HAMPSHIRE INTEGRATION AND BETTER CARE FUND PLAN

2021 – 2022

NOVEMBER 2021

CONTENTS

HAMPSHIRE INTEGRATION AND BETTER CARE PLAN

1. Introduction

This updated Hampshire Integration and Better Care Fund (IBCF) narrative plan describes the high-level local vision for health and care services for the population served by Hampshire Health and Wellbeing Board through Hampshire, Southampton and Isle of Wight and Frimley Clinical Commissioning Groups (CCGs) and Hampshire County Council. It builds on previous submissions, demonstrating how the IBCF investment supports the move towards more integrated health and social care services delivery. The plan explains how our system is working to meet national conditions as well as the partnership working.

Our plan supports our vision of commissioning to meet expectations of the NHS Long Term Plan and enabling the delivery of high quality, integrated person-centred health and care that removes artificial divides between primary, community and secondary healthcare and social care. Wherever possible, a prevention-based approach, contributing to the improving the health and wellbeing of Hampshire residents is promoted. In 2021/22 the value of the Hampshire BCF has increased to £137,344,836. This sum includes the CCG minimum contribution of £92,732,577 of which £60,999,388 is invested in NHS out of hospital services. This investment is being targeted to make a direct impact that will:

- Improve health related quality of life for people with long-term conditions;
- Help older people to recover their independence more quickly after illness or injury.
- Increase independence and self-reliance so that people retain control of their lives

In the longer term these changes to lifestyle will:

- Reduce premature and total mortality from the major causes of death;
- Reduce the difference in life expectancy between people living in the least and most deprived areas.

COVID-19 has had a disproportionate impact on many who already face disadvantage and discrimination. A central part of responding to COVID-19 and restoring services is to increase the scale and pace at which the Clinical Commissioning Group and all local NHS acute and community providers, the County Council and eleven Districts and Boroughs of work together to tackle health inequalities to protect those at greatest risk.

We are working together to strengthen service integration to more support individuals health seeking behaviour, building patient activation and behavioural change to deliver effective prevention services and improve access. Our plan reflects our continued commitment to meet and address the local and national challenges. We recognise we will only deliver our aims if we continue to co-produce solutions with our communities, involving and engaging local providers across the system.

2. Organisations involved in our Better Care Fund Plan

Figure 1: Organisations involved

The IBCF is an enabler that supports local system to deliver "joined up" health and care that meets the needs of local people, involving many partners (see Figure 1 above). The Hampshire Health and Wellbeing Board brings together all leaders and interests. The new leadership architecture across a single CCG, with a single Accountable Officer is facilitating a more synchronised approach to health commissioning. Aligning decision making for integration is being achieved through a number of established governance arrangements at a whole Hampshire and Isle of Wight population level, Hampshire-wide population level and local system place-based level in preparation for the emergent Integrated Care System in 2022.

All the providers and commissioners across Hampshire working together in their local Integrated Care Partnership (ICP) have designed, developed, provide and contract for services that can care for people at locations as close to their home as possible, supporting them to manage long-term conditions, to live with dignity and independence at home and in the community and to access high quality hospital services when they need it. The investment in the Hampshire Better Care Fund contributes to the delivery of these services. Systems coherence under an overarching approach for delivery of the Hospital Discharge and Home First Programme across Hampshire facilitated additional short term investment within all systems.

The ICPs operate on a foundation of mutual trust and transparency to share accountability and risk. The participants work to a set of principles based on collaboration and partnership, with organisations working collectively to ensure best outcomes and value for all patients and taxpayers rather than the interests of individual organisations. Their local governance arrangements oversee delivery of a work programme. Each ICP relies on local health and social care professionals making decisions about services in partnership with their patients and communities.

As a two-tier authority the Housing Authorities (11 Districts and Boroughs) are represented in the Health and Wellbeing Board, work jointly with the County Council to develop and implement housing solutions for local communities e.g. extra care housing schemes, and in the context of local health and wellbeing fora that take forward place-based discussions. This had resulted in a number of schemes that support the IBCF policy aims. Similarly, the Voluntary and Community Services sector also influences and contributes to local plan delivery either directly providing commissioned services funded through the IBCF for example: Carers services, dementia advisory services etc. and contributing to the design of other schemes such as supporting hospital discharge and community connectors that may be funded through funded through other means supporting the aim of more "joined up" arrangements.

3. Executive Summary

Since the inception of the Better Care Plan policy our vision has always been for a simple, *"joined-up"* and integrated health and social care pathway, supporting people to be as independent as possible and remain in their communities. Although the overall Hampshire system is complex due to the multitude of infrastructure organisations, local governance arrangements ensure oversight of delivery of a work programme to meet local need in a person-centred approach.

3.1 Priorities for 2021 – 22

As an enabler to the wider system NHS delivery plan[1] and the Adults Health and Care Strategy 2019-2024[2] the Integration and Better Care Plan contributes to this strategic agenda.

Our vision for 2021-22, reflecting the assumptions and ongoing aspiration of the Integration and Better Care Fund Policy Framework. (2021) is to:

- To transform service delivery to enable people to remain independent and live healthier lives
- To accelerate and implement new models of care in each community through integrated care delivered by a network of providers
- To address the issues that lead to avoidable admission or delay people in transferring out of hospital

The actions on these priorities are influenced by learning since 2019, particularly during the Coronavirus Covid-19 Pandemic and has shaped the key changes that have occurred.

3.2 Key Changes since previous Better Care Fund plan

Hampshire investment through the IBCF is targeted upon the out of hospital care model, in particular the community health and social care response to meeting needs of local people including when they are recovering from their health being unstable and having required acute hospital care.

The 2019 plan aimed to enable the health and care system to drive ambition for the delivery of the NHS Long Term Plan (2019) in areas relating to integrated care, networked care, improving access, prevention and workforce particularly. Hampshire system level partners worked with population health analysis to understand different health needs between cohorts to tackle the wider determinants of health (e.g. housing), case finding, proactive care planning, behaviour change interventions including a successful approach to community connectors at Primary Care Network level to enable care navigation and other primary care access initiatives as well as supporting discharge and flow.

By adopting this approach partners aimed to realise the objectives proposed by Newton 2018/19 to reduce delayed transfers and length of stay, adopting a system approach to focus upon:

[1] HIOW Strategic Delivery Plan (hiowhealthandcare.org)
[2] Adults Health and Care Strategy final.pdf (hants.gov.uk)

• reducing patient waits for bedded care (from 37%)
• reducing patient waits for a decision on where they will go next (from 35%)
• reducing patient waiting to get home with some support (from 21%)

During 2019 place–based and system wide monitoring indicated good progress made in these areas and partners used learning from for-runner projects in build resilience in integrated intermediate care. The IBCF plan investment supported vital delivery of community based and social care services that enable the PCN arrangements to fulfil the multi-agency requirements in local areas.

Responding to the subsequent Coronavirus Covid-19 pandemic was a test of all the local arrangements. Whilst agreed IBCF investment continued as planned, the Hampshire system response was coordinated under the auspices of the "Hospital Discharge and Home First" Programme. During March and April 2020, the system responded to national requirements for new service provisions, different ways of working, staffing models and funding streams. Temporary legislation and additional NHS Hospital discharge funding, which enabled investment in temporary, short-term home based and bed-based services to rapidly implement a Discharge to Assess model that aimed to support both the flow and discharge through Acute Hospital systems and residents in the community. The joint response:

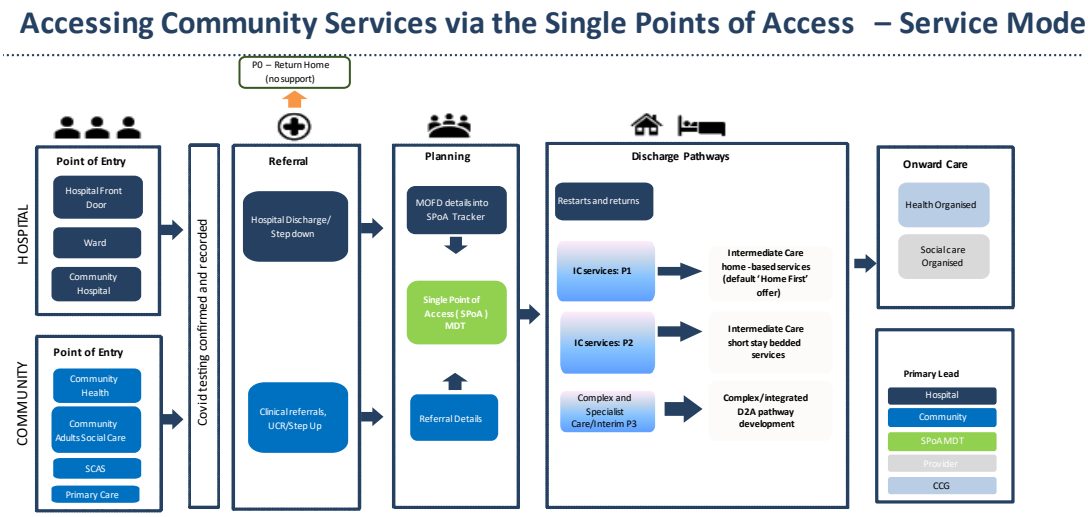
- operated under the principle of a **right service for the right person at the right time**
- **conveyance** to acute hospital dictated by clinical need using and alternative suite of options when a person reaches a health crisis at home
- **coordinated** by multi-professional teams without silos and with equitable access to resource and timely access to a senior decision maker
- ensured **no individual moved to a long-term service without the opportunity to improve, engage and be part of a personal assessment within a short-term service.**
- **reconfigured** wider community health and social care short term bed offer to remove silos, and maintain >90% occupancy. Some community bed capacity geared to support highly complex CHC type D2A
- ensured a variety of **consistent and appropriate Home and Bed Based Short Term Services** which would support timely discharges, admission avoidance and community options for Hampshire residents to enable a strength based, person-centred assessment.
- provided services that would ensure positive outcomes utilising **accurate data** and information on meaningful patient focused outcomes
- secured competitive pricing with the market and managed the market in a constructive and positive way, for both long term and short-term service provision.
- ensured the correct associated **staffing for service assessment and delivery**
- retained the ability to **flex capacity throughout the year.**

By April 2020 the system had established additional bed capacity to support Covid-19 wave 1. By February 21 this had risen to over 1,000 community hospital / D2A beds and with increasing focus on "Home First" has reduced to 767. Modelling, based on the Kent and Medway methodology is being used to predict bed capacity required. Core community services funded through Integration and Better Care Fund (IBCF) investment were incorporated in this response during unprecedented times augmented by the Hospital Discharge Fund. Access to services was also streamlined, standardised and simplified through the adoption of single points of access based around each hospital setting within the Hampshire footprint. These are illustrated in Figure 2 below and represent a significant change in the partnership approach between health and non-health agencies working in an aligned way to facilitate the most complex patients achieve safe, effective discharge. Of necessity community services evolved and transformed as described in Figure 3 below.

The system has benefited from additional investment through the hospital discharge fund throughout the pandemic. Throughput of referrals via the Single Point of Access (SPOA) and other services has led to notional reductions of 104,000 bed days in the acute sector per year (at a decreased cost of approximately £20.8m), based on reduced length of stay and avoided admissions. The Hampshire and Isle of Wight Hospital Discharge Plan and Home First Evaluation (June 2021) indicates

additional community services and capacity through the second half of 2020 and into 2021 made a substantial difference to the number of individuals supported at home. Home-based Intermediate Care (Reablement and Rehabilitation) volumes more than doubled in 12 months; 434 in April 2020 to 893 in April 2021. Discharge to Assess bed capacity supported 23,068 bed days at April 2021 and of those people 31% transferred to permanent residential and nursing care – a marked improvement on historic levels. Rapid Discharge Services (RDS) and Live in Care has been effectively utilized. These enhancements positively improved discharge and flow from the acute hospitals reducing the number of people waiting for discharge from 327 in November 2020 to 165 in April 2021, a 50% reduction over 5 months.

Figure 2 (Source Hampshire and Isle of Wight Hospital Discharge and Home First Programme)



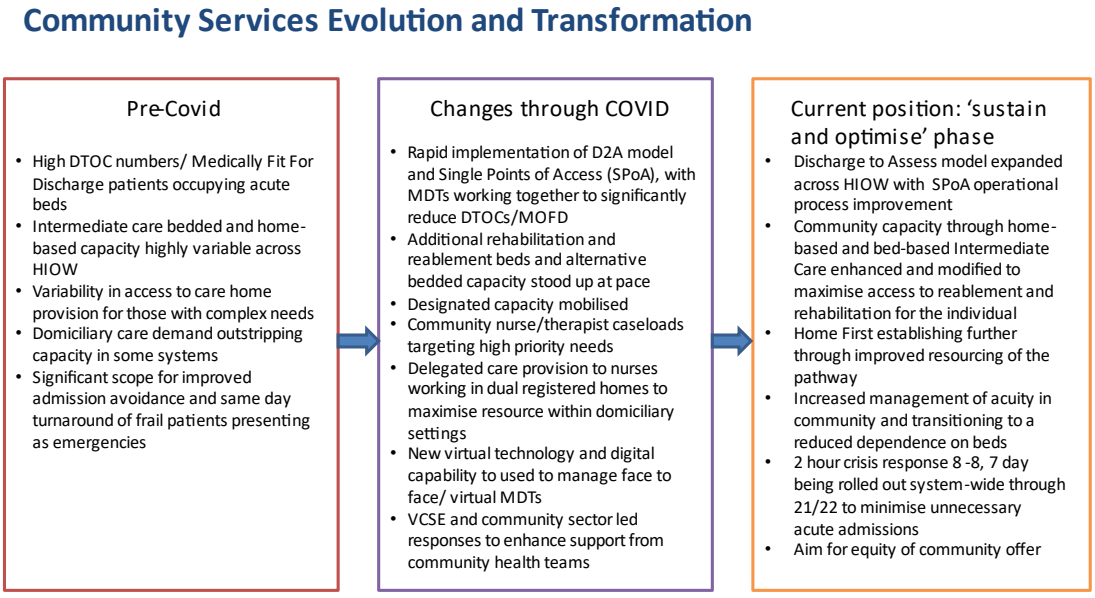


Figure 3: Community Services Evolution and Transformation (Source Hampshire Hospital Discharge and Home First Programme)

Hampshire's directly provided Reablement Services (funded through the IBCF) have supported 8,657 people to leave hospital safely through home care (CRT), Occupational Therapy and Sensory Services. Furthermore, the Hampshire Equipment Service (part funded through the IBCF) has responded and delivered 114,462 items (11% increase in 2020/21), serving a client base of 56,713. 5660 individuals have received reablement services via CRT as an interim service following discharge with 43% recovering with no ongoing care needed. Reablement have also oversee the Rapid Discharge Service.

In the same way the North East Hampshire area has continued to focus their local integration journey on integrating health and care services in the community to support the local population to "stay happy, healthy, at home". The integrated care teams went from strength to strength and the pandemic response has supported the further integration of services to keep patients out of hospital. The Hospital Discharge Programme Funding has enabled the local system to implement further services to support patients' discharges out of the acute hospital. Services including the Rapid Discharge Service, Live in Carers service and Discharge to Assess beds for those patients that needed bedded care upon discharge have been commissioned. The Integrated Referral and Information Service based at Frimley Park Hospital has brought together health and care partners as well as the voluntary sector to support discharges underpinning local plans to pilot integrating a social worker role within the intermediate care team and increasing the therapy support for our D2A beds with reablement and rehabilitation teams working together.

Technology supporting the delivery of the model, although not funded directly through the IBCF has played a significant role in augmenting and enabling the integrated model of care both in terms of monitoring Clinically Extremely Vulnerable people to offer support, devices to support combat social isolation and communication with others as well as safe and independent living and an innovative "Cobot" Programme deployed in the domiciliary care market to support safe handling practice and where appropriate reducing reliance on the care workforce.

The domiciliary and care market experience during the pandemic is well documented. The system has supported their efforts to both protect the health and wellbeing of their service users as well as the resilience of the market itself. During 2020/21 and early part of 2021/22 six care home providers have ceased trading and the occupancy in some care settings has significantly reduced, undermining viability. Support for this sector has benefited from additional and separate short term national grant funding managed through the Local Authority has supported providers of domiciliary and residential care to continue to operate. These services continue to be a core element of community-based services that local people need alongside IBCF funded input. Another aspect of the plan that was more challenging has been maintaining the level of Disabled Facilities Grant activity due to restrictions accessing people's homes, availability of staff and contractors as well as delays in accessing building materials. All District and Borough Housing Authorities have been working to complete projects since restrictions have eased.

These key changes across the Hampshire system have been overseen through established governance and accountability structures.

4. Governance

The governance across the Hampshire systems is complex due to the high number of autonomous infrastructure bodies and patient flows across natural communities that are not congruent with administrative boundaries. These include:

- Presence in 2 Integrated Care System footprints
- 2 CCG Governing Bodies
- Two tier local government (one County Council, eleven Districts and Borough Councils)
- 7 Acute Trusts supporting 4 place-based systems – Frimley, north and mid Hampshire, south west Hampshire and south eastern Hampshire and Portsmouth
- 3 main Community Providers including 9 Community Hospitals
- 2 main community Mental Health Services providers
- 125 GP practices in Hampshire (5 in Surrey) with related Out of Hours service providers
- I Ambulance Trust
- 1 Health and Wellbeing Board
- 3 Local Authority Social Care commissioners and providers (Hampshire, Portsmouth and Southampton)

In 2015/16 a governance framework and joint leadership arrangement covering all the phases of the plan linked to both County Council and CCG transformation and efficiency plans was put

in place, to oversee delivery. Whilst our original principles still apply, the governance structures are evolving to remain fit for purpose taking account of wider national policy changes so that strategic vision for integration is translated into operational reality. Figure 4 below illustrates the alignment across the four systems that incorporate each of the place-based footprints – south west Hampshire, south eastern Hampshire, North and Mid Hampshire and Frimley Health System (including north east Hampshire population).

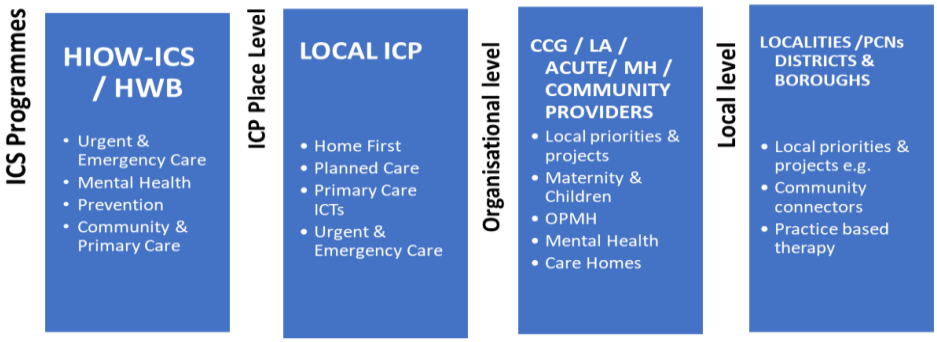


Figure 4:

In 2020/21 systems cohered under an overarching approach for delivery of the Hospital Discharge and Home First Programme across the Hampshire system. In 2021/22 the Hampshire and Isle of Wight Sustainability and Transformation Programme governance moved forwards with former Hampshire based CCGs coming together as part of a single Hampshire, Southampton and Isle of Wight Integrated Care System set up. Former North East Hampshire and Farnham CCG has been incorporated into Frimley Health System at the same time whilst maintaining strong links to Hampshire Health and Wellbeing and visa versa.

The arrangements continue reflect the fundamentally different approach in an agile system leadership required to deliver plans that focus on a common goal. Integrated arrangements for Hampshire continue to be overseen by the Hampshire Health and Wellbeing Board (HWB). Monitoring the direct delivery of Integration and Better Care Fund schemes and overseeing the operational detail of all Section 75 agreements is delegated to the Integrated Commissioning Board. The membership of the Integrated Commissioning Board incorporates Hampshire County Council, NHS Hampshire, Southampton and Isle of Wight Clinical Commissioning Group and NHS Frimley Clinical Commissioning Group. The Board acts as a single health and wellbeing commissioning voice for Hampshire to ensure effective collaboration, assurance, oversight and good governance across the priority areas for integrated commissioning arrangements between partners.

This Board has been established to compliment and not duplicate work done within local “place-based” system level covering natural communities across the scale of the Hampshire geography and has operated in a similar way to the separate “Hospital Discharge and Home First Programme” approach that aligns local and County-wide change management. There are an agreed set of priorities that blend the IBCF areas and other wider aspirations to maximise the opportunity for integrated commissioning such as supporting people with mental health needs, jointly commissioning services for people living with a learning disability and those who are assessed as eligible for NHS Continuing Healthcare.

In this way, assurance of the overall delivery of the IBCF continues to be integral and monitored through and reported to the Integrated Commissioning Board and HWB. Delivery of the schemes and performance is being assessed through existing CCG Contract and Performance quality monitoring meetings with providers and where applicable involve the County Council.

These governance structures are underpinned by legal agreements as follows:

- Section 75 pooled budget agreements allowing pooling of resources to support integrated commissioning and provision.

- Over-arching Section 75 partnership agreement providing framework for integrated working.
- Section 256 agreements (with both NHS England and local commissioners) support expenditure on social care that has a benefit for health services.

The North East Hampshire and Farnham system, including around 12% of the Hampshire population is now incorporated within the an Integrated Care System Health System that centres on “Frimley Health System” that was accelerated in its development through the National Vanguard Programme. The local programme governance gives all partners equal membership, responsibility and voice alongside local communities to design and deliver the whole population management approach as detailed in Figure 5 below. A representative successfully creates a connection to the Hampshire based Integrated Commissioning Board and Health and Wellbeing Board governance arrangements.

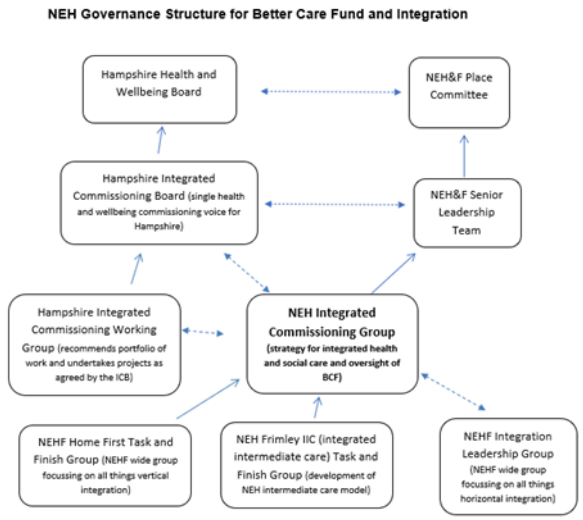


Figure 5: Exemplar placed based governance North East Hampshire IBCF governance

The key metrics proposed for monitoring the impact of the IBCF Plan have been prescribed and continue to support assessment of outcomes in the overall approach.

5. Overall approach to integration

As stated previously, since the inception of the IBCF plan policy the Hampshire vision has been for a simple, *“joined-up”* and integrated health and social care pathway, supporting people to be as independent as possible and remain in their communities. This vision continues to underpin our work together and aims to address our on-going key priorities illustrated in Figure 6 below:

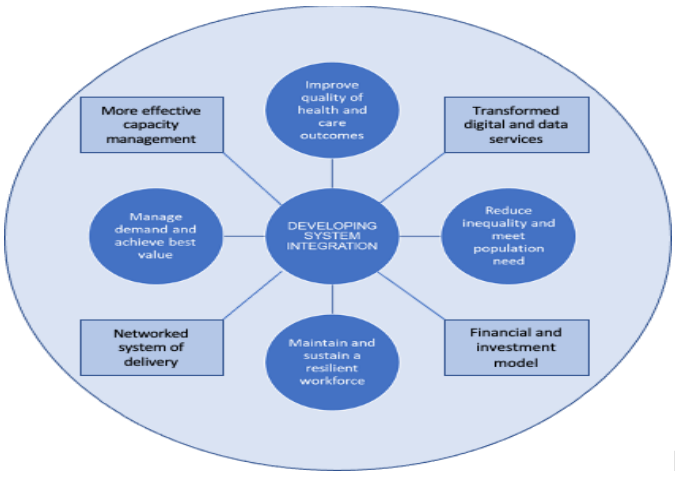


Figure 6

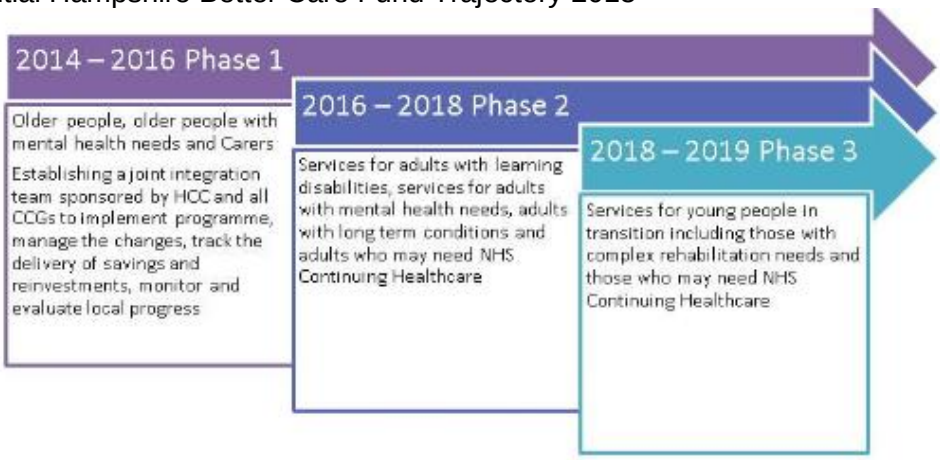
The overall approach to integration continues to be informed by our Joint Strategic Needs Assessment (JSNA[3]) which sets out our agreed strategy for developing healthy, happy, resilient, thriving and protected communities where people have access to services and equality of opportunity, and where all our residents residing across 1,400 square miles of the County geography, 11 districts and CCG, are able to live healthier and more fulfilled lives. Partners work together to further improve wellbeing, independence and social connectivity through the wider determinants of health including housing, employment, leisure and the environment. The Health and Wellbeing Board has continued to have a clear and important role as part of the architecture of 'place' and influence at a scale of Hampshire and Isle of Wight, using the joint strategic needs assessment and joint health and wellbeing strategy to support planning and delivery. The Overview and Scrutiny Committee role continues to be leveraged in providing invaluable democratic oversight. The Joint Health and Well Being Strategy identified four key objectives:

- **Starting Well**: so that every child can achieve its potential and will thrive through transition to adulthood;
- **Living well**: empowering people of all ages to live healthier lives;
- **Ageing well**: supporting people to exercise choice, remain independent in their own homes, in control with timely access to high quality services; and
- **Healthier communities**: helping communities to be resilient, strong and support those who may need extra help.

We understand that many factors influence mortality and morbidity. As our work evolves it is being influenced by other national policy developments. We continue to build on our understanding of evidence from the JSNA [4] and focus on the common themes and challenges for people in greatest need, to make a real difference to the individual, the people who deliver services and the system of care that partners seek to deliver as described in previous submissions of the IBCF plan.

From its inception in 2015 the Hampshire approach to the IBCF Plan anticipated embedding integration would be phased (see Figure 6 below). The model adopted recognised interdependency and the need to avoid destabilising the system of care. It was considered necessary to transform aspects of the health and care system simultaneously. Those early initial phases, as set out below in Figure 7 below continue to guide our trajectory, albeit the pace is variable in different local systems, due in part to historical factors and investment levels.

Figure 7: Initial Hampshire Better Care Fund Trajectory 2015



Our earlier adoption of the National Voices definition of integrated care has ensured commissioned services deliver benefits described in Figure 8 below, for local people.

[3] Joint Strategic Needs Assessment | Health and social care | Hampshire County Council (hants.gov.uk)
[4] Joint Strategic Needs Assessment | Health and social care | Hampshire County Council (hants.gov.uk)

- Improved outcomes for people with long term conditions/multiple co-morbidities
- Reduced A&E attendances/admissions for target conditions
- More people living independently at home
- Extended and expanded primary care access due to improved skill-mix in wider workforce

Figure 8: Benefits for local people

We continue to strive to transform outcomes for local people who use our services, valuing mental and physical health equally to ensure that all needs are met whilst delivering longer term sustainability by working at scale. Our approach in a changing health and care market involves engaging local stakeholders to "co-produce" models of care so that we can create the conditions necessary to deliver the aims and objectives as described in the Hampshire and Isle of Wight Strategic Delivery Plan 2019-2024[5] (see Figure 9 below) and the Hampshire Adults Health and Care Strategic Plan[6].

Figure 9: Integrated Model of Care (Source HIOW Strategic Delivery Plan)

As the new model of out of hospital care accelerated through learning during the Coronavirus Covid-19 pandemic and Hospital Discharge and Home First Programme becomes further embedded, inpatient care will be preserved for people whose needs cannot be met appropriately or effectively elsewhere.

In this approach preventing ill health and actively supporting people to be independent and lead healthy lives through our early help schemes will be the norm. This means people will have greater responsibility for their own health and wellbeing, supporting them through "strengths based approach" to adopt healthier lifestyle so that they enjoy an improved quality of life overall. Importantly, people will not experience the unwarranted variation and system fragmentation. The fully integrated community-based care integrated care is part of the approach to 'Ageing Well', including the two hour crisis response[7] [8]. The outcomes and metrics outlined in the IBCF Plan are translated in the local trajectories align with the Hampshire and Isle of Wight Strategic Delivery Plan 2019 - 2024[i] and local place-based system delivery requirements. This ensure both local and countywide delivery is understood.

[5] HIOW Strategic Delivery Plan (hiowhealthandcare.org)
[6] https://hiowhealthandcare.org/application/files/9616/1124/7160/20191115_HIOW_SDP_V6.pdf
[7] https://www.hants.gov.uk/socialcareandhealth/publichealth/jsna/ageingwellsummary/ageingwell
[8] https://hiowhealthandcare.org/application/files/9616/1124/7160/20191115_HIOW_SDP_V6.pdf

6. Approach to embedding integrated, person-centred health, social care and housing

Local transformation and integration continues to reflect the place based population needs so that the integrated care model ensures a high quality, sustainable health and care system for all localities across Hampshire. Our previous submissions have articulated the population characteristics that have informed our approach to support health improvement for the current 1,389,000 resident population of Hampshire, the tenth least deprived principle authority, of whom:

- Children and young people under the age of 20 years now constitute almost one quarter of the total population with around 29,000 children and young people living in poverty
- 1 in 4 of our current residents are under 19 years old (less than a quarter of the population). This proportion is lower than the national average.
- Across Hampshire currently, just over 1 in 5 people (20%) are aged 65 years or above compared to nearly 1 in 6 nationally. This means that more that 286,000 people living in Hampshire are over 65 years old.
- Of the over 65 year old population, 1 in 2 are over 75 years and 1 in 7 are over 85 years. By 2025 our over 85 year old population is expected to increase by 25%.
- By 2030 for every 2 working age people it is expected there will be 1 person of pensionable age in Hampshire.
- The area accommodates a large proportion of armed forces personnel.
- The population is predominantly white British however ethnic diversity is increasing.
- 85% of the county is classified as rural, with 23% of the population living in these areas.

To respond to key issues and challenges the IBCF Plan aims to contribute to creating the conditions where:

- **Our CCG and Social Care Commissioners** continue to work together to specify joint outcomes where appropriate
- We have **maintained a focus on prevention at scale and earlier intervention** and are extending this approach through **strengths based delivery.** This support for people to remain independent and able to 'live well', is reducing the impact of social isolation and reliance on publicly funded support
- **Investment** and procurement support **integrated care delivery.**
- **Our Community Providers** are implementing **new models of integrated care delivery** that have co-produced and draw on assistive technologies where this is appropriate supporting 7 day working with care co-ordinated around individuals and connecting with the voluntary sector capacity.
- **Our General Practitioners and primary care contractors** are collaborating in wider Primary Care Networks across the CCG focused on populations of 20,000 – 50,000 within agreed geographical areas to deliver at scale
- **Our Care Home and Domiciliary Care Market** is working tirelessly to support people to remain or return to their own setting
- **Access to high quality, efficient urgent and emergency and acute care** services is being delivered locally through one of 7 acute hospitals.
- **Effective discharge and flow** ensures people only remain within an acute or community hospital bed based service when their clinical condition requires.
- **The volume of emergency and planned care activity** in hospitals, nursing and residential care homes is being managed.

The Hampshire IBCF Plan has always focused on developing a sustainable out of hospital system model for local communities. Although the impact of the Coronavirus Covid 19 pandemic has made local circumstances within each of the different systems challenging, the principles of out of hospital care model described in the 2015/16 plan remained coherent. For 2021– 2022,

through the Hospital Discharge and Home First Programme, the system has been building on the strong response throughout the pandemic during which time partners have driven innovations such as establishing a robust response to discharge needs, the 85 bed Clarence Unit Discharge to Assess facility, 3 Designated Settings, 111 First, Community Oximetry, , Urgent Community Response teams, hot hub arrangements across primary care, Virtual Wards a Long Covid service and Total Triage in Primary Care. The system is now working towards recovery, taking the learning from the pandemic to respond to the current challenging financial climate, the wider system transformation ambitions for health and care, including delivery of Strategic Delivery Plan work streams and Adults' Health and Care Strategy[9] [10]. Our approach continues to re-shape and developing the health and social care market with key elements of a whole system model as illustrated in Figure 10 below.

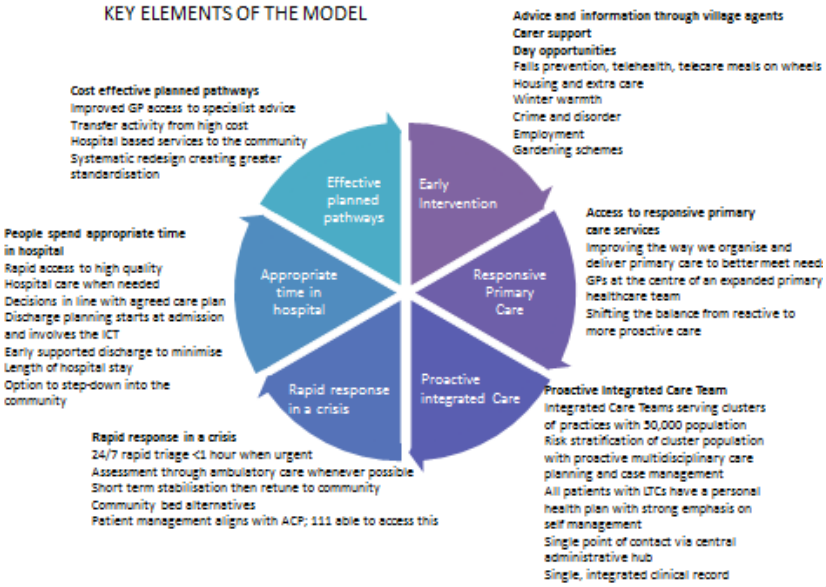


Figure 10

This means that:

- **Independence is the expectation** with support at home in the community empowering people to manage their own health and wellbeing in a strengths-based approach
- **Care is co-ordinated** around individuals, targeted to their specific needs, so they will know about and be able to access information, care and support including relevant technology, in their local community to keep them at home
- **Responsive, proactive and "joined-up" case management** reduces the likelihood that people will have to rely on more specialist services and rapidly regain their independence when they do
- **Experience of care is positive** with the appropriate services available where and when they are needed
- **Outcomes improve** enhancing independence, reducing premature mortality and morbidity

Aligned place-based projects that extend prevention and self-management, provision of primary care to facilitate fewer steps to specialist support, reducing duplication and maximising the benefits of an integrated workforce, including information sharing, single assessment and strengthened leadership. This is underpinned by a number of key enabling elements, that are commissioned as part of a wider strategic work programme in the following areas:

- Collaborative Commissioning for Rapid Discharge Services, Help to Live at Home (formerly Care at Home) including NHS Continuing Healthcare and Funded Nursing Care.
- Jointly commissioning an integrated approach to Reablement / Rehabilitation

[9] A Strategy for the Health and Wellbeing of Hampshire 2019–2024 | About the Council | Hampshire County Council (hants.gov.uk)
[10] Adults Health and Care Strategy final.pdf (hants.gov.uk)

- Commissioning innovative technology as part of an integrated out of hospital care plan
- Commissioning Integrated Provider Delivery Model

Whilst the market position of help to live at home services (domiciliary care) is not evenly distributed across Hampshire, with differential supply in rural and urban areas Joint and collaborative commissioning is enabling a stronger and better understood social care offer as illustrated in Figure 11 below. The recent use of more live-in care and opportunity of extra care housing are contributing more to the options available.

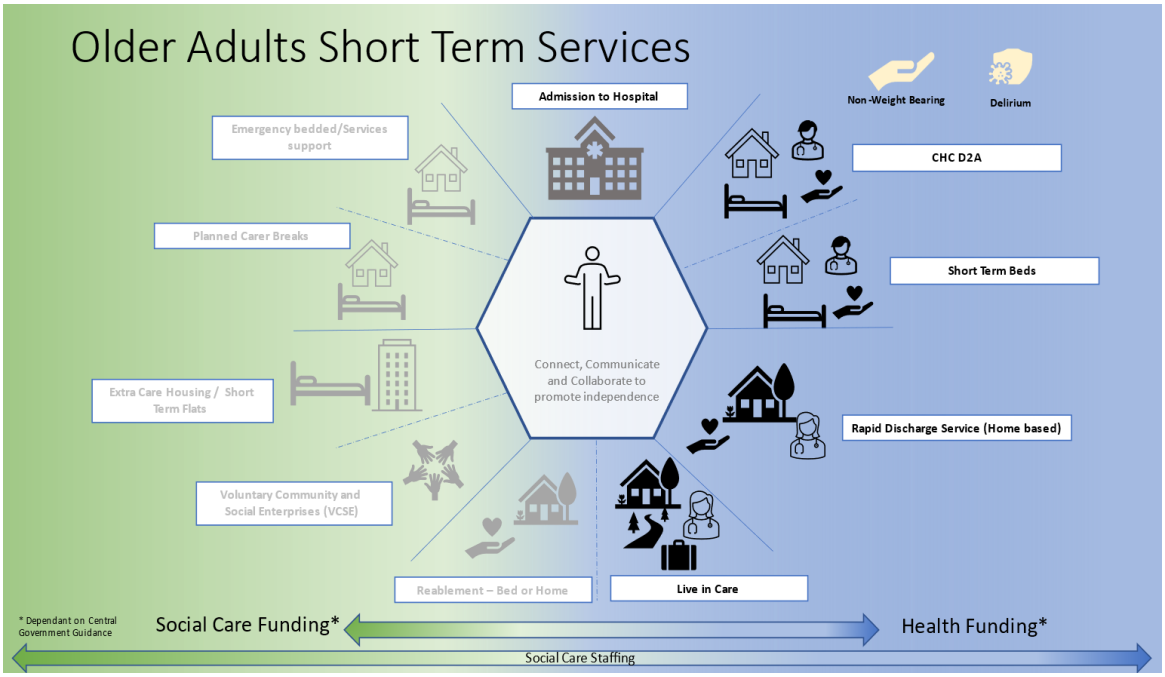


Figure 11. (Source Hampshire Adults' Health and Care)

Connect to Support Hampshire[11] a suite of web based information and resources that enables people, their carers and local communities to identify sources of support that can meet their needs continues to be commissioned and well used. Telecare services across Hampshire continues to go from strength to strength. The award- winning approach of the Argenti Consortium makes a real difference to people's lives, maintains independence and reduces the revenue costs of adult social care across all client groups. The *device agnostic* methodology deploying technologies available via the *internet of things* and support of novel innovation is also extending potential even further using experience during the Coronavirus Covid-19 pandemic.

Workforce capability and capacity remains a challenge and critical success factor due to competition in the labour market and the ongoing impact of Covid-19. Partners continue to explore how different approaches such as an "employee passport" as a catalyst for changing behaviour and developing new skills. For the **domiciliary and residential care** providers who struggle to recruit and compete directly with each other, the Local Authority has actively supported the national "Call to Care" [12]initiative with individuals being recruited via the Connect to Hampshire Agency. For services meeting needs of people with a Learning Disability, the "Least Restrictive Practice programme expands the skills to support stuff to respond positively to behaviours that challenge. These new ways of working extend beyond traditional professional boundaries. Hampshire County Council workforce development team is continuing to support the care market to maintain capability and capacity.

These system features continue to resonate and are reflected in partner commissioning plans

[11] https://connectsupport.hants.gov.uk/
[12] Call to Care in Hampshire

7. How Integration Better Care Fund services are supporting the approach to integration

The CCGs and the Council continue to consider both the core BCF and IBCF for 2021-2022 together. The policy guidance for the core BCF records a 5.6% inflation in 2021/22 for all of Hampshire except the area covered by the Frimley Health System ICS where allocations and 4.3% inflation has been applied. The CCGs have confirmed their planning assumptions aligned with policy guidance. The entire BCF resource is committed to contracted services that contribute to the out of hospital care model including commissioned community health services and domiciliary care.

In 2021/22 the minimum BCF for Hampshire was increased to £92,732,577 with a minimum CCG ring fenced value of £60,999,388 for out of hospital services in line with national guidance. £31,733,189 of the core BCF value for 2021/22 is allocated to social care. The funding agreement relating to the IBCF plan continues to protect the following adult social services to support the delivery of core elements of the integrated out of hospital model:

- Community Independence interventions
- Hospital Discharge Teams
- Reablement
- Care Act duties
- Carer Support including day opportunities
- Palliative Care

Since the pooled fund has always been an existing resource, apart from the value of the contribution, there are no changes to the schemes included 2020/21 BCF and the plan reflects the allocated values. However, in the context of the CCG financial position and the challenging County Council medium term financial strategy, partners recognise that merely commissioning services covered by the pooled fund together will not ensure the system is financially sustainable. CCG commissioned services and investment in out of hospital spend supported via the IBCF are detailed in the accompanying planning template. Whilst these resources are being deployed in pathways including Discharge to Assess, Enhanced Recovery at Home, Community Rehabilitation and Integrated Care Teams, a significant addition of the short-term Hospital Discharge Fund has been added to system resources to augment, expand and develop the model under the “Hospital Discharge and Home First Programme”.

The allocation of the Improved Better Care Fund (£25,605,329) and Winter Pressures funding (£4,747,497) contributes to adult social care demand. For 2021/22 a further £14,252,433, is designated to fund Disabled Facilities Grants (DFGs), allocated centrally, has transferred locally to the 11 Housing Authorities. Details of the spending plan are confirmed in the accompanying Hampshire Planning Template. All specific IBCF funded activity is firmly positioned in contributing to and supporting the out of hospital care model described in section 9 below.

8. Supporting discharge (national condition 4)

By its nature Hampshire is a complex health and care system in which partners have been working together to address the whole system challenges. Root causes of delays have been analysed in detail, using data, operational experiences and the experiences of local people using our services. Performance of the whole system has historically been volatile, accentuated by the prevailing care market conditions across Hampshire.

System wide improvements established through the “Hospital Discharge and Home First Programme” in 2020/21 are being embedded into the core discharge and flow model. All four placed-based systems noted in section 4 above are working to deliver agreed performance requirements. Each has agreed a system wide trajectory for improvement that all partner organisations have signed up to. This covers:-

- maintaining SPOA coordination
- optimising Discharge to Assess
- reducing dependence on long term placement and supporting flow in the acute sector, thereby enabling elective restoration.
- Enhancement and alignment of urgent community response and same day access to urgent care provision

The approach is intended to comply with the Hospital Discharge Policy, continuation of the move from bed based to home based care and manage system cost pressures. Each of the four place-based systems have an established leadership group working together to provide an integrated health and social care system fit for the future covering. Acute Hospital Trusts are key members of these leadership groups that include:

- 111 First - NHS 111 Online and NHS 111 Calls
- GP / Primary Care Access
- Urgent Community Response
- Ambulance services
- "Home First" enhanced recovery and support to return home
- Hospitals response of all Acute Trusts
- Local Authority social care

This means people being able to access seamless services that meet their physical and mental health needs through the right care, at the right time and in the right place. Through focus on the individual, as opposed to structure, there is increased focus on prevention and pro-active care rather than reactive treatment. Figure 12 below illustrates an exemplar "Home First" plan for 2021/22 in North and Mid Hampshire with clearly stated anticipated outcomes. This approach is mirrored across the Hampshire area.

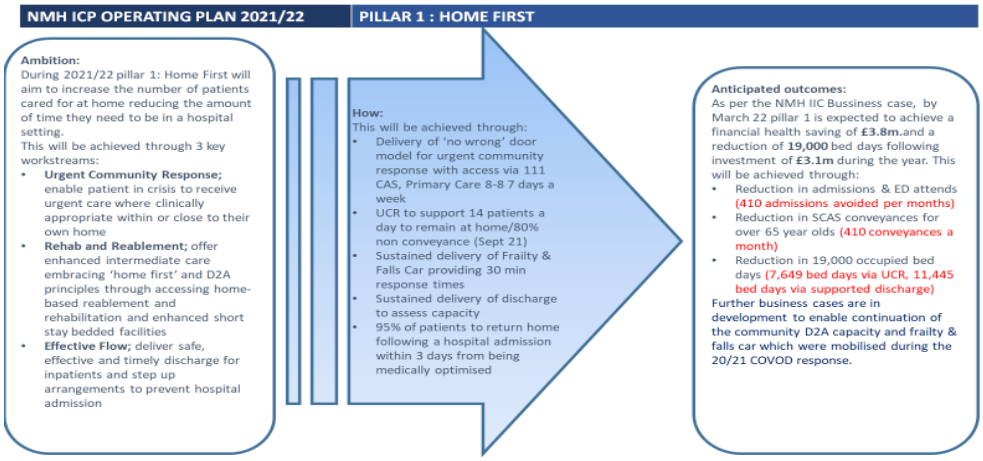


Figure 12: Exemplar Home First 2021/22 plan - North and Mid Hampshire system.

Each plan outlines the high-level actions being implemented and further work continues. Figure 13 below illustrates the alignment of the IBCF out of hospital model to the effective flow and discharge pathway that deliver the elements of "Home First" incorporating areas of good practice in the high impact change model.

The commissioned interventions for Adult Social Care compliment those of the NHS to:

- ensure a variety of **consistent and appropriate Home and Bed Based Short Term Services** which would support timely discharges, admission avoidance and community options for Hampshire residents to enable a strength based and person-centred assessment.
- provide services that would ensure positive outcomes for individuals who need services.
- work under the principle of a right service for the right person at the right time
- ensure that **no individual moves to a long-term service without the opportunity to improve, engage and be part of a personal assessment within a short-term service.**
- secure competitive costings with the market and manage the market in a constructive and positive way, for both long term and Short-Term services.

- ensure the correct associated **staffing for service assessment and delivery**
- retain the ability to **flex capacity throughout the year.**

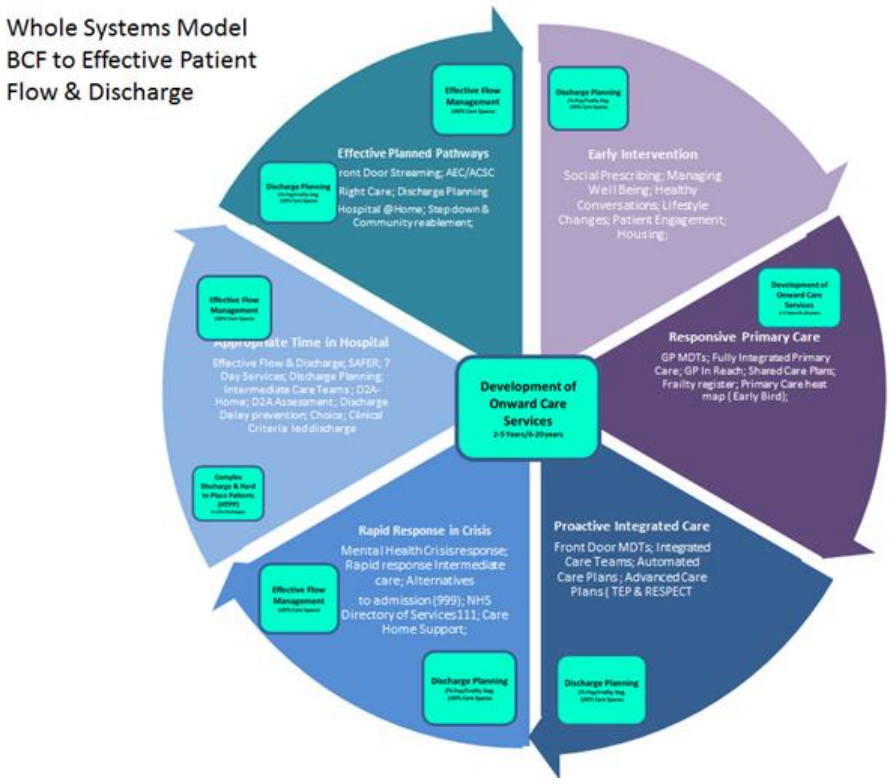


Figure 13

Monitoring of non-elective admissions continues in each system. Figure 14 illustrates performance across Hampshire for chronic ACS conditions as a whole.

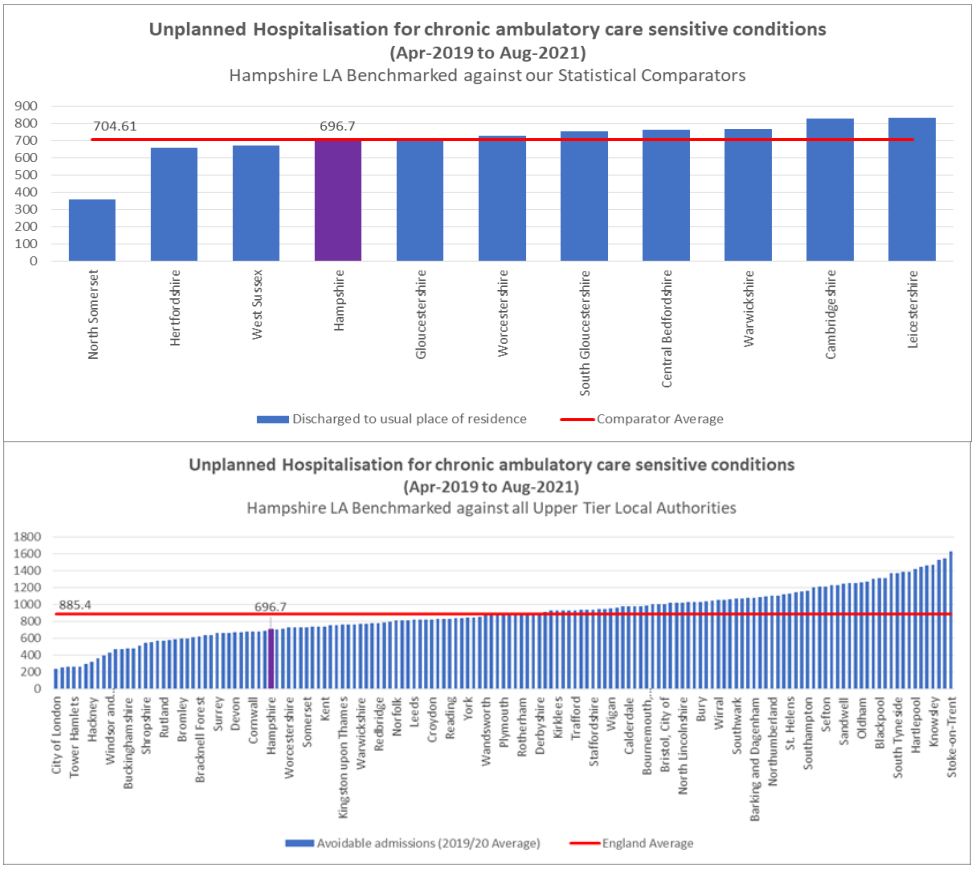


Figure 14 Hospitalisations for ACS conditions – Hampshire overall

The Evaluation of Home First and Discharge to Assess (September 2021) analysis of data for 2021/22 to date illustrated in Figure 15 below. The percentage of hospital discharges who went 'Home First' remained steady at 90% for the reporting systems: 93% in Hampshire Hospitals NHS Foundation Trust, 91% in Portsmouth Hospital NHS University Trust and 86% in University Hospital Southampton NHS Foundation Trust.

- Total discharges decreased in September, with only Acute discharges from Hampshire Hospitals NHS Foundation Trust remaining at approximately the same level as the previous month.
- Community Service capacity and utilisation highlights:
  - Total **D2A bed capacity remained steady** at 229 in September compared to 227 in August. Average D2A utilisation across those systems has increased to a high of just over 96% in September, compared to 84% just 3 months ago, in June.
  - Total **RDS capacity decreased** from 7786 hours in August to 6386 hours in September. Overall utilisation increased from 81% in August to 85% in September, with a notable increase in North and Mid system.
  - **Live in Care capacity remained steady** with 56 carers although utilisation reduced from 70% in August to 67% in September.
- Post D2A (short term service) outcome data for the Hampshire Systems reported:
  - 42% of individuals returned home with or without care/support, 38% were placed into Residential/Nursing 16% returning to hospital.

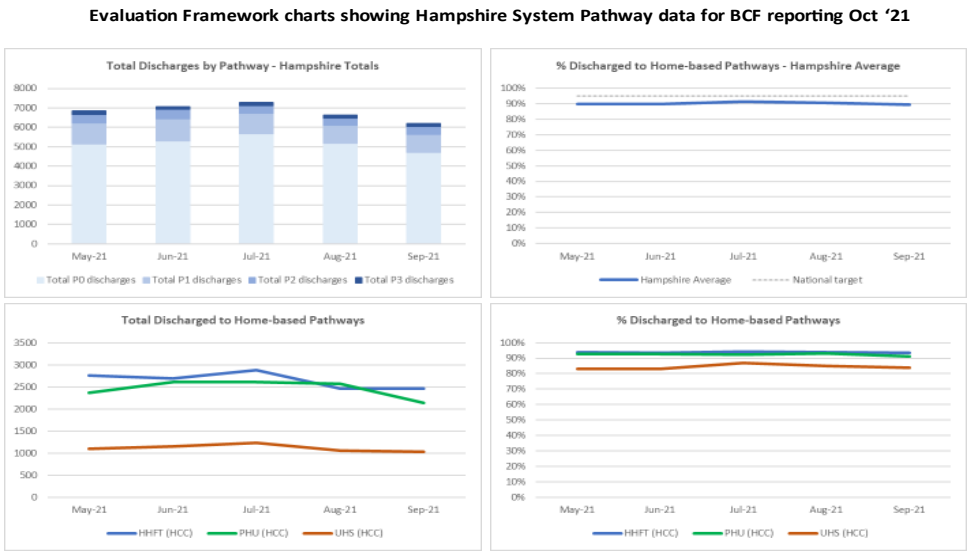


Figure 15: Hampshire Discharge Pathway Data to September 2021/22 (Source "Hospital Discharge and Home First Programme")

The challenges in each system in achieving and sustaining discharges performance are not underestimated and are becoming better understood in each system.

Further improvement opportunities are being pursued in the following areas:

- Flexing capacity requirements linked to the latest demand and capacity modelling
- Reducing care packages from 6 to 4 weeks
- Refining and consolidating the short-term service offer
- Developing an approach to self-funders
- Decreasing reliance on long-term nursing and residential care
- Resolving process issues in the NHS Continuing Healthcare / complex pathway
- Optimising admission avoidance including 2 hour response
- Enhancing the clinical model to support managing increased complexity at home
- Managing the impact of multiple systems escalating at the same time through stronger whole system working

9. Disabled Facilities Grant and wider services

The grant funding to support the provision of Disabled Facilities Grants awarded for the purpose of enabling vulnerable individuals to stay living independently within their own home, preventing them from becoming homeless or having to move unnecessarily into a less independent institutional setting is passed to the Housing Authorities with the objective of:

- Facilitating timely hospital discharge
- Reducing admissions to residential care homes
- Reduce the cost of providing domiciliary care
- Contributing to the wider prevention agenda of housing, social care, and health authorities by facilitating improvements in individual wellbeing, and reducing hospital admissions.

The full value of this allocation has been transferred to the eleven Hampshire District and Borough Housing Authorities as required. Individual partnership agreements set out the relationship with the County Council including data submissions to demonstrate levels of spend and activity. Each housing authority works within the DFG Partnership Group and with all other stakeholders and relevant parties to deliver of DFGs in a timely manner to the agreed standards.

Although there is not yet a single unified arrangement for the whole of Hampshire the majority of the Housing Authorities in Hampshire have discretionary elements to their financial assistance policy for housing[13], making it possible for:

- Mandatory DFGs
- Discretionary DFGs
- Discretionary home improvement grants
- Home improvement loans

These arrangements make provision that extends beyond the scope of more than the 20 year old housing legislation requires.

Housing Authorities have worked to enable elements of the Better Care Fund ambitions in various ways including directly employing Occupational Therapists. New Forest District Council has also funded an adaptation scheme specifically support hospital discharge.

In the wider context housing partners in districts and boroughs together with colleagues in north east Hampshire (part of NHS Frimley CCG) are continuing to work to move people on from temporary accommodation as a consequence of the Coronavirus Covid-19 pandemic. Work continues to strengthen our joint approach; sharing our learning and expertise.

10. Equality and health inequality

System partners have committed to addressing inequality and inequity of access to services and restoring services inclusively, improving outcomes for those in greatest need and include a proactive response on diabetes, cardiac, mental health and COVID-19 risk factors. The Hampshire Integration and Better Care Plan was initially developed to respond to system demands and meet the needs of the changing older people's population of Hampshire. Our 2021-2022 Integration and Better Care Plan continues to be influenced by the evidence of population increase. With this increase comes greater demand for services.

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Data assessed for the Joint Strategic Needs Assessment (JSNA)[14] and used to inform local plans indicates:

- An ageing demographic – increasing frailty and multimorbidity, this will be a big driver in health and social care needs. This is particularly expected in West Hampshire
- 93.8% white population although indications the population becoming more diverse. Diversity is greatest in north east Hampshire
- Inequalities exist within the County with males in the most deprived areas living 5.2 years less and females living 3.2 years less than the most affluent areas
- Birth data show a steady decrease in the number of live births and general fertility rate.
- Cancer and circulatory disease reported in 2019 account for over half of the deaths (55%) across the STP in 2017

Concerning older people, the JSNA indicates the following key themes:

- Higher **dementia** prevalence compared to England, 0.86% compared to 0.76%. By 2025 there will be an estimated 8,000 more 65yrs+ patients with dementia
- Increasing **frailty** in older people causes greater demands on health and social care, increased risk of falls. Over one year (2017/18) there were 12,000 admissions where frailty was coded, half had fallen or had tendency to fall recorded. People aged 75 years and over accounted for nine out of ten emergency fall related admissions.
- **Multimorbidity** often associated with reduced quality of life, higher mortality, polypharmacy and high treatment burden, higher rates of adverse drug events, and much greater health services use (NICE Guidance QS153). It is estimated that 26,000 older people across the STP have three or more 3 chronic conditions

The system wide approach to responding to these inequalities[15], particularly in relation to older people that have been the focus of the Hampshire Integration and Better Care Plan includes:
- Increasing funding for primary and community care
- Bringing together different professionals to coordinate care better including community connectors that assist in care navigation
- Helping more people to live independently at home for longer
- Developing more urgent community response teams to prevent avoidable hospital admission, and speed up discharges home.
- Upgrading NHS staff support to enhance the care people living in communal residential and nursing homes.

In keeping with the rest of England and the UK, responding to the impact of the Coronavirus Covid-19 pandemic since March 2020 has clearly been a priority and has been a related factor in the work to progress the Integration and Better Care Plan particularly in relation to hospital admission and discharge rates (see Figure 16 below).

In assessing need in relation to Covid-19 it has been identified that certain communities and individuals within Hampshire have been more vulnerable to harm[16]. Different factors have contributed to this vulnerability which has become evident in the recovery process. Three separate indices have been developed and are being used to inform the next phase of the response:

- **Clinical vulnerability to COVID-19**: those at higher risk of experiencing severe outcomes from contracting COVID-19
- **Wider risks from Covid-19** through work and living conditions
- **Vulnerability to policies relating to Covid-19** such as the negative effects of restrictions or economic downturn.

[14] 2019 STP JSNA (hants.gov.uk)
[15] Prevention and inequalities :: Hampshire & Isle of Wight STP (hiowhealthandcare.org)
[16] COVID-19 Data and Intelligence | Health and social care | Hampshire County Council (hants.gov.uk)

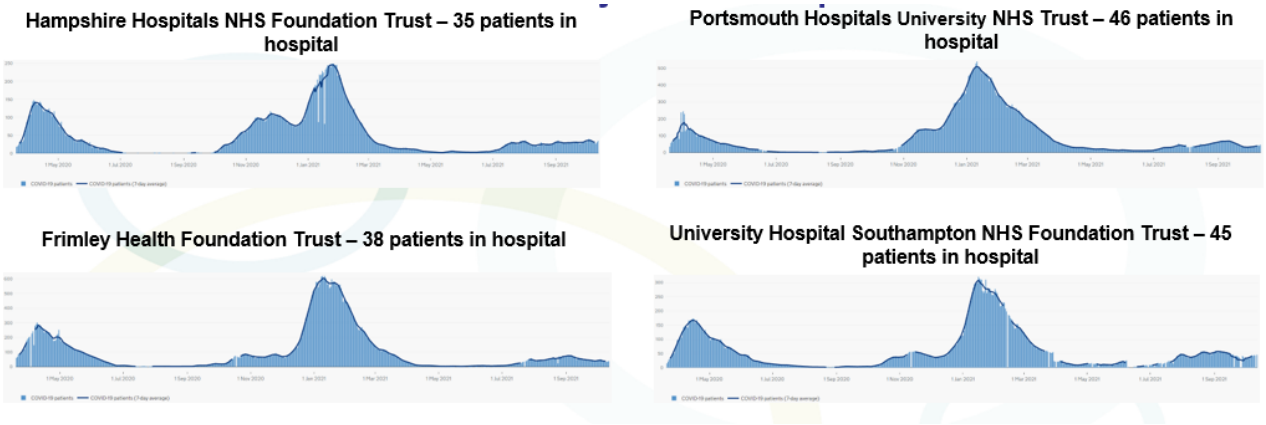

Figure 16: Hospital admission due to Covid-19 (source PHE)

Most recent data (October 2021[17]) indicates a cumulative rate in Hampshire of 9,992.64:100,000 population. Whist in the initial phase on the pandemic older people were most notably affected, this has now shifted to 11-14 years olds (see Figure 17 below). Older people were more vulnerable to serious illness and deaths from COVID-19 and more likely to shield. Decreased social connectiveness for older people who were also less likely to use online communications to supplement their interactions. Impacted on mental health with increased anxiety and depression reported as well as increases in cases of self neglect and self harm including self neglect. There was an increase in unpaid carers during the pandemic as people provide inform help for family member. The impact of service closures, social distancing restrictions has also compounded social isolation and reduced mobility, so people may require social care services earlier than they may otherwise have done. The progress being made in the vaccination programme along with wider public health campaign aims to mitigate risks of harm.

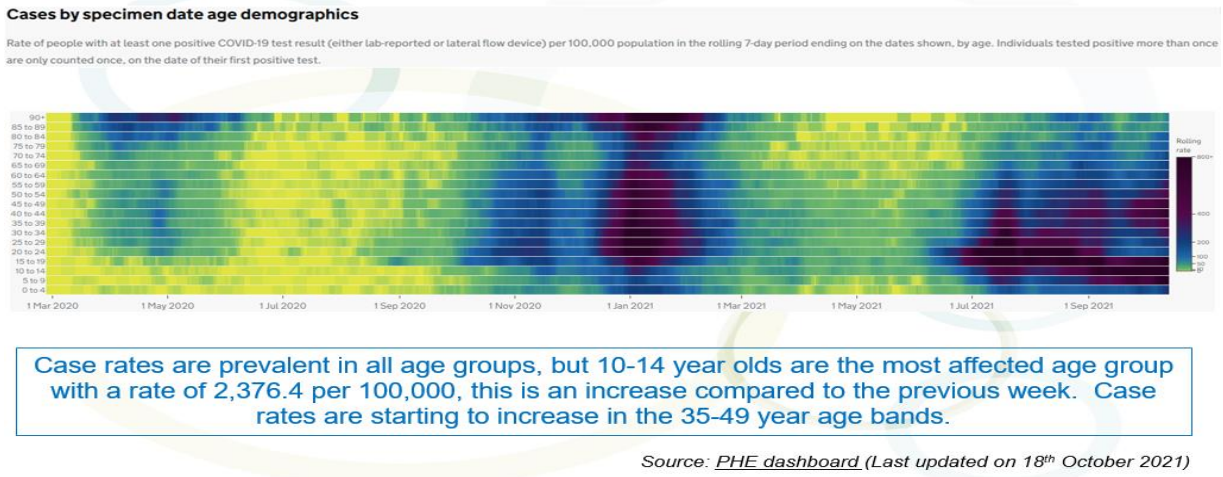

Figure 17: Current age-related prevalence (source PHE)

By working to address the needs of vulnerable adults experiencing the impact of multiple long term conditions, including hospital admission and discharge, the IBCF funding invested in mainstream core community services and social care support is contributing to the systems' ability to tackle the wider determinants of health and mitigate some of the effects of inequality.

[17] Name of report Detail of report (hants.gov.uk)