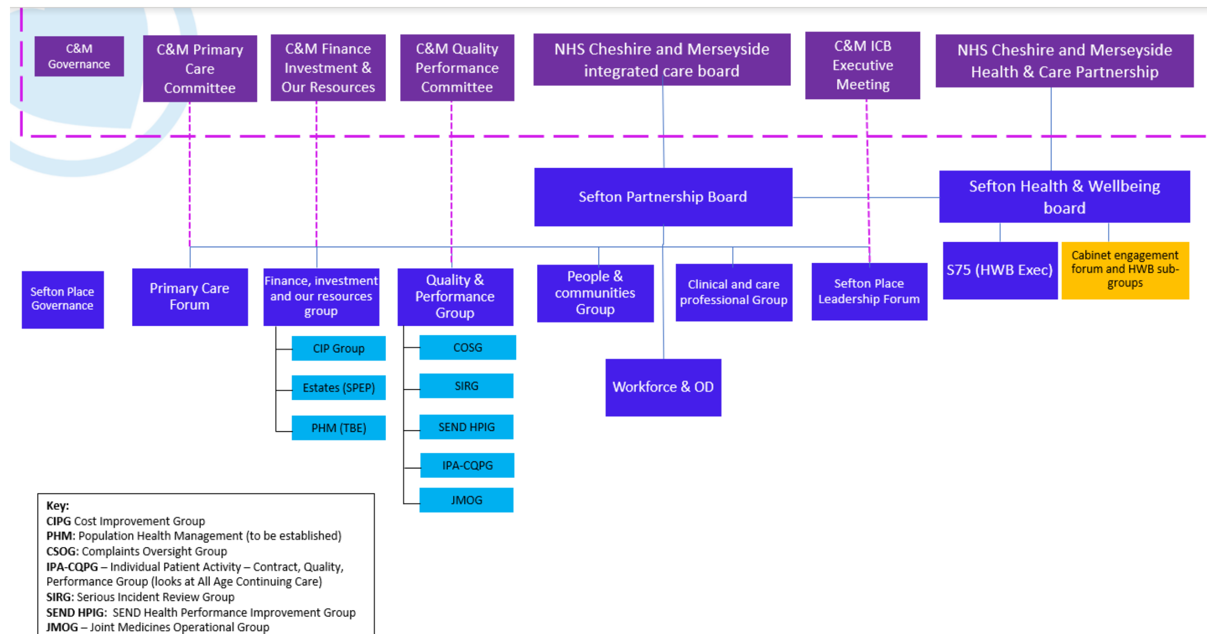
Strategic Housing Forum, Sefton CVS, NHS Acute providers and Community Providers, Health Watch, Sefton Council, ICB – Sefton Place.

How have you gone about involving these stakeholders?

Utilisation of the Sefton Partnership infrastructure, we have shared with the Partnership board for comment, and we have actively engaged with key stakeholders from this group through our BCF working group.

Governance

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



Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

The plan reflects our key priorities to support maximising independence at home wherever possible. It reflects a clear commitment to Intermediate care growth and working with the domiciliary care market differently to deliver. It also represents our ambition to grow alternatives such as adaptations, creative uses of the DFG programme and growth of the use of telecare and community equipment. We continue to see elements of key children's service delivery which has helped us drive integrated improvements in this area. A big development is the investment in 2-hour response, third sector support to discharge and widening of the discharge hub model. All these elements contribute to early intervention and prevention, and we believe the overall reduction in unplanned care and getting people home quicker when they do need hospital support.

National Condition 1: 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 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

Our Partnership plan supports delivery of the borough's health and wellbeing strategy, Living Well in Sefton. We share a single vision, namely that Sefton will be:

"A confident and connected borough that offers the things we all need to start, live and age well, where everyone has a fair chance of a positive and healthier future".

Our plan sets out our objectives across the life-course, starting from pregnancy and continuing right through to supporting those who are nearing the end of their life. This underpins our shared commitment to adopting a "whole population, whole partnership" approach to delivery. In order to realise both our vision and shared commitment, we have identified three cross-cutting themes: reducing health inequalities, service transformation and community first.

Please see our appended place plan for more detail.

Key achievements to date of the partnership that use the BCF to help drive integration are:

With the support of our partners, we developed a new delivery model that provides an integrated frailty unit with intensive reablement at our Chase Heys service.

The service launched in January 2023 with an additional 14 beds and has already **achieved some impressive outcomes, supporting patients to return home more quickly and releasing hospital beds.**

Our new 2-hour Urgent Community Response (2hr UCR) service has been highly effective in reducing the need for our most vulnerable patients to be admitted to hospital.

We have seen referrals jump with performance rates averaging 80-90% against a 70% target. We continue to develop the service, to support more admission avoidance, as well as ensuring integration with wider developments.

National Condition 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

Within the BCF plan, Sefton have an integrated health and social care intermediate care strategy. The strategy has four models of delivery; 2-hour urgent care response (UCR), reablement, home first and bed based intermediate care. The aim of intermediate care is to enable people to stay independent within their own homes for as long as possible.

The delivery of the 2-hour UCR has been commissioned collaboratively across a range of private, community, local authority, and voluntary sector services. Following the initial response there is a reablement period which requires services to work in an integrated way to ensure that the needs of the individual are met.

Examples of this work include, falls pick up services working with reablement and therapy services, Northwest Ambulance Services interfacing with community teams and the acute visiting service. We have invested in specialist service provision to ensure that teams are equipped to deal with complex clinical presentations such as exacerbation of respiratory illness or intravenous therapy for the treatment of skin and lung infections. This integrated team accepts referrals 12 hours per day, 7 days per week and outcomes show that we >70% of referrals are seen within 2hrs and that patients are being treated and remaining in their own homes.

In Sefton via the BCF, we have provided bespoke urgent care response for the open care home market which has demonstrated effective outcomes such as reducing demand on the ambulance service and reductions in hospital conveyances.

Pivotal to the delivery of our intermediate care strategy, is the integrated community reablement assessment service (ICRAS). This team consists of nurses, therapists, frailty specialists, primary care medical team, pharmacy, reablement, VCF health and well-being practitioners and unpaid carers. Together they deliver home first services, reablement services and in reach multidisciplinary and discharge services to the acute trust and community bed bases. Referrals are accepted from the community and the acute trust. The aim to assist the individual to remain at home following a period of illness or if they need

support to regain independence. This team can step up or step-down individuals into the community bedded facilities for a short period if required.

In some instances, individuals may require closer monitoring on discharge from hospital or have a greater risk of hospital readmission. This may be due to certain treatment regimes or a change in clinical condition and involves virtual clinical management of vital signs in collaboration with nursing and medical teams. The integrated services within the 2hr UCR or community MDT's will be able to refer into the virtual ward from primary, community or secondary care via the UCR, this also includes paramedics. All virtual wards will support Early Supportive Discharge from hospital, they include respiratory, heart failure and frailty at present and will include palliative care.

The BCF plan also includes support to our carer's advocacy service and the vital work of unpaid carers. Sefton Carers Centre provides free advice and guidance, emotional and practical support, training, and a range of holistic therapies for unpaid carers living in Sefton. The pooling of budget through the better care fund allows us to take an integrated approach to planning a long-term service that allows carers to keep on caring for loved ones. They also provide Sefton's one-off personal health budget service to support individuals and families to purchase essential items such as bedding or kitchen equipment to ensure that activities of daily living are maintained and reduce risk of ill health.

Our DFG process has seen significant improvements and we hope to continue to grow this in the coming 2 years. We have reduced bureaucracy through the development of the Adult Social Care online Portal, development of extended warranties and revised means testing now applied only for applications over £10k. This allocation also includes monies for increasing capacity to manage expected increase in demand for DFG's of around 3 posts. This is recognised as critical in keeping more people at home with a minimised need for more formal care and support.

The Better Care Fund supports our community equipment service and its continued growth this service is vital in providing personalised solutions to maintain independence for longer and we continue to expand our discharge offer, work in partnership to maintain the level of service, meaning urgent request can be fulfilled with 24-48 hours supporting and promoting effective discharge. The expansion serves both adults and children and improvements to the service offer such as increasing the digital ordering system reach and expanding the range of specialised equipment available. We also continue to progress to a single pathway for technology enabled care, equipment, and adaptations.

Through joint working, a no wrong door approach reduces hand offs, and our Integrated Care Teams ensure that holistic care is delivered. Close working with Primary Care Networks has seen the development of new roles to support our residents to self-care where possible and deliver focused care where necessary. The development of a medicines hub means that everyone discharged has their medications reviewed to maximise compliance and reduce the risk of readmission.

Improving same-day access for urgent care is key to reducing unwarranted hospital attendance and creating space in primary care to deliver more continuity of care. Some of the initiatives that have been implemented include direct booking from primary care to secondary care same day emergency centre (SDEC) services, primary care paramedic

clinics, access to NHS urgent medicine supply advanced service (NUMSAS) pharmacy provision. The development of primary care networks and the interface between the wider MDT is within our BCF plan. Delivery of services at neighbourhood level, intervening early and responding to the person in the context of the community is our system approach. Utilising community assets to support the individual with short- or long-term care goals to ensure that they remain as well as possible and as independent as possible.

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations

    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

  how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

The 23/24 capacity plan has been modelled on 22/23 demand. In 22/23, we were able to utilise the additional funding from the national discharge fund to commission the capacity required to support discharge and hospital avoidance. The recurrent funding is now included in the BCF, and we have been able to evaluate the previous year's activity and plan against this.

We have also been able to identify areas of unmet demand and profile this against 23/24 commissioning intentions. Approximately 25% of all reablement referrals were redirected to alternative providers due to lack of capacity. The additional investment within the BCF has been allocated to address the capacity shortfall within reablement services. We have also had to utilise short term bedded placements at times of pressure for patients waiting for packages of care. Health and Social Care have undertaken a competitive procurement process to develop a framework of domiciliary care providers and adjusted the rates of pay to address the cost-of-living increase to mitigate the risk of capacity deficit going forward.

Sefton recognise that without a period of adequate recovery or reablement, there is a risk of over prescribing long-term care provision. Within our BCF plan and UEC recovery planning, is a commitment to level up reablement provision to meet demand, allowing for an adequate assessment of need to take place in the residents own home. The aim of this is to reduce demand on domiciliary care services. The community bed based intermediate care operates a discharge to assess and recovery model so that all individuals have access to therapy and a period of recovery before deciding about long-term placement. Our aim is getting more people referred into home-based services to reduce the burden of community bed provision and limit the risk of overprescribing.

We do not envisage there to be any gaps within our planned provision, however, there continues to be a risk of patients navigating inappropriate pathways which could be detrimental to their recovery and independence. This is the focus of our improvement work for 23/24.

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

Sefton has a multitude of admission avoidance services at multiple touch points across healthcare to support people to stay in their usual place of residence. The 2hr Urgent Community Response provides rapid assessment and triage of 9 clinical conditions as well as acute illnesses and infections that can be supported in the community by a range of services such as the Integrated Community Reablement and Assessment Team (ICRAS), the Community Respiratory Team, IV Therapy Team and the Acute Visiting Service (AVS) that can respond with 2 hours of referral 7 days, 08:00-20:00. Both residential and nursing Care Homes can call the AVS directly to ask for clinical advice and visit a patient within 2 hours to treat or onward refer to the most appropriate service. Any of the services within the UCR will act as a community case finder for the Acute Respiratory Infection, Frailty or Heart Failure Virtual Wards for those that may require admission but can be managed at their usual place of residence. However, any healthcare professional will be able to refer into the virtual ward from primary, community or secondary care via the UCR, including paramedics. All virtual wards will support Early Supportive Discharge from hospital. The UCR also

includes 48-hour reablement support delivered by VCSE organisations to provide reablement as well as wraparound support and includes support which also includes financial, housing, adaptations, counselling, addition support amongst others to enable people to remain or gain their independence.

Sefton have commissioned a falls pick up service for all level 1 falls which operates 24/7 basis and a Sefton Emergency Response Vehicle to respond to level 2 falls. These services are integrated into the 2hr UCR service and community specialist falls service. These services respond to self-referral, health professional referral and care home referrals.

Sefton are expanding pathways that can be managed in the community that currently only exist as an in-patient stay in an acute hospital. Patients in Sefton can now have IV antibiotics for cellulitis, which would have resulted in a hospital stay for a minimum of 5 days. Other IV antibiotic pathways are being progressed to include UTI's, upper and lower respiratory infections that require IV therapy and also sub-cut fluids to support dehydration in Care Homes.

Sefton will be implementing Integrated Community Teams (ICT) in the north of the borough to mirror the ICTs in the south. This will provide a proactive, integrated multidisciplinary approach including using a case finding IT solution to identify those at most risk of hospital admission and prioritise those with the greatest needs. The ICTs will expand to a whole family approach and will support all ages including children. This will be a fully integrated service with physical and mental health, social, voluntary, police and housing organisations working together to provide proactive support to families across Sefton.

Acute Respiratory Infection hubs implemented by the PCN during the previous winter have continued to run in Sefton and have expanded into additional pathways such as ENT, cellulitis and soon to expand into a more general urgent care hub for primary care presentations. We're planning to utilise these hubs to step-up to the virtual wards and the UCR as well as step down and taking a holistic approach to care by onward referring into the ICT or the 48hr reablement to promote independence and reduce risk of crises occurring in the future.

Sefton has a High Intensity User (HIU) service that supports people with mental health, addiction and complex lives or complex health needs that requires an MDT approach to reduce reliance on urgent and emergency care services. This service has expanded into frequent user of community mental health services and via the ICTs we are currently working with people using GP practices frequently to provide additional support from a psycho-social perspective. These HIU services encourage integration of services by coordinating MDT's individual and tailored to individual patient needs to deliver holistic care to the individual and their family or/and carer. Sefton have also commissioned Crisis Cafés to ensure that individuals have support out of hours and at weekends.

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered 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, in line with the Government's hospital discharge and community support guidance.

- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

. With the establishment of the Transfer of Care Hub model utilising BCF funds, it is anticipated will that decision making regarding discharge pathways will switch from a hospital prescribed approach to a MDT led by Social Care and Community Health providers challenging all decision for bed based care. This systematic change with increased reablement offers, it is expected will enhance the numbers of patients being discharged on a pathway 1. The Discharge Fund is being used for a range of schemes to support discharge on pathway 0 and 1, such as voluntary sector co-ordination, carers support and personal health budget. This includes the provision of 'Carers Cards' which are issued predominately for Pathway 0 discharges and used by people to make one-off purchases to facilitate and support their discharge. The funds are loaded onto a pre-paid card which allows them to purchase essential items to maintain independence. This scheme is operated by Sefton Carers Centre in order to provide a further method of supporting Carers.

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
    - how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Monthly profiles for hospital discharge and community demand reflect current demand i.e. latest available data (22/23 actuals). Current proportions of discharges for Sefton patients at LUHFT and S&O were then applied to split hospital discharge demand by provider.

For 2hr UCR, the latest monthly data available in 2023 was used to forecast demand for 23/24 and historical profiles of activity from the MCFT ICRAS service was then applied.

Capacity has been set to match demand, by this we mean we maximise the amount of capacity we are able to purchase to budget but do continue to manage this through our Market Sustainability plan.

We have continued to fund those services that made the biggest impact on demand through a longer-term approach reflected in the plan; for example, Discharge Hubs, 7 day working and block bookings.

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

Our BCF is supporting a number of schemes that will ensure that the individual is discharged to their usual place of residence. Primarily the function of the Transfer of Care Hubs (or Discharge Hubs as they a known locally) will ensure that a Multi-Disciplinary Team respond and review all pathway routes for individuals being discharged from Hospital. The expectation is that with the transfer of care prescribing a discharge pathway as opposed to the Hospital Ward will strengthen this agenda. This system approach, alongside with strengthening of our reablement offer, should ensure an increase in number of individuals being discharged to their home. This alongside with other schemes such as the co-ordination of the voluntary sector, a discharge grant and closer alignment of the Care Centra, the expectation is that Long Length of Stay numbers will reduces and individuals being discharged either to pathway 0 or pathway 1 will increase across our system.

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

Sefton Place have adhered to the High Impact Change Model (HICM) principles envisaged by the LGA, NHS England and ADASS (2019) in their approach to the implementation of IBCF funded schemes relating to discharge of individuals from hospitals. Providing personalised care and support is integral to the aims and values of Sefton Place anyhow, and Sefton Adult Social Care have adopted a "three conversation" model to enhance a strength based approach. This three conversation model, has been influential in the Transfer of Care Hubs plans, with co-production between all partners to ensure clarity of the roles and responsibilities in implementing this model being defined in a operational framework document. Whilst

the ethos of "valuing patients time" is central to this model, the education and approach of the three conversations model will hopefully ensure the individual being discharged is central to all decision making around their discharge. At present the Local Authority and Community Health Provider have completed information to be circulated across the Trusts educating all NHS staff to the "three conversation" model and are in the process of completing workshops across the system to emphasise the need of providing personalised care and support to enhance outcomes for patients.

In terms of how as a system we are collating feedback from individuals, we are utilising our local Healthwatch offer to independently gain feedback adopting a Think Local Act Personal (TLAP) approach (the use of I and We statements). This information and associated learning will be not only be shared across the system with key stakeholders. With a mixture of focus groups and questionnaires it is hoped that Sefton Place can measure how well the IBCF Sefton Place funded schemes are adhering to the principles of HICM and supporting that correct decisions are being made for individuals being discharged. Data has been shared with Healthwatch who are in the process of contacting patients discharged across pathway's one, two and three to evaluate how well Sefton Place are adhering to the HICM.

In terms of the specific schemes originally included in the BCF we would provide the following narrative:

1. Early Discharge Planning – Transfer of care hub pilot initiated at LUHFT which identifies the patient at the front door and case manager supports the patient throughout the hospital spell until early discharge. Transfer of care hub model to be standardised across C&M and is currently a priority scheme within the ICB workstreams. Acute trusts are implementing Optica which will assist with tracking and discharging patients when ready. Daily board rounds remain in place to identify patients who have NCTR and who are ready for discharge. Sefton have continued to support the acute trusts with a Nurse Director for urgent care and system flow and Senior manager in LA to provide leadership in weekly long length of stay reviews and NCTR reviews.

2. Monitoring and responding to system demand and capacity – Weekly monitory of capacity and demand in place via the CIPHA team. There has been an intermediate care capacity, demand and outcomes dashboard developed in collaboration with all 9 places across C&M. Data flow was due to go live on 6th July and this will give each place real time information regarding capacity and inform commissioning decisions. Sefton currently do not have a capacity deficit within intermediate care services.

3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge – Daily MDT review in place to support discharge from the acute trusts and the community bed base. There is a weekly system wide bed board meeting with all partners to support and expedite discharge. There is a regular monthly community bed MADE to assist with flow. Transfer of care hub developed in LUHFT and improvement work commenced in line with C&M ICB UEC team to standardise the offer.

4. Home First/Discharge to Assess - process support/core costs – There is currently a value for money service review of reablement services led by Sefton Local Authority, which plans to redirect resource and increase reablement capacity ahead of Winter 23/24. There is improvement work required to integrate health and social care provision seamlessly to support patients home prior to describing care needs. This is a key priority for Sefton and aligns directly to the UEC recovery plan and C&M Tier 1 improvement plan. LUHFT has an offer of enhanced ECIST support to improve discharge and home first is a key work area. Sefton have reached out to benchmark against intermediate care front runners and neighbouring places to agree areas for improvement. The LA have initiated a review of the joint health and social care intermediate care strategy to base line progress to date. This will inform our continual improvement going forward.

5. Flexible working patterns (including 7 day working), discharge services and hospital avoidance services operate on a 7 day working basis. There is ongoing improvement work with the ICB C&M UEC team to look at in hospital processes and reduce variance at weekends which is a key area for improvement in Sefton.

6. Trusted Assessment – Sefton have commissioned a trusted assessor approach within reablement services and have trusted assessors within health services. There is improvement required to increase competency, capacity and capability within discharge to assess process (completion of checklists and DST's) within local MDT's.

7. Engagement and Choice – Sefton have additional brokerage function funded utilising Hospital Discharge Funds to assist engagement with families and carers and source appropriate care arrangements to facilitate discharge.

8. Improved discharge to Care Homes – In terms of placements, Sefton have less numbers of individuals being discharged into care homes. Where an individual is being discharged, we have appropriate operational and contractual arrangements in place to ensure this can be facilitated on the same day, seven days a week.

9. Housing and related services – Sefton have commissioned an organisation to support individuals who are deemed to be either homeless on admission or have complex housing issues. This organisation works closely with emergency departments across the Sefton footprint to ensure hostel accommodation is sourced.

10. Red Bag scheme – This scheme would require a relaunch due to the loss of red bags returning to care homes on discharge.

Sefton Place have been working with C&M ICB to identify areas of focused improvement which align to the HICM.

The main areas for improvement include,

Increase capacity, Improve and embed a consistent home first approach. Including a clearer reablement strategy, particularly for frail older people.

Implement a consistent discharge to recover and assess process across Sefton Place utilising the trusted assessor model.

Improve consistency of discharge processes via a transfer of care hub model. The ICB UEC team are looking to standardise this approach across C&M footprint. Work has already commenced in LUHFT and will be implemented in MAWL hospital trust.

Standardise data reporting across intermediate care provision at place to track and match capacity and demand.

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

Sefton Place has utilised the Integrated Better Care Fund to promote schemes that encourage co-operative working across organisations to secure the safe and timely discharge of patients (as per schedule 3 of the Care Act). Sefton Adult Social Care are completing proportionate and appropriate assessments as per the Care Act to ensure no individuals remain an inpatient longer than they need to be. These proportionate assessments allow for a long-term assessment (or conversation three as they known locally) to take place outside of hospital. The IBCF has funded an additional bed base within access to a MDT setting to facilitate discharge flow, in circumstances when an individual's care may not be immediately available or the individual may need a fuller assessment. This fulfils the remit of the Care Act in as much as it ensures that no long-term decisions about an individual's care is made in a long-term bed and that the focus is always on the individual returning to live independently, as they can, in a community setting.

Furthermore, the additional schemes that have been funded by the Hospital Discharge Grant, that now sits in the IBCF are very much centred on a strength-based approach, as per the narrative of the Care Act and emphasises individuals returning to their usual place of residence to recover rather than a bed in a alternative setting. The ethos of these schemes is that individuals have a bed already and that is in their own home. For instance, the monies have been utilised to fund schemes with the Sefton Place Voluntary Sector and Carers Centre, which support individuals to be discharged home without the resilience or potential wait for a long-term commissioned support from statutory services.

Supporting unpaid carers

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

The Better Care Fund provides funding to Sefton Carers Centre. The Sefton Carers Centre provides free advice and guidance, emotional and practical support, training and a range of holistic therapies for unpaid carers living in Sefton. This includes providing Carers assessments, supporting Direct Payments and the use of Personal Health Budgets and supporting Children and Young People through Transition. They are a key stakeholder in designing the discharge hub and have a specific hospital discharge service as part of the discharge funding.

The Pre-paid card accounts support the Council in delivering improved administration arrangements for the monitoring of direct payments including annual reviews and audit requirements ensuring Care Act compliance and supporting the Council in identifying breaches in direct payment agreements due to mismanagement of the account.

This service gives people greater choice and control by allowing people to choose and purchase support services by means of a Direct Payment, offering the individual a simpler mechanism to manage their direct payment, and meet their obligations to submit information to the Council.

Benefits include;

- It is used in the same way as a debit card, but it has a predefined amount of cash loaded on it by the Council.

- The card can be used to pay for Personal Assistants (PA), agency or other Direct Payment agreed costs by using the online banking facilities that the card provider offers.

- You cannot go overdrawn on your prepaid card account.

- Reduces paperwork - Reporting facilities within the system helps to improve the information that is reported back to the Council

- Enables the Council to support the client to make payments.

- Enables the Council to have oversight in real time, identifying any issues and offering support.

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

Housing and our strategic approach: -

The Strategic Housing Commissioning Group has been established to ensure close strategic and operational alignment between Housing Services, both Children's and Adult Social Care Services and Health.

The group has been set up as a response to the ongoing difficulties in sustaining needs led accommodation to support both Children's & Adults Social Care and Health.

The Strategic Housing Commissioning Group overarching aims are to:

- Promote a greater understanding of the role of each of the services.
- Ensure that housing is actively engaged in helping to meet specialist housing need in the borough as per Sefton's Housing Strategy 2022 -27.
- The group will ensure that there is a clear and robust route to the housing market that is based on:
    - Needs identified through ASC Housing Panel, the CSC Accommodation Strategy (ASC Market Position Statement & Children's Sufficiency Strategy) and health.
    - Business cases
    - Approved models of care and support
- Ensure strategic planning and a coordinated approach to the housing and support needs of vulnerable residents.
- Evaluate opportunities for greater efficiencies and ongoing service improvements, including the resolution of operational issue in a managed way.
- Evaluate and manage grant funding, potential capital and disabled facilities grant opportunities with a view to furthering the joint objectives of the group.
- Providing oversight of the Joint Housing Protocol (Children's Services and Housing) requirements covering: 1 Care Experienced Young People, 2 Homeless 16- & 17-Year Olds, 3 Intentionally Homeless Families, 4 No Recourse to Public Funds Families (supported by Children's Services who obtain status that provides access to public funds and services).

The Strategic Housing Commissioning Group will fulfil the following functions:

- Provide a strategic clear, transparent, route to market for accommodation-based service need within Sefton as per CSC, ASC health needs.
- Develop a prospectus of the requirements that will be shared with the market based on the needs analysis provided by CSC, ASC, and commissioning colleagues. Linked to sufficiency strategy and improvement plans.
- Review all offers of accommodation against the agreed needs. The group will consider all offer with a view to making recommendations to ECG.
- All new social care accommodation provided by an external body should be taken through this group without exception.

- Build upon strategic links with RP's, developers, CVS, and the private sector.
- Ensure appropriate revenue budget is Available.
- Collaborating with developers and our planning process to ensure we are clear on what is needed, and nominations rights are considered.
- To support Cared for Children and Care Experienced Young People who are the responsibility of Sefton Council to make a successful transition from care to adulthood and independent living.
- Support Sefton's Housing Strategy Action plan with a focus on the following themes contained within it:
- Enabling people to live independently.
- Tackling Barriers to obtaining suitable housing for the most vulnerable and ensuring equal access to housing services

The outcomes of the Housing Panel look to achieve are as follows:

- One clear process that can support the council with its strategic aims in delivering accommodation requirements that meet ASC, CSC and health needs.
- Supporting the delivery of the Housing Strategy and priority themes
- Ensuring that Cared for Children and Care Experienced Young People have access to a range of supported and independent accommodation opportunities that improves their life chances and outcomes.
- Transparency (mitigate against challenge)
- Agree priorities (assess sites and needs against one another)
- Review potential developments across the borough to see if needs can be met.
- Produce regular progress reports for ECG and Cabinet Members.
- Develop a culture of positive challenge on requirements and look at alternative solutions and innovation.
- Move away from a provider led market of offers of accommodation.
- Develop strategic internal processes,
- Launch event and subsequent market engagement events bi-annually.
- Strategic partner list approved.

Accommodation:

Children's requirements:

- **Residential Homes (2/3/4/5 bedroom) registered by Ofsted.**

Cross over

- **Care experienced children (current model expanded)**
- **Semi-independent age 16-18**
- **Semi-independent age 18-24**
- **Young parent and child accommodation**

Adult's requirements: -

- **Supported Living (Learning Disabilities and or Autism & Mental Health)**
- **Mental Health Provision including both long- & short-term accommodation**

- **Extra Care Accommodation (Older persons/intergenerational)**
- **Extra Care model (Learning Disabilities and or Autism & Mental Health)**
- **Homelessness provision**

Extra Care Housing:

Extra care housing is specialist housing provision designed for older people that combines accommodation with care and support services to offer safe, private and secure accommodation whilst allowing service users to retain their independence of having their own home and reduce our reliance on residential homes.

Sefton currently has two schemes and an ambition to deliver 1,306 units required by 2,036 (approximately 15 schemes). 5 such schemes are currently at the planning stage and will deliver c500 units over the next 3 years.

A nominations policy, process and system has now also been consulted on with Sefton residents with the policy aiming to promote independence and well-being; facilitate a balanced, vibrant and sustainable community for residents with care and support needs within the setting of extra care housing which will play a key role in preventing and avoiding admissions to residential care and hospitals and contribute to our preventative agenda.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

Yes, the RRO has allowed us to introduce discretionary funding grants, these allow clients who's required adaptations my exceed the £30k threshold (not available for residential social landlord clients) to be implemented.

Clients who qualify for this additional funding, may receive the initial mandatory grant of £30k and costs above this may be met via a separate application (discretionary grant funding application). A land charge is placed against the property in connection with the mandatory grant of £30k and will be removed ten years from the works certified completion date and a second land charge is registered for the discretionary element, this second land charge is

registered on a permanent basis until the property is sold or transferred. This helps to protect DFG funding by ensuring repayment is received.

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

There is no limit for the use of Discretionary funds in place. This type of funding is to assist clients where necessary and in accordance with the relevant conditions which are in place, whilst there are sufficient DFG funds available.

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

As a Sefton Place Partnership, we recognise there are stark differences in the quality and length of life across Sefton and that we need to work together to prioritise those who stand to gain the most. This is one of the three priorities of our place plan which defines integrated delivery for Sefton. Big differences in living standards and life chances cause big differences in health, including how long someone can expect to live in good health. Sefton has the second most divided distribution of wealth and poverty in England, just behind Kensington and Chelsea. The big causes of long-term illness in Sefton are smoking, obesity, poor quality food, not being active, alcohol use, diseases affecting the heart, brain and blood vessels, lung disease, cancers, mental illness and injury. About half of this ill-health can be prevented and are the biggest cause of ill health in Sefton.

To impact on this priority over the next two years the plan commits us to the following:

Proportionate universalism

The resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need. Services are universally available, not only for the most disadvantaged, and are able to respond to the level of presenting need. This aims to improve the health of the whole population, across the social gradient, while simultaneously improving the health of the most disadvantaged fastest.

Core20PLUS5

A national NHS England approach to reducing inequalities that is focused on the most 20% deprived communities, those groups who suffer particular disadvantage, and across priority areas for action and for both adults and children. We know that Sefton is more unequal than most of England with large gaps between the expected lifespan of residents who live in the richest and poorest parts of the borough.

There will be cumulative benefits beyond health outcomes of our adopting both approaches, and by prioritising and targeting resources in a joined-up, evidence-based way. For example, this should help to reduce future demand on heath and care services, which ties in with the

role all partners have in supporting early intervention and prevention. We are therefore embracing a “whole population, whole partnership” approach to reducing health inequalities as part of our plan.

The following section details some of the key areas of work our place plan commits us to and that the Better Care fund will act as an enabler to.

This includes commitment to developing an expanded offer for CYP and their families/carers with emotional health and well-being needs, with a specific focus on children in care that reflects a partnership approach to the role of corporate parent, and development of support for those aged 19-25.

Integrated practice that is supported by co-location, with opportunities for integrated induction of staff, strengthened through shared training, shadowing and observation across partners, team meetings, case management discussions and matrix management approaches.

Shared access to data and IT systems in order to collate evidence of early help across Sefton Partnership, ensuring it is utilised to target and identify genuine gaps in provision. Such gaps will be prioritised for service investment through adopting a whole pathway approach, within a shared outcomes framework.

Embed measures to improve health and reduce inequalities, including a continued focus on CVD, obesity, diabetes and smoking cessation. Accelerate preventative programmes that engage those at greatest risk of poor health outcomes using the pregnancy register to target immunisations and other health messages, including the rollout of a treating tobacco dependency programme at providers accessed by Sefton women and the mobilisation of a Sefton stop smoking in pregnancy group.

Development of Integrated Care Teams (ICT) that encompass a ‘Whole Family Approach’ working in partnership with Mersey Care, Alder Hey, Adult Social Care, Children’s Social Care and the VCF sector to develop and enhance the existing model to reflect an all-age focus.

Co-produce an employment pathway that provides individuals with meaningful training, volunteering and employment opportunities that lead to paid employment, working in partnership with Department of Work and Pensions, colleges, advocacy organisations, Get Involved Group, and VCF sector.