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In response to the committee's request for additional information on the challenges of integrating health and social care, we have provided further information on case studies within the Bristol, North Somerset and South Gloucestershire (BNSSG) ICB footprint.

The two examples we have provided are around S117 Mental Health Aftercare and Adult's Continuing Health Care. Both issues have national guidance which is unclear and pushes the funding conversation onto ICBs and Local Authorities. We feel this inhibits partnership working and closer integration of health and social care as challenging, at times adversarial, conversations between partners are often required.

In addition to the requested evidence, we have also provided further information on the rise of working-age adults as a proportion of ASC budgets, and case studies of successful partnership working on transfer of care hubs within Bristol City Council (BCC), with an invitation to visit a hub and our nationally pioneering Specialised Supported Housing at our latest site, Oldland Common.

Section 117 Mental Health aftercare (S117)

Alongside CHC, issues like S117 are key contributors to straining relations between ICBs and local government, preventing meaningful integration between health and social care.

Guidance on S117 Mental Health aftercare

Section 117 of the Mental Health Act 1983 ("Section 117") states: "It shall be the duty of the integrated care board and of the local social services authority to provide or arrange for the provision of, in co-operation with relevant voluntary agencies, after-care services for any person to whom this section applies until such time as the integrated care board and the local social services authority are satisfied that the person concerned is no longer in need of such services but they shall not be so satisfied in the case of a community patient while he remains such a patient."

In Annex B: national guidance on how budgets and responsibilities should be shared to pay for section 117 aftercare (Mental Health Act 1983) it states: "Section 117 funding arrangements should therefore be determined in accordance with local agreement between NHS and LSSAs to meet the needs of the eligible persons. Local systems will choose to administer a joint funding process which will fall within different broad categories of aligned or pooled budget arrangements. The duty to fund aftercare under the MHA should be approached as an opportunity to explore stronger integrated arrangements between NHS and local authorities."

It is evident from the guidance that there is no nationally determined approach to S117, and it is left to local areas to agree. The impact of this is not enhanced devolutionary potential, but rather a barrier to our best efforts at integrating health and social care.

Case study: S117 in Bristol, North Somerset and South Gloucestershire

At Bristol City Council (BCC), we work with the Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB). This is an excellent partnership which works well together, with the three Chief Executives of the Local Authorities sitting on the ICB Board. Despite this commitment to partnership working, S117 Mental Health aftercare has been a source of significant disagreement and relationship strain.

S117 funding split was determined by BNSSG ICB pre-pandemic at a 70/30 split, with BCC paying the majority and the ICB the minority. The BCC DASS began to challenge this, but priorities shifted as the COVID-19 pandemic began.

This is an exceptional agreement, with most areas having agreed to operate on a case-by-case, a 50/50 split or a different proposition (eg 57.5/42.5). With one exception, which was challenging the split, BCC was unable to identify an ICB footprint which operated with a split of 70/30 (BCC did review other LAs but most asked to be kept confidential). The cost to BCC annually of a 70/30 split compared to a 50/50 is almost £8 million, a considerable contributor to the overspend of council budgets in recent years.

Since October 2022, BCC has been regularly interacting with the ICB on S117 funding arrangements. Despite there being no written agreement to a 70/30 split, and BCC evidencing the unfairness of the arrangement when compared to other regions (including the agreement BNSSG ICB has with South Gloucestershire), the ICB has been unwilling to move to a fairer funding split.

S117, alongside CHC, has been the key item discussed at bi-monthly Chief Executive meetings and the cause of significant officer time to come to a resolution. It has impacted relationships across senior management and prevented integration, as negotiations continue to struggle over S117 in part due to a lack of clear government guidance on what is a fair funding arrangement.

More recently, this has been escalated to a back and forth of legal letters between BCC and the ICB, with BCC withdrawing from the 70/30 arrangement and seeking a 50/50, or evidence-based split. Since December 2024, a temporary agreement to assess each new case individually has been reached, with decisions being made on cost sharing in a weekly forum. To date, this indicates that the split should be approx. 50/50. This is a time-consuming approach which neither side sees as a permanent solution. In addition to this, BCC has developed a cost apportionment matrix, which is intended to automate the cost sharing process, and this is currently under consideration by the ICB.

BNSSG ICB has agreed to develop an evidence base by undertaking 100 joint S117 reviews with the three LAs, and that the evidence collected through these reviews will inform a new cost sharing split, although it is currently unclear what objectivity these reviews will bring to the process.

Adults' Continuing Care (CHC)

Continuing Healthcare (CHC) is a legal entitlement for NHS-funded care for people whose needs are assessed to be primarily 'health' rather than social care related.

Eligibility depends on assessed needs, not on a diagnosis or particular condition and a decision is meant to be made within 28 days of an assessment. A patient may have some health needs but not be eligible for NHS continuing healthcare, in which case the NHS may part for part of the package of care alongside the local authority.

We would be able to collaborate and do much more together with ICBs if we were able to avoid repeatedly having difficult conversations about money. We view CHC as an anachronistic financial mechanism which is counter-productive to the government focus on shifting into community-orientated (integrated locality team) Neighbourhood Health.

Case Study: CHC in Bristol

The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care recommends that the ICB should consider joint packages for individuals whose needs are deemed as being below the threshold for CHC funding. However, Bristol has a minimal amount of joint funded packages of care, except for S117 cases.

The current joint funding application process has not been developed in partnership with Local Authorities in BNSSG and does not flow out of CHC assessments in a way which a previous Joint Funding policy (pre-COVID) enabled.

We have a lack of confidence that the ICB will apply CHC thresholds equitably, so governance and decision-making is a challenge. For example, ICB wider data shows that by the end of 2022/23 there were 114 fewer CHC cases across BNSSG, at a time that we know demand for, and complexity of health and social care need is increasing. The average number of people assessed for CHC per month in Bristol has decreased by 32 a month from 2021 to 2023. The rate of eligibility went from 18% in 2021, to 14% in 2022 and 12% in 2023: a total decline of 6%.

Bristol estimates the reduction in assessments and eligibility rate has cost the local authority around £5 million per year. We want to pool budgets with the ICB once we have an agreed and understood set of rules around funding responsibilities – however again the lack of clear guidance is preventing joint working and integration on this issue.

Rise in working age adults as users of ASC services

National expenditure on social care support for working age and lifelong disabled adults has risen by over a third between 2020 and 2023 in England. The longer-term trend for care needs for working age adults continues to grow, likely due to more than a decade of under-funding of mental health and learning disability services and inadequate community provision.

Case study: Working age adults requiring social care support in Bristol

The rise in working age adults requiring social care is particularly acute in core cities and urban centres like Bristol. Bristol is particularly young as a city, with a median age of 33.7 compared to 40.5 (England average). Bristol is also a regional hub for sanctuary seekers and homeless populations who require greater ASC resources than other cohorts.

Accommodation for working-age adults receiving care services is very expensive and has shifted quickly to become our largest financial challenge on ASC. In Bristol, close to 60% of the total ASC commissioning budget is now spent on younger adults (under 65) with enduring multiple, and complex needs (this was 52% in 2017/18).

Bristol spend on ASC increased by more than 10% in 2023 alone, with the majority of the increase due to working age adults. Since 2017/18 our working age (under 65) has increased in numbers by 21%, cost increased by 66%. (£51m increase in spend). Of the £200m BCC spend on ASC Commissioning, £131m is now spent on working age adults (£80m in 2017/18). The cost per week per person increased from £452 to £608 for over 65's, but from £524 to £783 for working-age adults.

In 2017/18, Bristol was spending 56% of total revenue on adult and children's social care, a figure which has risen to 75% by 2023/24. The proportion of funding for all other services, including place-building, housing and other aspects which support healthy communities, has had to be cut.

Reform is needed to reverse the ever-increasing proportion of funding required for social care, particularly in working age adults. Within this, there are opportunities to reduce costs through capital investments, such as specialised supported housing (SSH).

Specialised Supported Housing (SSH)

Nationally, there is a projected annual need for 2,300 new SSH units, but only a small fraction of these are currently being delivered.

For people with learning disabilities, autistic people and individuals with mental health needs, the lack of suitable housing remains a significant barrier to independent living. As a result, many remain in residential care or hospital settings despite being capable of thriving in the community with appropriate housing and support.

The Government's commitment to shifting care from institutional/hospital settings into the community presents an opportunity to align the housing agenda with this ambition. Specialised Supported Housing enables people to live safely, with dignity and independence, while reducing reliance on institutional care.

SSH consistently delivers better outcomes for individuals with complex needs and is more cost effective in the long term, once the initial capital investment is made. It is a classic example of how up-front investment can deliver long term sustainability and improved outcomes.

The supply of high quality SSH, designed around the needs of people who require bespoke housing alongside care and support, is therefore critical.

Bristol Case Study: Oldland Common

Bristol City Council is recognised as a leader in the development and delivery of SSH with innovative approaches to both development and funding models.

In one example we partnered with Elim Housing Association to create a bespoke, lifelong home for a young woman with severe learning disabilities and Autism who had spent over 22 years in a locked hospital ward. This partnership driven by Elim's capital investment and a multi-disciplinary team enabled her transition into a purpose-built home within the community. She has now been living in significantly less restrictive conditions for nearly two years, demonstrating the transformative potential of SSH.

While difficult to quantify, In Bristol the average care cost per person in SSH is £41,000 per year lower than in equivalent residential care placements. This is based on the fact that on average 35% of a residential care package is housing costs, therefore this saves £800pw on an average care package costing £2,000 per week. However, the key cost is to the individual, so even if there was no saving it is still better to provide a home rather than residential or hospital care.

We have funded projects through the NHS England capital grant programme (currently limited to £16 million per year nationally). These schemes are delivered by not-for-profit Registered Providers, whose capacity is constrained by the high build cost of SSH, and the inability to access Homes England social housing grant on an equal footing with general needs and ordinary supported housing. Currently no public subsidy by way of discounted land or grant (aside from NHSE grant) is allowed into SSH. Amending this criterion would dramatically improve delivery.

To address this, we have:

- Worked with Homes England to test Affordable Homes Programme grant under the Affordable Rent model.
- Developed a BCC asset disposal scheme, assessing surplus land and buildings before auction for SSH potential.
- Where viable, collaborated with investors and RPs to repurpose assets for people with complex needs.

Bristol currently has 70 SSH units in the development pipeline, including six recently completed units at Oldland Common.

We would like to extend an invitation to the committee to visit Oldland Common, to see how SSH can transform lives and understand how these schemes can be successfully delivered through local authorities and housing association partnerships.

Transfer of Care Hubs (ToCHs)

Transfer of Care Hubs (ToCHs) are an example of joint social care, NHS and VCSE sector 'Home First' collaboration model in Bristol.

The ToCHs strengthen discharge processes by promoting multidisciplinary collaboration, improving patient outcomes, and enhancing hospital efficiency. The result is timely, safe, and person-centred discharges, reducing unnecessary hospital stays and readmissions.

Bristol has worked with partners in the NHS to create ToCHs based in North Bristol NHS Trust (Southmead Hospital) and UHBW NHS Trust (Bristol Royal Infirmary). This has resulted in the hospital-facing BCC social care team being expanded and co-located in the hospitals with wider multi-agency and multi-disciplinary NHS and VCSE colleagues to improve hospital discharge processes and interventions for people requiring post discharge support to return home or who may require longer term bedded care.

The BCC staffing for the ToCHs is funded by BCC, and the ICB under the Better Care Fund funding umbrella. The council directly funds a Team Manager, two Senior Practitioners, 5.5 Social Workers and 0.8 of an Interim Bed Coordinator. The remainder of the Bed Coordinator is funded through the Better Care Fund, as are a further Senior Practitioner, six Social Workers, two Social Workers focused on homeless service users, two Occupational Therapists and four Coordinators.

Strengths of the ToCHs approach in Bristol:

1. **Improved coordination and communication** through multi-disciplinary and multi-agency collaboration (healthcare professionals, social workers, voluntary and community services, care providers) streamlines communication and decision-making reduces duplication of efforts and promotes a holistic approach to patient care.
2. **Efficient discharge planning** facilitates timely and safe discharges by proactively identifying discharge needs and coordinating resources. It also minimizes unnecessary hospital stays by arranging appropriate community support or rehabilitation services.
3. **Patient-centred care** ensures patient and family involvement in discharge decisions, promoting personalized care plans and enhances patient satisfaction by considering their preferences and needs.
4. **Reduced delays and bottlenecks** by streamlining complex discharge cases by removing administrative and logistical barriers, identifying and resolving delays related to social care, transportation, or home adaptations.
5. **Enhanced data sharing and monitoring** through shared electronic records and real-time data to improve continuity of care and reduce miscommunication, as well as enabling better tracking of patient outcomes.
6. **Resource optimization** to prevent unnecessary hospital admissions, promoting early supported discharges and optimising staffing resources.

Impacts of the ToCHs approach in Bristol:

1. **Reduced length of hospital stays** through quicker decision-making and discharge freeing up acute beds, further preventing associated risks of prolonged hospitalisations.
2. **Lower readmission rates** by ensuring appropriate post-hospital support through effective discharge planning.
3. **Improved patient flow** between community and hospital settings, potentially reducing emergency department congestion.
4. **Enhanced patient outcomes** with timely discharges and improved continuity of care.

5. **Cost Savings** by reducing avoidable hospital days and readmissions, resulting in financial savings for the healthcare system and more efficient use of social care resources.
6. **Staff Satisfaction** noted as a result of improved collaboration and streamlining processes reducing workload duplication.

Challenges with ToCHs in Bristol

ToCHs are a further example of how a lack of clarity over guidance for paying for joint services is inhibiting integration.

The funding for 2025/26 is flat with no inflationary uplift (2024/25 there as a 5.6% uplift). BCC's costs are not flat, with both a NI and pending pay award increases for 2025/26. BCC is currently reviewing its establishment cost base against the proposed budget. If the staff cost base exceeds the available budget, and no NHS BCF uplift is forthcoming, we will need to look at vacancy management and potential staff reductions. This will impact on our MDT input and Care Act Assessment (CAA) capacity and may have a negative impact on hospital discharge flow management and outcomes.

Under the NHS 'Who Pays' guidelines the ICB is the commissioner of the ToCHs and there is no pooled budget arrangement in place with the council. The budget for Bristol City Council social care staff is part of the formal BCF plan sign off process. BCC has to invoice the two NHS acute trusts under the ICB annually for service costs, as the ICB views the arrangement as they have implemented a 'lead provider' model with the acute trusts. The three local authorities disagree with this view, and believe funding should come directly to them, as it would avoid invoicing process costs. ToCHs should be viewed as multi-disciplinary platforms jointly hosted.

The 'lead provider' approach is now putting BCC at financial risk. The ICB views the budget as being agreed between trusts and local authorities, meaning trusts can choose to pay less than the agreed budget. Due to budget pressures on all sides this has happened, challenging the working relationship and impacting LA budgets further.

ToCHs outcomes and return on investment

Whilst it is difficult to assess the impact of ToCHs specifically, preliminary data Bristol City Council received a 25% increase in D2A referrals following the ToCHs launch October 2023, although this has now flattened at a higher level than pre-ToCHs figures. This has also seen ongoing reductions in discharge delays attributed to the Local Authority.

ToCHs have been successful in delivering pathway shifts from bedded options to home-based services, as evidenced by the closure of 72 P2 and P3 community beds across the BNSSG system between March '23 and March '24. The hubs have also directly contributed to the bed savings in D2A Pathways 1-3 associated with process delays.

The improved joint multi-disciplinary team decision making is expected to have lasting benefits for D2A and non-D2A activity as the operational teams continue to drive down delays associated with cross partner processes.

Although Bristol remains significantly above the national average, the number of people delayed in acute beds have improved in line with reported D2A pathway savings. Whilst savings and pathway shift ensure a route to lower sustained levels of capacity requirements in the longer term, they do not resolved backlogs in acutes quickly.

We would like to extend our invitation to the committee to include a visit to one of our ToC Hubs to see firsthand how integrating health and social care can make tangible differences to both the health system (hospital discharges) and social care (providing appropriate support and outcomes for patients).

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