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Health and Wellbeing Board

Tuesday, 3 October 2023 at 2.00pm

in Council Chamber Council Offices
Market Street Newbury

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Date of despatch of Agenda: Monday, 25 September 2023

For further information about this Agenda, or to inspect any background documents referred to in Part I reports, please contact Gordon Oliver on (01635) 519486
e-mail: gordon.oliver1@westberks.gov.uk

Further information and Minutes are also available on the Council's website at www.westberks.gov.uk.

West Berkshire Health & Wellbeing Board

West Berkshire Council

To: Councillor Alan Macro (Executive Portfolio Holder: Adult Social Care and Health Integration), Sarah Webster (Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board), Councillor Heather Codling (Executive Portfolio Holder: Children, Education and Young People's Services), Councillor Lee Dillon (Leader of Council; Executive Portfolio Holder Strategy, Communications and Public Safety), Councillor Janine Lewis (Portfolio Holder for Public Health, Culture, Leisure, Sport and Countryside), Councillor Joanne Stewart (Shadow Portfolio: Adult Social Care; Integrated Health; Public Health), Councillor David Marsh (Minority Group Spokesperson on Health and Wellbeing), Prof John Ashton (Director of Public Health for Reading and West Berkshire), Bernadine Blease (Berkshire Healthcare Foundation Trust), Paul Coe (Interim Executive Director - People (DASS & DCS)), Matthew Hensby (Sovereign Housing), Jessica Jhundoo Evans (Arts and Leisure Representative), Supt Helen Kenny (Thames Valley Police), Stephen Leonard (Royal Berkshire Fire & Rescue Service), Janet Lippett (Royal Berkshire NHS Foundation Trust), Sean Murphy (Public Protection Manager), April Peberdy (Acting Service Director - Communities and Wellbeing), Garry Poulson (Voluntary Sector Representative), Dr Heike Veldtman (Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board) and Fiona Worby (Healthwatch West Berkshire)

Also to: Adrian Barker (Mental Health Action Group Chairman), Gordon Oliver (Principal Policy Officer- Democratic Services and Scrutiny) and Vicky Phoenix (Principal Policy Officer - Scrutiny)

Agenda

Part I

Page No.

Standard Agenda Items 1

4	**Declarations of Interest** To remind Members of the need to record the existence and nature of any personal, disclosable pecuniary or other registrable interests in items on the agenda, in accordance with the Members' Code of Conduct. The following are considered to be standing declarations applicable to all Health and Wellbeing Board meetings: • Councillor Alan Macro – Governor of Royal Berkshire Hospital NHS Foundation Trust, and West Berkshire Council representative on the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Partnership; and • Councillor Janine Lewis – Governor of Berkshire Healthcare NHS Foundation Trust.	25 - 26
5	**Public Questions** Members of the Health and Wellbeing Board to answer questions submitted by members of the public in accordance with Part 3.2 of the Council's Constitution (Questions Appendix). (Note: There were no questions submitted relating to items not included on this Agenda.)	27 - 28
6	**Petitions** Councillors or Members of the public may present any petition which they have received. These will normally be referred to the appropriate Committee without discussion.	29 - 30
7	**Membership of the Health and Wellbeing Board** To agree any changes to Health and Wellbeing Board membership.	31 - 32

Items for discussion

Strategic Matters

8	**Better Care Fund Plan 2023-25** Purpose: To gain formal sign-off for West Berkshire's Better Care Fund Plan for the period 2023-25.	33 - 98

Operational Matters

Other Information Not for Discussion

16	**Members' Question(s)** Members of the Health and Wellbeing Board to answer questions submitted by Councillors in accordance with Part 3.2 of the Council's Constitution (Questions Appendix). (Note: There were no questions submitted relating to items not included on this Agenda.)	179 - 180

Standard Agenda Items 2

17	**Health and Wellbeing Board Forward Plan** An opportunity for Members of the Health and Wellbeing Board to suggest items to go on to the Forward Plan.	181 - 182
18	**Future meeting dates** 7 December 2023 22 February 2024 2 May 2024 (All meetings to start at 9.30am)	

Sarah Clarke
Service Director: Strategy and Governance

If you require this information in a different format or translation, please contact Stephen Chard on telephone (01635) 519462.

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Health & Wellbeing Board – 3 October 2023

Item 1 – Apologies

Verbal Item

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Note: These Minutes will remain DRAFT until approved at the next meeting of the Committee

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON WEDNESDAY, 28 JUNE 2023

Present: Councillor Alan Macro (Executive Portfolio Holder: Adult Social Care and Health Integration), Sarah Webster (Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board), Councillor Janine Lewis (Portfolio Holder for Public Health, Culture, Leisure, Sport and Countryside), Councillor Joanne Stewart (Shadow Portfolio: Adult Social Care; Integrated Health ; Public Health), Councillor David Marsh (Minority Group Spokesperson on Health and Wellbeing), Paul Coe (Interim Executive Director - People (DASS & DCS)), April Peberdy (Acting Service Director - Communities and Wellbeing) and Garry Poulson (Voluntary Sector Representative)

Members Attending Remotely: John Ashton (Director of Public Health) and Fiona Worby (Healthwatch West Berkshire)

Also Present: Rob Bowen (Acting Director of Strategy and Partnerships), (Gordon Oliver (Principal Policy Officer)

Apologies for inability to attend the meeting: Councillor Heather Codling, Zahid Aziz, Matthew Hensby, Jessica Jhundoo Evans, Stephen Leonard, Janet Lippett, Sean Murphy, Dr Heike Veldtman and Gail Muirhead and Dr Heike Veldtman

Members Absent: Councillor Lee Dillon and Bernadine Blease

PART I

1 Declarations of Interest

There were no declarations of interest received.

2 Membership of the Health and Wellbeing Board

It was noted that membership of the Health and Wellbeing Board was on an organisational basis. A standing item was retained on the agenda to note any changes in personnel. Changes since the last meeting included:

- Appointment of Councillors Alan Macro, Heather Codling, Lee Dillon, Janine Lewis, Jo Stewart and David Marsh to the Health and Wellbeing Board at the annual meeting of Council on 25 May;
- Stephen Leonard had been nominated as a representative of the Royal Berkshire Fire and Rescue Service.

RESOLVED to note the changes.

3 Joint Forward Plan Response

Rob Bowen (Acting Director of Strategy and Partnerships, BOB ICB) presented the Joint Forward Plan (JFP) (Agenda Item 4).

The Board was invited to comment on the JFP or ask questions of the ICB.

A question was asked about whether the views of young people and their parents / carers had been sought to inform the Joint Forward Plan. It was explained that a wide range of stakeholders had been involved. A series of focus groups had been held, which included various voluntary / community sector organisations, and there had been an emphasis on the 'start well' aspects. Although there had not been direct engagement with children and young people so far, the ICB aimed to do this in future. It was stressed that the JFP was an annual plan. All parties had been feeling their way with this first version, and it was recognised that there were things that could be done better for the next version. The ICB indicated that it would welcome ideas, advice and support about how to better engage with children and young people in future.

Paul Coe (Executive Director – People) presented the Board's draft formal response to the JFP.

The Board was invited to comment on the Board's draft response.

It was noted that the response was similar to that of the Reading Health and Wellbeing Board in that the JFP was broadly supported and it was seen as the first stage in a longer journey. It was suggested that integrated action by partners at the 'place' level would be critical to delivery of change, but concern was expressed that the default position would be high level, NHS-based activity. It was stressed that the Health and Wellbeing Board and the Director of Public Health had key roles to play in ensuring integration of activities across all partners, but there were issues about capacity. It was stressed that Berkshire West did not exist as an entity, so the focus needed to be on the contribution of each Council and Health and Wellbeing Board and delivery of the Joint Health and Wellbeing Strategy.

Members praised the honesty that was evident in the JFP, particularly in recognising the shortcomings of available data. It was recognised that there were challenges associated with certainty of future funding levels and that things may need to change as these were confirmed. Workforce issues were also recognised as a key challenge and it was suggested ways needed to be found to make people want to stay in the NHS.

Members felt that the proposed response referenced the key points. However, it was suggested that the Board was too remote in terms of how the Joint Health and Wellbeing Strategy was performing and regular updates were requested, which gave assurance about alignment with the JFP.

It was noted that the voluntary and community sector had interacted with the JFP development process. An alliance had been established between the voluntary sectors across the BOB area and it was felt that the sector had been well-heard, with ample opportunities to input to the JFP.

It was highlighted that the JFP referred to tackling tobacco and alcohol consumption, which were Public Health functions, which suggested that there was a clear need for integrated working.

Councillor Janine Lewis proposed to accept the report's recommendation and agree the proposed response to the JFP. This was seconded by Councillor Jo Stewart. At the vote, the motion was carried.

RESOLVED to agree the contents of Appendix A for inclusion in the final Plan.

(The meeting commenced at 10.01 am and closed at 10.34 am)

CHAIRMAN ……

Date of Signature ……

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Note: These Minutes will remain DRAFT until approved at the next meeting of the Committee

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON THURSDAY, 13 JULY 2023

Members Present: Councillor Alan Macro (Executive Portfolio Holder: Adult Social Care and Health Integration), Councillor Heather Codling (Executive Portfolio Holder: Children, Education and Young People's Services), Councillor Janine Lewis (Portfolio Holder for Public Health, Culture, Leisure, Sport and Countryside), Councillor Vicky Poole (Substitute), Councillor Joanne Stewart (Shadow Portfolio: Adult Social Care; Integrated Health; Public Health), Councillor David Marsh (Minority Group Spokesperson on Health and Wellbeing), Sean Murphy (Public Protection Manager), April Peberdy (Acting Service Director - Communities and Wellbeing) and Dr Heike Veldtman (Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board)

Members Attending Remotely: Prof John Ashton (Director of Public Health), Belinda Seston (Interim Integrated Care Board Director of Berkshire West) and Fiona Worby (Healthwatch West Berkshire)

Also Present: Zoe Campbell (Interim Service Lead - Public Health and Wellbeing), Gordon Oliver (Principal Policy Officer), and Benjamin Ryan (Democratic Services Officer)

Apologies for inability to attend the meeting: Sarah Webster (BOB ICB Director of Place for Berkshire West) (Vice Chairman), Councillor Lee Dillon (Executive Portfolio: Leader of Council, Strategy Communications and Public Safety), Bernadine Blease (Berkshire Healthcare NHS Foundation Trust), Paul Coe (Executive Director - People), Matthew Hensby (Sovereign Housing), Supt Helen Kenny (Thames Valley Police), Stephen Leonard (Royal Berkshire Fire and Rescue Service) and Garry Poulson (Voluntary Sector Representative)

Councillor(s) Absent: Jessica Jhundoo Evans (Culture and Leisure Sector Representative)

PART I

4 Minutes

The Minutes of the meeting held on 20 April 2023 were approved as a true and correct record and signed by the Chairman.

5 Actions arising from previous meeting(s)

Progress on actions from the previous meetings was noted.

6 Declarations of Interest

There were no declarations of interest received.

7 Public Questions

There were no public questions submitted to this meeting.

8 Petitions

There were no petitions presented to the Board.

9 Membership of the Health and Wellbeing Board

It was noted that membership of the Health and Wellbeing Board was on an organisational basis and a standing item was retained on the agenda to note any changes in personnel. Since the last meeting, Helen Kenny had replaced Zahid Aziz as the Thames Valley Police representative.

10 Building Berkshire Together Update

Alison Foster (Programme Director) gave an update on the Building Berkshire Together New Hospital Programme (Agenda Item 8).

Members asked about what public feedback there had been in relation to the preferred location for a new hospital. It was explained that a survey carried out by the University of Reading had shown that most people were in favour of a new hospital built on a new site. The survey had not asked for possible locations, since this would be determined by availability. The survey results would be published on the Building Berkshire Together website. It was noted that access was the biggest issue raised in relation to the new hospital. Lots of work had been done around parking for the existing site, with staff moved off site and a park and ride established.

There was some discussion about whether the sale of the existing site was factored into the business case. It was confirmed that this was factored into the sum that could be raised, but not the costs. It was stressed that there would be a lot of work to make the site ready for sale. The next stage in the business case development process would involve looking at the costs of each option.

Given that redevelopment of the existing site would need to be done on a piecemeal basis, Members asked how long this would take. It was confirmed that the original proposal had been developed on the basis of being ready by 2030, but this would have required work to have started in early 2022. However, this did not take account of the new standardised approach set out in Hospital 2.0, and this would be considered as part of the next stage.

Members noted the commitment to achieve Net Zero Emissions by 2030, which was 10 years ahead of the wider NHS target, and asked if any hospitals had already achieved this. The Trust recognised this was an ambitious target but confirmed that it had been developed with partners, including the University of Reading who were world leaders in this field. While no hospitals had achieved Net Zero, a small health facility in Scotland had done so. A collaboration of universities and industry partners were coming together as part of the national new hospital programme to consider this.

Members asked if funding was just for the hospital construction or if it would include a contribution to equipment. It was confirmed that there would be some provision for equipment, but the amount was not yet known. Some equipment would transfer to the new site and there may be different requirements depending on which option was progressed.

The Board noted that there had been media coverage about potential sites at Thames Valley Park and Thames Valley Science Park, which would be difficult for West Berkshire residents to access. Members asked about the status of these sites. It was explained that the Trust was in the early stages of identifying potential sites. Access was a key criterion in the assessment process. The above properties met many but not all the criteria and the next stage would be to consider public transport and parking issues. While these were currently the two highest scoring sites, it was hoped that other landowners would come forward with alternatives. West Berkshire Council had previously passed a motion that its preferred option would be a new hospital on a site that would be easy for local

residents to access by public transport, but the above sites would not satisfy this criterion.

It was queried whether options had been considered to optimise integrated care across community care, primary care and secondary care rather than defaulting to rebuilding the hospital. It was confirmed that this was being considered as part of the clinical model work. Some services had already been moved to West Berkshire Community Hospital. Discussions were ongoing with primary care colleagues around future models, which were being considered in terms of both capital and ongoing revenue costs. The New Hospital Programme had confirmed that they were encouraging clinical models that improved integration where this delivered best value to the community.

Members asked if the Trust was looking at having a primary care facility associated with the site to relieve pressure on A&E. It was suggested that this could also include occupational health functions. The Trust confirmed that they had not discounted anything at this stage and that the Clinical Services Strategy would consider how the hospital interacted with primary care, the voluntary sector and local authorities.

It was suggested that one option could be to further develop the West Berkshire Community Hospital site and other community hospitals. Again, it was confirmed that no options were off the table and facilities had already been expanded at West Berkshire.

It was agreed that the Board should receive further updates as and when there were new developments to report.

RESOLVED to:

(a) note the report; and
(b) receive further updates as and when there were new developments to report.

11 Berkshire West Place Based Partnership

Belinda Seston presented the item on the Berkshire West Place Based Partnership (Agenda Item 9).

Members had no questions or comments.

RESOLVED to note the report.

12 West Berkshire Better Care Fund Annual Report 2022/23

April Peberdy (Interim Service Director - Communities and Wellbeing) presented the Better Care Fund Annual Report 2022/23 and the Adult Social Care Discharge Fund Annual Report 2022/23 (Agenda Item 10).

In relation to the metric for the percentage of people discharged to their normal place of residence, Members asked if these cases were monitored to ensure that patients were not readmitted to hospital due to being discharged too soon. It was confirmed that the proportion of people who were still at home 91 days after discharge from hospital was a key metric.

Members highlighted the large number of acronyms used in paragraph 4.7 of the report. It was suggested that these should be explained in future reports.

Action: Councillor Jo Stewart to raise the use of acronyms with Maria Shepherd.

It was noted that residential admissions were a concern for the Council, since there was a considerable cost. Clarification was sought as to what was meant by a 'trusted assessor'. It was explained that before patients were discharged from hospital, they were assessed to ensure that care was available to support them at home. It was recognised

that there were challenges around who would fund what aspects of care and it was suggested that further work was required to ensure that funding issues were not affecting discharge decisions.

Action: April Peberdy to liaise with Maria Shepherd and provide further detail on the 'trusted assessor' role and funding to support hospital discharges.

It was stressed that it was important to try to keep people out of hospital in the first place, which would require a whole system approach, with improvements to housing, as well as investment in primary and community care. It was suggested that a patient's discharge plans should be started on the day of their admission, with early consideration given to the suitability of their housing. To facilitate this, it was suggested that a housing sector representative could sit on each hospital board. It was highlighted that social workers were placed within hospitals to facilitate planning for when patients were discharged.

Officers highlighted the success of the 'Be Well This Winter' campaign where a system-wide approach had been adopted to support residents and keep them out of hospital. This included signposting residents to where and when they could get the right care. However, it was stressed that this was only part of the answer and it was suggested that there needed to be strong links between health, housing and planning. Historically, the NHS had been poor at linking to the housing sector, but the Health and Wellbeing Board was well-placed to have these conversations.

Members highlighted that the new Local Plan had a policy for 10% of new homes to be wheelchair accessible, but the Planning Inspector had questioned if there was evidence to support this need.

Although the Lifetimes Homes Standard had been around for some time, it was acknowledged that this was easier to implement in urban areas than in rural areas. It was suggested that local authorities had a role to play in encouraging people to think about their housing needs in the last 20 years of their lives to avoid issues with patients being unable to return home following a hospital admission.

Reassurance was provided that lots of work had been done within Berkshire West to improve planning for discharge from hospitals. However, it was acknowledged that more work was needed in relation to cases where patients were discharged too soon and had to be readmitted. It was stressed that discharge to care homes was a safe option, since patients had 24-hour care, so it should not be viewed negatively.

The Board was challenged to find ways to better celebrate successes, particularly around reablement, since patients had more faith in the system when they saw how others had been helped. It was suggested that the success of the vaccination centre at Newbury Racecourse had been instrumental in encouraging more people to volunteer and lessons could be learned from this.

Reassurance was provided that housing was a high priority for the Council. The Environmental Health Team was doing a lot of work in relation to private sector housing and a housing condition survey was being carried out. Also, the Housing Team offered facilities grants to residents. While there had been an increase in damp and mould over the winter, the Council was seeking to tackle this with private sector landlords.

Action: It was agreed to bring the housing stock condition survey back to a future meeting of the Health and Wellbeing Board.

RESOLVED to note the report.

13 Berkshire West Health and Wellbeing Strategy Delivery Plan Review

Zoe Campbell (Interim Service Lead – Public Health and Wellbeing) presented the report on the Health and Wellbeing Strategy Delivery Plan (Agenda Item 11).

It was requested that the Delivery Plan be provided in Excel format in future, since it was difficult to view in PDF format.

Action: Officers to review the format for the delivery plan for future reports.

Members welcomed that the Health and Wellbeing Board sub-groups were being reviewed. It was noted that the Mental Health Action Group had experienced challenges related to resourcing, responsibility and empowerment. These issues were affecting the sub-group's ability to progress initiatives.

Councillors Lewis and Stewart indicated that she would like to be involved in the review.

Action: Councillors Lewis and Stewart to be involved in the review.

It was noted that charities were keen to be involved in the Mental Health Action Group, but were restricted by resources and funding. They often had valuable data, but it was not possible to act on this data and reports often had to be referred on to other groups. It was suggested that the sub-group needed more senior representation to help progress key initiatives.

It was noted that there had been changes to membership, with some people no longer attending. It was acknowledged that there was a challenge with having so many partners involved. While there was a desire to do things, the frustration at the lack of progress was clear.

Action: The Delivery Plan Task Group to consider potential solutions to the challenges faced by sub-groups.

It was noted that the Ageing Well Task Group was due to meet shortly to consider its future.

Members suggested that the sub-groups should be invited to present to the Health and Wellbeing Board and should be given the opportunity to highlight any barriers to implementation. It was explained that there would be a rolling programme of reports to future Board meetings, which would be themed according to each of the Strategy's priorities. It was suggested that these could be presented by the relevant sub-group chairmen.

Action: Sub-group chairmen to be invited to present to future HWB meetings.

It was noted that the Board used to have 'hot focus' sessions in between formal meetings, which provided an opportunity to focus on the work of a particular sub-group. Also, the annual conference provided an opportunity to showcase the work of the sub-groups.

Action: Officers to look at resuming the 'hot focus' sessions.

It was noted that the early years cohort was no longer represented as a result of recent changes to the sub-groups.

RESOLVED to:

(a) note the report; and
(b) endorse the approach proposed by the Health and Wellbeing Board Steering Group for reviewing the Delivery Plan and reporting progress through the rolling programme of Progress Reports for each of the Strategy's priorities.

14 Delivery Plan Progress Report - Priority 1

Zoe Campbell (Interim Service Lead – Public Health and Wellbeing) presented the Delivery Plan Progress Report for Priority 1 (Agenda Item 12).

Members noted that there had been a large number of actions that had been completed or were now considered 'business as usual'. In particular, several of the closed actions related to Educafé. This was seen as a Newbury focused initiative which some residents may not be able to access, particularly those living in more deprived areas within Calcot and Lambourn without access to a car. Members stressed the need for caution when deleting indicators.

The Board welcomed actions designed to address cardiovascular disease, but highlighted the need to track their impact. Members highlighted the importance of communicating with patients in relation to programme success stories, since this helped to build trust in initiatives. It was suggested that all partners needed to be involved in CCD prevention and in celebrating success stories.

It was noted that work was ongoing in relation to health inequalities. A needs assessment had been completed and the next step was to look at hidden inequalities, through community participation.

Officers stressed that they were looking to improve in terms of demonstrating the impact of initiatives.

In relation to comms, it was suggested that as well as communicating success stories, there was also a need to improve in terms of providing advice and patient signposting. It was proposed that the Health and Wellbeing Board Engagement Group should be re-established to coordinate this.

Members stressed the importance of joint working with the Integrated Care Board and NHS Foundation Trusts on key messages.

The Board recognised the importance of ensuring that messages were relevant to all communities within West Berkshire. It was suggested that villages could have wellbeing hubs where good news stories could be shared.

Members stressed the importance of using the right language in health messages and finding the appropriate trigger words and motivators to drive desired behaviours amongst residents.

It was felt that community wellbeing hubs could build on the success of the Health on the Move Van and the 'Be Well This Winter' outreach programme. It was suggested that hubs should not just signpost people to services such as health checks, but rather they should offer those services.

Officers confirmed that they were looking at existing assets such as libraries, leisure centres, Shaw House, and the museum to see how health could be integrated into people's visits. It was noted that some parish councils were opening their buildings for warm hubs and over-50s clubs. Village and church halls, schools, community centres and pubs could all potentially be used as hubs. It was suggested that they could also help improve residents' mental health by reducing isolation.

It was noted that other local authorities had strategies for villages / parish council areas and this could be a way of addressing the Newbury focus of local activities. This could be progressed alongside other initiatives such as family hubs and women's hubs. It was suggested that this could be discussed at the District Parish Conference to understand what initiatives were already underway and what appetite there was to explore the wellbeing hub concept amongst parish councils.

Action: Raise the wellbeing hub concept with the District Parish Conference organisers as a potential agenda item for the next meeting.

RESOLVED to:

(a) note the report and the progress made to date;
(b) agree the proposed actions;
(c) agree the actions to be referred upwards to the 'Place' or 'System' levels; and
(d) commit their respective organisations to delivering the agreed actions.

15 Local Response to Cost of Living Increases

Sean Murphy (Public Protection Manager) presented the report on the Local Response to the Cost of Living Increases (Agenda Item 13).

Members noted the positive messages related to the Council's response and the observations of service users and asked if these were being used in communications with residents. It was stressed that that the response had involved a wide range of partners and not just the Council. The Working Group had felt that there was a clear need to build on the success of the Cost of Living Hub.

Clarification was sought in relation to the figures and percentages quoted in sections 4.12 and 5.2 of the report. It was confirmed that the percentages quoted in 5.2 related to the survey responses, while figures quoted in 4.12 related to the number of referrals to the service.

Members asked if work had been done to learn where customers had found out about the Hub. There was surprise at the low levels of referral from the Citizens Advice Bureau and the Board wondered if this needed to be promoted more.

The importance of Making Every Contact Count was recognised, particularly since experience with the Cost of Living Hub had shown that often the first thing that customers raised was often not the main issue.

The Board had been impressed by how quickly the Cost of Living Hub had been set up, which had built on the success of the Covid Hub. It was recognised that conversations held through the Hubs had built up trust and momentum.

It was noted that a foodbank located in a school in a prosperous part of Newbury was well-used by parents. Members expressed anger that such measures were necessary in such an affluent country.

A question was asked about whether the Household Support Fund was fully utilised. Members noted that many of the claims were for small amounts. It was confirmed that most of the funding had been spent. This was the first time that the funding had been paid for a full year – previous allocations had been for six months. The fund had not launched until 23 June and there had been a flurry of applications at the start. It was thought that additional applications would have been made since the report had been written. There had been allocations for free school meal vouchers during the holiday period.

It was highlighted that in other local authorities, the Household Support Fund had been managed by the Director of Public Health. The current round of funding gave more discretion as to how it could be used. The Board felt that it would be useful to know more about how people were being supported, who was being supported and what the funding was being spent on. It was proposed that further information could be provided as part of future reports to the Board.

Concern was expressed about the fact that the Food Bank and Newbury Soup Kitchen were struggling due to losing volunteers and falling donations. Also, the Soup Kitchen had reported additional problems with customers who were struggling with addictions. Support was expressed for a further meeting with statutory and voluntary sector partners to agree a way forward for providing ongoing support for residents who were struggling to cope with the rising cost of living.

The Board praised the work of officers in setting up and running the Cost of Living Hub and asked that their thanks be passed on to those involved.

Members highlighted additional pressures facing many families due to rising mortgage and rent payments.

RESOLVED to:

(a) note the report and the response of partners to date;
(b) agree that the Public Protection Manager should arrange a meeting of statutory and voluntary sector partners and other interested partners to consider options and agree a way forward for providing ongoing support to residents who are struggling to cope with the rising cost of living; and
(c) receive further updates on the impacts of the cost of living on local residents at each of the remaining meetings for the 2023/24 municipal year.

16 Changes to Pharmaceutical Services

April Peberdy (Interim Service Director – Communities and Wellbeing) presented the report on Changes to Pharmaceutical Services (Agenda Item 14).

It was noted that some of the notifications appeared to be retrospective. It was explained that these pre-dated the formal arrangements for considering changes to pharmaceutical services that were adopted in April 2023. It was noted that there had been an apology in the email where local authorities had not been informed of the changes in advance.

Members highlighted a recent news story about Boots closing some of its pharmacies and asked if any sites in West Berkshire would be affected. It was confirmed that no such notifications had been received yet.

It was suggested that the Board should keep track of the cumulative impacts of changes to local pharmaceutical services.

RESOLVED to:

(a) note the planned and recent changes to pharmaceutical services in West Berkshire;
(b) note that the changes have been assessed as having a minimal impact on provision of pharmaceutical services, and agree that there is no requirement to update the Pharmaceutical Needs Assessment or publish a supplementary statement.

17 Buckinghamshire, Oxfordshire and Berkshire West ICB Annual Report

The Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board Annual Report 2022/23 (Agenda Item 15) was provided for information only and was not discussed at the meeting.

RESOLVED to note the report.

18 Members' Question(s)

There were no questions submitted to the meeting.

19 Health and Wellbeing Board Forward Plan

The Health and Wellbeing Board Forward Plan (Agenda Item 17) was reviewed and the following changes were agreed:

- Cost of Living Update to be added to the agenda for each of the next four meetings.
- Housing Conditions Survey to be added to the December meeting agenda.
- Community Hubs Strategy to be added to a future meeting agenda (TBC).

20 Future Meeting Dates

The dates of the future meetings were noted.

(The meeting commenced at 9.30 am and closed at 11.33 am)

CHAIRMAN …….

Date of Signature …….

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Actions arising from Previous Meetings of the Health and Wellbeing Board

Ref	Meeting	Agenda item	Action	Action Lead	Agency	Status	Comment
153	24/09/2020	Health and Wellbeing Board Meetings	Seek another peer review of Health and Wellbeing Board.	April Peberdy	WBC	**In progress**	It has been agreed that this will be deferred until the Place Based Partnership is operational - a start date of spring 2024 is proposed.
197	19/05/2022	Berkshire West PBP Transformation Programme	Have a discussion with the Unified Executive about how they could be more agile and report back	Belinda Seston / Sarah Webster	ICB	**In progress**	Discussions are ongoing in relation to development of the Place Based Partnership. An update was given to the HWB meeting on 17 July 2023. A further update to the HWB is scheduled in Q3.
218	23/02/2023	Healthwatch Report - Asylum Seekers	Officers to look at the report's recommendations in the context of their statutory functions to see what improvements could be made.	Sean Murphy / Nick Caprara	WBC	**In progress**	A WBC asylum meeting took place on 30 March which Housing, Education, Health, Public Protection, Transport reps all attended. The Head of Hotel Mobilisation from Clearsprings attended this meeting to discuss the key findings of the Healthwatch report.
220	23/02/2023	Financial Problems and Mental Health	Incorporate fraud prevention within the report's recommendations.	Adrian Barker	MHAG	**In progress**	The report is being updated and will be presented to the Health and Wellbeing Board in October 2023.
221	23/02/2023	Financial Problems and Mental Health	Consider how the Better Care Fund could be used to support initiatives to tackle financial problems and mental health.	Maria Shepherd / Adrian Barker	WBC / MCAG	**In progress**	Adrian Barker invited to the LIB to discuss further. However, it has not been possible to find a mutually convenient date.
222	23/02/2023	Health and Wellbeing Strategy Delivery Plan - Progress Report Q3 2022/23	Officers to ensure that more detailed updates are provided for Delivery Plan actions.	April Peberdy / Gordon Oliver	WBC	**Complete (13/07/23)**	A Task Group has been set up to review the Delivery Plan and the reporting mechanisms. The Delivery Plan will be imported to InPhase project management software, which will provide a more user-friendly dashboard. However, there have been signficant delays and it is not known when this work will be completed. As an alternative, a rolling programme of reports will provide updates on individual JLHWS priorities - the first report was presented to the Board on 13 July 2023. It is also proposed to have 'hot focus' sessions for HWB Members between public meetings.
233	13/07/2023	West Berkshire Better Care Fund Annual Report 2022/23	Highlight the use of acronyms with Maria Shepherd.	Cllr Jo Stewart	WBC	**Complete (02/08/23)**	This will be addressed in future reports.
234	13/07/2023	West Berkshire Better Care Fund Annual Report 2022/23	April Peberdy to liaise with Maria Shepherd and provide further detail on the 'trusted assessor' role and funding to support hospital discharges.	April Peberdy	WBC	**Complete (21/08/23)**	This refers to the fact that the Council is trusting partners at the Royal Berkshire Hospital to make assessments.
235	13/07/2023	BerkshireWest Health and Wellbeing Strategy Delivery Plan Review	Officers to review the format for the delivery plan for future reports.	Gordon Oliver	WBC	**Complete (02/08/23)**	The software used for meeting papers can only produce documents in PDF format. However, the original Excel files can be provided to HWB members upon request.
236	13/07/2023	Berkshire West Health and Wellbeing Strategy Delivery Plan Review	Councillors Lewis and Stewart to be involved in the review of the sub-groups	Gordon Oliver	WBC	**Complete (03/08/23)**	Email exchange to confirm the process being followed and the improvements being put in place. Cllr Lewis made some suggestions for improving sub-group linkages with the Health and Wellbeing Board.
237	13/07/2023	Berkshire West Health and Wellbeing Strategy Delivery Plan Review	Delivery Plan Task Group to consider potential solutions to the challenges faced by sub-groups.	Gordon Oliver	WBC	**Complete (20/07/2023)**	Actions are being owned by individual sub-group members and are being escalated as required. A number of the sub-groups are reviewing their focus / terms of reference and are using this to re-engage with key partners.
238	13/07/2023	Berkshire West Health and Wellbeing Strategy Delivery Plan Review	Sub-group chairmen to be invited to present Priority Reports to future HWB meetings.	Gordon Oliver	WBC	**Complete (20/07/2023)**	This has been agreed.
239	13/07/2023	Berkshire West Health and Wellbeing Strategy Delivery Plan Review	Officers to look at resuming the 'hot focus' sessions.	Gordon Oliver	WBC	**In Progress**	A series of 'hot focus' session will be organised to allow HWB members to engage with the work of individual sub-groups. The first session will be to look at the work of the Children's Early Help and Prevention Partnership (date TBC).
240	13/07/2023	Delivery Plan Progress Report- Priority 1	Raise the wellbeing hub concept with the District Parish Conference organisers as a potential agenda item for the next meeting	Gordon Oliver	WBC	**Complete (01/08/2023)**	Raised with Building Communities Partnership as a possible agenda item for the autumn 2023 District Parish Conference.

Updated: 04/09/2023

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Health & Wellbeing Board – 3 October 2023

Item 4 – Declarations of Interest

Verbal Item

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Health & Wellbeing Board – 3 October 2023

Item 5 – Public Questions

Verbal Item

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Health & Wellbeing Board – 3 October 2023

Item 6 – Petitions

Verbal Item

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MEMBERSHIP OF HEALTH AND WELLBEING BOARD

Name	Role/Organisation	Substitute
Cllr Lee Dillon	WBC Leader of the Council	Cllr Vicky Poole
Cllr Alan Macro (Chairman)	WBC Portfolio Holder for Adult Social Care and Health Integration	
Cllr Janine Lewis	WBC Portfolio Holder for Public Health, Culture, Leisure, Sport and Countryside	
Cllr Heather Codling	WBC Portfolio Holder for Children, Education and Young People's Services	
Cllr Jo Stewart	WBC Conservative Group Spokesperson for Health and Wellbeing	Cllr Dominic Boeck
Cllr David Marsh	WBC Green Group Spokesperson for Health and Wellbeing	Cllr Carolyne Culver
Paul Coe *	WBC Executive Director - Adult Social Care	Maria Shepherd
AnnMarie Dodds *	WBC Executive Director – Children and Family Services	Dave Wraight
April Peberdy	Interim WBC Service Director – Communities and Wellbeing	Zoe Campbell
Sean Murphy	WBC Public Protection Manager, Public Protection Partnership	
Prof John Ashton	Director of Public Health for West Berkshire and Reading	
Jessica Jhundoo-Evans	Arts & Leisure Representative	Katy Griffiths
Bernadine Blease	Berkshire Healthcare Foundation Trust	Helen Williamson
Sarah Webster (Vice Chairman)	**Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board (1)**	Belinda Seston Helen Clark
Dr Heike Veldtman	Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board (2)	
Fiona Worby	Healthwatch West Berkshire	Mike Fereday
Stephen Leonard	Royal Berkshire Fire and Rescue Service	Gail Muirhead Paul Thomas
Dr Janet Lippett	Royal Berkshire NHS Foundation Trust	William Orr Andrew Statham
Matthew Hensby	Sovereign Housing	Kate Rees
Supt. Helen Kenny	Thames Valley Police	Emily Evans
Garry Poulson	Voluntary Sector Representative	Rachel Peters

* AnnMarie Dodds will start as WBC Executive Director – Children and Family Services on 16 October 2023. Paul Coe will remain as Interim Director – People (DASS and DCS) until that date when he will assume his new role as Executive Director – Adult Social Care.

Better Care Fund Plan 2023-2025

Report being considered by:	Health and Wellbeing Board
On:	3 October 2023
Report Author:	Maria Shepherd, Integration Lead
Report Sponsor:	Councillor Alan Macro
Item for:	Decision

1. Purpose of the Report

The purpose of this report is to gain formal sign-off for West Berkshire's Better Care Fund Plan 2023-2025. The plan consists of a narrative plan and planning template.

2. Recommendation(s)

To approve the Better Care Fund Plan for 2023-2025.

3. Executive Summary

3.1 The Better Care Fund Policy Framework for 2023-25 provides continuity from the previous rounds of the programme and is a two year plan.

3.2 The Policy Framework was published on 5th April 2023.

3.3 The Policy Framework sets out four national conditions:

(1) A jointly agreed plan between local health and social care commissioners and signed off by the Health and Wellbeing Board.

(2) Maintaining the NHS's contribution to ASC and investment in NHS commissioned out of hospital services.

(3) Implementing the **two** BCF objectives of: Providing the right care, at the right place, at the right time and Enabling people to stay well, safe and independent at home for longer.

3.4 The Policy Framework also sets out five national metrics:

(1) Avoidable admissions - indirectly standardised rate of admissions per 100,000 population

(2) Falls – Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000. (This metric is new for 2023-25)

(3) Discharge to usual place of residence – percentage of people, resident in HWB, who are discharged from acute hospital to their normal place of resident.

(4) Residential Admissions – long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population.

(5) Reablement – proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/rehabilitation service.

3.5 The BCF planning requirements for 2023-25 required a narrative plan and a planning template to be submitted to NHS England. The planning template details the schemes funded by the BCF, targets for the five metrics, expected monthly demand and capacity for hospital discharge by pathway and expected monthly demand and capacity for intermediate care services from community resources.

3.6 BCF plans will be approved by NHS England following a joint NHS and Local Government assurance process at regional level.

3.7 The South East region advised us on 10th August 2023 that they were pleased to recommend our HWB BCF Plan for approval. The plan has subsequently been approved by NHS England.

3.8 West Berkshire's BCF Plan was submitted from the Health and Wellbeing Board on 28th June 2023 and delegated Authority was granted by the Chairman for this to happen prior to formal sign-off from the Board.

3.9 The National timetable suggests that section 75 agreements should be signed and in place by 31st October 2023.

4. Supporting Information

The formal governance for the Better Care Fund plan sits within the Locality Integration Board, a sub-group of the Health and Wellbeing Board.

5. Options Considered

None.

6. Proposal(s)

To approve the Better Care Fund Plan as presented.

7. Conclusion(s)

One of the conditions set out within the Policy Framework is to have a jointly agreed plan between local health and social care commissioners that is signed off by the Health and Wellbeing Board.

8. Consultation and Engagement

Councillor Alan Macro, Health and Wellbeing Board Chairman; Steve McManus, Integrated Care Board Chief Executive; Sarah Webster, ICB; Nigel Lynn, Chief Executive; Paul Coe, LA Director of Adult Social Care; Joseph Holmes, LA Section 151 Officer; Adult Social Care Housing and DFG Leads; Public Health; Buckinghamshire, Oxfordshire and Berkshire Integrated Care Board; Berkshire West

Urgent Emergency Care Board; Primary Care Networks; Berkshire Healthcare Foundation Trust; Royal Berkshire NHS Foundation Trust; South Central Ambulance Service NHS Foundation Trust; Representatives from Voluntary Sector; West Berkshire Healthwatch; Community Pharmacy; and Locality Integration Board.

9. Appendices

Appendix A – BCF Narrative Plan

Appendix B – BCF Planning Template

Background Papers:

None

Health and Wellbeing Priorities Supported:

The proposals will support the following Health and Wellbeing Strategy priorities:

☐ Reduce the differences in health between different groups of people
☒ Support individuals at high risk of bad health outcomes to live healthy lives
☐ Help families and young children in early years
☐ Promote good mental health and wellbeing for all children and young people
☒ Promote good mental health and wellbeing for all adults

The proposals contained in this report will support the above Health and Wellbeing Strategy priorities by driving health and social care integration, using pooled budgets.

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Better Care Fund Plan for 2023-2025

West Berkshire Health and Wellbeing Board

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

How have you gone about involving these stakeholders?

West Berkshire's BCF plan was developed with contributions and agreement from the following partners: -

- West Berkshire Council (Adult Social Care, Housing and DFG Leads, Public Health and elected Councillors)
- Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB)
- Urgent Emergency Care Board
- A34 Primary Care Network
- Kennet Primary Care Network
- West Berkshire Rural Primary Care Network
- West Reading Villages Primary Care Network
- Berkshire Healthcare Foundation Trust (BHFT)
- Royal Berkshire NHS Foundation Trust (RBFT)
- South Central Ambulance Service NHS Foundation Trust
- Representatives from the Voluntary Sector
- West Berkshire Healthwatch
- Community Pharmacy
- Social Care Providers through Commissioning and Market Management Lead

West Berkshire's BCF plan has been developed as a progression of previous plans and national guidance. Our programme supports the Berkshire West Health and Wellbeing Strategy, Integrated Care System's Joint Forward Plan and Urgent and Emergency Care Strategy (UEC).

Our system partners are updated on BCF performance and the BCF finances through a monthly highlight report, which is presented to the Locality Integration Board. We also provide monthly verbal updates to both the HWB (via HWB Steering Group) and UEC programme board on key developments and spending within the BCF.

Governance

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

The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care **System** (BOB ICS) takes strategic decisions at scale for the benefits of its 1.8 million population.

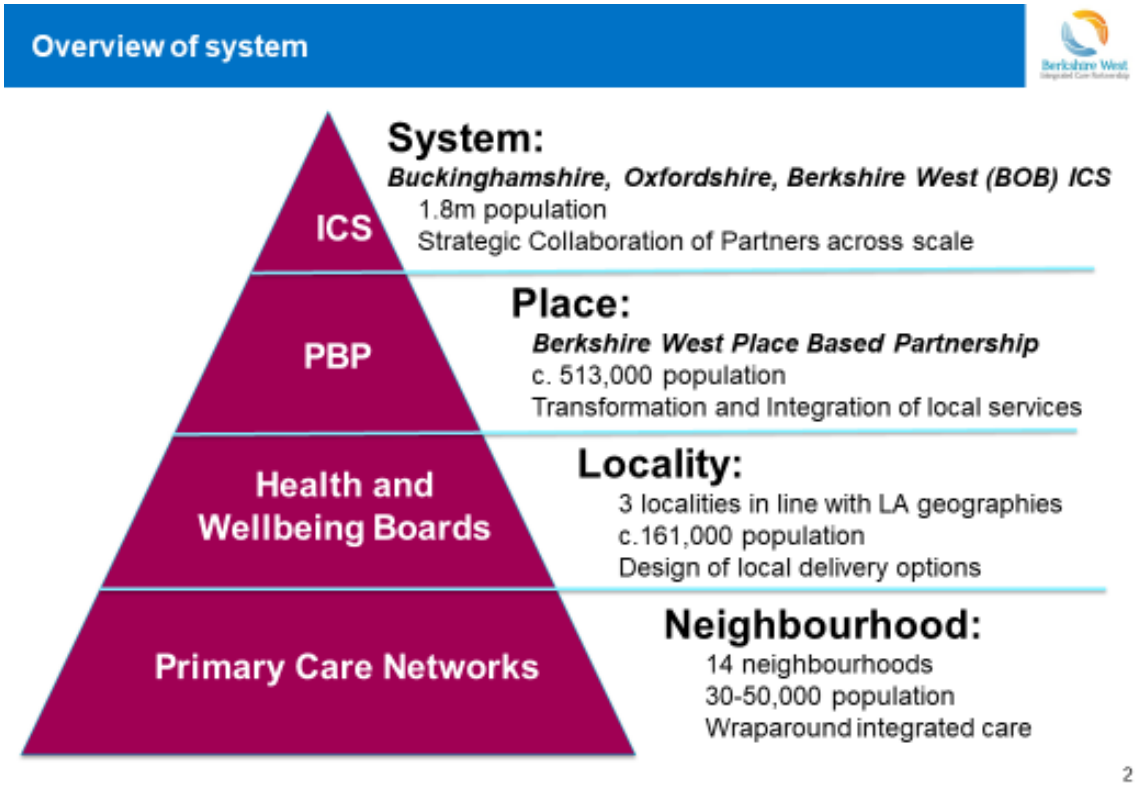
The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board was formally established on 1 July 2022.

The Berkshire West Place Based Partnership (PBP) brings together NHS foundation trusts, ambulance service and Local Authorities which serve the 513,000 residents of Reading, West Berkshire and Wokingham. The partnership works on a **place** basis to transform and integrate local services so patients receive the best possible care.

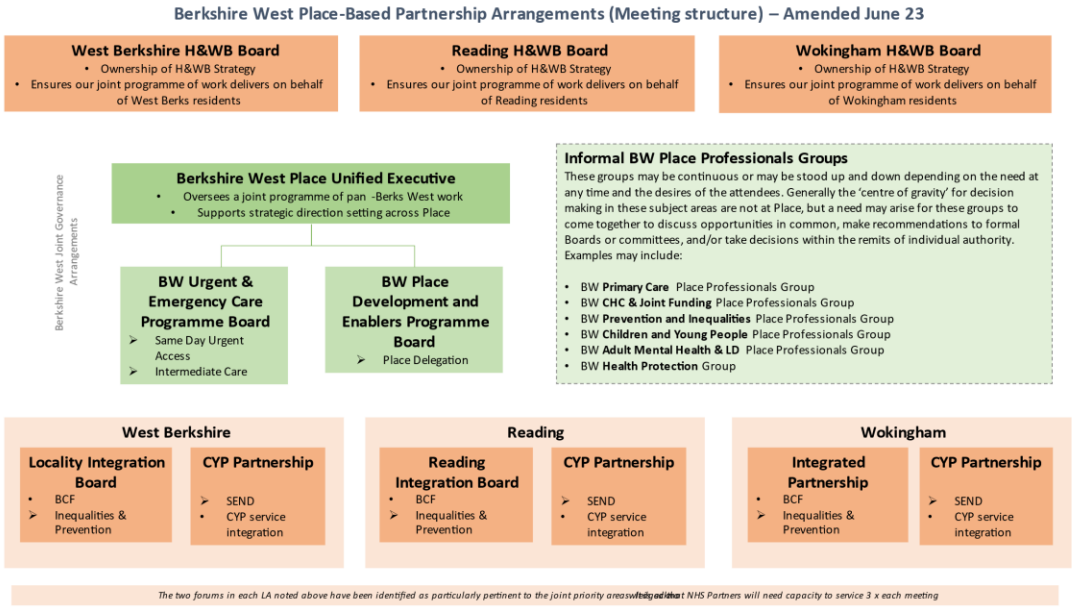
While the ICS and PBP are committed to strong joint working at place level, they recognise that there remains a need to design local delivery options to meet their strategic objectives.

The West Berkshire **Locality** Integration Board fulfils this function for the circa 161,000 residents of West Berkshire.

Primary Care Networks are clusters of GP practices who serve **neighbourhoods** of up to 50,000 patients. Community services will wraparound these emerging networks to deliver care closer to patients.



West Berkshire's Locality Integration Board is a sub-group of the West Berkshire Health and Wellbeing board. Its main responsibility is overseeing the Better Care Fund Plan and implementing a programme of work to develop integrated Health and Social Care Services for West Berkshire at a locality and neighbourhood level. The Locality Integration Board also provides regular updates to the PBP and UEC programme board.



Executive Summary

This should include:

- Priorities for 2023-2025
- key changes since previous BCF plan

West Berkshire's BCF plan for 2023-25 builds on previous plans, National Guidance and a review of our priorities across the Berkshire West Place Based Partnership and Urgency and Emergency Care Board.

Two priorities from our previous BCF plan will remain in 2023-25: -

- **Targeted Community NHS Health Check Outreach Programme** – This project was delayed due to recruitment issues but will now start in 2023/24. It aligns with the Core20plus5 approach outlined by NHS England to support the reduction of health inequalities. We are supporting a two year project to design, implement and evaluate a targeted NHS Health-Check service in West Berkshire using specialist community engagement to reduce hospital admissions & health inequalities related to CVD and COVID-19 for disproportionately impacted and under-represented groups. This service will be supplementary to the universal NHS Health Check service offered by local GPs.

- **Joy Platform**– The funding for this project was agreed at the end of December 2022 but there was a 6-8 week mobilisation period. It will support the Primary Care Networks with the role out of the JOY Social Prescribing Platform across several GP practices. We agreed to pilot this for 12 months. In West Berkshire Social Prescribers and Care Co-ordinators are based in GP surgeries; an integral part of surgery MDT's but also a crucial interface with social are, the voluntary sector and the wider community who work in partnership to help reduce health inequalities. The JOY platform supports all daily client related activities from case notes to referrals and enables health and social care professionals to link clients to local services

During 22/23, the BCF also funded the following schemes: -

- **Infection Control Service** – this scheme was delivered by a team of infection control nurses from the BOB ICS. It offered visits, support and training to Care Homes across West Berkshire to enable them to manage covid during the winter period and avoid hospital admissions.

- **Be Well this Winter** – this scheme enhanced the Berkshire West Winter communication plan. It targeted support and messages to the local communities in West Berkshire during December 2022 – March 2023. There was a particular focus on: self-care, cost of living, falls, staying warm and vaccinations. This service was delivered through a highly targeted outreach service to residents at higher risk of poor health outcomes through support and engagement, Health on the Move Bus, information and signposting and supporting all partners in getting messages out to the community. This scheme was one of our success stories in 2022/23.

- **Reducing inequalities –** this project was set up to support PCN's to improve take-up of LD and SMI health checks. A closure report is scheduled to be shared with Locality Integration Board in June 2023.

In 2023-25 we have an ambition of looking at the following priorities: -

- **Workforce** - recruitment and retention of Social Workers and Occupational Therapists to support both BCF policy objectives.

- **Falls Pathway** – a) identify any gaps in the falls pathway in order to support the new BCF metric on falls and help avoid hospital admissions and b) receive updates from our partners within the BOB ICB to learn from the pilots taking place within Care Homes of the use of falls prevention and detection technologies and potentially submit an expression of interest to the DHSC for funding to support a pilot within West Berkshire c) continue to deliver our steady steps prevention classes and d) look at opportunities to raise awareness about falls prevention and encourage partners to do the RoSPA and RSA fall fighter training so they can onward share the information with groups/staff they work with.

- **Self-Care Programmes** - initiate a number of self-care programmes across the system to help reduce non-elective admissions.

- **Trust Intelligence Notification Assistance (TINA)** – investigate the options of access to the Trust's system for local authority personnel in order to help speed up hospital discharge and avoid unnecessary meetings across the system.

- **Reduce the number of people coming out of hospital on pathway 3** – review how and when decisions are made and the impact this is having on capacity within the care market.

- **Deep dive into data** relating to Avoidance Admissions and Discharge to normal place of residence.

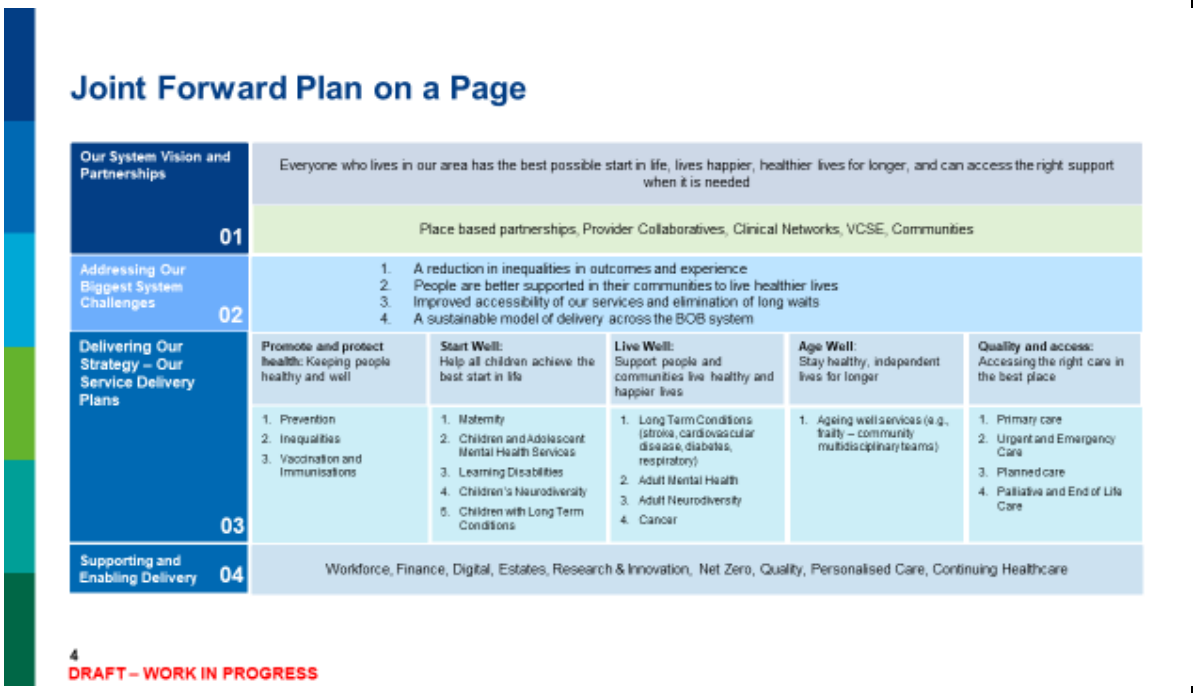
We remain committed to delivering against the national metrics as well as supporting both the Health and Wellbeing Board, the Integrated Care Partnership and the BOB ICB to deliver its priorities through a number of local and national initiatives through the PBP flagship priority programme boards, urgent and emergency care and long term conditions.

National Condition 1: Overall BCF Plan and approach to integration

Please outline of 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.

The BOB Integrated Care Board was formally established on 1 July 2022 and our Joint Forward Plan (JFP) describes how we intend to deliver the ambition of the BOB ICS Strategy. It also sets out how we will deliver national NHS commitments and recommendations, including the requirements of the 2023/23 operational plans.



Joint Forward Plan on a Page

Our System Vision and Partnerships 01	Everyone who lives in our area has the best possible start in life, lives happier, healthier lives for longer, and can access the right support when it is needed				
	Place based partnerships, Provider Collaboratives, Clinical Networks, VCSE, Communities				
Addressing Our Biggest System Challenges 02	1. A reduction in inequalities in outcomes and experience 2. People are better supported in their communities to live healthier lives 3. Improved accessibility of our services and elimination of long waits 4. A sustainable model of delivery across the BOB system				
Delivering Our Strategy – Our Service Delivery Plans 03	**Promote and protect health:** Keeping people healthy and well	**Start Well:** Help all children achieve the best start in life	**Live Well:** Support people and communities live healthy and happier lives	**Age Well:** Stay healthy, independent lives for longer	**Quality and access:** Accessing the right care in the best place
	1. Prevention 2. Inequalities 3. Vaccination and Immunisations	1. Maternity 2. Children and Adolescent Mental Health Services 3. Learning Disabilities 4. Children's Neurodiversity 5. Children with Long Term Conditions	1. Long Term Conditions (stroke, cardiovascular disease, diabetes, respiratory) 2. Adult Mental Health 3. Adult Neurodiversity 4. Cancer	1. Ageing well services (e.g., frailty – community multidisciplinary teams)	1. Primary care 2. Urgent and Emergency Care 3. Planned care 4. Palliative and End of Life Care
Supporting and Enabling Delivery 04	Workforce, Finance, Digital, Estates, Research & Innovation, Net Zero, Quality, Personalised Care, Continuing Healthcare				

4

DRAFT – WORK IN PROGRESS

The Hewitt Review : an independent review of Integrated Care Systems built on a great deal of prior work including the messenger review, the fuller stocktake of primary care, Sir Chris Ham's report on ICS's, the integration white paper and so on. The Berkshire West Place Based Partnership and the Berkshire West Unified Executive started work in January 2023 to develop our operating model, governance and joint priorities.

The Place Based Partnership priorities are: -

1. **Same Day Access** - Fuller Stocktake Report (2022) focuses on 3 key aims: On the day demand, continuity and complex team, and reducing health inequalities. The opportunity is to develop a new model for delivering urgent care for high volume, lower acuity conditions, by segmentation (based on John Hopkins approach, pre-assessment of risk levels). Patients who identify as green risk could be dealt with in a digitally enabled service, with a largely virtual hub and service points across Berkshire West. Red and amber risk patients to be dealt with in general practice,

plus overflow into hubs. Hubs are required to manage surge, especially during winter months. Linked to this, there may be opportunities to address the level of demand for same day access through education and engagement. Simultaneously, the creation of the Primary Care Clinical Services Strategy for Berkshire West, will describe what General Practice and Primary Care will need to deliver and look like over the next 5-10 years. This approach will join up general practice with other systems across the BOB footprint.

2. **Intermediate Care Review** - Undertake a review of the provision for patients on an intermediate care pathways in each locality and explore opportunities to reduce the variation in delivery models to provide improved resilience and value for money.

3. **Reducing Preventable Premature Deaths** - Targeted health and wellbeing outreach initiatives in community venues, as a collaborative between PCNs, Public Health, Community and Secondary Care, and the VCSE. Developing a sustainable solution supported by excellent data and intelligence.

4. **CHC/Joint Funding** – Develop a transformation programme to establish ICB structure for CHC, BOB wide policies and take advantage of market leverage. Develop a Frimley share care policy to be used as a framework for BOB joint funding policy at place. Improve relationships between health and LA's.

5. **Special Educational Needs and Disability (SEND)** - Increase prevention interventions to support child and parents prior to EHCP being needed.

6. **High Complex, high cost placements** - There may be opportunities to develop consortia arrangements for the purchasing of placements. There is already a BOB Children and Young People programme around this issue. Oxfordshire County Council is leading on this and there is engagement from all the local authorities to see if they can commission placement together for these cohorts. A similar approach might be possible for adults.

7. **Mental Health, Children & Young People** - 24/7 crisis and home treatment teams, further investment/ upskilling of MH support teams in schools, improve transitions to adult services, de-medicalise our approaches and emphasis prevention and community based support and intervention and PHM/ health inequalities approach to identify whether children from certain backgrounds are more likely to have undiagnosed MH conditions.

8. **Reducing infant mortality** - Support is offered to women to ensure a healthy pregnancy with targeted actions focused on women from deprived communities and from minority ethnic groups who have historically experienced more problems during pregnancy and poorer outcomes, support women experiencing mental health difficulties during pregnancy and after their baby is born and improve the help we offer to pregnant women and their partners to stop smoking. Opportunities currently being actioned and led at BOB level include: personalised risk profiles to capture socio-economic determinants of health for each maternity patient, improve availability of translation services, reduce digital exclusion and improve accessibility standard of information, enhance asset based community development – accelerate programme of maternity advocates, review zero-day admissions of infants and children with a view to improve parental health literacy and strengthen out-of-hospital services for managing demand and set up a Women and birthing people seeking sanctuary clinic.

The Berkshire West Health and Wellbeing Strategy for 2021-2030 consists of five priorities: -

1. Reduce the differences in health between different groups of people
2. Support individuals at high risk of bad health outcomes to live healthy lives
3. Help Children and Families in early years
4. Promote good mental health and wellbeing for all children and young people
5. Promote good mental health and wellbeing for all adults

The strategy has eight principles: -

1. **Recovery from Covid-19** – The Covid-19 pandemic has presented unprecedented challenge to Berkshire West's Health and Care services and the way residents live their lives on a daily basis. As we move towards a recovery phase, we now have an opportunity to "build back fairer", taking account of the widening health inequalities that have been highlighted by Covid-19 and working together to ensure that equality is at the heart of local decision making to create healthier lives for all.

2. **Engagement** – Public engagement has been at the core of the development of this Strategy and will be essential to how it is delivered. We will work towards creating more permanent engagement structures and processes to ensure residents' voices are heard as we roll out this plan over the next ten years. This may include the creation of citizen panels, specialist groups and committed champions in our communities who can lead with both their specialist knowledge and local commitment.

3. **Prevention and early intervention** – prevention and early intervention are key to reducing long term poor health and wellbeing. By shifting our approach away from treating ill health to preventing it from happening in the first place, we can contribute significantly to reducing physical and mental ill health.

4. **Empowerment and self-care** – we want to support our local people to become more actively involved in their own care and to feel empowered and informed enough to make decision about their own lives, helping them to be happy, healthy and to achieve their potential in the process.

5. **Digital enablement** – The Covid-19 pandemic has led to many opportunities in digital transformation for health, social care, both at work and at home. But for those who are unable to participate in online services, it has resulted in greater social isolation and exclusion. We want to embrace the opportunities that digital enablement presents; improving digital literacy and access across the whole of Berkshire West whilst at the same time ensuring services and support are available for those who prefer not to or who are unable to access information digitally.

6. **Social cohesion** – The diversity of our areas is an asset that we will aim to develop and leverage going forwards. There is already a wealth of community activity taking place across each region and we will work collaboratively with community members, service providers and statutory bodies to help eliminate community specific health inequalities.

7. **Integration** – Whole system integrated care is about ensuring every person in Berkshire West can have their needs placed at the centre – this is done through joining up the range of health, social care services and relevant community partners. The aim is to increase access to quality and timely care, supporting

people to be more independent in managing their conditions and becoming less likely to require emergency care. To achieve this, we also need to build on existing relationships in the broader BOB ICS, linking policies, strategies and programmes with those at the ICP, Local Authority and Neighbourhood levels.

8. **Continuous learning** – the actions that will be delivered through this strategy will be reviewed and adapted in a timely manner as the world around us changes. We need to accumulate experience, share best practices and learn from one another.

The Strategy is accompanied by a local delivery plan for each of the three Local Authority areas. The delivery plan for West Berkshire is currently being reviewed/refreshed by all of the sub-groups that report into the HWB (May 2023). The Locality Integration Board will own a number of these actions, once formally agreed the actions will be shared with the board and they will provide a quarterly updated to HWB.

The Berkshire West Urgent and Emergency Care Board has developed a programme of work for 2023-24. The Strategy has 4 key objectives: -

1. **To be confident that prevention strategies are in place which address health inequalities and support people to stay well and keep healthy**.

   The work streams identified across the system that support this objective are: Anticipatory Care and Review of Intermediate Care Services.

2. **To have in place admission avoidance services that support people with an urgent need to be cared for in their own home.**

   The work streams identified across the system to support this objective are: Ageing Well Programme and SDEC and virtual Wards.

3. **Re-design of same day urgent care capacity ensuring optimum model/s in place to respond to all urgent on the day minor illness/injury demand.**

   The work streams identified across the system to support this objective are: Resilient Primary Care and Health and Social Care hubs.

4. **Patient flow is maximised through Acute and Community Hospitals 7 days a week and hospital lengths of stay are reduced**.

   The work streams identified across the system to support this objectives are: Flow and Discharge, Community Bed Provision and Sustainable Care Market.

The BOB ICB and the 3 Local Authorities in Berkshire West jointly commission a number of services through the BCF to support avoidable admissions and hospital discharge. These services include: -

- **BHFT Reablement Contract** – provides Reablement and rehabilitation services across West Berkshire to support both Hospital Discharge and avoidable admissions.

- **Carers Information & Advice Service** – The contract is jointly commissioned with the Berkshire West ICB and Reading Borough Council, who are the Lead Commissioners. The service is available to all carers in West Berkshire. It includes the provision of a telephone helpline, facilitation of peer support groups,

updates on useful information through email mail outs, support to access breaks, support to complete carers' assessments. The Partnership run a range of activities for Carers Week and Carers' Rights.

- **Rapid Response and Treatment Service for Care Homes** – this is a joined up health and Social Care service reducing avoidable admissions, carrying out medication reviews and provide support and training to care home staff.

- **Out of Hospital Speech and Language Therapy** – eating and drinking service

- **Out of Hospital Care Home in-reach**- support to facilitate hospital discharge

- **Out of Hospital Community Geriatrician** – community geriatrician service working within the Care Homes.

- **Out of Hospital Health Hub** – provides an acute single point of access to community health services.

- **Out of Hospital Intermediate Care night sitting, rapid response, Reablement and falls –** rapid response services delivered to patients in their own homes avoiding hospital admission.

- **Connected Care** – an integrated IT system sharing information across Health and Social care to improve patient care.

- **Integrated Discharge Service** – this service operates using a multi-disciplinary team across Health and Social Care focussing on a home first approach. It is co-located in RBFT and continues to look to develop as a system wide service. The aim is to reduce the time people spend in an acute, community or mental health bed at the point they no longer need clinical care and prevent avoidable admissions.

- **Mental Health Street Triage** – this service operates from Reading and Newbury Police station with the aim to reduce use of police custody and use of section 136 of the Mental Health Act, allowing the police to take the person to a place of safety from a public place. Enabling the right support at times of potential crisis and reduce avoidable hospital admissions and A&E attendances.

- **The Berkshire Community Equipment Service** - is jointly commissioned across 6 Local Authorities in Berkshire and their Health Partners

- **Falls and Frailty** – this service aims to improve the user experience of emergency care by providing an acute, blue light multi-disciplinary response to the frail elderly who have fallen in their own homes to reduce A&E Attendances

Another priority that is not funded by BCF but overlaps with some of the outcomes within the BCF is the Ageing Well Programme and virtual wards. West Berkshire are represented on the programme board and working together with health partners to implement this programme across the BOB ICS.

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 joint up approaches to population health management, 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.

Our vision for better care is based on improving outcomes for individuals through the joint delivery of care which is responsive, enabling and available as close to home as possible. We are committed to doing things with, rather than to, service users and therefore meaningful engagement is a key part of how will continue to implement change.

We are committed to delivering: -

- person centred care that focus on outcomes rather than outputs
- provision of good quality information and advice that empowers people to make good choices and self- manage
- care closer to home as the first option
- flexible services that operate across 7 days where appropriate
- services will be simpler to access, have less duplication and reach service users earlier
- delivery of health and social care to be localised wherever possible
- A&E and other services that meet local residents' needs
- A greater range of local services that promote independent living
- Reduction in avoidable hospital admissions
- Lengths of stay in hospital will be kept to a minimum with timely discharges
- Increased numbers taking up health and social care personal budgets
- Focus on prevention to enable people to remain as independent as possible, including support for carers

Adult Social Care has three locality teams, East, West and Central. We also have other teams with specific/specialist functions, such as the Sensory Needs team, the Hospital Discharge Team, the Specialist Mental Health team and the Review Team.

The locality teams receive requests from people in the community. This structure means that we avoid "hand offs" where people are passed from team to team, instead they should receive consistent support even if their needs change. The localities are not organised according to strict geographical boundaries, but according to registration with specific GP surgeries. This means that Health and Social Care can be more efficient and joined up.

Our Locality Teams have created links with their local GP surgeries in different ways, often responding to the variety of ways in which the individual surgeries operate their MDTs and other meetings. Where it is deemed helpful, MDT meetings are regularly attended. In our East locality on the outskirts of Reading where there are many GP surgeries with just a few registered West Berkshire residents, we found it more useful to have regular meetings with the community nursing team that covers all the surgeries in the area. All the Localities have found the relationship with the Social Prescribers/Co-ordinators invaluable and there is a lot of communication and exchanges of information between them.

In West Berkshire, Social Prescribers and Care Co-ordinators are based in GP surgeries; an integral part of the surgery MDT's but also a crucial interface with Social Care, the voluntary sector and the wider community who they work in partnership with to help reduce health inequalities. Towards the end of 22/23 we agreed funding from the BCF to support a pilot of the JOY Social Prescribing Platform for use across all of the PCN's. The app will support all daily client related activities, from case notes to referrals and enable health and social care professionals to link clients to local services. For the residents of West Berkshire, JOY will provide:

- A market place where they can self-refer to local providers
- Increase attendance rates at services signposted to and being kept in the loop about the status of their referrals
- An ability for the less IT literate to access services through a highly intuitive and accessible design
- Inclusivity where eg. The market place can be converted to a number of different languages to increase accessibility

The progress and success of the JOY will be monitored during 2023/24.

Adult Social Care's first commitment to its residents is to support them to maintain or develop their independence. This is seen in a number of services, including the Reablement Service, the Sensory Needs Service and Resource Centres.

It is also seen in our use of the Three Conversation Model, which is based upon the principle that we should only provide long-term services where absolutely required and that we should first approach people to manage without our long-term intervention. These approaches align with the Care Act focus on preventing, reducing and delaying the need for care and support.

Our 10 key commitments are: -

1. We will focus on the strengths and abilities of each individual to support the highest level of independence possible
2. We will work with families, carers and their wider community networks, not just individuals, in order to find the solutions they are looking for
3. We believe in support that reduces dependency
4. We are here to work with residents, rather than to do to or for them
5. Our first offer is expertise, knowledge and experience
6. We will do as much as possible, as quickly as possible, for residents and our benefit
7. We will stick with residents until we find a solution that works
8. We will not plan long-term when someone is in crisis
9. We recognise that, for everybody, life is always changing and we will seek to build flexibility into support plans to reflect changing needs

10. We will advise how to keep residents safe and agree how any risk can be minimised.

Tier one conversation: Help to Help Yourself

Accessible, friendly, timely provision of information, advice, signposting (West Berkshire Directory, link with social prescribers and care co-ordinators within the GP surgeries and JOY), practical support with a focus on prevention. Here the worker will establish: -

- What the person wants to happen/thinks should happen
- What they are able to do for themselves
- What support they can get from their family or community
- How they can stay as independent as possible.

Tier two conversation: Help when you need it (for people in crisis)

Immediate short term help, intensive support to regain independence, minimal delays, no presumption about long term support, goal focussed, integrated. Here the work will establish:

- What needs to change in order to stabilise the situation

Tier three conversation: Ongoing support for those who need it.

Self-directed, personal budget based, giving choice and control, highly individualised. Here the worker will establish: -

- How the person's needs will be met in the long-term
- What the care will cost

One of the key principles underpinning the model is that short-term costs can be relatively easily managed even when they are expensive, but it is the on-going, long term costs which constitute the bigger cumulative demand on Health and Social Care resources. Consequently, it is essential that Health and Social Care only commits to long-term services when it is absolutely necessary.

Housing are represented at the Locality Integration Board and Health and Wellbeing Board and specific areas of focus has been addressing homelessness. Making Every Adult Matter (MEAM) has been operational in West Berkshire since January 2018 and brings together the Council, Police, Social Services, Two Saints (local provider for homeless people in West Berkshire), Probation Service, BOB ICB, Berkshire NHS Trust, Fire and Rescue, DWP, ambulance Service, Sovereign Housing and various voluntary agencies. MEAM is an approach to homelessness which aims to identify those very vulnerable individuals with complex multiple needs who fall through the net. These people might have mental health issues, addictions or a history of life on the streets and for whatever reason they find it impossible to engage with the system. They tend to lurch from crisis to crisis at great cost to themselves and to the agencies which respond to each emergency as it arises.

West Berkshire has three Extra Care Housing schemes offering 151 units for older and disabled people. We have a range of offers for adults with Learning Disabilities and Mental Health and we are also working on another scheme, which will offer up to 12 units of supported accommodation for adults with Learning Disabilities and Mental Health, it is hoped this will be operational within the next 12-18 months.

Whilst not funded by the Better Care Fund, the Ageing Well Programme also supports people to maintain their independence and only attend hospital when absolutely necessary, including virtual wards and virtual care.

Through the BCF West Berkshire has an ambition to develop a number of priorities and schemes during 2023-25 to help avoid hospital admissions: Targeted Community Health Checks, Joy Platform, Workforce recruitment and retention, falls pathway, falls prevention and detection technology, self-care programmes, reducing the number of residents that go onto pathway 3 and a Deep dive into data relating to Avoidance Admissions and Discharge to normal place of residence.

In addition, we have a number of schemes which run across Berkshire West to help reduced avoidable admissions: -

- **BHFT Reablement Contract** – provides Reablement and rehabilitation services across West Berkshire to support both Hospital Discharge and avoidable admissions.

- **Carers Information & Advice Service** – The contract is jointly commissioned with the Berkshire West ICB and Reading Borough Council, who are the Lead Commissioners. The service is available to all carers in West Berkshire. It includes the provision of a telephone helpline, facilitation of peer support groups, updates on useful information through email mail outs, support to access breaks, support to complete carers' assessments. The Partnership run a range of activities for Carers Week and Carers' Rights.

- **Rapid Response and Treatment Service for Care Homes** – this is a joined up health and Social Care service reducing avoidable admissions, carrying out medication reviews and provide support and training to care home staff.

- **Out of Hospital Speech and Language Therapy** – eating and drinking service

- **Out of Hospital Care Home in-reach**- support to facilitate hospital discharge.

- **Out of Hospital Community Geriatrician** – community geriatrician service working within the Care Homes.

- **Out of Hospital Health Hub** – provides an acute single point of access to community health services.

- **Out of Hospital Intermediate Care night sitting, rapid response, Reablement and falls** – rapid response services delivered to patients in their own homes avoiding hospital admission.

- **Connected Care** – an integrated IT system sharing information across Health and Social care to improve patient care.

- **Integrated Discharge Service** – this service operates using a multi-disciplinary team across Health and Social Care focussing on a home first approach. It is co-located in RBFT and continues to look to develop as a system wide service. The aim is to reduce the time people spend in an acute, community or mental health bed at the point they no longer need clinical care and prevent avoidable

admissions.

- **Mental Health Street Triage** – this service operates from Reading and Newbury Police station with the aim to reduce use of police custody and use of section 136 of the Mental Health Act, allowing the police to take the person to a place of safety from a public place. Enabling the right support at times of potential crisis and reduce avoidable hospital admissions and A&E attendances.

- **The Berkshire Community Equipment Service** is jointly commissioned across 6 Local Authorities in Berkshire and their Health Partners

- **Falls and Frailty** – this service aims to improve the user experience of emergency care by providing an acute, blue light multi-disciplinary response to the frail elderly who have fallen in their own homes to reduce A&E Attendances

The Disabled Facilities Grant is partly managed through the Local Authority's Housing team and partly to support the Berkshire Community Equipment Service. The strategic approach to the use of the DFG has raised awareness and increased applications for these grants and has allowed individuals to remain in their own home.

The Housing Grants, Construction and Regeneration Act 1996 enables Local Authorities to provide Disabled Facilities Grants (DFGs) to eligible applicants in order to carry out appropriate adaptations so that they can remain in their homes and live as independently as possible.

With a renewed focus of prevention and collaborative working across the Housing Service and the recognition that housing is a key determinant of health, we look to include any opportunities relating to health in the delivery of our service.

National Condition 2 (continued)

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 22-23 such as:

- **where numbers of referrals did and did not meet expectations,**
- **unmet demand, ie 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 – eg admissions avoidance and improved care in community settings, plus evidence of under-utilisation or over-prescriptive 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 figures for Demand and Capacity in the Community have been provided by partners from Berkshire Health Foundation Trust and the following assumptions have been made:

- UCR demand based on trajectory
- UCR capacity based on number of NP's seen
- Hospital discharge Demand / capacity for Reablement or rehabilitation in a patient's own home based on referrals/discharges from community and acute hospitals (BHFT providing Community hospital discharges)
- Capacity for step down P2 based on community bed base – and 24 days LOS
- Community demand / capacity for intermediate care based on referrals to / NP seen in all community pathways (including dom physio, falls, 2 day pathway)

Social Support (including VCS) – this could potentially include those that the LA support through a Tier 1 and Tier 2 conversation but these are recorded as a case note within our case management system and we are not able to pull out numbers.

National Condition 2 (continued)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes of 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 those long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.**

Our existing schemes listed on page 14 & 15 will remain in place. The two priorities that we delayed in 2022-23 and our **new** BCF schemes for 2023-25 that will support avoidable hospital admissions are: -

Targeted Community NHS Health Check Outreach Programme – This project aligns with the Core20plus5 approach outlined by NHS England to support the reduction of health inequalities. We are supporting a two year project to design, implement and evaluate a targeted NHS Health-Check service in West Berkshire using specialist community engagement to reduce hospital admissions & health inequalities related to CVD and COVID-19 for disproportionately impacted and under-represented groups. This service will be supplementary to the universal NHS Health Check service offered by local GPs.

Joy Platform– This project was agreed at the end of December 22/23 to support the Primary Care Networks with the roll out of the JOY Social Prescribing Platform across several GP practices. We agreed to pilot this for 12 months. In West Berkshire Social Prescribers and Care Co-ordinators are based in GP surgeries; and integral part of surgery MDT's abut also a crucial interface with social are, the voluntary sector and the wider community who work in partnership to help reduce health inequalities. The JOY platform supports all daily client related activities from case notes to referrals and enables health and social care professionals to link clients to local services.

Workforce - recruitment and retention of Social Workers and Occupational Therapists to work within the locality teams to support residents within the community and operate the three conversation model (see page 13), work with GP practices, Social Prescribers/care co-ordinators, community health teams and attend MDT's where appropriate to help avoid a hospital admission.

Falls pathway - a) identify any gaps in the falls pathway in order to support the new BCF metric on falls and help avoid hospital admissions and b) receive updates from our partners within the BOB ICB to learn from the pilots taking place within Care Homes of the use of falls prevention and detection technologies and potentially submit an expression of interest to the DHSC for funding to support a pilot within West Berkshire c) continue to deliver our steady steps prevention classes and d) look at opportunities to raise awareness about falls prevention and encourage partners to do the RoSPA and RSA fall fighter training so they can onward share the information with groups/staff they work with.

Self-care programmes - Self-Care Programmes - initiate a number of self-care programmes across the system to help reduce non-elective admissions.

Deep dive into admission avoidance data – to provide us with data/evidence of further areas to target within the community.

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.

Our vision for better care is based on improving outcomes for individuals through the joint delivery of care which is responsive, enabling and available as close to home as possible. We are committed to doing things with, rather than to, service users and therefore meaningful engagement is a key part of how will continue to implement change.

We are committed to delivering: -

- person centred care that focus on outcomes rather than outputs
- provision of good quality information and advice that empowers people to make good choices and self- manage
- care closer to home as the first option
- flexible services that operate across 7 days where appropriate
- services will be simpler to access, have less duplication and reach service users earlier
- delivery of health and social care to be localised wherever possible
- A&E and other services that meet local residents' needs
- A greater range of local services that promote independent living
- Reduction in avoidable hospital admissions
- Lengths of stay in hospital will be kept to a minimum with timely discharges
- Increased numbers taking up health and social care personal budgets
- Focus on prevention to enable people to remain as independent as possible, including support for carers

Through our BCF we also provide a Joint Care Provider Service (JCPS), Reablement Service, Link Workers to support three Acute Hospitals, a Community Hospital, a Mental Health Hospital and a Health Hub to support safe and timely hospital discharge for all West Berkshire Residents.

The JCPS is an integrated resource staffed by employees from both West Berkshire Council and Berkshire Healthcare Foundation Trust (BHFT). The team's role is to support all local residents through the Hospital system to discharge and follow up in the community.

The service is multi-disciplinary which includes Social Workers, Occupational Therapists, Physiotherapists, Social Care Practitioners, Reablement Officers and Therapy Assistants.

We provide link worker cover to all the hospitals in the area with two dedicated members of staff providing support within the hospital system. This includes three acute hospitals: Royal Berkshire Hospital in Reading, Great Western Hospital in Swindon and the North Hampshire Hospital as well as the Community Hospital in Newbury. We also provide 7 day cover with a Social worker based at the Royal Berkshire Hospital and a duty Director on call to support all Hospitals.

The JCPS operates a pathway desk, which deals with incoming referrals via the BHFT Trust hub, also funded through the BCF and focusses on sourcing care promptly to expedite discharge for all West Berkshire Residents and support the home first approach using the four pathways defined by the NHS.

The JCPS follows up with all residents discharged from hospital in the community as soon as possible providing welfare checks and therapy visits to assist with rehabilitation and improving outcomes for the residents.

After 4 weeks, residents are discharged from JCPS either with long term care or no ongoing care. Residents who received rehabilitation through our BCF funded reablement service are again followed up 91 days after discharge to ensure the package received meets requirements, we are improving outcomes for residents and helps us to meet the national requirement : proportion of older people (65 and over) who were still at home 91 days after discharge form hospital into reablement services.

In addition to the Local activity above the Berkshire West ICP hold a weekly Directors Discharge meeting to discuss hospital discharges with partners including: Local Authorities, RBH, BHFT, BW ICB and South Central Ambulance Service (SCAS) to problem solve, facilitate and expedite hospital discharges as necessary.

In order to help with Winter planning all of the above continues but with some enhancement to the Reablement Service, capacity in the care market and encouragement for providers to support hospital discharges at weekends. We introduced a dashboard last year which is shared with our partners at the Acute Trust and provides the following information in order for us to have a shared understanding of the pressures within the Care Market and manage the capacity: -

- No. of people waiting for Care
- Total hours waiting to be sourced
- No. of care hours waiting to be sourced
- Intensity of Care Being Sourced
- Length of time waiting for Care
- Care Hours to be sourced by location

In order to help our social Care providers address the cost of living and ensure we have a healthy care market an uplift of 5.6% was offered in 22/23 and a further 2.7% uplift has been offered for 23/24 to providers operating in West Berkshire. However, we do need to ensure we are able to create capacity to sustain a vibrant market to support both admission avoidance and hospital discharge. (Our Market Position Statement (MPS) will also reflect future needs). The additional discharge funding, both LA and ICB elements will support with buying additional capacity to support hospital discharges through the year.

In the event that the Berkshire West ICP need to implement its escalation system whereby the Acute Trust is at full capacity this meeting is stood up as many times as needed in order to expedite hospital discharges. Berkshire West ICP follows the South East Regional OPEL framework.

The system also has a weekly Discharge Group meeting. This group was formerly known as the Rapid Community Discharge Group. The following initiatives were introduced in 22/23 and have been refreshed for 23/24: -

- **Promotion of single handed care** – This was re-instated in November using the winter discharge funding. The team received national recognition for the work. It ended in March 2023. The system are reviewing how this can be funded going forward.

- **Complex booking guidance for transport** was rolled out to all wards, this has led to fewer errors, which are demonstrated by the medically optimised for discharge (MOfD) data collection. It will be reviewed in the Autumn.

- **A dedicated phone helpline** was put in place for care homes to contact the acute hospital following a hospital discharge to raise any concerns. This is still in place, calls are minimal.

- **A bariatric/plus size forum** was created to take a system-wide approach and standard operating procedure. This took a back seat over the winter but Berkshire West are currently looking that the bariatric pathway and whether we can commission beds together to support a speedy discharge.

- **Medicine Discharge Service** to support vulnerable individuals and those with multiply medications – this is still in place.

A self-assessment review of the Hospital Discharge and Community Support Guidance, published on 31st March 2022 was conducted in May 2022, to help shape the direction of travel and joint working between Health and Social Care and mapped across to the 100 day challenge and High Impact Change Model within Berkshire West.

A System Flow Improvement Plan was drawn up across Buckinghamshire, Oxfordshire and Berkshire West (BOB) in May 2022, to improve hospital discharge flow. Berkshire West "Place" had the lowest average length of stay across the three "Places" within the Integrated Care System (ICS). The key areas of focus identified for were in relation to discharges to Care Homes. We have referenced the Rapid Community Discharge (RCD) project group initiatives in the previous section and expand on these further here, taken from the System Flow Improvement Plan:

1. The predominant issue to address is the delay in discharges to Care Homes.

2. RCD Project -aims to improve liaison and communication with Care Homes in order to streamline transfers and repatriation.

3. Care Home Forum -A monthly forum in which concerns and processes needing improvement can be raised. This has recently been expanded to include key Nursing leads in Berkshire West who are linked to Care Homes. Community Hospital leads are also included in the expansion.

4. Transfer documentation revised -In response to Care Homes concerns around the level (lack of) of information being transferred with the patient to a care Home, the transfer documentation has been revised and simplified -from a 5 page document to a 2 page document. More work is needed to roll this out across the Trust.

5. Format of 72 hour 'diaries' review -The current 72 hour diary is old and not well formatted –a new format has been produced and is being trialled in Elderly Care.

6. Care Home Help-Line -In January a dedicated telephone line was introduced to enable any Care Home to call should they be unable to get through to a ward to discuss a patient. The qualified nurse at the end of the help-line will facilitate the ward liaison or will use EPR to answer the query directly.

7. Revitalise the Red Bag Project-The initial Red Bag project was seen as a success but has fallen down during Covid times. This hasn't really materialised.

8. Business Case for a dedicated Care Home Liaison Practitioner -The success of the Care Home Help-line has demonstrated the benefits of dedicated liaison. A dedicated practitioner would support Care Home Assessment, placement of self-funders and set up of meetings such as 'Best Interest Meetings' as well as general liaison on a day to day basis. This is not currently seen as a priority but if any further money becomes available, this will be put in place.

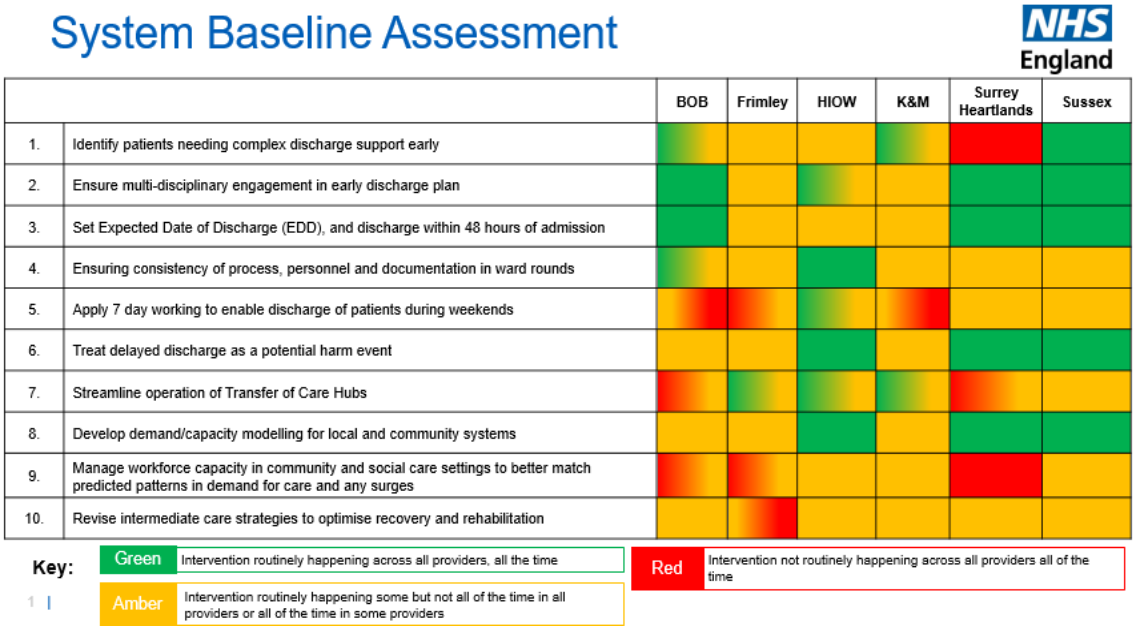
9. Introduction of care Home 'Clinic' in May 2022 -A new concept in which key Care Homes are invited to join the Care Home Forum attendees to share concerns, good news stories and learning in general. It is felt that any unmet training needs can be picked up and addressed in this forum.

10. Training Sessions instigated for Care Homes -In order to facilitate transfer to a care Home RBFT has set up simulated training in the Sim Lab in order for Care Home staff to be trained when training is vital for the transfer. This has been provided by acute clinical experts free of charge. Further training will be provided as required.

11. Visits to key care Homes -The System Lead Co-ordinator and Lead for Complex DC have a series of visits underway to key Care Homes to build a system of trust and liaison. This includes follow-up of complex patients who are accepted into Care Homes and where the care Home wishes to develop admission-avoidance plans for the future.

The BCF supports this work through the jointly commissioned integrated discharge service and the Care home service detailed above.

The diagram below demonstrates a system baseline assessment of the NHS 100 day challenge: -



Discharge Improvement Plan 2023

- A discharge improvement event was held in January where 3 groups, one looking at pre-referral, one looking at referral processes and another looking at post referral, were challenged on short term actions, myths and long term actions (see below).
- Smaller groups are meeting on a regular basis to review narrative updates, RAG ratings and further work to be conducted.
- Further work to be done on myths as some are stubborn to dispel
- Groups will meet again at the end of next quarter to discuss and close actions down
- We also undertook a short-focused audit to review failed discharges in depth to establish the cause, split by local authority

Short Term Actions and Myths: -

- Social Services to ensure presence at the Wednesday morning LOS meeting
- MYTH: MOfD patients who become 'unfit' are deferred not removed from the HDS list; need education to staff
- MYTH: Community hospital stays and PoC are not always for 6 weeks they are designed to meet patient need
- MYTH: Social workers take weeks to pick up a referral (need to map and share any examples where this is reported to be the case)
- MYTH: Communications to Therapists to dispel the myth regarding a second referral form having to be completed if a discharge is delayed
- Undertake analysis of Reading snapshot data to understand the number of P1 patients that become unwell resulting in lost capacity in the care market and to consider what is the 'sweet spot' for declaring a patient as MOfD
- LAs to consistently notify HDT of the arrangements for packages of care including the provider and who to contact in the event of issues
- BHFT to maintain focus on embedding pull model
- Review data to understand increasing trend in P2 referrals (possibly linked to reduced waits for community beds rather than genuine need)
- RBFT to ensure TTOs and discharge letters are completed in a timely manner especially for more specialist drugs not held by BHFT
- Review discharge focussed meetings and ensure LAs are sighted on which meetings they need to attend for the week
- CHC to be asked to consider immediately moving to 50:50 funding for complex cases
- All to consider how we capture the patient's experience of discharge and whether Healthwatch could provide support

Long Term Actions: -

- Agree and establish an early notification system (particularly for bariatric and confused patients). Explore using a software platform (or re-introduce the old section 2 type referral system)
- Dedicated social workers attending ward rounds / allocated to wards
- Visits to good practice sites - ECIST Support

- Referrals for care homes: investigate the alignment through the whole system and change the timing of the daily sitrep again to a time more convenient for everybody.
- "How trusted is the Trusted Assessor form and how is it utilised. Should the form be simpler?
- Think about who completes the form, what information should be included, appropriateness of a Trust Assessor; currently completed by OT but requires clinical experience as well as therapy experience"
- Deeper dive into time lags between referrals being sent and them reaching the Integrated Health Hub
- Better understanding of some commissioning processes and whether as a system there is coordination. Is the process as succinct as needed to enable providers to expedite patient flow
- Due to the complexity of the middle phase could spend more time on referral to Hub, screening, out within 2 hours, picking up by provider, commissioning, financial approval and what is expected next
- Review high number of lists in terms of whether the right people are managing them as a lot of time is spent going through and updating them – time could be better spent on actions
- Review high number of meetings where hours can be spent discussing patients as this is not always the best use of time within the system
- Do we reintroduce the safety net team as a substantive team

A Trust Intelligence Notification Alerts (TINA) system that runs parallel to the Trust's EPR system, access to which will be shared with local authority colleagues, to assist with both early notification, complex patients and preventing failed discharges.

The weekly Director Discharge Oversight meeting logs themes one of which relates to issues around bariatric patients. The system is currently reviewing this pathway and looking at commissioning a bed to support timely discharges.

We will be holding a Winter planning workshop in July 2023 across the BOB ICS.

In addition a key priority identified was to support the avoidance of admissions and increase bed capacity through, Anticipatory Care, Virtual Wards and Virtual Care, and we are working with system partners at a Berkshire West "Place" level to improve capacity. We have recently been advised that the funding has been awarded and we are in the planning stage of implementing the required services to support winter pressures and enable timely hospital discharge, which will support the Better Care Fund metrics for 2023/25.

National Condition 3 (continued)

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 22-23 such as:

- **where numbers of referrals did and did not meet expectations,**
- **unmet demand, ie 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 – eg admissions avoidance and improved care in community settings, plus evidence of under-utilisation or over-prescriptive 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 assumptions we have made to support the figures for Demand Hospital Discharge on the planning template are: -

Social Support (including VCS) pathway 0 – a monthly average has been taken from SUS plus financial year 22/23 data. This analysis was completed by the SE performance analysis team. It details the total number of pathway 0 discharges from acute hospitals.

Reablement at Home pathway 1 – all residents living in West Berkshire are discharged from hospital through our Joint Care Pathway and are all given the opportunity for reablement. Therefore there are no figures for rehab at home or short term domiciliary care as these are included in reablement at home pathway 1.

The assumptions we have made to support the figures for Capacity Hospital Discharge on the planning template are: -

Social Support (including VCS) pathway 0 – residents go home with no care and we do not currently commission any support with the VCS to support these residents so assume demand as per capacity.

Based on the year end SALT data LTs001b West Berkshire has seen a 3% increase in people supported in the community and 7% increase in people supported in residential/nursing homes. 65% of new admissions are currently going into residential/nursing homes and we are seeing a growing ageing population with more complex needs. Therefore demand for social care is likely to increase – this has been reflected in capacity.

National condition 3 (continued)

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

- **Discharge to usual place of residence**

Please refer to pages 20, 21, 22, 23 and 24 of the plan.

In addition our new schemes that will support hospital discharge are:

Trust Intelligence Notification Assistance (TINA) – investigate the options of access to the Trust's system for local authority personnel in order to help speed up hospital discharge and avoid unnecessary meetings across the system.

Reduce the number of people coming out of hospital on pathway 3 – review how and when decisions are made and the impact this is having on capacity within the care market.

Workforce - recruitment and retention of Social Workers and Occupational Therapists to work within the Hospital Discharge team to support residents being discharged from Hospital, including self-funders. (see page 19 & 20 of the plan). This will also include providing staff to liaise with Care Homes if and when we set up D2A beds should we see a spike in demand.

Deep dive into data relating to Discharge to normal place of residence. The SUS Data on the Better Exchange Fund states that Q1 was 91.4%, Q2 was 91.6%, Q3 was 91.1% and Q4 is forecast to finish at 91%. However, we have been reporting lower than this locally. A deep dive into the backing data is currently taking place to see if a trust is duplicating records locally. Also local data is reporting less discharge code 19 (usual place of residence), this would indicate that some records are missing from local data.

National condition 3 (continued)

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

Please refer to pages 21 & 22 of the plan.

National condition 3 (continued)

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.

The Care Act 2014 places a series of new duties and responsibilities on local authorities : - prevention, information and advice and shaping the care market and support services.

Through the use of the BCF Funding, iBCF and ASC Discharge Funding: -

- We are able to consider the person's own strengths and capabilities, and what support might be available from their wider support network or within the community to help' in considering 'what else, other than the provision of care and support, might assist the person in meeting the outcomes they want to achieve'. This is done by taking an approach that looks at a person's life holistically, considering their needs in the context of their skills, ambitions, and priorities through our three conversation model. (see pages 11-15)

- We are able to help develop the care market within our local area and ensure there is a wide range of sustainable, high quality care and support services to support both admission avoidance and hospital discharge.

- We are able to commission a Carer's Information and Advice Service which is available to all carers in West Berkshire. (see page 28).

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.

Better Care Fund monies are used to support unpaid carers in West Berkshire in the following ways:

To commission a Carers Information and Advice service. This is provided by the Reading and West Berkshire Carers Partnership

The contract is jointly commissioned with the Berkshire West ICB and Reading Borough Council, who are the Lead Commissioners. The service is available to all carers in West Berkshire. It includes the provision of a telephone helpline, facilitation of peer support groups, updates on useful information through email mail outs, support to access breaks, support to complete carers' assessments. The Partnership run a range of activities for Carers Week and Carers' Rights Day.

£200K per annum is used to pay for respite care. This follows an assessment/carer's assessment to identify a suitable level of support and identify reasonable costs. Although the service user is the person in receipt of the care, carers derive significant benefit from being able to take a break from caring. These funds are used to commission from a wide range of suitable care providers.

£60K per annum is available for direct payments to Carers, mostly used as one-off payments, following an Assessment, to provide Carers with the support required to meet their own identified and assessed need.

£191k per annum is used to pay for a Carers Support Service, consisting of a sitting service (including an urgent response service) to ensure that carers can take time away from the cared for person when needed. This contract is currently with Crossroads.

£20.9K is provided to the CAB for the provision of advice and information to carers. This is in addition to £10k specifically to meet Information and Advice duties in the Care Act.

BCF monies are also used to fund a number of services which have benefit to both service users and their carers. For example:

£33K for Stroke Care
£22K for Younger People with Dementia
£12.7K for Mencap Family Advisor
£36K for Dementia Advisors Service

All of the above services deliver critical support to unpaid carers. It is recognised that this is a large cohort who make an invaluable contribution through the care they provide. It is also recognised that there is a long-term toll on carers, often leading to poor health outcomes. The above services look to prevent or reduce this harm. West Berkshire's Carers Strategy has identified collaboratively the key areas of work to support carers in the district.

In addition we are working with Age UK Berkshire and subsidising activities to support Carers week on 5-11 June 2023.

Disabled Facilities Grant (DFG) and wider services

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

The Disabled Facilities Grant is partly managed through the Local Authority's Housing team and partly to support the Berkshire Community Equipment Service. The strategic approach to the use of the DFG has raised awareness and increased applications for these grants and has allowed individuals to remain in their own home.

The Housing Grants, Construction and Regeneration Act 1996 enables Local Authorities to provide Disabled Facilities Grants (DFGs) to eligible applicants in order to carry out appropriate adaptations so that they can remain in their homes and live as independently as possible.

With a renewed focus of prevention and collaborative working across the Housing Service and the recognition that housing is a key determinant of health, we look to include any opportunities relating to health in the delivery of our service.

Our Housing Grants and Loans policy updated in 2021 sets out West Berkshire Council's approach in terms of how we manage and allocate the Disabled Facilities Grant funding through the Housing Service's Home Improvement Agency Team (HIA). The HIA Team have systems in place to process Disabled Facilities Grant referrals which are then given to the Occupational Therapists whose role is to complete the assessment process by visiting applicants at their home to determine their needs and what aids and adaptations are required. The Technical Officers within the team will then ensure that the assessments for aids and adaptations are drawn up and can fit within the home. This has allowed for a far more efficient service and ability to process DFG applications swiftly and therefore installation of grant funded works quicker.

DFGs help to facilitate a range of adaptations from stair lifts, level access showers, extensions, hoists, through floor lifts and many more. The HIA Team continue to successfully deliver DFG funded works and across the last financial year, the team achieved 100% satisfaction rate 7 out of 12 months with an overall average of 93% across the year. The table below demonstrates the number of referrals received and awards made : -

	No. of referrals	No. of awards
2019-2020	285	136
2020-2021	323	108
2021-2022	315	122
2022-2023	347	153

Our existing Housing Grants and Loans Policy is written under the Regulatory Reform Order (RRO). When this was last reviewed and updated in 2021, we introduced a

discretionary Home from Hospital grant to enable us to support those identified across social care teams who could not be discharged from hospital without appropriate modifications to their home.

The Housing Grants and Loans Policy will be reviewed and updated again this year with a view to providing additional discretionary funding streams and mechanisms to be able to support more disabled and vulnerable residents across West Berkshire.

The completed adaptations cut across all tenures and ages to deliver to those in need.

Further links between the Acute Trust and Housing have been made with leaflets relating to DFG now available on wards and partners able to expedite hospital discharges through urgent DFG applications where necessary.

There are strong links with Adult Social Care to fund OT equipment from the DFG budget which also enables applicants to remain in their home and move about safely and independently.

The Berkshire Community Equipment Service is jointly commissioned across 6 Local Authorities in Berkshire and their Health Partners. West Berkshire is committed to the provision of equipment to people in the community to enable them to live more independently.

The service is based on a "recycling" model which means that costs are reduced if equipment is returned once it is no longer needed.

In addition, from 2019-2020 the Local Authority invested £142,000 into a Technology Enabled Care Project. This project employed a TEC Advisor and provided expert support and advice to Social Workers in delivering some aspects of care in a different way, where possible, by increasing the appropriate use of Assistive Technology and avoiding costs to the Health and Social Care economy by promoting individual choice and independence for as long as possible and avoiding a hospital admission. The project saw an 8% increase in the use of TEC in the community. However, due to staffing issues this project was temporarily paused in February 2022.

The project recommenced in November 2022 and in the period from November 2022 and May 2023, 49 clients have engaged with the TEC Service.

The Local Authority invested a further £150K into this area work in 2022/23.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) Order 2022 (RRO) to use a portion of DFG funding for discretionary services? Y/N

Yes, Our existing Housing Grants and Loans Policy is written under the Regulatory Reform Order (RRO). When this was last reviewed and updated in 2021, we introduced a discretionary Home from Hospital grant to enable us to support those identified across social care teams who could not be discharged from hospital without appropriate modifications to their home

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

We didn't ring fence an amount as we were unsure of the take up on the Home from Hospital grant and whether this would be necessary. We have supported 1 person over the last 12 months.

Equality and health inequalities.

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

- Changes from previous BCF plan.
- How these inequalities are being addressed through the BCF plan and services funded through this.
- Inequality of outcomes related to the BCF national metrics.

Health inequalities are defined as "avoidable, unfair and systematic differences in health between different groups of people"[1]. Action on health inequalities is one of the three key functions of all public health systems, as outlined in "*Quality in Public Health: A Shared Responsibility'*[2]*.*

Groups who are most likely to experience health inequalities are often defined across four dimensions (figure 1).

1) Socio-economic
2) Geography
3) Specific characteristics including Protected Characteristics under the Equality Act 2010
4) Socially excluded groups

The Berkshire West Health and Wellbeing Strategy for 2021-2030 consists of five priorities. Priority one is to reduce the differences in health between different groups of people. This acts as a pillar within the strategy, underpinning each of the other four priority areas.

The strategy is accompanied by a local delivery plan for each of the three Local Authority areas (West Berkshire, Wokingham and Reading), describing how the strategy will be implemented in each area.

As of May 2023, the West Berkshire delivery plan contains the following objectives under Priority 1:

Objective	Description
Take a Health in All Policies approach	Identify a current opportunity for a multi-team HiAP pilot project within the Council that can be used as a showcase piece in further staff education
	Refine and improve process for reviewing new council policies and impact on health and emotional wellbeing (including a focus on reducing health inequalities)
Address the variation in the experience of the wider social, economic and environmental determinants of health	Pilot a whole community approach in a local ward to tackling health inequalities, using data and engaging with local communities

1 https://ww.kingsfund.org.uk/publications/what-are-health-inequalities

2 Quality in public health: a shared responsibility - GOV.UK (www.gov.uk)

	Development of a health impact policy for planning to support healthy environments
Ensure services and support are accessible to those most in need through effective signposting, targeted health education, digital inclusion and in particular addressing sensory and communication needs. All in a way that empower communities to manage their health and wellbeing.	Increase awareness and uptake of council support services for those most in need e.g. winter grant

In West Berkshire a Health Inequalities Task Force was established in February/March 2021 to develop this delivery and action plan.

The Task Force had the following purpose:

- To communicate between stakeholders and group members and monitors actions to support the whole system;
- To develop the local authority's leadership role on health inequalities at locality level, and set out how the local authority may work collaboratively to support a whole-systems and place-based approach to health inequalities;
- To feed into and monitor the development of the Health in All Policies (HiAP) approach for the Council, which aims to embed action on the wider determinants of health across all Council service areas with a strong focus on reducing health inequalities.

An action plan for HiAP was recently accepted by the Council's Corporate Board. The proposed actions can be summarised as follows:

Proposed HiAP action plan
1. Local Government Association to deliver HiAP educational and baseline review piece amongst Senior Leadership and Members.
2. Roll out further education piece (delivered by LGA or in-house) to Officers identified by Senior Leadership to become 'Champions' or 'Super-users' of Public Health data in their service areas. The training these Officers will receive will be on using core Public Health data (JSNA, Observatory, Fingertips etc.) and how to use in their work.
3. Establish a network for leads of all Council strategies and delivery plans, to meet quarterly and utilise Teams channels, in order to discuss service priority areas and opportunities for collaboration. Key aim will be to identify areas for collaboration, and where priorities should be based on the health inequality intelligence we have. This could contribute to multiple strategies and reduce inequalities in the District.

The design and purpose of the group of representatives across the Council who have received HiAP training is still under consideration, as is its relationship (or merging) to the Health Inequalities Task Force which is also currently under review. The intention, however, is for a group to be (re)established, with a new set of strategic priorities and actions, based on the data we have available that outlines the areas of inequalities we must target in West Berkshire. Potential priority areas include:

- Promoting the targeted outreach NHS health checks programme
- Reducing the employment gap between the general population and adults with learning disabilities
- Improving school readiness and educational attainment for children eligible for free school meals

These priorities and subsequent actions will also be informed by the Health Inequalities Needs Assessment, to be completed by the end of September 2023, that will provide:

- a deeper understanding of current health inequity in West Berkshire based on the wider determinants of health, population health data, community engagement and community asset based practice;

- an understanding of stakeholder's views about addressing the prioritised health inequity issues, including actions on the wider (or social) determinants of health.

This will help the Council to develop a place-based approach to reducing health inequalities, and implement a Health Inequalities Delivery Plan, incorporating evidence based, systematically applied and appropriately resourced actions.

The BCF is also supporting a two year project to design, implement and evaluate a targeted NHS Health-Check service in West Berkshire using specialist community engagement to reduce hospital admissions & health inequalities related to CVD and COVID-19 for disproportionately impacted and under-represented groups. This service will be supplementary to the universal NHS Health Check service offered by local GPs.

This project will:

- Develop a mobile Targeted Community Outreach service for the delivery of NHS health checks pathway, alongside community engagement around CVD prevention, and using community centred approaches. The Provider will demonstrate how they will reach priority groups in partnership with the Commissioner, with a focus on increasing uptake of Health Checks from residents facing increased risk of cardiovascular disease in disproportionately impacted and under-represented groups;

- Develop and deliver a specialist social prescribing offer, to provide support and information to service users of the risks associated with CVD, and encourage behavioural lifestyle changes for the persons wider physical and mental health as well as additional lifestyle services where required, as well as signposting for services related to the social determinants of health e.g. housing and financial support;

- Take an outcomes-focused approach to the design, delivery and evaluation of the Service. This will include the Provider building a Theory of Change or Logic Model for the Service, clearly showing the inputs, outputs, outcomes and impact.

In addition Berkshire West Place has been allocated £1.3m of ICB funding for the next two financial years (£2.6m in total) to invest in addressing 'Inequality & Prevention Priorities'. The funding will be deployed into one leading proposal (community wellness outreach) and one supporting proposal (Population Health and Prevention Intelligence coordination). The Community Wellness Outreach model will have a consistent 'core' offering across the

three Local Authority areas to focus on adult cardiovascular disease prevention, the leading cause of all preventable premature deaths in the UK, along with supplementary 'local' offerings based on most pressing local need. The Locality Integration Boards will each be delegated a share of the funding to determine the most appropriate delivery models, while oversight at Berkshire West will ensure a level of consistency of outcome. The Population Health and Prevention Intelligence coordination proposal will develop a coordinated approach across Berkshire West, enabling partners to consider this intelligence in a strategic way to inform future programmes of work.

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BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.

4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.

6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

7. Please ensure that all boxes on the checklist are green before submission.

8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in ‘yellow’. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:

- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:

- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme

- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:

- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs

- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:

- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where ‘Social Care’ is selected and the source of funding is “NHS minimum” then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:

- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select ‘Joint’. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:

- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

9. Source of Funding:

- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:

- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme

- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.

The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.

The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.

2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	West Berkshire
Completed by:	Maria Shepherd
E-mail:	maria.shepherd@westberks.gov.uk
Contact number:	01635 519782
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes
If no please indicate when the HWB is expected to sign off the plan:	

	Role:	**Professional Title (e.g. Dr, Cllr, Prof)**	**First-name:**	**Surname:**	**E-mail:**
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Alan	Macro	alan.macro@westberks.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Steve	McManus	steve.mcmanus4@nhs.net
	Additional ICB(s) contacts if relevant		Sarah	Webster	Sarah.Webster42@nhs.net
	Local Authority Chief Executive		Nigel	Lynn	nigel.lynn1@westberks.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Paul	Coe	paul.coe@westberks.gov.uk
	Better Care Fund Lead Official		Maria	Shepherd	maria.shepherd@westberks.gov.uk
	LA Section 151 Officer		Joseph	Holmes	joseph.holmes1@westberks.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: West Berkshire

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£2,065,205	£2,065,205	£2,065,205	£2,065,205	£0
Minimum NHS Contribution	£11,788,726	£12,455,968	£11,788,727	£12,455,969	-£1
iBCF	£806,499	£806,499	£806,499	£806,499	£0
Additional LA Contribution	£340,205	£0	£340,205	£0	£0
Additional ICB Contribution	£84,707	£0	£84,707	£0	£0
Local Authority Discharge Funding	£113,070	£188,450	£113,070	£188,450	£0
ICB Discharge Funding	£773,000	£1,365,869	£773,000	£1,365,869	£0
Total	**£15,971,413**	**£16,881,992**	**£15,971,413**	**£16,881,992**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£3,189,717	£3,370,255
Planned spend	£4,876,064	£4,881,150

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£5,845,226	£6,176,065
Planned spend	£6,265,573	£6,909,869

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	130.3	127.5	132.4	129.0

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,717.2	1,686.0
	Count	542	531
	Population	31789	31789

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	91.4%	91.6%	91.1%	91.0%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	608	616

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Implementing the BCF policy objectives	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: West Berkshire

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:

- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	See page 16 and 25 of narrative plan which outlines the assumptions we have made.

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!

Trust Referral Source (Select as many as you need)	Demand - Hospital Discharge Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
ROYAL BERKSHIRE NHS FOUNDATION TRUST	Social support (including VCS) (pathway 0)	0	0	0	0	0	0	0	0	0	0	0	0
ROYAL BERKSHIRE NHS FOUNDATION TRUST	Reablement at home (pathway 1)	117	88	129	123	110	83	129	125	91	125	106	98
ROYAL BERKSHIRE NHS FOUNDATION TRUST	Rehabilitation at home (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0
ROYAL BERKSHIRE NHS FOUNDATION TRUST	Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0
ROYAL BERKSHIRE NHS FOUNDATION TRUST	Reablement in a bedded setting (pathway 2)	30	24	25	23	27	24	28	25	34	34	19	27
ROYAL BERKSHIRE NHS FOUNDATION TRUST	Rehabilitation in a bedded setting (pathway 2)	23	20	22	23	23	18	28	19	26	20	24	18
ROYAL BERKSHIRE NHS FOUNDATION TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home	14	25	14	10	12	12	14	8	21	6	6	23

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	138	138	138	138	138	138	138	138	138	138	138	138
Reablement at home	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation at home	101	112	116	96	99	95	96	104	86	97	92	89
Reablement in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Reablement at Home	Monthly capacity. Number of new clients.	113	85	125	119	107	81	125	121	79	121	103	95	0%	100%	0%
Rehabilitation at home	Monthly capacity. Number of new clients.	23	20	22	23	23	18	28	19	26	20	24	18	100%	0%	0%
Short term domiciliary care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Reablement in a bedded setting	Monthly capacity. Number of new clients.	30	24	25	23	27	24	28	24	34	34	19	27	0%	0%	100%
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	115	115	115	115	115	115	115	115	115	115	115	115	0%	0%	100%
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	13	23	13	10	12	12	13	8	19	6	6	21	0%	100%	0%

3.4 Capacity - Community

Capacity - Community Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Urgent Community Response	Monthly capacity. Number of new clients.	183	180	189	184	173	185	211	212	240	219	200	221	0%	0%	100%
Reablement at Home	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Rehabilitation at home	Monthly capacity. Number of new clients.	85	116	102	102	103	107	134	103	118	104	109	109	100%	0%	0%
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	30	24	25	23	27	24	28	24	34	34	19	27	0%		100%
Other short-term social care	Monthly capacity. Number of new clients.	13	23	13	10	12	12	13	8	19	6	6	21	0%	100%	0%

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: West Berkshire

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
West Berkshire	£2,065,205	£2,065,205
DFG breakdown for two-tier areas only (where applicable)		
Total Minimum LA Contribution (exc iBCF)	**£2,065,205**	**£2,065,205**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
West Berkshire	£113,070	£188,450

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	£773,000	£1,365,869
Total ICB Discharge Fund Contribution	£773,000	£1,365,869

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
West Berkshire	£806,499	£806,499
Total iBCF Contribution	**£806,499**	**£806,499**

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
West Berkshire	£340,205	£0	Brought forward funding from 2022/23
Total Additional Local Authority Contribution	**£340,205**	**£0**	

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	£11,788,726	£12,455,968
Total NHS Minimum Contribution	**£11,788,726**	**£12,455,968**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	£84,707	£0	2022/23 ICB underspend
Total Additional NHS Contribution	**£84,707**	**£0**	
Total NHS Contribution	**£11,873,433**	**£12,455,968**	

	2023-24	2024-25
Total BCF Pooled Budget	**£15,971,413**	**£16,881,992**

Funding Contributions Comments
Optional for any useful detail e.g. Carry over

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: West Berkshire

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£2,065,205	£2,065,205	£0	£2,065,205	£2,065,205	£0
Minimum NHS Contribution	£11,788,726	£11,788,727	-£1	£12,455,968	£12,455,969	-£1
iBCF	£806,499	£806,499	£0	£806,499	£806,499	£0
Additional LA Contribution	£340,205	£340,205	£0	£0	£0	£0
Additional NHS Contribution	£84,707	£84,707	£0	£0	£0	£0
Local Authority Discharge Funding	£113,070	£113,070	£0	£188,450	£188,450	£0
ICB Discharge Funding	£773,000	£773,000		£1,365,869	£1,365,869	£0
Total	**£15,971,413**	**£15,971,413**	**£0**	**£16,881,992**	**£16,881,992**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£3,189,717	£4,876,064	£0	£3,370,255	£4,881,150	£0
Adult Social Care services spend from the minimum ICB allocations	£5,845,226	£6,265,573	£0	£6,176,065	£6,909,869	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No

>> Incomplete fields on row number(s):

60, 61,

									Planned Expenditure						
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Expected outputs 2023-24**	**Expected outputs 2024-25**	**Units**	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding
1	Under 65 LD residential and supported living	Residential Placements	Residential Placements	Care home		23.7	23.3	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution
2	Carers (Payments to Providers)	Carers Services	Care Act Implementation Related Duties	Safeguarding					Social Care		LA			Private Sector	Minimum NHS Contribution
3	Reablement	Intermediate Care Services	Home Care or Domiciliary Care	Domiciliary care packages		11131	11784	Hours of care	Social Care		LA			Local Authority	Minimum NHS Contribution
31	Reablement	Intermediate Care Services	Home Care or Domiciliary Care	Domiciliary care packages		7522	7522	Hours of care	Social Care		LA			Local Authority	iBCF
4	Memory and cognition over 65	Home Care or Domiciliary Care	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Private Sector	Minimum NHS Contribution
41	Memory and cognition over 65	Home Care or Domiciliary Care	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Private Sector	iBCF
42	Memory and cognition over 65	Residential Placements	Residential Placements	Nursing home		0.9	23.3	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution
5	Physical Support over 65	Home Care or Domiciliary Care	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Private Sector	iBCF

52	Physical Support over 65	Home Care or Domiciliary Care	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Private Sector	Minimum NHS Contribution
53	Physical Support over 65	Residential Placements	Residential Placements	Nursing home		1.3	1.4	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution
54	Physical Support over 65	Residential Placements	Residential Placements	Care home		0.3	0.4	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution
6	LA Discharge Funding	Support with Hospital Discharge	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		4916	8193	Hours of care	Social Care		LA			Private Sector	Local Authority Discharge
61	Carers support	Carers Services	Care Act Implementation Related Duties	Safeguarding					Social Care		LA			Private Sector	Minimum NHS Contribution
62	ICB Discharge Funding	Support with Hospital Discharge	Home-based intermediate care services	Reablement at home (to support discharge)		164	290	Packages	Social Care		LA			Charity / Voluntary Sector	ICB Discharge Funding
66	Under 65 LD residential and supported living	Residential Placements	Residential Placements	Care home		14.2	14.6	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution
7	Over 65's Care Homes	Residential Placements	Residential Placements	Care home		23.7	23.3	Number of beds/Placements	Social Care		LA			Local Authority	Minimum NHS Contribution
71	Over 65's Care Homes	Residential Placements	Residential Placements	Supported housing		2.6	2.7	Number of beds/Placements	Social Care		LA			Local Authority	Minimum NHS Contribution
8	Joint Care Pathway	Intermediate Care Services	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		8151	8654	Hours of care	Social Care		Joint	10.0%	90.0%	Local Authority	Minimum NHS Contribution
81	Joint Care Pathway	Intermediate Care Services	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		11518	12229	Hours of care	Social Care		Joint	10.0%	90.0%	Local Authority	Minimum NHS Contribution
82	Joint Care Pathway	Intermediate Care Services	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		9443	9443	Hours of care	Other	Joint Health and Social Care Service	Joint	10.0%	90.0%	Local Authority	iBCF
83	Joint Care Pathway	Intermediate Care Services	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		9591	10183	Hours of care	Other	Joint Health and Social Care Service	Joint	10.0%	90.0%	Local Authority	Minimum NHS Contribution
84	Joint Care Pathway	Intermediate Care Services	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		23854	25130	Hours of care	Other	Joint Health and Social Care Service	Joint	10.0%	90.0%	Local Authority	Minimum NHS Contribution
9	DFG	DFG Related Schemes	DFG Related Schemes	Adaptations, including statutory DFG grants		325	325	Number of adaptations funded/people	Social Care		LA			Private Sector	DFG
10	DTOC Projects	Mental Health Link Worker	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Private Sector	iBCF
11	DTOC projects	EDS	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	iBCF
12	CHC Reviews	CHC review	Other						Social Care		LA			Private Sector	Additional LA Contribution
13	Locality Lead	BCF Lead	Other						Social Care		Joint	0.0%	100.0%	Local Authority	Minimum NHS Contribution
13	CHC Reviews	CHC review	Other						Social Care		LA	0.0%		Local Authority	Minimum NHS Contribution
141	BCF Data Analyst	Other	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	Minimum NHS Contribution

15	IMHA and Veterans	Prevention/Early intervention	Prevention / Early Intervention	Risk Stratification					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution
17	BHFT Contract	Intermediate Care Services (Reablement)	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		888	888	Hours of care	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
18	BW PMO	Share of cross Berkshire West Programme Management	Enablers for Integration	Programme management					Other	ICB	NHS			NHS	Minimum NHS Contribution
19	CCG Continency	Share of cross Berkshire West Contingency Funding	Other						Other	contingency	NHS			NHS	Minimum NHS Contribution
20	Risk Share	Risk Share	Other						Other	Risk Share	NHS			NHS	Minimum NHS Contribution
21	Care Homes (RRAT) (ICB Hosted scheme)	Intermediate Care Services	Prevention / Early Intervention	Risk Stratification					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
22	SCAS falls and frality (ICB Hosted scheme)	Cross Berkshire scheme to prevent hospital admissions	Prevention / Early Intervention	Risk Stratification					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
23	Street Triage (ICB Hosted scheme)	Reduce the number of section 136's	Prevention / Early Intervention	Risk Stratification					Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution
24	Connected Care (ICB hosted)	Data Integration between Health and Social Care	Enablers for Integration	System IT Interoperability					Other	Joint Health and Social Care Service	NHS			Private Sector	Minimum NHS Contribution
25	CHS	Service was commissioned by Acute - now done through LA	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		NHS			Local Authority	Minimum NHS Contribution
26	Out of Hospital Services - Speech & Language	Intermediate Care Services	Prevention / Early Intervention	Risk Stratification					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
27	Out of Hospital Services -Care Home in reach	Support Care Homes across BW to prevent hospital admissions	Prevention / Early Intervention	Risk Stratification					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
28	Out of Hospital Services - Community	Support Care Homes across BW to prevent hospital admissions	Prevention / Early Intervention	Risk Stratification					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
29	Out of Hospital Services - Intermediate Care	Intermediate Care Services	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		108	108	Hours of care	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
30	Out of Hospital Services - Health Hub	Integrated care planning and navigation	Integrated Care Planning and Navigation	Care navigation and planning					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
31	Out of Hospital Service - Intermediate Care	Intermediate Care Services	Home-based intermediate care services	Rehabilitation at home (to support discharge)		181	181	Packages	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
42	23/25 priority 1	Recruitment & Retention (Enabler to support BCF Objectives) (using 22-23 Carry Forward WBC and £84k ICB	Workforce recruitment and retention						Social Care		LA			Local Authority	Additional LA Contribution
44	23/25 priority 2	Targeted Community Outreach Programme (using 22.23 Carry Forward)	Other						Social Care		LA			Local Authority	Additional LA Contribution
45	23/25 priority 3	Falls Pathway (using 22.23 Carry Forward)	Other						Social Care		LA			Local Authority	Additional LA Contribution
47	23/25 priority 4	Self Care Programmes (using 22.23 Carry Forward)	Other						Social Care		LA			Local Authority	Additional LA Contribution
48	23/25 priority 5	Market Management Position (winter)	Other						Social Care		LA			Local Authority	Minimum NHS Contribution

43	23/25 priority 1	Recruitment & Retention (Enabler to support BCF Objectives) (using 22-23	Workforce recruitment and retention						Social Care		LA			Local Authority	Minimum NHS Contribution
46	23/25 priority 3	Falls Pathway (using 22.23 Carry Forward)	Other						Social Care		LA			Local Authority	Minimum NHS Contribution
142	BCF Data Analyst	Other	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	iBCF
48	23/25 priority 1	Recruitment & Retention (Enabler to support BCF Objectives) (using 22-23	Workforce recruitment and retention						Social Care		LA			Local Authority	Additional NHS Contribution
49	DTOC Projects	MH Link Worker	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	Minimum NHS Contribution
50	DTOC projects	EDS	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	Minimum NHS Contribution

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.

15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: West Berkshire

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	130.2	127.5	132.4	129.0	We continue to peform well in this area and our one of the top 10 performing systems across the country. We will maintain our peformance from last year against an increase in our population 65+.	Our local plan includes: a deep dive into our local data, workforce Recruitment and retention of Social Workers and Occupational Therapists, Self-care programmes, Targeted Community NHS Outreach Programme, JOY App, health checks, Ageing Well, Virtual Wards, Resiliant Primary Care, Social Care Hubs
	Number of Admissions	238	233	242	-		
	Population	158,465	158,465	158,465	158,465		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	130.3	127.5	132.4	129		

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,779.3	1,717.2	1,686.0	Data has been extracted from the SUS inpatients Episode data in line with given methodology: primary diagnosis code, external case code for fall found in a secondary diagnosis, episode order number of 1, admission method code starting in 2, admissions only included where a Local Authority code can be identified and patient aged 65+ at time of	Our local plan includes: SCAS Falls & Frality Services, BHFT Falls Service, continue running our Steady Steps prevention classes, a number of prevention activities through our public health team including : wellbeing walks, get berkshire active (GBA), Love to Pedal. The Ageing Well group, which is a sub-group of the HWB has develped a falls preventation web
	Count	565	542	531		
	Population	31,789	31,789	31,789		

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	91.4%	91.6%	91.1%	91.0%	The SUS Data on the Better Care Exchange differs to what we have been reporting locally. Locally we reported: Q1, 88.7%, Q2, 89.9%, Q3, 88.6% and Q4 88.5%. This has been escalated to the ICB who are doing a deep dive into the data. We are looking to maintain performance of 91%.	A deep dive into the backing data is currently taking place to see if a trust is duplicating records locally. Also local data is reporting less discharge code 19 (usual place of residence), this would indicate that some records are missing from local data. The local plan is to continue to adopt the Home First approach.
	Numerator	2,536	2,570	2,619	2,631		
	Denominator	2,774	2,806	2,875	2,891		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Quarter (%)	91.4%	91.6%	91.1%	91.0%		
	Numerator	2,536	2,570	2,619	2,631		
	Denominator	2,774	2,806	2,875	2,891		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	607.6	611.7	645.5	616.4	The final year end outturn for 22/23 was 210 new admissions (ASCOF 2A, part 2). Admissions have significantly increased this year. The early part of 22/23 was really challenging in sourcing care in the home - this is when high admissions were	The LA's Hospital Discharge Team held an away day on 24/5/23 and this issue was discussed. We must try to re-educate the Trusts that Home First should be tried first, it was reported that once a consultant makes up their mind re: PW3 it is very
	Numerator	189	199	210	205		
	Denominator	31,106	32,533	32,533	33,257		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	88.3%	85.3%	88.7%	85.0%	The outturn for 22/23 was 88%. Over the last few years West Berkshire has continued to see an increase in the number of people accessing reablement from hospital, we have a low threshold to access this service. The increase can also	Currently our threshold for accepting people on to enablment is low, but we are aiming to review the pathway meaning we can target enablement more effectively. However this process change will take time to progress but is is hoped the review
	Numerator	159	162	181	170		
	Denominator	180	190	204	200		

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4**	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan

Additional discharge funding	**PR5**	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans
NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan

Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Have stretching ambitions been agreed locally for all BCF metrics based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan

Right Care, Right Person

T/Superintendent Helen Kenny

What is Right Care Right Person ?

- National partnership agreement between National Police Chiefs Council (NPCC), Home Office, Department of Health and Social Care, NHS England
- Partnership agreement signed July 2023
- Aim of RCRP is to ensure an appropriate response from the appropriate agency is given to incidents where there are concerns for welfare linked to mental health, medical or social care issues.
- Primary driver: right person with the right skills, training and expertise responds.
- Police are often the default first responder despite the fact we are often not the appropriately trained or skilled service provider
- People in need feeling stigmatised or criminalised by police involvement

What is Right Care Right Person?

- Developed in Humberside in 2019 following the HMICFRS report “Picking Up the Pieces” which identified the excess police time and resource dealing with Mental Health.
- NPCC and College of Policing have worked with Humberside to develop this into a national protocol. National Partnership Agreement and guidance toolkits agreed and developed to support implementation on a local basis.
- Right Care Right Person is NOT about demand reduction, however this may be an outcome of ensuring that the police are not inappropriately used in health incidents.
- Free up police capacity to service demand that only the police can deal with.

RCRP Principles

- **To ensure health calls for service are responded to by those with the right skills and expertise to provide the best possible service**

- **Police will continue to respond where:**
  - Clear policing purpose
  - Immediate threat to life
  - Immediate threat of serious injury

- **Legal Responsibilities**
  - Real and Immediate threat to life – Article 2 ECHR
  - Real and Immediate threat of serious harm / torture / inhumane treatment – Article 3 ECHR
  - Common Law duties of care
  - Statutory duties

RCRP Model

Health Calls for Service	Police will not automatically respond to a call for assistance if it is assessed that the Health partner should be in a position to manage the situation.
Welfare Checks	Police will not automatically conduct a welfare check on behalf of another organisation. If there is no police power that is required and it is “just” a concern, it is unlikely that police will deploy.
AWOL patients from psychiatric hospitals	S18 MHA gives hospital staff and others the same power to return a patient as a constable. The hospital will be expected to manage their patient and take all reason able steps to return them without resorting to police in most circumstances.
Walk out from health facilities (e.g. A&E)	The facility has a duty of care to their patient and will be expected to undertake all reasonable enquiries to locate their patient if that is necessary. Unless there is an Article 2/3 issue, it is unlikely to be a matter for the police.
Police Use of S136	Work is underway to explore health based triage and Mental Health Ambulances. Consideration being given to real alternatives to S136.
Voluntary Attenders	Partnership work is required to improve practice in this area. Police need to ensure that any Duty of Care that has been assumed by the police is properly discharged. (If we have taken someone voluntarily to A&E then we have an assumed Duty of Care.)

RCRP in Thames Valley

- Early evaluation force – supported by the Home Office
- Chief Constable sign off April 2023
- Phased roll out from May 2023
- TVP Management Group – Led by Chief Supt Emma Garside
- TVP invested 10 specialist mental health officers
- Bi-weekly national RCRP governance
- COP released 3 toolkits to support Forces
- Contact Management has already received training on the toolkit and have started to use the guidance to decide on deployment. Under continuous review based on feedback from partners

RCRP in Thames Valley

- Three areas of RCRP adopted:

1. Concern for safety (welfare checks)
2. AWOL from psychiatric hospitals
3. Walk outs from healthcare settings

- Three areas not adopted

1. Section 136
2. Voluntary mental health patients
3. Transportation / conveyance

- Not applicable to children

RCRP in Thames Valley – Strategic Engagement

- Chief Constable meeting with Mental Health Chief Executives
- Police and Crime Commissioner Strategic Management Board Mental Health Strategic Partnership meeting
- Local Authority Community Safety Managers
- Letter and briefing pack to all partners
- TVP and NHS England meeting to discuss next steps
- SCAS and Fire and Rescue
- Local Authority Chief Execs and Directors of Adult Social Care
- ICB Chief Execs
- Safeguarding independent chairs
- Independent Office of Police Complaints (IOPC) Thames Valley Coroners
- Strategic Management Board for RCRP (Police / NHS England co-chair)

Local Response to Cost of Living Increases Update Report

Report being considered by:	Health and Wellbeing Board
On:	3 October 2023
Report Author:	Sean Murphy
Report Sponsor:	Sean Murphy
Item for:	Decision

1. Purpose of the Report

This purpose of this report is to update the Health and Wellbeing Board on the collective response to the impact on residents in West Berkshire of the rise in the cost of living.

2. Recommendation(s)

That the Health and Wellbeing Board:

(a) **NOTES** the report and the response of partners to date.

(b) **RESOLVES** that the Service Lead for Public Protection report on progress to the Board at its meeting in December 2023.

3. Executive Summary

3.1 On the 13th July 2023 the Board received an update on the response by the Council and voluntary sector partners to support residents facing challenges as a result of the increase in the cost of living.

3.2 Since the 13th July meeting, we have seen further decreases in the headline rate of inflation. This week it was reported that Consumer Prices Index (CPI) inflation stood at 6.7% in the year to August. However, the inflation rate for food and non-alcoholic beverages stands at 13.6%. This is one of the major causes of financial pressure on households. There has also been an increase in petrol and diesel prices, which continue to tick up. However, fuel prices are significantly lower than 12 months ago. A summary of inflationary effects and drivers can be found here: Consumer price inflation, UK - Office for National Statistics

3.3 On 1st October, the energy price cap was reduced to £1,923 a year for a typical household who use gas and electricity and pay by Direct Debit. The level of the energy price cap is based on typical household energy use and reflects recent falls in wholesale energy prices. The July 2023 to September 2023 price cap had stood at £2,074 for an average household. Although the trend is downward, the energy price cap (reverting slightly below the April 2022 level) is still significantly higher than the October 2021 where it stood at £1,277.

3.4 The other significant issue is the rise in interest rates and the effect on borrowing including mortgages. At the time of writing the BoE 'base rate' stands at 5.25%. In December 2021 it stood at 0.1% and had been below 1% since January 2009 until early 2022. This has had significant affect for those on variable rate mortgages and those on fixed rate mortgages where the fixed period has ended leaving holders with 'Standard Variable Rate' mortgages of around 8.5%. There is some evidence that new fixed rate mortgages are falling slightly, but they are significantly higher than the rates householders previously held or had access too. Inevitably this has impacted rentals which have also risen significantly.

3.5 At the meeting on the 13th July 2023, it was also resolved that we should arrange a meeting between the Council, Greenham Trust and voluntary sector partners to discuss challenges faced by the organisations (some of which were set out in the July report), as well as options for working together over the 2023/24 autumn / winter period. Because of the summer holiday period, the earliest that meeting could be organised was the 29th September 2023. Therefore, the outcomes of that meeting will be reported verbally.

4. Household Support Fund

4.1 At the July meeting, there was also a discussion regarding the allocation and distribution of the Household Support Fund for 2023/24. It was agreed that more information would be provided to the Board.

4.2 The allocation for West Berkshire for 2023/24 is **£1,389,699.** There are guidelines issued with the allocation to create a delivery plan on how the funds should be spent and distributed with a number of priorities being identified including:

- Funds should be spent or committed before 31 March 2024 and cannot be carried over for future usage.
- Use the funding from 1 April 2023 to 31 March 2024 to meet immediate needs and help those who are struggling to afford energy and water bills, food, and other related essentials. Authorities can also use the funding to support households who are struggling to afford wider essentials including housing costs where existing housing support does not meet this need.
- It is understood that local priorities for the Fund may change over the course of the Fund Period, including in response to local feedback, such as from professionals working with households.

4.3 Having considered the guidelines, the below policy was completed 2 May 2023 and determined that the Fund should be distributed as set out below:

Scheme	Detail	Allocation
Free School Meal Vouchers	7 weeks of support per annum at £3 per day per child. Estimated support c4,000 children.	£420,000
Older people	Targeted funding in partnership with registered providers or other identified charities.	£40,000

Main element	Large Family claim – £300 Family Claim - £250 Household claim – £150 per claim	£740,729
Main element	Set aside funding for distribution through local charities and match funded projects	Up to £50,000
Admin	Max eligible 10%	£138,970
Total		**£1,389,699**

4.4 The criteria for spend in the main element includes energy, food, clothing and household costs. At the w/c 18th September 2023, the number of applications received was 1,105 with 602 approved and 451 rejected. The remainder were pending. The main reasons for rejection were: duplicate applications, not enough information provided, and those not eligible. The total spend on the main fund is circa £150k. This is expected to rise significantly through the autumn and winter period with the effect of winter energy bills.

4.5 Looking ahead there is a campaign planned to promote the scheme. We are particularly looking at how we can support older people by working with partner agencies. To date the take up amongst this demographic has been low. This is something we also plan to raise at the meeting with the voluntary sector on the 29th September 2023.

5. Conclusions and Next Steps

5.1 The cost-of-living challenges faced by many have not gone away. Food inflation remains significantly higher than wage growth and this is one of the major drivers of pressure on household incomes. Whilst energy prices have fallen this year, they remain over £600 a year higher for a typical bill player than two years ago. There are also no energy vouchers available this year to mitigate costs for those on pre-paid meters.

5.2 The voluntary sector continues to report increasing pressures. A recent discussion with the Community Resource Centre explored the significant increase in the demand for appliances and whether working collaboratively could help address the demand.

5.3 The issues that people are facing are by and large the same issues that were in part addressed last winter through the Cost-of-Living Hub. The meeting on the 29th September 2023 will explore options for this year and will be reported to the Board on the 3rd October 2023.

6. Appendices

None

Background Papers:

- None

Health and Wellbeing Priorities Supported:

The proposals will support the following Health and Wellbeing Strategy priorities:

☒ Reduce the differences in health between different groups of people
☒ Support individuals at high risk of bad health outcomes to live healthy lives
☒ Help families and young children in early years
☒ Promote good mental health and wellbeing for all children and young people
☒ Promote good mental health and wellbeing for all adults

The proposals contained in this report will support the above Health and Wellbeing Strategy priorities by helping to mitigate the impacts of the cost of living increases.

Agenda Item 11

Finance and Mental Health

Report being considered by:	Health and Wellbeing Board
On:	3 October 2023
Report Author:	Adrian Barker
Report Sponsor:	Cllr Janine Lewis
Item for:	Decision

1. Purpose of the Report

The Mental Health Action Group (MHAG) presented its report on financial problems and mental health to the Health and Wellbeing Board (HWB) at its meeting on 23rd February. The Board asked the MHAG to refine its proposals, in conjunction with partner organisations, before bringing them back via the Steering Group, to the Board for final approval.

2. Recommendation(s)

The Board is asked to agree the proposals outlined below and note progress against achievement of the original proposals

3. Executive Summary

3.1 The Mental Health Action Group has reviewed the original proposals it put to the Board at its meeting in February 2023, in conjunction with partner organisations. The results of that further work are set out in the Appendix. The majority of the original proposals are either complete or in train and the Board is asked to note those. There are three areas where further consideration by the Board is requested, as set out in full in the Appendix. These are summarised below in section 6, Proposals.

4. Supporting Information

4.1 The work of contacting relevant bodies to refine the proposals has been taken forward principally by Adrian Barker, as chair of the Mental Health Action Group and Rachel Johnson, as the lead support to the MHAG. In the earlier phases, there was support from Cllr Jo Stewart as the Council's then mental health champion. An interim report was taken to the Board's Steering Group in June, as a result of which further help was offered to obtain responses from various stakeholders. At its most recent meeting the group initiated further action, being led by Cllr Janine Lewis and Cllr Jo Stewart.

4.2 This report does not attempt to revisit the original report, which is taken as given. The appendix provides a brief summary of the background to each proposal, before reporting on progress. Some additional information gleaned from further investigation is also provided where relevant in relation to some of the proposals (particularly around council tax and debt collection).

5. Options Considered

For each of the proposals, different ways in which the objectives could be achieved, within given resources, have been considered.

6. Proposal(s)

6.1 The Board is asked to agree the recommendations, as set in more detail in the appendix, on proposals as follows:

6.2 On Proposal 4, supporting and developing the Community Mental Health Transformation Programme, the original proposals were largely in line with the ICB Joint Forward Plan, so they have been revised to adhere even more closely to that wording. The Board is invited to agree the revised recommendation, supporting the roll out of the Community Mental Health Transformation Programme and further objectives as set out in the ICB's Joint Forward Plan and Service Delivery Plan, building GP-led integrated neighbourhood teams with the supporting estates strategies.

6.3 On Proposal 5.4, The Board is invited to request that the BHFT representative on the Board provides a response to the original proposal on front-line mental health support staff providing basic financial advice signposting.

6.4 On Proposal 10, the Board had previously suggested that consideration be given to the problem of people being in financial difficulties because they were victims of fraud or scams, noting the work of Thames Valley Police on this. This is acknowledged in the appendix which proposes that the Health and Wellbeing Board supports the work and that partner organisations help spread appropriate messages and make links to resources where possible.

6.5 The Board is asked to note progress on the remaining original proposals. No further action from the Board is needed on these at the present time.

7. Conclusion(s)

7.1 Mental health problems linked with people's personal financial problems are a significant problem. However, the causes of the problems are complex and multiple factors need to be addressed. Many of the things which could help with financial problems and mental health will also help address other objectives in the Health and Wellbeing Strategy. Ideally, a whole-systems approach would be undertaken due to the complex interplay of factors that influence not only people's mental health but also their physical health, social needs and health inequalities.

7.2 While quite ambitious, the original proposals put to the Board, as noted in the original report, in many ways just scratched the surface and had to be seen as a starting point. The Mental Health Action Group will therefore continue to do what it can to continue to address these issues, working with other sub-groups where appropriate and possible.

8. Consultation and Engagement

The individuals and organisations consulted in preparation of this report include:

- Revenues and Benefits Manager, WBC

- Health and Wellbeing in Schools Coordinator, WBC
- Environment Delivery Manager, WBC
- Lead for All Age Mental Health, LD, Autism and SEND, BOB ICB
- Digital Literacy Lead, BOB ICB
- Citizens Advice West Berkshire
- Volunteer Centre
- Sovereign: Senior Customer Accounts Manager and Customer Accounts Manager Reading and Newbury
- Superintendent, Area Commander – West Berkshire Local Police Area
- Health and Wellbeing Board Steering Group

9. Appendices

Appendix A – Commentary on Proposals

Background Papers:

A number of external reports and documents have been used in the preparation of this report and these are referenced.

Health and Wellbeing Priorities Supported:

The proposals will support the following Health and Wellbeing Strategy priorities:

☒ Reduce the differences in health between different groups of people
☒ Support individuals at high risk of bad health outcomes to live healthy lives
☐ Help families and young children in early years
☐ Promote good mental health and wellbeing for all children and young people
☒ Promote good mental health and wellbeing for all adults

The proposals contained in this report will support the above Health and Wellbeing Strategy priorities by seeking to reduce some of the factors impacting on mental health, particularly those already suffering from health inequalities such as those living in poverty, many of whom will be at high risk of bad health outcomes.

Appendix A

This appendix provides the commentary on the progress against each of the original proposals and explains the reasons for the recommendations in this report.

10. Proposal 1 – Work with schools

Original proposal:

> P1.1. Primary and secondary schools to develop students' financial management skills in appropriate ways, building this into the curriculum where possible. The Schools Health and Wellbeing Officer to be asked to oversee the implementation of this proposal, delegating to others as appropriate. They should be asked to report back on progress to the Health and Wellbeing Board by February 2024.

As the original report noted, developing children and young people's financial management skills can have considerable beneficial effects well into the future. Improving financial education in schools is already a national objective, being pursued by the arm's-length government body, the Money and Pensions Service. There are already some requirements within the national curriculum to cover relevant issues. In primary school, children should be able to recognise the symbols for pounds and pence and be able to add and subtract money values and work out what change to give. In secondary school, it is covered as part of citizenship and maths. "Pupils should be taught about the functions and uses of money, budgeting, managing risk, credit and debt, insurance, savings and pensions, financial services and applying maths to financial contexts (such as calculating interest)."[1]

The Health and Wellbeing in Schools Coordinator was already active in pursuing this objective and has welcomed further suggestions as part of this work. For instance, he produced, with the help of Citizens Advice, a video that was sent to West Berkshire schools at the end of April 2023, talking about financial issues relevant to children and young people.

There was limited response by schools to a request from the Health and Wellbeing in Schools Co-ordinator as to current provision of financial management education. Only three of the ten secondaries replied, but it is thought likely that their responses were representative of the others. They offered approximately six lessons around money and financial decisions at Key Stage 3 (years 7-19, ages around 11-14). One school had an external speaker on the risks of gambling. All 3 schools then followed up with lessons around personal finances in sixth form. It is thought that most of the secondary schools would be doing something similar.

A survey that was developed by officers from West Berkshire Council in partnership with Berkshire Youth was conducted in January and February 2023 (again, already underway, not as a result of this work). In total 6,353 responses were received for the questionnaire which equates to half (49.7%) of all students at West Berkshire maintained and academy secondary education settings. One of the questions asked was, "What do you think are the most important concerns facing you and other young people at the moment?" with 20 options, out of which they could pick five. The second highest, at 54.6% was 'Mental health and wellbeing'. The seventh highest was 'Money' at 23.2%.

[1] https://www.moneyandpensionsservice.org.uk/financial-education-in-schools/

Elsewhere, (question 9), the survey asked "Which issues, if any, would you like more information or support with" and 22.4% responded "Money", the fourth most popular, and higher than bullying and relationships. The second highest was "Mental health and wellbeing".

In discussion with the Schools Health and Wellbeing in Schools Coordinator, it is felt that the most helpful approach will be to signpost to teachers the many existing (and mostly free) resources that will support the teaching of financial understanding and skills. We are therefore helping with identifying the relevant resources that the Health and Wellbeing in Schools Coordinator will raise awareness of. It is also worth noting that there is a 'Talk Money Week', from 6-10 November 2023 and it may be possible for some activities to be organised on the back of that.

It is proposed that the Board note this ongoing work. Given that the Health and Wellbeing in Schools Coordinator is already progressing this work, it is not felt that a report on progress in February 2024 will be necessary.

11. Proposal 2 – Information and Advice

Original proposals:

> P2.1 As part of delivery action 2.9.5 and 2.9.6 it is proposed that a brief task and finish group, including relevant voluntary organisations and individuals, be set up to review the content of the West Berkshire Directory and Cost of Living hub, and make sure all relevant sources (including those described above) are linked to.
>
> P2.2. The Public Health and Wellbeing team at West Berkshire Council, and others providing such material, should be asked to review the leaflets, z-cards and other hard copy information they provide to make sure the full range of information on financial management is available.
>
> P2.3. The Health and Wellbeing Board is asked to consider whether any other communications such as videos or an information campaign would be worthwhile and if so to delegate action to the appropriate communications teams

Some progress has already been made against these proposals, including updating some of the Council's hard copy leaflets, such as the mental health 'z-card'.

Council officers and voluntary sector organisations have expressed their willingness in principle to be involved in further reviews of hard copy and online information, so the Mental Health Action Group is now exploring ways in which this might be taken forward, perhaps in conjunction with Proposal 8.

Given all the other work that has been done, arising out of the cost of living crisis, including setting up the hub and links to sources of help on the Council's website, it is not felt that a broader information campaign would be helpful at this time.

The Board is asked to note ongoing progress in implementing this proposal.

12. Proposal 3 – Digital Inclusion

Original proposal:

> P3.1. It is proposed that a task and finish group be set up to consider how this work could best be co-ordinated and report back to the Health and Wellbeing Board by September 2023. Invitations to attend should include representatives of the ICB (e.g. the Digital Programme Manager / Digital Literacy Lead), the Berkshire Digital Infrastructure Group, NHSE South East Region and the Patient Panel West Berkshire.

Contact was made with the various bodies thought to have a role. The Berkshire Digital Infrastructure Group felt that as their role was purely about infrastructure, it was not appropriate for them to get involved. The Digital Literacy Lead in the Primary Care Digital Team at the BOB ICS kindly organised two meetings of relevant parties, which was very helpful in allowing each to understand what the others were doing, and to aid co-ordination. The Digital Literacy Lead also provided further valuable information about her work.

A task of developing digital inclusion champions has been allocated to the Mental Health Action Group in the revised Health and Wellbeing Strategy delivery plan. Options for how this could be delivered are currently being considered by the Mental Health Action Group and any implementation will be taken forward through the appropriate processes.

In addition, there is scope for bringing together some of the existing work across health, the local authority, voluntary and private sectors. Digital inclusion is only one of many wider issues impacting on mental health and it is also relevant to a number of other Health and Wellbeing objectives. It is therefore often a small part of the job of many different organisations and individuals. A worthwhile objective, to move this agenda forward, would be to co-ordinate existing activity with a view to expanding its effectiveness through information sharing and mutual support. This would relate to the objectives of a number of other HWB sub-groups, but particularly the Health Inequalities Task Force, who could also be involved, subject to other demands on them. This might be done by, for instance, running occasional liaison events to bring the various parties together and encourage sharing of information between the events.

The Board is asked to note the progress on developing digital inclusion champions and promoting the digital inclusion agenda by bringing together those already working on this issue to share information and provide mutual support.

13. Proposal 4 – Support and Develop the Community Mental Health Transformation Programme

Original proposals:

> P4.1. The Health and Wellbeing Board should commit to supporting this initiative and making it a success. That should include leading by example in supporting the programme, encouraging its partner members to engage productively with it and receiving regular progress reports on the implementation.
>
> P4.2. The second element of this proposal is, in time, to expand the programme to support a wider range of people.

> P4.3. The third element of this proposal is to build into the estates strategies or other policies (such as land use planning) of the HWB constituent bodies the identification of suitable premises to form physical wellbeing hubs.

MHAG has received a number of updates from BHFT on the progress of the Mental Health Transformation Programme, including the Mental Health Integration Community Service (which is the local model for implementing the Community Mental Health Framework).

The MHAG has taken on as an objective:

> "5.4.5: Monitor and support the implementation and development of the new Mental Health Integrated Community Service in West Berkshire"

The original proposals are largely in line with the way the ICB is moving forward. For instance, the service delivery plan of the Joint Forward Plan includes in its objectives and actions:

- 'Continue to mobilise the community mental health framework for Adults and Older People' (p.42)

The five year ambition for primary care includes:

> "We will transform how primary care is delivered in each community / neighbourhood, enabling integrated primary care provision which **improves the access, experience and outcomes for communities aligned to their needs**. Through the mobilisation of integrated neighbourhood health and care teams, primary care services will become more sustainable, and patients will get the support they need when they need it." (p.83)

The 'delivery focus' associated with that ambition includes:

> "Create the infrastructure across BOB to implement the change (Estates, Workforce & digital)." (p.83)

Estates strategies are to support the broader goals, e.g.:

- "Develop BOB primary care strategies for estates and workforce linked to system, place and neighbourhood.
- Complete roll out of the PCN Estates toolkit." (p.101)

It therefore suggested that the proposal be revised accordingly, to read:

The Health and Wellbeing Board should commit to supporting the Community Mental Health Transformation Programme to help make it a success. That should include leading by example in supporting the programme, encouraging its partner members to engage productively with it and receiving progress reports on the implementation as appropriate.

The Board supports the BOB ICB's objectives in the Joint Forward Plan and its service delivery plan to continue developing the community mental health framework, build GP led integrated neighbourhood teams and develop the estates strategies, including 'participation in work public estate initiatives', to achieve the objectives.

14. Proposal 5 – Financial management

14.1 Voluntary sector training

Original proposal:

> P5.1. The Volunteer Centre should be asked to co-ordinate training offered on a voluntary basis, whether to public or voluntary sector organisations. This should also include basic mental health training.

We approached the Volunteer Centre and then put them in touch with the individuals we had come across offering free training on financial management. The course was then advertised to voluntary organisations.

It is also worth noting that the Volunteer Centre already runs courses on suicide prevention. They also held a voluntary sector forum examining issues on mental health.

It is therefore felt that the original aims of this proposal have been met. The Mental Health Action Group will continue to liaise with the Volunteer Centre to consider any other opportunities that may arise.

The Board is asked to note the progress made.

14.2 The Commissioning of Financial Management Training

Original Proposal:

> P5.2. The Locality Integration Board should be asked to consider whether training of this sort could be commissioned in future as part of the Better Care Fund.

The Chair of the Mental Health Action Group has been invited to speak to the Locality Integration Board, when this can be considered (see also Proposal 6, below).

The Board is asked to note progress.

14.3 Benefit calculators on the Council website

Original proposal:

> P5.3 The relevant Council departments should be asked to review the benefit calculators they use to ensure that comprehensive advice is being given.

This issue was raised with us by stakeholders because the benefit calculator on the Council Tax area of West Berkshire Council's website provides an assessment of benefit that may be available only for Council Tax Reduction and Housing Benefit. It was therefore thought that this may be misleading for people who may not be aware of other benefits for which they are eligible.

There are links to a number of other comprehensive benefit calculators, from the cost of living area of the Council's website. We also heard how the cost of living hub takes a holistic approach, directing people to those calculators, other general sources of help or more specific local support, as appropriate.

The benefit calculator on the council tax area is only designed to apply to that particular area of benefits, and it would not be feasible for the council to make it more

comprehensive. However, it should be possible to make clear to anyone using it, that it is just for that purpose and to provide links to the other, more comprehensive calculators.

The Mental Health Action Group will continue to progress this with the council tax department as part of Proposal 8.2.

The Board is asked to note progress.

14.4 Provision of basic financial advice signposting by front-line mental health support staff

Original proposal

> P5.4. The Berkshire Healthcare Foundation Trust, through its representative on this Board, be asked to review the extent to which its front-line staff are able to offer basic financial advice and signpost to sources of help and how this could be improved, and to report back to this Board by September 2023.

The BHFT representative on this Board has been asked to address this proposal. No response has been received at the time of writing.

The Board is invited to request that the BHFT representative on the Board provides a response to this proposal.

15. Proposal 6 - Develop voluntary sector and peer support

Original proposal:

> P6.1. It is proposed that under the auspices of the Locality Integration Board, the commissioners of voluntary sector services, from the ICB and Council, together with the Volunteer Centre, be invited to review arrangements for commissioning services which could impact, directly or indirectly, on financial problems and mental health. They should also consider ways of improving the take-up of funding opportunities on offer. Where it is estimated to be cost-effective in the longer term, taking account of the full range of social costs and benefits, to consider inviting bids for services that would prevent such problems developing. This might be done through a joint commissioning arrangement or the Better Care Fund.

The Chair of the Mental Health Action Group has been invited to speak to the Locality Integration Board, when this can be considered. It has to be recognised that this is a potentially far-reaching proposal, with resource implications that may limit the options available. If any changes were deemed feasible and worthwhile as a result of this discussion, there might therefore need to be further decisions made by the partner bodies, including by elected members of the council.

The Board is asked to note the ongoing discussions on this issue.

16. Proposal 7 – Employers' Charter

Original proposal:

> P7.1. It is proposed that under the auspices of the Skills and Enterprise Partnership (a sub-group of this board), the key business related partners such as the Thames Valley Local Enterprise Partnership, the Thames Valley Chamber of Commerce and

the Newbury Business Improvement District, be invited to consider the value of employer charters and commitments to employers as well as employees, and if thought appropriate, to progress the introduction of one or more schemes into the area.

The Skills and Enterprise Partnership have agreed to receive and consider a paper considering the possible benefits of employer charters and commitments. No further action is therefore needed by the Health and Wellbeing Board.

The Board is asked to note progress on this proposal.

17. Proposal 8 - Improve service providers' processes

17.1 Feedback to service providers

Original proposal

P8.1. It is proposed that the Volunteer Centre and Citizens Advice be invited to take account of the issues raised in this report when providing feedback to service providers and consider whether it would be worthwhile holding a themed series of co-production events.

Having made a substantial input into this work, Citizens Advice are well aware of the issues the original report raised and will be using that experience in their contacts with providers. The Volunteer Centre, too, has done much work in this area and continues to do much valuable work, particularly on suicide prevention.

The Mental Health Action Group has not had the resources to pursue the idea of holding a themed series of co-production events, at this stage, but will continue to work with a range of stakeholders on this issue.

The Board is asked to note progress.

17.2 Council Tax

Original proposal

P8.2. It is proposed that West Berkshire Council, in consultation with relevant voluntary organisations, such as Citizens Advice, investigate ways of reducing the council tax burden on the most vulnerable families.

In our initial work, we heard how for some people, council tax liability constituted a significant financial burden, which contributed to stress and mental health problems. This was especially so when their total income was insufficient to meet their total outgoings.

In re-assessing the original proposal, we have done some further research on the problem and the issues that would be involved in undertaking the sort of review originally proposed.

There are clearly changes that could be made to local council tax arrangements to reduce the burden on the most vulnerable people (which are discussed further below). However, there would be a resource implication of such a review and it would take some time to be conducted and implemented. Once a review had been conducted and changes agreed, there would need to be a 12 week consultation period, with changes made from the following April (so in practice not until April 2025).

The review would have to consider the costs and benefits of any changes. There would be a benefit to the individuals whose council tax burden was reduced. However, this would have to be offset against the cost to the council[2] of the changes which would likely mean cuts to other services, with potential harm to the same or other groups. In theory, the reduced burden and mental health implications of changes to council tax could lead to savings in other public sector costs, particularly mental health and social care treatment, but this could be hard to demonstrate. There could also be implications of changes in council tax discounts for collection rates. It is also worth noting that the policy landscape has changed since the Council Tax Reduction Scheme was last amended in 2017 (e.g. the introduction of the Household Support Fund, in place of previous support).

If the Health and Wellbeing Board were minded to propose a review, it would still, of course, be up to West Berkshire Council, as the responsible body, on whether to undertake it. This would need to take a wider range of policy factors into account, beyond the impact on mental health.

As noted in the original report, we received a good deal of feedback, which is supported by research evidence, of the impact of financial problems on people's mental health. It is also worth noting that the council tax system is complicated and hard to understand, potentially making it difficult to negotiate, particularly for those under stress or who are time-poor.

If a review of the council tax burden were to be undertaken, there are a number of possibilities that could be considered. It is worth remembering that there are also a number of statutory discounts available (such as for students, hospital patients, residents of homeless hostels or people with permanent, severe, mental impairment) but we are here only concerned with those available to local discretion, principally through the Council Tax Reduction Scheme.

Councils have considerable discretion in how they set up their Council Tax Reduction Schemes. The main criteria are that it should specify reductions for people, or classes of people, who the authority considers to be in financial need. Reductions must also be made for certain classes of pensioners.

The main areas for discretion previously considered in relation to West Berkshire's scheme are:

- Change the minimum amount of Council Tax that working age adults have to pay, even if they are receiving a discount. This is currently 30%.
- Change the amount of capital that working age people can hold, above which they are not entitled to a discount. This was reduced from £16k to £6k from 2017.
- Change the Council Tax band to which support is provided. This was changed from band D to band C in 2017. In other words, for anyone in a band D or above property, the amount of discount is the level it would be if they were paying a band C rate.
- Change the minimum weekly amount of support. This was changed from £3 to £10 in 2017. In other words, if the amount of discount someone would be entitled to is £9.99

[2] Councils receive a grant from central Government to "contribute to the costs of administering local council tax support (LCTS) schemes. Allocations are calculated based on the latest LCTS caseload data and the latest Area Cost Adjustment." https://www.gov.uk/government/publications/localised-council-tax-support-administration-subsidy-grant-2022-to-2023. The amount allocated to West Berkshire for 2022-23 was £97,987. The amount could alter as a result of changes to the Council Tax Scheme.

a week or less, they receive nothing, meaning they could lose up to £500 over the full year.
- Change the taper used in the means-test calculation, currently 30%.
- Change the definition of 'vulnerable persons'. This is currently defined as those receiving various disability benefits, Employment and Support Allowance, a war pension or 'limited capability for work' within universal credit.

There are other ways of devising a Council Tax Reduction scheme. One approach which has been increasingly used by councils in recent years is escalating discounts based on income, organised into bands (this reduces the number of changes needed when income changes by a small amount). Under these, the discount rate depends on the range within which a person's income falls. For instance, there might be a 75% reduction for incomes below £115 a week, a 60% reduction for incomes between £115 and £184, 40% for incomes between £184 and £254 and so on. The bands can be different according to circumstances, e.g. whether or not there are children in the household, according to disability or caring responsibilities and so on.

It is also worth noting that Councils have a general power to reduce any council tax bill, including to zero, if they see fit, under S13a of the Local Government Finance Act 1992. This is generally only used in exceptional situations (such as if a house has been made uninhabitable because of flooding) but some organisations have suggested it could be used more broadly, such as if someone's income isn't enough to meet their outgoings, even after having tried to reduce expenditure and boost income. The Council also has an Exceptional Hardship Scheme which allows for discretionary payments to assist in customers reducing their Council Tax burden.

If the Council Tax Reduction scheme were to be reviewed, it would have to consider how different groups (with varying needs and vulnerabilities) would be affected by different permutations, as well as the impact on the total tax take. However, it would be difficult to model the cost of any revised scheme since much of the data would be unavailable, e.g. of those who wouldn't qualify under the current scheme but would under a new scheme.

As well as any review of the Council Tax Reduction scheme. it may be worth considering ways of making the scheme more understandable and easier to access. This could be done by reviewing and possibly expanding both generally available and targeted information. The current scheme is quite hard to explain and it may be worth reviewing how it is described on the website and in leaflets.

There may also be scope for an information campaign, targeting individuals or geographical areas where eligibility for discounts is likely, to let them know that they may be able to get reductions on their council tax bills and how to apply.

This could also be done in conjunction with efforts to encourage people to address any problems with arrears as soon as possible (see more on this below).

As noted above, the benefit calculator is an important tool for assessing how much benefit someone may be entitled to. However, it should be clearer that this does not calculate eligibility for all benefits and links should be provided on the council tax pages, to other, more comprehensive benefit calculators.

In conclusion, while there is some merit in the original proposal put to the Board, because of the nature of the work required and the range of factors requiring political decision, it is

not felt appropriate to make a specific recommendation, on whether or not there should be a review of the Council Tax Reduction scheme. However, this may be something given further consideration in the workshop to consider debt collection arrangements, proposed below.

The Board may wish to encourage further work to simplify explanations relating to council tax and the reduction scheme. Given the implications for a wider range of health and wellbeing strategy objectives beyond just mental health, this might be best done in conjunction with various other sub-groups.

The Board is asked to note ongoing work (together with action under Proposal 2) to revise hard copy and online information to make it more accessible and comprehensible and the possibility of considering revisions to the Council Tax Reduction scheme as part of the workshop on debt collection proposed below.

17.3 Debt Collection

Original proposal

> P8.3 it is proposed that the Health and Wellbeing Board asks the departments involved in debt collection in the council, relevant health bodies and other local organisations who are willing to participate, to review their arrangements through co-designed groups involving voluntary organisations and people with relevant lived experience.

As noted in the original report to this Board, there is a link between debt and mental health and this is frequently exacerbated when bailiffs (or enforcement agents, as they are properly called) are involved.

While people in debt may owe money to a wide range of organisations, including energy, telecoms, other utilities and private organisations, in attempting to address the problem locally, there are too many of them, often operating regionally or nationally, to be able to invite them all to come together to review their debt collection arrangements. We have held discussions with the Council and Sovereign, as the main such bodies with local discretion. In any event, it appears that councils are the main users, nationally, of bailiffs.

According to a 2020 report, councils were then the biggest users of bailiffs in the country[3]. Council tax arrears nationally have increased from £3.2bn in 2018-19 to £5.5bn as at March 2023[4]. The number of people claiming Council Tax Reduction in West Berkshire was 5,234 at March 2023 according to Government figures.

A number of problems with debt collection emanate from national rules, which mean that debts can quickly escalate. For instance, seven days after a reminder for a missed instalment payment, the council can demand payment of the whole of the rest of that year's council tax, within seven days. If bailiffs are instructed, there are set charges that the debtor (not the council) has to pay, in addition to what they already owe, including a £75 instruction fee, (for the case being sent to the bailiff), £235 for a bailiff visit and £110

[3] 'Collecting Dust', Centre for Social Justice, 2020, https://www.centreforsocialjustice.org.uk/library/collecting-dust-a-path-forward-for-government-debt-collection

[4] https://www.gov.uk/government/statistics/collection-rates-for-council-tax-and-non-domestic-rates-in-england-2022-to-2023

for removing and selling goods from the property. If someone does not take immediate action (for instance, if they are scared to open reminder letters) a relatively small debt could soon quickly escalate.

A report by the Centre for Social Justice[5], says:

> "Councils widely use measures in the Council Tax (Administration and Enforcement) Regulations 1992, which entitle them to rapidly escalate one missed council tax payment into an annual bill.(23) Within nine weeks, households struggling to meet the average Band D payment of £175 can therefore become liable for a £1,750 payment, before being subject to a range of additional and punitive charges which serve to exacerbate the initial debt issue.(24)" (p.10)

The report goes on:

> "Councils' growing reliance on bailiffs to enforce debts has made them the largest user of bailiffs in the country today (referring on 2.6m debts in 2018–19) (25). Yet this remains an ineffective and costly approach. For every £1 of debt referred only 27p is returned (26). Meanwhile, this activity puts downward fiscal pressure on a wide range of support services due to the proven negative effects of enforcement, not least the stress and anxiety it causes those already in vulnerable or financially difficult circumstances.(27)"

Government advice to councils on council tax collection reports the various ways councils deal with the issue to increase collection rates and reduce the stress on people owing money[6].

There have been campaigns and attempts nationally over recent years to improve standards in the bailiff (enforcement agents) industry. For instance, earlier this year, the Enforcement Conduct Board was set up to try and improve standards, on a voluntary basis[7]. They are due to be setting up a registration scheme for enforcement agents, imminently.

Sovereign, like other housing associations[8] takes a supportive approach to managing tenant arrears. This long-standing approach was enhanced last year by the establishment of an internal debt advice team which works with the tenancy support team. There is also a customer income adviser team to help people with benefits and an employment and training section, to help get people into training or paid work. Their processes are built on the principle of helping tenants manage their finances. At an early stage, they will make contact with tenants to identify relevant issues and either provide help directly or refer them to other sources of support. Mental health, as well as other disabilities, is one of a range of factors taken into account when dealing with tenants' issues. For instance, teams will tailor their communications with tenants based on particular circumstances.

As with council tax arrears, there can be difficulties when people do not engage. One approach to this taken by Sovereign is to contract with Shelter, to whom they can refer

[5] Collecting Dust, 2020, https://www.centreforsocialjustice.org.uk/library/collecting-dust-a-path-forward-for-government-debt-collection
[6] https://www.gov.uk/government/publications/council-tax-collection-best-practice-guidance-for-local-authorities/council-tax-collection-best-practice-guidance-for-local-authorities#next-steps-when-a-resident-misses-an-instalment
[7] https://enforcementconductboard.org/
[8] https://www.housing.org.uk/resources/housing-associations-tenancy-sustainment-coronavirus/

tenants in difficulties. They can be seen as more impartial and therefore hopefully more acceptable to tenants. This was piloted last year in Devon and has now been taken on across all of the areas in which Sovereign operates.

The bulk of those that the Association works with are current tenants, with slightly different processes, but the same general ethos, for former tenants and those with leaseholder or shared ownership. Bailiffs are not used for current tenants. Whilst a third-party collection service is used for former tenant debt, the costs of that are not passed on to the customer.

The ultimate action to deal with unpaid debt is repossession of the property but every effort would be made to avoid this, with a series of checks and actions at each stage of the process. Very few cases actually end up in court, but even then, further steps are taken to try to resolve the situation without an eviction.

Sovereign's approach is in many ways similar to that in Lambeth and Southwark as described in the original report to this Board in February, which provides "a holistic response to people's financial and health support needs."[9]. However, the Lambeth and Southwark scheme also brings together GP practices, Primary Care Networks, social prescribing teams, and local authority and housing association creditors together with advice and community-based support agencies and is supported by a Joint Debt Protocol.

Whilst there are important lessons to be learned from Sovereign's approach, it would be naïve to think it could be simply transplanted into other organisations locally. They have different regulatory frameworks, histories, resource constraints and other circumstances. On the other hand, it would be a mistake to think that no lessons could be learned or to miss the opportunities for more effective working across local organisations.

The Mental Health Action Group therefore plans to organise a half day workshop, bringing together a wide range of stakeholders across all sectors, to promote learning from good practice and start to look for ways of working more effectively together for the benefit of those hit by financial and mental health difficulties.

The Board is asked to note progress in addressing the intent of this proposal.

18. Proposal 9 – Other ways to increase income and reduce expenditure

P9.1. It is proposed that the council and local housing providers be asked to jointly investigate options for supporting the provision of low cost, sustainable energy and improved insulation in deprived areas and for vulnerable families.

A meeting has been held with the Environment Delivery Manager (WBC) to discuss what options might be available to address this issue. The council is already looking at options for ways of improving domestic insulation and energy efficiency in the district. This would be targeted at those unable to afford to do the work, or have it done, themselves. By definition, therefore, it would help those more likely to have financial problems and therefore mental health difficulties. The Mental Health Action Group will try to support this work as best it is able to do. It is more difficult to find ways to help those renting their properties. We will continue to work with others to look for ways in which support could be provided.

[9] Ibid, p.59

The Board is asked to note progress.

19. Proposal10. Incorporate fraud prevention within the report's recommendations

The minutes of the February meeting record that "The Board noted that some people were in financial difficulties because they were victims of fraud / scams. Work was ongoing with Thames Valley Police on a joint initiative to tackle this. It was suggested that something could be built into the report's recommendations around fraud prevention."

Contact was made with Superintendent Zahid Aziz, the then local Area Commander and police representative on the Health and Wellbeing Board. He was very helpful in clarifying the work being done by TVP. The following wording for a proposal to the Board was agreed.

""The Board noted that some people were in financial difficulties because they were victims of scams and fraud. Such fraud often involves loss of money which cannot be recouped. The financial loss as well, often, of trauma, will take an emotional toll on people's mental health. Preventing such fraud happening in the first place is therefore very important.

Thames Valley Police have a Central Fraud Unit with 36 staff, who are specially trained to identify fraud, assist with prevention and advise on online fraud including identity theft.

There is also a fraud protection toolkit, The Little Book of Big Scams, available from the Thames Valley Police website (**https://www.thamesvalley.police.uk/advice/advice-and-information/fa/fraud/personal-fraud/prevent-personal-fraud/**). This provides advice to members of the public on a number of areas of fraud, including online shopping, banking and card fraud and identity theft. It covers situations where people may be contacted by phone, messaging services, email, websites, post or on the doorstep. Partner agencies are invited to share this information where possible.

It is proposed that the Health and Wellbeing Board indicates its support for this work and that partner organisations spread appropriate messages and links to resources where possible."

Changes to Pharmaceutical Services

Report being considered by:	Health and Wellbeing Board
On:	3 October 2023
Report Author:	Sarah Shildrick and Gordon Oliver
Report Sponsor:	April Peberdy
Item for:	Decision

1. Purpose of the Report

This report provides details of recent and planned changes to pharmaceutical services in West Berkshire and advises the Health and Wellbeing Board on the implications for the West Berkshire Pharmaceutical Needs Assessment.

2. Recommendation(s)

The Health and Wellbeing Board is asked to:

(a) note the changes to pharmaceutical services in West Berkshire;

(b) note that the changes have been assessed as not having a significant impact on provision of pharmaceutical services, and agree that there is no requirement to update the Pharmaceutical Needs Assessment or publish a supplementary statement.

(c) agree that the Integrated Care Board (ICB) be requested to prepare a report on the resilience of pharmacies across West Berkshire; and

(d) agree that Healthwatch be approached to see if they would perform a survey of waiting times at pharmacies across West Berkshire.

3. Executive Summary

3.1 The West Berkshire Health and Wellbeing Board has a duty to keep its Pharmaceutical Needs Assessment (PNA) under review in the light of any notifications of changes in provision of pharmaceutical services within the district.

3.2 A notification was received on 25 July 2023 from NHS England advising of a change of ownership for the community pharmacy at 3 The Square, Pangbourne, RG8 7AQ.

3.3 A further notification was received on 10 August 2023 from the South East Pharmacy, Optometry and Dentistry Commissioning Hub advising of the permanent closure of the Superdrug Pharmacy at 81-82 Northbrook Street, Newbury, RG14 1AE. This is the fourth closure of a pharmacy listed within the West Berkshire PNA.

3.4 The implications of the above changes have been assessed in accordance with national guidance and legislative requirements.

4. Supporting Information

Background

4.1 The Health and Social Care Act 2012 established health and wellbeing boards and made them responsible for developing and updating PNAs with effect from 1 April 2013. The NHS Act 2006, amended by the Health and Social Care Act 2012, sets out the requirement for health and wellbeing boards to develop and update PNAs. The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (the 2013 regulations), as amended, set out the minimum information that must be contained within a PNA and outline the process that must be followed in its development.

4.2 PNAs are used and referred to by those wishing to open a new pharmacy or dispensing appliance contractor premises. They are used by NHS England and NHS Improvement to determine applications, and NHS Resolution refers to them when applications go to appeal.

4.3 Following publication of a PNA, health and wellbeing boards must assess the impacts of any changes in provision of pharmaceutical services in their area and determine whether the changes warrant refreshing the PNA or publishing a supplementary statement to the existing PNA in accordance with national guidance and legislation, or if no action is required because the changes do not create a gap in provision.

Change of Ownership

4.4 NHS England sent notification on 25 July 2023 advising that the pharmacy previously operated by Lloyds Pharmacy at 3 The Square Pangbourne, RG8 7AQ (FQF63) would be operated by Click Solutions Ltd, with immediate effect.

4.5 There has been no change to the services provided or the opening hours. Opening hours are as follows:

	Core opening hours	**Total opening hours**
Monday	09:00-13:00 15:00-18:00	08:30-18:30
Tuesday	09:00-13:00 15:00-18:00	09:00-18:00
Wednesday	09:00-13:00 14:30-18:00	09:00-18:00
Thursday	09:00-13:00 14:30-18:00	09:00-18:00
Friday	09:00-13:00 15:00-18:00	09:00-18:00
Saturday	09:00-13:00	09:00-13:00
Sunday	Closed	Closed

Pharmacy Closure

4.6 A notification was received on 10 August 2023 from the South East Pharmacy, Optometry and Dentistry Commissioning Hub advising of the permanent closure of the Superdrug Pharmacy at 81-82 Northbrook Street, Newbury, RG14 1AE (FN512) from 16 September 2023.

4.7 The impacts of the closure have been assessed in terms of services offered, access and opening hours.

Essential Pharmaceutical Services

4.8 Essential services are offered by all pharmacy contractors as part of the NHS Community Pharmacy Contractual Framework. These are:

- Dispensing Medicines
- Dispensing Appliances
- Repeat Dispensing
- Clinical governance
- Discharge Medicines Service
- Promotion of Healthy Lifestyles
- Signposting
- Support for self-care
- Disposal of Unwanted Medicines

4.9 The closure of Superdrug has resulted in a small reduction in the overall availability of essential pharmaceutical services provision in the district.

Advanced Pharmaceutical Services

4.10 Advanced services are NHS England commissioned services that community pharmacy and contractors and dispensing appliance contractors can provide subject to accreditation as necessary. These include:

- New medicines service
- Seasonal influenza vaccination
- Pharmacy consultation service
- Hypertension case-finding service
- Pharmacy contraception service
- Smoking cessation (for patients who started their stop-smoking journey in hospital)

4.11 In addition, there are two appliance advanced services that pharmacies and dispensing appliance contractors may choose to provide:

- Appliance use reviews; and
- Stoma appliance customisation.

4.12 A Hepatitis C service was previously offered at the time the PNA was prepared, but this was decommissioned from April 2023.

4.13 The current PNA findings indicated that there was strong coverage of these services within West Berkshire and in pharmacies just beyond the local authority boundary. Superdrug (FN512) was identified in the PNA as offering the following services:

- Seasonal influenza vaccination (1 of 19 in West Berkshire)
- Pharmacy consultation service (1 of 21 in West Berkshire)

Other Pharmaceutical Services

4.14 These are services commissioned by the West Berkshire Council and Frimley Health and Care to fulfil a local population health and wellbeing need. They are listed below:

- Substance misuse service:
  - needle exchange
  - supervised consumption
- Emergency hormonal contraception service
- Access to palliative care medicine
- Provision of antiviral medication

4.15 The current PNA showed that there was good coverage of these services within West Berkshire. Superdrug (FN512) was identified in the PNA as offering the following services:

- Needle exchange (1 of 18 in West Berkshire)
- Supervised consumption (1 of 19 in West Berkshire)
- Emergency hormonal contraception service (1 of 20 in West Berkshire)

4.16 There is still a good level of provision of the above services following the closure.

Access

4.17 Within the current PNA, accessibility of services was determined by whether residents lived within a 1-mile radius of a pharmacy for urban areas, or within 20 minutes' drive to a pharmacy for rural areas.

4.18 Superdrug (FN512) is located within Newbury town centre. There are two other pharmacies within 400m walking distance - Day Lewis in Strawberry Hill to the north of the site, and Boots in Northbrook Street to the south of the site, The analysis indicates that no additional residents will be excluded from being within a one mile radius or 20 minutes travel time of a pharmacy. These alternative pharmacies are within Newbury town centre or on its fringe and are therefore well-served by public transport, cycling and walking networks. While the Day Lewis pharmacy is up a short hill, Boots is on the same level as Superdrug.

4.19 There were 21 community pharmacies in West Berkshire when the PNA was prepared in 2021/22. Following the closure of Superdrug (FN512), 17 community

pharmacies remain within the district. This equates to just under 1.1 community pharmacies per 10,000 residents in West Berkshire. The national average for England is just over 1.9 per 10,000 residents.

4.20 The latest dispensing contractor data[1] for April 2023 shows that Superdrug fulfilled around 5,000 prescriptions per month, which is just under 10% of the total number handled by all pharmacies across Newbury. The PNA found that existing contractors had spare capacity. Local analysis and discussion with Community Pharmacy Thames Valley confirms that this remains the position.

4.21 Opening hours for Superdrug (FN512) were 8.30am to 5.30pm Monday to Friday, and 9am to 5.30pm on Saturdays, totalling 53.5 hours per week. There are five other pharmacies within a two-mile radius of this site, including four that open on Saturdays, three that open on Sundays, and two that have late evening opening. This suggests that there is no gap in provision at particular times of day or days of the week.

5. Options Considered

The options available to the Health and Wellbeing Board are:

(a) to refresh the PNA;

(b) to issue a supplementary statement;

(c) to do nothing

6. Proposal(s)

Public Health officers consider that the changes to pharmaceutical services described above will not create a significant gap in provision of pharmaceutical services, and so no further action is required. However, it is acknowledged that there are some concerns about the operation of pharmacies across West Berkshire and the impact of recent closures, and there have been episodes where patients have experienced long queues and delays. Therefore, it is proposed that the ICB be asked do some further investigation regarding the resilience of pharmacies across West Berkshire. It is also proposed that Healthwatch be approached to see if they could perform a survey of waiting times at local pharmacies.

7. Conclusion(s)

The changes in pharmaceutical services have been assessed in accordance with national guidance and relevant legislation.

8. Consultation and Engagement

Local ward councillors have been informed of the changes to pharmaceutical services outlined in this report.

9. Appendices

Appendix A – Supporting Analysis

[1] https://www.nhsbsa.nhs.uk/prescription-data/dispensing-data/dispensing-contractors-data

Background Papers:

West Berkshire Pharmaceutical Needs Assessment 2022-2025

Pharmaceutical Needs Assessments: Information pack for local authority health and wellbeing boards, DHSC, October 2021

Health and Wellbeing Priorities Supported:

The proposals will support the following Health and Wellbeing Strategy priorities:

☒ Reduce the differences in health between different groups of people
☒ Support individuals at high risk of bad health outcomes to live healthy lives
☒ Help families and young children in early years
☐ Promote good mental health and wellbeing for all children and young people
☐ Promote good mental health and wellbeing for all adults

The proposals contained in this report will support the above Health and Wellbeing Strategy priorities by ensuring that there are sufficient pharmaceutical services in the District to meet the needs of the local population.

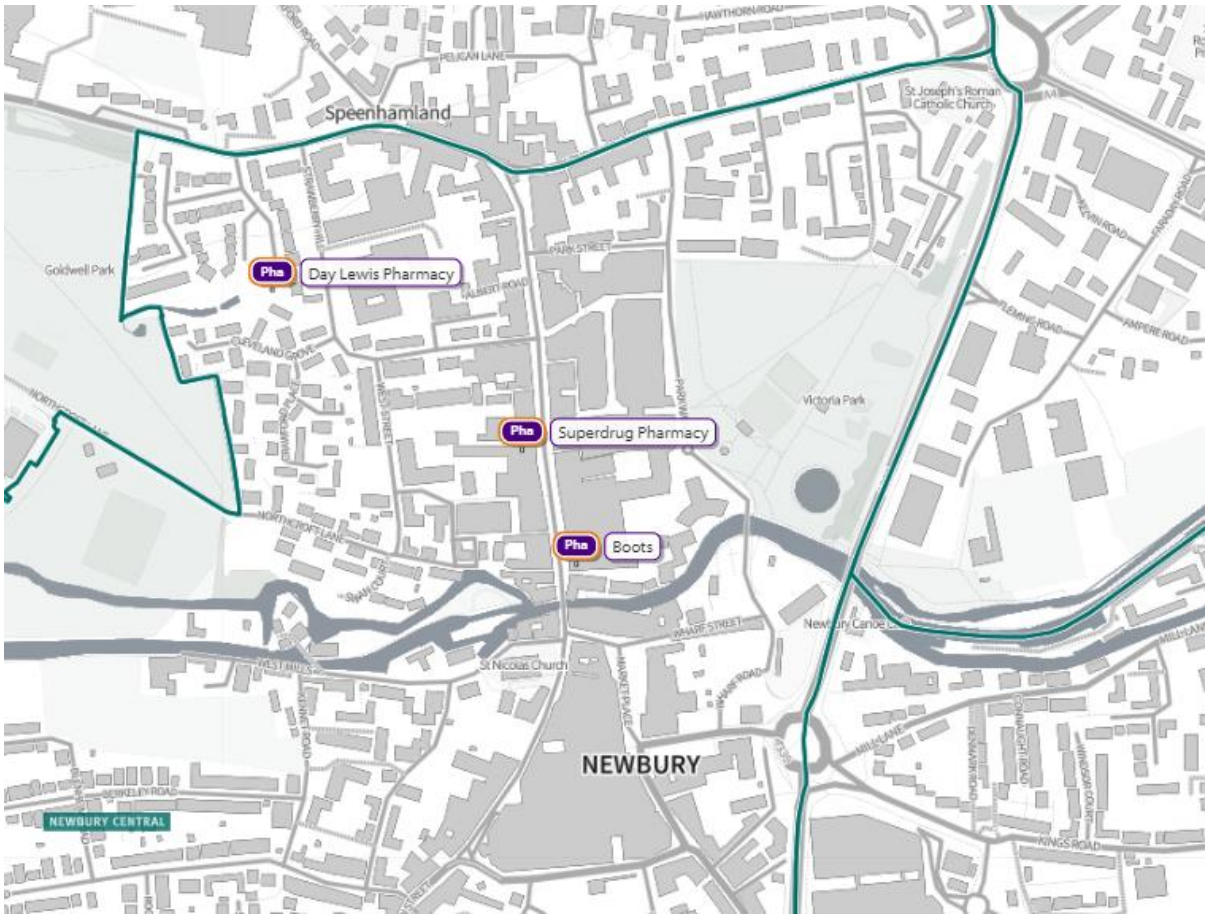
Appendix A: Supporting Analysis

Community pharmacy numbers

	At time of writing PNA	At 11/08/2023 (excluding FN512)
Community pharmacies in West Berkshire	21	18 (17)
Community pharmacies within a one-mile radius of West Berkshire's boundary	11	10
Excluded population based on 1 mile radius criteria. West Berkshire residents including pharmacies located in West Berkshire only.	43,192	50,922 (50,922). No additional excluded population as result of closure

Pharmacy proposed for closure

Superdrug Pharmacy, Northbrook Street (Newbury Central Ward)



Services listed in PNA

- Saturday opening (1 of 19 in West Berkshire)
- New medicine service (1 of 20 in West Berkshire)
- Seasonal flu vaccine service (1 of 19 in West Berkshire)
- Community pharmacist consultation service (1 of 21 in West Berkshire)
- Needle exchange (1 of 18)
- Supervised consumption (1 of 19)
- Emergency hormonal contraception (1 of 20)

Alternative pharmacies

Pharmacies within a one-mile radius of FN512

	Saturday opening	**New medicine service**	**Seasonal flu**	**Community pharmacy consultation service**	**Needle exchange/ supervised consumption**	**Emergency hormonal contraception**
Day Lewis, Strawberry Hill (FWX13)	YES	YES	YES	YES	YES	YES
Boots, Northbrook Street (FJV50)	YES	YES	YES	YES	YES	YES

Progress Report - Priority 2: Support Individuals at High Risk of Bad Health Outcomes to Live Healthy Lives

Report being considered by:	Health and Wellbeing Board
On:	03 October 2023
Report Authors:	Gordon Oliver
Report Sponsor:	April Peberdy
Item for:	Discussion

1. Purpose of the Report

1.1 The Berkshire West Joint Local Health and Wellbeing Strategy (JLHWS) sets out five priorities:

(1) Reduce the differences in health between different groups of people.

(2) Support individuals at high risk of bad health outcomes to live healthy lives.

(3) Help children and families in early years.

(4) Promote good mental health and wellbeing for all children and young people.

(5) Promote good mental health and wellbeing for all adults.

1.2 Each of the three Health and Wellbeing Boards within the Berkshire West 'Place' has developed its own Delivery Plan to address these shared priorities, tailoring the approach to their particular needs and circumstances.

1.3 A rolling programme of reports will update the Health and Wellbeing Board on progress in implementing the actions set out in West Berkshire's Delivery Plan for each of the above priorities. This report focuses on the second priority *support individuals at high risk of bad health outcomes to live healthy lives*.

2. Recommendation(s)

2.1 The Health and Wellbeing Board is asked to:

(1) note the report and the progress made to date;

(2) consider if the actions are still appropriate, if existing actions need to be updated, or if additional actions are required;

(3) agree the actions to be referred upwards to the 'Place' or 'System' levels;

(4) commit their respective organisations to delivering the agreed actions.

3. Executive Summary

3.1 This report relates to actions in the JLHWS Delivery Plan that relate to the priority *support individuals at high risk of bad health outcomes to live healthy lives*. It presents the progress that has been made since the Strategy was adopted in December 2021 and highlights key deliverables that will be targeted in the coming year. It also identifies where actions would be more appropriate to be progressed by other partnerships operating at the 'Place' or 'System' level.

4. Supporting Information

4.1 Differences in health status between groups of people can be due to a number of factors, such as income, geography (e.g. urban or rural) and disabilities. The health needs of those groups at high-risk of bad health outcomes could place heavy and unpredictable demands on health services and must therefore proactively be identified and addressed. Issues impacting groups at high risk are:

(1) Lack of easy access to healthy activities and food.

(2) Limited availability of information about health and wellbeing services.

(3) Increased loneliness and isolation (exacerbated by COVID-19).

(4) Barriers to accessing GPs and primary health services.

4.2 The JLHWS identified the following groups as being at high risk of bad health outcomes:

- Those living with dementia
- People with learning disabilities
- Unpaid carers
- Rough sleepers
- People who have experienced domestic abuse

4.3 The Strategy set out the following objectives under this priority:

- Raise awareness and understanding of dementia, and ensure support for people for who have dementia is accessible and in place for them and their unpaid carers. We will work together to ensure the Dementia Pathway is robust, including pre-diagnosis support, improving early diagnosis rates, rehabilitation and ongoing support.
- Improve identification and support for unpaid carers of all ages. Work with unpaid carers and partner agencies to promote the health and wellbeing of unpaid carers.
- Work together to reduce the number of rough sleepers and improve the mental and physical health of rough sleepers and those who are homeless, through improved access to local services.

- Prevent, promote awareness and provide support to those who have experienced domestic abuse in line with proposals outlined in the Domestic Abuse Bill.

- Support people with learning disabilities, engaging with and listening to them, through working with voluntary organisations, in order to concentrate on issues that matter most to them.

- Increase the visibility of existing services and signposting to them, as well as improving access for people at higher risk of bad health outcomes, working with and alongside voluntary and community organisations who are supporting these groups.

4.4 The Delivery Plan set out a range of actions designed to achieve the above objectives. Good progress has been made and many of the original actions have now been completed as set out in Appendix A. Some of the key actions are highlighted below:

- The young carers dashboard has been developed and is now being used to monitor the progress of both new contacts received and young carer assessments. This has provided assurance that there is no drift and delay and enables monitoring of the support young carers are engaged with to determine the appropriate support for the individual child / young person.

- In order to better support homeless patients discharged from hospital settings, the Hospital Discharge Policy has been shared and reviewed, housing leaflets have been placed in elective wards at the Royal Berkshire Hospital and a Rough Sleeper Prevention Officer is in regular contact with the hospital's therapy lead.

- A Lived Experience Group has been established, which reports into the Domestic Abuse Board. This is being used to inform decision making and system change. Further detail is provided as part of the case studies in Appendix B.

- A pilot project was completed using aDoddle to create the West Berkshire Community Life Connected Map to identify and map local community groups. Agreement has been secured to continue the work with communities to support the map. aDoddle has also been used to map and promote Warm Spaces across West Berkshire.

4.5 The Delivery Plan was reviewed in Quarter 1 of 2023/24. As part of this process, a number of actions were identified for deletion due to: being complete; now being considered 'business as usual' activity; a lack of budget / resources; or not being an agreed action. Further details are provided in Appendix A.

4.6 Looking forward, further progress is expected with some of the above actions, with work also starting on a number of new / amended actions. Key priorities for 2023/24 include:

- Provision of additional support for residents with dementia:
    - Increasing Memory Café provision in West Berkshire.

  - Providing induction training on dementia for all Adult Social Care staff.
  - Working with local businesses to raise awareness of their role within the community and their role as an employer of unpaid carers.
  - Developing a journey for people with dementia pre- and post-diagnosis.

- Additional support for young carers:
  - The introduction of a Young Carers Card to raise awareness and support their identification.
  - Production of a Young Carers Newsletter, with involvement from GP practices and Berkshire Healthcare Foundation Trust.
  - Increasing the number of peer support groups and improving signposting to support that is available within the community.
  - Improved support for carers' health and wellbeing through carer assessments and supporting access to mental health support groups and other services such as social prescribing.

- Measures to improve the mental and physical health of rough sleepers and those who are homeless:
  - Putting a process in place for dental registration.
  - Adoption of the serious case review protocol to inform and improve practice.

- Measures to prevent, promote awareness of, and provide support to those who have experienced domestic abuse:
  - Completing a local needs assessment for accommodation-based support.

- Additional support for people with learning disabilities:
  - Delivery of events designed to implement positive behaviour support across health and social care.
  - Extension of the Developing Life Skills programme, which is designed to give students greater self-esteem, increased confidence and social and communication skills.

- Increasing the visibility and signposting of services and improving access to services:
  - Re-establishing the Health and Wellbeing Board Engagement Group.
  - Creating a stakeholder map of current community and voluntary sector partners who are working with those at higher risk of bad health outcomes.

4.7 Finally, a number of Delivery Plan actions have been identified as being more appropriate for delivery at the Place or System levels, and will be escalated accordingly:

- Work with Voluntary and Community Sector organisations to improve access to health checks for those with learning disabilities and improve the quality of health checks for those with learning disabilities.
- Promote alternatives to admission through increased support for people in the community:
    - Commission an all-age Intensive Support Team
    - Green light toolkit
    - Post-diagnostic support
- Reduce waiting times for Autism and ADHD Diagnosis

5. Options Considered

5.1 All actions have been reviewed by the Delivery Plan Task Group to understand:

- if they are still relevant;
- if they have the necessary support, resources and budget;
- if they are completed and should be removed;
- if they represent business as usual activity that will be delivered through existing business / service plans;
- if actions would be best delivered at the 'Place' or 'System' level;
- if additional actions are needed to respond to circumstances that have changed since the Delivery Plan was first adopted.

5.2 The Health and Wellbeing Board may choose to accept the changes or make recommendations for further changes.

6. Proposal(s)

The Health and Wellbeing Board is asked to:

- consider if the actions designed to deliver Priority 2 of the JLHWS are still appropriate, if existing actions need to be updated, or if additional actions are required;
- agree the actions to be referred upwards to the 'Place' or 'System' levels;
- commit their respective organisations to delivering the action plan.

7. Conclusion(s)

This report provides the Board with assurance that Delivery Plan actions around the JLHWS priority *support individuals at high risk of bad health outcomes to live healthy lives* are being delivered and updated.

8. Consultation and Engagement

8.1 The Health and Wellbeing Board Steering Group has been consulted on this report.

9. Appendices

Appendix A – Priority 2 Delivery Plan

Appendix B – Case Studies

Background Papers:

Berkshire West Health and Wellbeing Strategy 2021-2030

Health and Wellbeing Priorities Supported:

The proposals will support the following Health and Wellbeing Strategy priorities:

☐ Reduce the differences in health between different groups of people
☒ Support individuals at high risk of bad health outcomes to live healthy lives
☐ Help families and young children in early years
☐ Promote good mental health and wellbeing for all children and young people
☐ Promote good mental health and wellbeing for all adults

The proposals contained in this report will support the above Health and Wellbeing Strategy priorities by ensuring that the JLHWS Delivery Plan actions are delivered and regularly reviewed.

Health and Wellbeing Strategy Delivery Plan 2022-2025														
								2023/24						
Objective	**Description**	**New 23/24**	**Owned by**	**Contact**	**Timescale**	**Indicator**	**Target**	**Q1**	**Q2**	**Q3**	**Q4**	**RAG Status**	**Commentary**
Priority 2 - Support individuals at high risk of bad health outcomes to live healthy lives														
2.1: Raise awareness and understanding of dementia and ensure support for people who have dementia is accessible and in place for them and their unpaid carers	1.1.2: Embed Population Health management approach across all programmes, incorporating 2021 census data when available		Escalate to BOB ICB ?	Discuss with Sarah Webster	Mar-24	Support increase in Diagnosis rates for Dementia	65% (April 22) 67% (Sept 22) To be reviewed.					A	Sept figures stand at 59%. We are currently undertaking a data cleanse that is estimated to add 200 more patients to the list bringing the performance up to 62.5%. Targeted work with individual practices continues to improve the diagnostic rate. Discussions progressing on BW Dementia group, to see if he group can get going again with health buy in. We cannot directly achieve, how can we support?
	2.1.2: Support the increase of Memory Café provision across West Berkshire	Amended to reflect 23/24 requirement	Ageing Well Task Group	Sue Butterworth	Mar-24	Set up and facilitate running of two new memory cafes in West Berkshire, with the objective that this becomes embedded and run in the Community in 2023/24.	Two new memory cafes opened and embedded					A	DFWB is a commissioned services funded by PH&WB. Contract extended until 2025.
	2.1.4: Induction training on Dementia to be undertaken for all Adult Social Care Staff: Event to be held with existing staff to raise awareness. Will be recorded as a webinar for future new staff	Amended 23/24	Ageing Well Task Group	Sue Butterworth / Hannah Cole	Mar-24	One Big Dementia Conversation held with existing Adult Social Care staff. Webinar to be incorporated into induction training for new staff	As a result of attendance at one Big Dementia Conversation staff are supported and have increased awareness and undertanding of the impact of dementia and how their role can support families in West Berkshire					A	Working with Hannah Cole with two events scheduled for Feb 2024 at Shaw House
	2.1.5: Work with local businesses in West Berkshire to raise awareness of role with the community, along with role as an employer for those who are unpaid carers		Ageing Well Task Group	Hannah Cole	Mar-24	Number of organisations & businesses that are members of Dementia friendly West Berkshire Number of Dementia Friendly businesses	???					G	Membership of DFWB has increased to 32 active members although this has been driven by DFWB. It will be really helpful to understand the work that Carers Strategy group are doing around this too and how we can work together. Going forward it will be good to invite representative SB to the Carers strategy group meetings. **Carers Strategy Group:** New Provider we are working with: Reading and West Berkshire Carers Partnership. Our partners comprise of Age UK Reading, Age UK Berkshire, Reading Mencap and Comminicare.
	2.1.6: Develop a promotional campaign for the Reading Well books available in West Berkshire Libraries, linking with Empathy day.	Amended Ownership	Mental Health Action Group	April Peberdy / Jacqueline Cooper	Mar-24	Delivery of promotional campaign No of books No. of books issued	One 36 140					G	
2.2: Work together to ensure that the Dementia pathway is robust, including pre-diagnosis support, improving early diagnosis rates, rehabilitation and ongoing support	2.2.1Raising awareness to increase identification of carers	New 23/24	Carers Strategy Group	Hannah Cole		Young carers card Good quality information and advice for carers Explore ways to encourage Carers to gain IT and Digital skills	On going support and encouragement to be provided to Carers to gain digital skills as this will help them to stay connected and be able to access services and support quicker.					G	Re. Social Media : The Young Carers Activity Co-ordinator feedback they have been putting timetables on for Young Carers to access. This is on Facebook and Instagram. In terms of general awareness they have been putting information about Carers Week and sharing articles with young Carers. They want Young Carers to also read about some of the challenges they face and for them to know they are not alone.

Health and Wellbeing Strategy Delivery Plan 2022-2025

Objective	Description	New 23/24	Owned by	Contact	Timescale	Indicator	Target	2023/24 Q1	Q2	Q3	Q4	RAG Status	Commentary
	2.2.2 Provide information and advice to carers	New 23/24	Carers Strategy Group	Hannah Cole		Young carers newsletter Linking with GP Practices and Primary Health Care and other partner organisations who provide information and advice to Carers.	GP Practices and BHFT representation in the Carers group- quarterly updates					G	Young Carers Newsletter was launched in September. The plan is that the newsletter will come out every 8-9 weeks. It contained information about recent summer holiday activities for example canoeing which the young carers enjoyed. We do have BHFT representation in the Carers group and will invite GP Heather Howells to one of our Carers Group meetings to explore how we can work in partnership with the GP Practices.
	2.2.3 Enable access to peer support groups for carers and young carers	New 23/24	Carers Strategy Group	Hannah Cole		Increase number of peer support groups available from 10 to 12 - Signpost to charities, other voluntary and private organisations that support carers and young carers.	Increase of 2 groups					G	We have the weekly Youth group for secondary school age carers. During the meetings Carers are offered a hot meal and there are always activities for them which may be craft, baking, sport or other physical activity.
	2.2.4 Support carers health and mental wellbeing	New 23/24	Carers Strategy Group	Hannah Cole		Ensure Carers assessments gives Carers time to explore their needs (mental, physical, emotional etc). Ensuring carers have access to services including mental health support groups Link with GP Practices and Social Prescribers Enabling participation in activities working in partnership with local leisure centres.	Quarterly updates on Carers assessment completed, Carers Partnership to provide update on signposting Carers to mental health support groups, gymn, local leisure centres, health checks etc.					G	Carers Partnership continues to report that they signpost Carers to gymn or to their GP's for health Checks (once they are registered as a Carer), leisure centres.
	2.2.5: Develop a journey for people with dementia pre and post diagnosis (service transformation – Berkshire West) Identify key stakeholders for working group Review pathway to identify gaps Review Clinical and non-clinical pathway. Engage service users and carers in development of proposals		Escalate to BOB ICB?	Sue Butterworth / escalate to Sarah / Belinda	TBC	Establishment of working group						G	Working group has now been reconvened with membership from Wokingham, Reading & West Berks LA's, VCSE partners and Health Colleagues. Initial meeting held and further meetings scheduled to look at a Berks West action plan for dementia
2.4: Work with partner agencies to promote the health and wellbeing of unpaid carers	2.4.2: Review and refresh the Carers Strategy Action plan	Transfer to LIB	Local Integration Board	Maria Shepherd / Hannah Cole	Mar-24	Actions as will be contained within the plan	N/A					G	In the process of updating the Action plan Amend from Carers Strategy Group to LIB (agreed with Maria S)
2.5: Reduce the number of rough sleepers	2.5.1: Continue to work together to prevent rough sleeping and reduce the number of people who do sleep rough (Implementation of the Homelessness and Rough sleeping strategy)		Homelessness Strategy Group	Nick Caprara	Jul-05	Number of people sleeping rough	< 2						No update available due to staff sickness.
2.6: Improve the mental and physical health of rough sleepers and those who are homeless through improved access to local services	2.6.2: Increase dental registration among rough sleepers and those in temporary accommodation: work with ICB? to develop a process for registration (placeholder - to be determined)	Amended	Homelessness Strategy Group SE inequalities board,	Nick Caprara	Year 1	Process in place for registering	N/A						No update available due to staff sickness.

Health and Wellbeing Strategy Delivery Plan 2022-2025													
								2023/24					
Objective	**Description**	**New 23/24**	**Owned by**	**Contact**	**Timescale**	**Indicator**	**Target**	**Q1**	**Q2**	**Q3**	**Q4**	**RAG Status**	**Commentary**
	2.6.3: Adoption of the Serious Case Review Protocol		Homelessness Strategy Group	Nick Caprara	Mar-22	Adoption of protocol	N/A						No update available due to staff sickness.
2.7: Prevent, promote awareness and provide support to those who have experienced domestic abuse	2.7.1: Continue to implement the action plan from the Local Domestic Abuse Strategy 2020-2023 to meet identified aims		West Berkshire Domestic Abuse Board (BCTP)	Jade Wilder	Refresh due in 2023	Action plan	Action plan fulfilled by 2023					G	On track - This continues to be a standing item for discussion at the bi-monthly DAB meetings. Action plan is reviewed and regularly updated. The new Strategy will be be beginning aroud October 2023.
	2.7.2: Implement the new Domestic Abuse Safe Accommodation Strategy 2021 – 23 and accompanying action plan		West Berkshire Domestic Abuse Board (BCTP)	Jade Wilder	To be combined with full DA Strategy as part of refresh in 2023	Needs identified being met through action plan	Action plan fulfilled by 2023					G	On track - This continues to be a standing item for discussion at the bi-monthly DAB meetings. Action plan is reviewed and regularly updated. The new Strategy will be be beginning aroud October 2023.
	2.7.3: Local needs assessment: need and demand for accommodation based support for all victims	Amended indicator	West Berkshire Domestic Abuse Board (BCTP)	Jade Wilder	Every 3 years (next due 2023)	Complete needs assessment by Dec 23	N/A					G	On Track - The needs assessment is underway. Victim/survivor and professionals surveys completed. Interviews with survivors underway. Data collection has now concluded with internal and external agencies. An early findings report has been produced with a final report scheduled Sep/Oct 23.
2.8: Support people with learning disabilities, engaging with them and listening to them through working with voluntary organisations	2.8.2: Implement Positive Behaviour Support across Health and Social care		Skills and Enterprise Partnership (working with MP Laura Farris)	Iain Wolloff	Annual	Delivery of event. Attendance. Feedback	40					G	The second annual Work & Careers Fair (the 'Destinations Expo') was successfully delivered on 13th October 2022 at Newbury College. Over 800 young people from local secondary schools attended, with around 50 employers and other organisations exhibiting. There was a strong focus on careers for students with disabilities, with over 100 attending and all employers attending a briefing on supported employment. The EBP projected managed the event, with financial support from the Greenham Trust. The 2023/24 event will be held on 12th October 2023, with a planned increase in the number of exhibitors and the numbers of young people attending.
	2.8.4: Extension of the "Delivering Life Skills" Programme, delivered by the EBP.		Skills and Enterprise Partnership	Iain Wolloff	Annual	Delivery of programme attendance Feedback from young people and schools	60 young people attending the DLS programme	250				G	The H&WB approved funding for this programme, which was delivered in secondary schools by the EBP. All sessions were completed by July 23, with a significant increase to 250 participants. A further funding bid for 2023/24 will now be submitted to the HWB Board.
2.9: Increase the visibility and signpost of existing services and improve access to services for people at higher risk of bad health outcomes	2.9.3: Re-development of the Health and Wellbeing Board engagement group	Amended	HWB engagement group	TBC		HWEG re-established and ToR agreed	Nov-23					G	A draft Terms of Reference has been prepared, which was discused at the HWB Steering Group on 15 September 2023. There are some concerns about resourcing the group, who will chair ir, and how it will be sustainable in the longer term. Discussions are ongoing as to whether coordination of comms could be achieved without the need for a formal sub-group.
	2.9.8: Use targeted paid adverts on social media to improve knowledge and awareness of services, tips and advice about health and wellbeing (placeholder)		Communities and Wellbeing	April Peberdy	Mar-24	To be developed	TBC					G	The Public Health Team puts frequent content on social media to support national campaigns, such as Covid and flu vaccinations, measles vaccinations, Mental Health Awareness Week, etc, as well as hot and cold weather alerts and messaging. They also share blogs from UKHSA on relevant topics. Paid adverts will be considered as necessary going forward.
	2.9.9 Organise an annual Health and Wellbeing Conference, which is focused on current issues and tackling health inequalities		HWB engagement group	TBC	May-24	To be developed	TBC					G	Following the last HWB conference, it was agreed that this should be decoupled from the District Parish Conference and that it be deferred until later in the calendar year, which may push it into the 2024/25 municipal year. This will be a key focus for the Engagement Group once formed. It is anticipated that there will be a paper to HWB in December to propose a date and themes for the 2024 conference.

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Appendix A - Escalated Actions

Health and Wellbeing Strategy Delivery Plan 2022-2025													
							2022/23						
Objective	Description	Owned by	Contact	Timescale	Indicator	Target	Q1	Q2	Q3	Q4	RAG Status	Commentary	
2.1: Raise awareness and understanding of dementia and ensure support for people who have dementia is accessible and in place for them and their unpaid carers	2.1.1: Improve Dementia diagnosis rates (partnership work with the ICP)	Escalate to BOB ICB	Discuss with Sarah Webster	Mar-24	Support increase in Diagnosis rates for Dementia	65% (April 22) 67% (Sept 22) To be reviewed.	66.70%	62.50%			A	Sept figures stand at 59%. We are currently undertaking a data cleanse that is estimated to add 200 more patients to the list bringing the performance up to 62.5%. Targeted work with individual practices continues to improve the diagnostic rate. Discussions progressing on BW Dementia group, to see if he group can get going again with health buy in. We cannot directly achieve, how can we support?	
2.2: Work together to ensure that the Dementia pathway is robust, including pre-diagnosis support, improving early diagnosis rates, rehabilitation and ongoing support	2.2.5: Develop a journey for people with dementia pre and post diagnosis (service transformation – Berkshire West) Identify key stakeholders for working group Review pathway to identify gaps	Escalate to BOB ICB?	Sue Butterworth / escalate to Sarah / Belinda	TBC	Establishment of working group						G	Working group has now been reconvened with membership from Wokingham, Reading & West Berks LA's, VCSE partners and Health Colleagues. Initial meeting held and further meetings scheduled to look at a Berks West action plan for dementia	
2.8: Support people with learning disabilities, engaging with them and listening to them through working with voluntary organisations	2.8.1: Work with Voluntary and Community Sector organisations to improve access to health checks for those with learning disabilities. Improve the quality of health checks for those with Learning disabilities	Escalate to BOB ICB NHSE	Niki Cartwright	Annual	% of individuals receiving a health check	67% (target for 2020/21). AHC LTP target is 75% (14+)							
2.9: Increase the visibility and signpost of existing services and improve access to services for people at higher risk of bad health outcomes	2.9.1: Promote alternatives to admission through increased support for people in the community: • Commission an all age IST • Green light toolkit • Post diagnostic support (Placeholder – work in development)	Escalate to Place Based Partnership BHFT (toolkit)	Jo Reeves										
	2.9.2: Reduce waiting times for Autism and ADHD Diagnosis: current demand being assessed to plan for workload capacity (placeholder)	Escalate to BOB ICB BHFT	Niki Cartwright	TBC	TBC	TBC					G	Investment made recurringly; activity has doubled over last 12 months	

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Appendix B: Priority 2 Case Studies

Domestic Abuse Lived Experience Group

As a result of establishing the Domestic Abuse Lived Experience Sub-Group, there has been improved collaboration between statutory agencies and survivors of domestic abuse. It has provided a place to escalate existing challenges faced by victims.

Thames Valley Police has invited survivors from the group to attend Team Training Days to give officers a better understanding of domestic abuse by hearing from victims directly.

Agencies have been held more accountable to understand their responses to domestic abuse when it occurs. For example: schools have been asked to report on support offered to child victims and all agencies have had to report on what they do when parental alienation occurs.

The sub-group recently participated in a victim survey and interviews as part of our local needs assessment, which will be used to inform our new five-year Domestic Abuse Strategy and Action Plan.

Two survivors currently sit alongside professionals as members of the Domestic Abuse Board to participate and support decision making, which is proving to be extremely valuable. This way of working has been used as a good practice example for other local authorities in the Thames Valley to capture the voices and views from victims.

The Domestic Abuse Board produced a set of behaviours and conduct as a result of this work, which has been added as an appendix to its terms of reference to ensure its members are working in a co-productive manner.

Developing Life Skills

See separate summary report.

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education business PARTNERSHIP

Inspiring our future workforce

The Health & Wellbeing Board

Summary Report 2022-2023

Overview

Over the 2022/23 academic year, Education Business Partnership (EBP) delivered 12 Developing Life Skills workshops on behalf of the Health and Wellbeing Board working with approximately 250 students.

Our Developing Life Skills programme aims to support and develop young people who would benefit from a little reinforcement to recognise their own strengths and abilities. By the end of the programme students have greater self-esteem, increased confidence and social and communication skills. The programme is also designed to increase students' motivation and encourage them to stay on track with their studies.

Details of the 8 workshops is provided in the table below.

School	Date	Year Group	Student Numbers
John O'Gaunt School	23rd September 2022	10	20
Park House School	8th March 2023	10	20
St Bartholomew's School	27th March 2023	11	20
The Downs School (2 streams)	3rd May 2023	9	40
The Downs School (2 streams)	4th May 2023	10	40
iCollege	25th May 2023	10	20
Mary Hare School	28th June 2023	12	20
Little Heath School (2 streams)	7th July 2023	10	50
Kennet School	17th July 2023	10	20

Summary of Impact of Developing Life Skills

Developing Life Skills workshops have been integral in school programming this year and has been gratefully received by schools. The workshops provide a safe space for students to further develop critical thinking, problem-solving skills and creativity. School staff and student comments reflect on the workshops ability to improve engagement and allow them to express themselves in unique yet supported way.

The workshops allow for self expression and a means to connect with others particulary in the turbulent time post pandemic where social skills and confidence were marred in many children's lives.

Developing Life Skills provides a much-needed reality check as to what could happen if we cooperated. The workshops are where imagination and knowledge meet and support social interactions and promote positive mental health and well-being.

Repeatedly the feedback from staff and students states the need for Developing Life Skills as a mean to build confidence, develop decision-making skills and promote resilience and focus.

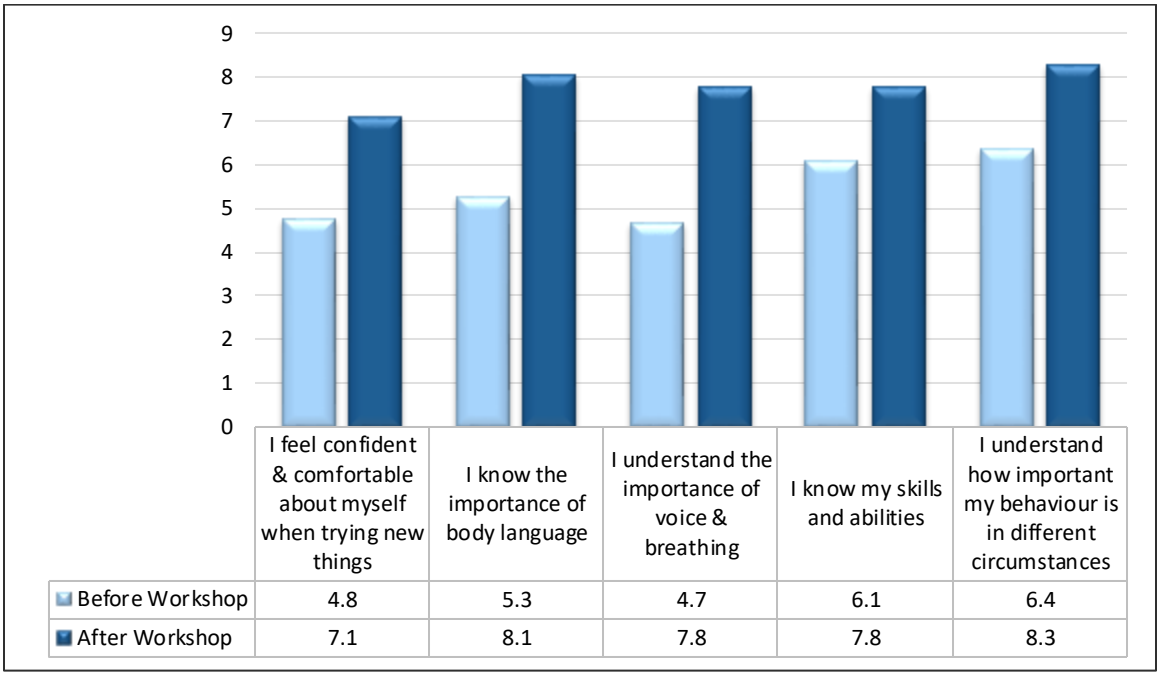
Feedback

For all Developing Life Skills workshops, evaluation forms are taken for the students and teachers to complete. The feedback received from these workshops is vital to EBP to ensure we are delivering the best content to the students. It also allows us to develop and strengthen these events for the future.

The following tables and analysis highlight the key statistics and feedback provided by students and teachers for workshops delivered this academic year.

Student Feedback

Knowledge levels
(Score where 1 = lowest/worse to 10 = highest/best)



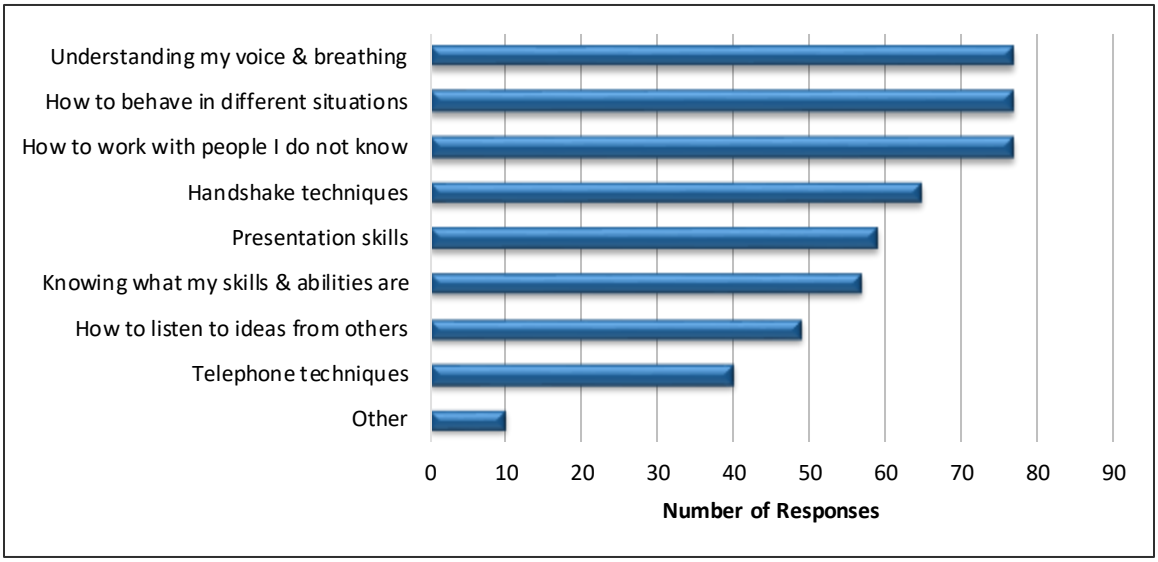
	I feel confident & comfortable about myself when trying new things	I know the importance of body language	I understand the importance of voice & breathing	I know my skills and abilities	I understand how important my behaviour is in different circumstances
Before Workshop	4.8	5.3	4.7	6.1	6.4
After Workshop	7.1	8.1	7.8	7.8	8.3

Highlights

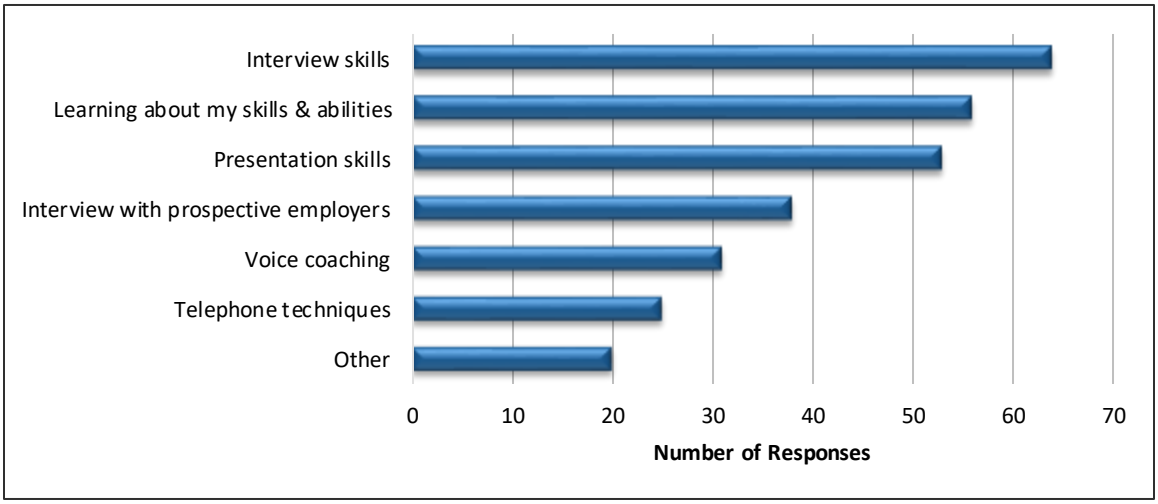
- 89% of students said they felt more confident and comfortable about themselves when trying new things after taking part
- 88% of students said they had increased their understanding of the importance of body language
- 91% of students said they had increased their understanding of the importance of voice and breathing in an interview
- 64% of students said they could better identify their skills and abilities
- 73% of students said they had increased their understanding of how important their behaviour is in different circumstances

Did you find the programme valuable?

What were the most important things you have learnt from this programme?



What did you enjoy the most about today?



If you had to sum up your experience in a sentence, what would it be?

- It was incredibly helpful and boosted my confidence
- Fun time doing things I thought I would never do
- An educative workshop that helps inform important information
- I found the workshop really helpful because I can identify my skills
- Enjoyable, fun and exciting
- An enjoyable experience
- It was a great experience and I learnt valuable lessons
- I found it enjoyable and fun to learn new skills and other important things
- Super fun and helpful!
- Very positive experience, and it really made me feel included and supported
- Very fun and interactive
- Very informative and helpful - I now know how to carry myself in difficult situations
- It helped with being confident even with people I know
- Really fun. Good day and allowed me to understand skills and techniques in the work place and interviews
- Very useful for the future and helped me come out of my personal bubble with people I don't know
- Absolutely amazing, learnt so much - I would love to do it again
- It's very helpful experience and I helps me to improve for the next step
- Helped me to understand myself and gave me confidence. Thanks!

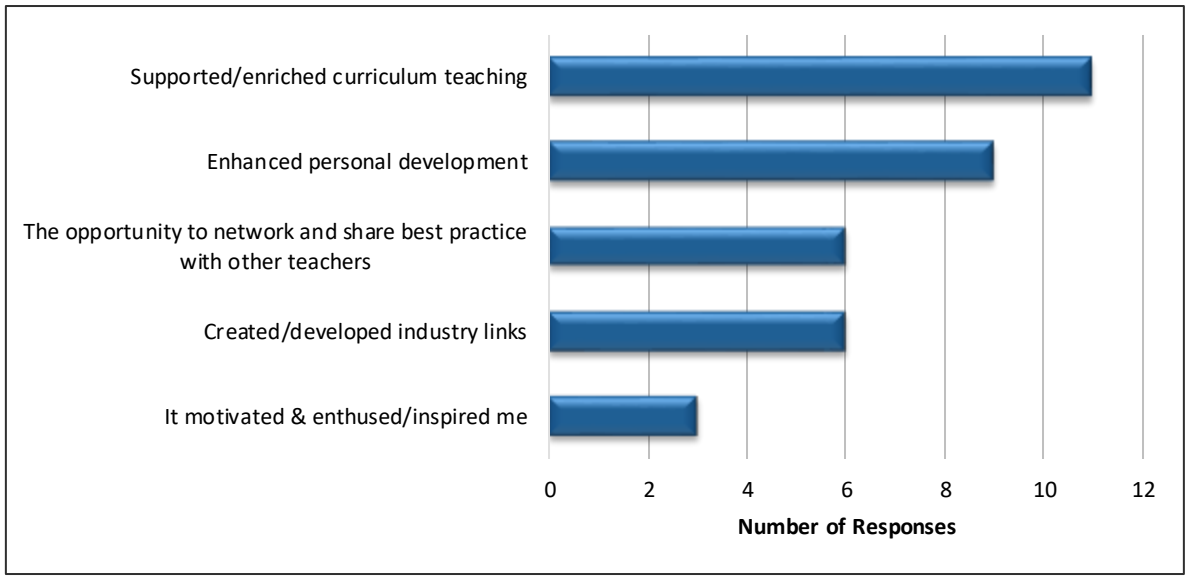
Teacher Feedback

How much do you think students benefited from this event?
Average score 9.6/10

How good did you think the organisations were that attended?
Average score 9.9/10

How good was the information given to you for this event?
Average score 8.9/10

What benefit did you get out of helping today?



What was the students' biggest learning point?

- Good for students to learn interview technique in terms of the basics like body language and polite conversation
- Confidence, teamwork, voice control and projection, communication. Leadership skills for some
- Confidence. Some of the students are generally very shy in those kind of situations
- I only attended part of the final hour but I was very impressed with how confi dent the students were - I couldn't believe some of the speeches they made!
- Students to interact with other students who they do not know. Team work. Gaining confidence and boosting their self esteem
- Understanding how the way they speak and body language can tell a story about them and create an impression to the people observing them. Learning some techniques to help them show a different story in situations such as an interview
- That it's ok to feel anxious and nervous at times but to have the skills to be able to show confidence through the session
- Taking part isn't as scary as they thought it would be. Scariest part is the first step.
- To overcome their embarrassment and enjoy themselves
- Loosening up, not taking themselves too seriously, then just getting involved.

Would you like to take part in this event again?
100% of teachers said "yes"

Comments

- Brilliant, engaging, interactive session that will bring students out of their shell! Great fun, and important life skills learnt
- I would highly recommend this workshop for any student needing a confidence boost. It was excellent
- Fabulous & great fun. After the first step you won't want to stop.
- This is the third time I've taken part and I have really enjoyed it every time
- We love you and this event, it really is the best of the year.
- Leaders very positive and enthusiastic - encouraged all to be involved
- Very enthusiastic presenters
- Great day! Well organised
- Brilliant session. The facilities have a knack of making the students totally at ease. The students were engaged from start to finish and hugely benefitted from this session
- Students were engaged and very keen to learn and gain new skills. All thanks to the excellent group leaders!
- Heidi was enthusiastic and passionate throughout. The event was highly engaging for students
- The students stepped out of their comfort zone and challenged themselves brilliantly
- Really helped our students to engage with each other, using skills that they already have, but may not have used them previously. Great opportunity

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Community Wellness Outreach Project

Report being considered by:	Health and Wellbeing Board
On:	3 October 2023
Report Author:	Zoe Campbell
Report Sponsor:	April Peberdy
Item for:	Information

1. Purpose of the Report

The purpose of this briefing is to provide the Health and Wellbeing Board with an update on the work undertaken by Public Health and Wellbeing to address premature mortality, with a focus on cardiovascular disease (CVD) through the development of a CVD Wellness Outreach service.

2. Recommendation(s)

2.1 The Board are asked to note the progress to date on the Community Wellness Outreach project.

3. Executive Summary

3.1 This report sets out a proposal for a CVD Wellness Outreach services. The Public Health and Wellbeing Team have developed this proposal to secure prevention and inequalities funding of £375,000 for West Berkshire Council, made available through the Berkshire West Place Partnership. The final proposal was presented to Locality Integration Board in September when it was agreed and funding confirmed. The next step will be to commission the service.

4. Supporting Information

Background

4.1 National, regional and local population health and public health data are key drivers for the project:

(a) Despite being largely preventable, CVD is the second largest contributor to avoidable (i.e. preventable and treatable) deaths in England. In 2020, it caused nearly 1 in 5 preventable deaths and 1 in 2 treatable deaths (ONS 2022a).[1]

(b) "Cardiovascular disease is one of the most common causes of death in Buckinghamshire, Oxfordshire and Berkshire West and a major contributor to the gap in life expectancy between people living in our most and our least deprived areas".[2]

[1] CVD_Report_Web.pdf (kingsfund.org.uk)
[2] Share your views on the BOB Integrated Care Partnership's strategic priorities | http://yourvoicebob-icb.uk.engagementhq.com

(c) Cardiovascular disease (CVD) is a significant cause of morbidity and mortality in West Berkshire. This is captured in local statistical 'headlines' from the British Heart Foundation, as of January 2022[3]:

- 1 in 4 deaths of West Berkshire residents are due to CVD
- CVD causes 26 deaths each month in West Berkshire
- Every 28 hours someone dies from CVD
- Around 15,000 residents are living with CVD
- Around 3,900 residents are living with Coronary Heart Disease
- There are around 2,500 stroke survivors living in West Berkshire

4.2 The current BOB Integrated Care Partnership's strategic principles and priorities[4] are also key drivers for the project:

- Principle 1: Preventing ill health. *We will help people stay well and independent, enjoying better health for longer.*

- Principle 2: Tackling health inequalities. *We will seek to improve the physical and mental health of those at risk of the poorest health. This will include making sure people can access health and care services, whatever their background*.

- *Priority 10: Reduce the number of people developing cardiovascular disease (heart disease and stroke) by reducing the risk factors, particularly for groups at higher ris*k.

4.3 The Berkshire West Place Partnership are required to deliver above principles and priorities for the communities of West Berkshire, Reading and Wokingham.

4.4 In February 2023, the BOB Integrated Care Board (ICB) confirmed a total fund of £2.6m for Berkshire West over the two financial years to March 2025. The fund is to support local prevention and inequality priorities, alongside the core ICB prevention priority on CVD. It has since been confirmed that any unspent allocation in year one can be accrued to year 2, noting the time required to develop and mobilise a service.

4.5 In response to this funding allocation, the Berkshire West Place Partnership established a prevention and inequalities working group of all partners in Berkshire West. The group has been meeting regularly since March 23. The outcome has been agreement on;

(a) preferred use of these funds; and

(b) the governance route to manage the funds and oversee delivery.

4.6 West Berkshire Interim Service Director for Communities and Wellbeing and the Director of Public Health for Reading and West Berkshire represented West Berkshire public health at the prevention and inequalities working group.

4.7 The working group followed a collaborative process engaging all partners to reach a broad consensus on how best to utilise the funding, based on population health needs and community assets in Berkshire West.

[3] https://www.bhf.org.uk/what-we-do/our-research/heart-statistics/local-statistics
[4] Share your views on the BOB Integrated Care Partnership's strategic priorities | http://yourvoicebob-icb.uk.engagementhq.com

4.8 A preference ultimately emerged for a main proposal and a supporting proposal:

(a) Main Proposal (c.95% of funding): Community Wellness Outreach programme.

- To take prevention initiatives and signposting to the heart of Berkshire West communities in a way that best suits local need.
- Building on existing services/initiatives and based around existing community assets where these exist, and establishing new ones where needed.
- Provide a consistent 'core' offering around CVD prevention which is supplemented by additional 'local' offerings based on local needs.

(b) Supporting Proposal (c.5% of funding): Population Health & Prevention Intelligence Coordination.

- Develop a coordinated approach to population health and prevention intelligence across Berkshire West, enabling the Place Partnership to consider this intelligence in a strategic way to inform future population health and Public Health programmes of work.
- Develop a Berkshire West live intelligence report with supporting local authority level report. Include intelligence on wider determinants of health such as deprivation, environment, crime and housing.

4.9 Within West Berkshire, the public health team developed a proposal for a CVD Prevention outreach service in 2022, as part of their programme to address health inequalities highlighted by the COVID-19 pandemic. This service was to be centred on the delivery of the NHS Healthcheck Pathway[5] (an established CVD Prevention intervention that LA Public Health teams are mandated to deliver/commission for residents) and incorporated learning from the successful COVID-19 and Winter Resilience outreach programmes in West Berkshire.

4.10 The Project Manager for the West Berkshire service (Charlotte Williams) was appointed in May 2023.

4.11 The West Berkshire CVD Prevention Outreach service was planned to be funded by better care fund following a successful bid to the Locality Integration Board (LIB) and West Berkshire public health reserves. Commissioning of the service was paused during 2022/23 with the direction of the Director of Public Health and paused again in Spring 2023, when the Place Partnership fund (above) was announced.

Current Status

4.12 In early June' 23, the proposals set out above in Section 2.9 were approved by the Unified Executive Meeting. A governance structure through the Locality Integration Board (LIB) was also signed off. The Unified Executive agreed that having the Berkshire West prevention and inequalities fund devolved to the LIB would realise benefits including;

[5] NHS Health Check - Commissioners and providers

(a) Existing formal forums in the place partnership governance arrangements.

(b) The Voluntary, Community and Enterprise Sector (VCSE) are integrated within each LIB and may be an integral part of the outreach model.

(c) The recent commitment to strengthen partner attendance at the LIB will ensure that each of our partner organisations are involved in the development of this service.

(d) Guidance can be provided to the LIB to ensure a level of consistency of outcome is achieved across Berkshire West whilst recognising that the actual delivery of the service may vary in each area based on the existing infrastructure already established.

4.13 In recent weeks, the Berkshire West prevention and inequalities working group met to agree a set of principles that underlined the community wellness model. It was agreed that the next milestone for the project was for each of the LIB to host a workshop in mid-July with an extended LIB membership. The key outcome for the workshop was to design and agree a local integrated operating model for community wellness outreach which meets the agreed principles.

4.14 In preparation for the West Berkshire LIB workshop, the Public Health Team finalised amendments to the original service specification for the CVD prevention outreach, to ensure it incorporated the principles agreed by the place partnership.

4.15 The West Berkshire LIB workshop agreed that the specification developed by Public Health met the requirements of the prevention and inequalities funding, but the specification needed some further development in collaboration with Primary Care Networks (PCNs) and CVD Prevention Leads within BOB.

4.16 The Public Health Team are taking forward this action and have had an initial meeting with PCN colleagues in order to identify key areas requiring a joined approach, including data sharing arrangements. Further meetings are scheduled and work is progressing well.

4.17 The approach for the community participation element of the specification is being finalised (in-house or commissioned) by the Public Health Team in collaboration with Council and VCSE partners.

4.18 The procurement timeline and strategy is being finalised. The aim is to commence service delivery in early 2024.

4.19 The table below summarises the current budget build for the project across Berkshire West:

Appendix 1 - ICB Inequalities Funding for Berkshire West

Funding allocations assuming mobilisation from start of Q3 23/24 (6 months) and full year 24/25 (12 months)

		6 Months 23/24	12 Months 24/25	Total	
BW Total Funding Allocation		**867**	**1,733**	**2600**	
Less: Population Health Analytic Support (Integrated posts responsible for project evaluation and population health strategic information development) £60k per annum x 3		(90)	(180)	(270)	10.4%
Total Funding for Community Wellness Outreach Service		**777**	**1,553**	**2,330**	
Less: Primary Care allocation:	*Full yr costs*				
PCN Training costs (Clinical time)- PCN champion- to top up PCN champions costing liase with the community outreach service, point of contact for issues, development of the integrated working. Practically assist with checks, where needed.	*(41)*	(20)	(41)	(61)	
PCN GP Ongoing mentoring/supervision- lead for integration, clinical assurance, governance at PCN level	*(73)*	(37)	(73)	(110)	
PCN Clinical follow-up (approx 5%)	*(29)*	(14)	(29)	(43)	
PCN Admin (searches, invitation, booking clinics, chasing, adminstration, Communications)	*(104)*	(52)	(104)	(156)	
"BWPCN" Co-ordination of PCNs- programme management, oversight of PCNs, accountability on PCNs delivering, Liason with Partners, Project & Admin Support	*(135)*	(68)	(135)	(203)	
"BWPCN Training" and protocol development - GP and nurse time, management time	*(81)*	(41)	(81)	(122)	
		(232)	(463)	(695)	29.8%
Remaining funding after Primary Care Allocation:		**545**	**1,090**		
Less: Other training costs (non-primary care) for outreach workers		(25)	(50)	(75)	2.9%
Remaining funding for local allocation via LIBs:		**520**	**1,040**		
Reading 52%		270	541	811	
Wokingham 24%		125	250	375	
West Berkshire 24%		125	250	375	

4.20 A detailed budget for the service is being finalised, including salary costs for the Project Manager (currently funded from public health reserves).

5. Options Considered

The project could have been funded through the Better Care Fund and Public Health Reserves, but utilising the Berkshire West Place Partnership funding will free up £150,000 to be spent on other priorities.

6. Proposal(s)

6.1 The Board are asked to note the progress to date on the Community Wellness Outreach project to date. The work reflects genuine collaboration between public health and BOB locality partners to reduce health inequalities experienced by our residents, led by April Peberdy.

6.2 In the short-term, this collaboration will support the development and delivery of an effective community wellness outreach model for residents disproportionately impacted by CVD within West Berkshire.

6.3 In the longer term, this collaboration is expected to strengthen, enabling effective locality efforts to address health inequity within West Berkshire.

6.4 Next steps are as follows:

- Commence pre-procurement, including market engagement process to engage providers.
- Continued partnership working with PCN's ensure effective and streamlined delivery.

7. Conclusion(s)

7.1 In conclusion, the Board are asked to note the work undertaken by Public Health and Wellbeing to address premature mortality, with a focus on cardiovascular disease (CVD) through the development of a CVD Wellness Outreach service. The team have developed this proposal to secure prevention and inequalities funding of £375,000 for West Berkshire Council, made available through the Berkshire West Place Partnership. The final proposal was presented to Locality Integration Board in September when it was agreed and funding confirmed. The next steps will be to commission the service.

7.2 Successful receipt of this funding will free up £150,000 of better care funding and public health reserves which was originally earmarked for delivery of this service.

7.3 Progress updates will be provided in due course as the partnership work develops and service delivery commences.

8. Consultation and Engagement

8.1 The proposal was discussed at Corporate Board before going to the LIB.

9. Appendices

None

Background Papers:

None

Health and Wellbeing Priorities Supported:

The proposals will support the following Health and Wellbeing Strategy priorities:

☒ Reduce the differences in health between different groups of people
☒ Support individuals at high risk of bad health outcomes to live healthy lives
☐ Help families and young children in early years
☐ Promote good mental health and wellbeing for all children and young people
☐ Promote good mental health and wellbeing for all adults

The proposals contained in this report will support the above Health and Wellbeing Strategy priorities by to addressing premature mortality, with a focus on CVD, through the development of a CVD Wellness Outreach service.

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Ageing Well Task Group

Update for HWB Steering Group
September 2023

Current Activity

The Ageing Well Task Group held a well-attended in-person workshop this quarter. This included:

- An overview of the Joint H&WB Strategy and Delivery plan for Ageing Well
- Falls prevention review of best practice and mapping and gapping exercise of local provision
- Ideas and action planning for the next 18 months

A summary of proposed ideas and actions has been shared and these will be prioritised and allocated at the next Ageing Well meeting in September.

The Ageing Well Task Group received a presentation about Technology Enabled Care from Adult Social Care.

Nature for Health - An intergenerational gardening project has been set up and is now being enjoyed at Newbury Grove Care home, working with children from Fir Tree School. This has proved hugely successful with the school children and residents alike and two groups have been required to enable all children who want to be involved to participate.

Future Actions

Sept - Agree and allocate priority actions with Partners for the next 18 months.

Oct - Working in partnership with Dementia Friendly West Berkshire and Age UK Berkshire to host an event at St Nicholas Church Hall on 5th October to celebrate National Older Persons Day. Stakeholders will be available to share information and chat to people about activities and services that support healthy ageing.

Nature for Health - Exploring development of a volunteer led offer to help older people with simple gardening support.

Building Communities Together Partnership

Update for HWB Steering Group – September 2023

Current Activity

- The Partnership met last on 11 July 2023 and will meet again on 10 October 2023
- The Partnership receive local crime and disorder data at each quarterly meeting and the sub groups have access to local police data to inform local activity and multi-agency problem solving
- At their July meeting the Partnership agreed the process and timeline for the annual Strategic Assessment of crime and disorder in West Berkshire
- The Strategic Assessment will consider data from partner agencies from the previous 12 months and will assist the Partnership in identifying issue of concerns and enable the Partnership to review the Shared Partnership Priorities within the Partnership Plan
- The Partnership Plan is a 'live' document that is reviewed at each meeting

Serious Violence

- In accordance with the Serious Violence Duty through the Serious Violence Steering Group the Partnership is developing a local Serious Violence Reduction Plan which will align with other locality Plans across the Thames Valley
- Compliance with the Serious Violence Duty is being overseen by the Thames Valley Police and Crime Commissioner who will publish, as required by the Home Office, a Serious Violence Strategy at the beginning of 2024
- West Berkshire is fortunate to have maintained a low prevalence of serious violence however the Duty requires that each locality develops a Serious Violence Plan and a Serious Violence Needs Analysis (first drafts are now in place for both of these documents for West Berkshire)
- A Violence Against Women and Girls (VAWG) survey has been undertaken seeking information on perceptions of areas where people feel unsafe and the data captured is now being analysed and the outcome will inform local partnership activity. Initial responses indicate positive feelings of safety.
- In support of the Safer Streets Fund (Round 5), West Berkshire feature as one of the bids submitted by the OPCC to obtain grant funding and focuses on reducing ASB. There are several key criteria for activity but if successful this will enable a number of necessary interventions, but via grant funding. The outcome of the bid is imminent.

Anti-Social Behaviour

- The statutorily required consultation on the expiry of the current Public Spaces Protection Order (PSPO) in Speen Lodge Court has completed with the results and recommendation presented at Corporate Board 05/09/2023.
- Corporate Board has agreed for consultation to commence on extending the Public Spaces Protection Order (PSPO) in Newbury town centre which is due to expire in February 2024.
- An Enforcement Protocol between West Berkshire Council and Thames Valley Police on the procedure for processing breaches of Public Spaces Protection Orders in West

Berkshire has been developed and is currently with the Council's Legal Team for review

Prevent

- The Prevent Steering Group met on 17 July 2023 and refreshed the Prevent Partnership Plan taking into account the Independent Review of Prevent, Home Office assessments and the Counter Terrorism Local Profile 2022/23
- There are currently zero cases in Channel and zero cases in Police Led Panels
- The CONTEST Strategy has been published and will inform local partnership working

Domestic Abuse

- The last domestic abuse board meeting took place on 17 July and will meet again on 25 September.
- The domestic abuse and safe accommodation local needs assessment is currently within the analysis stage and is expected to have concluded by October/November. A new 5-year domestic abuse strategy will then begin to be written with a workshop scheduled for all agencies mid-November.

Modern Slavery

- The Modern Slavery and Human Trafficking Statement 2022-23 has been written and is with internal colleagues for review prior to final sign off by Chief Executive.

District Parish Conference

- Work has started on preparing for the next District Parish Conference and a survey of towns/parish councils will be undertaken to better understand the most appropriate structure and content for future events. The online survey is due to be issued week commencing 11th September.

Members' Community Bids

- A new Members' Bid funding round has just opened on 10th August 2023 with £82k to distribute towards community projects. The deadline for completed applications has been set for 31st October 2023 and the Panel will determine the bids on 21st November.

Town/Parish Councils

- There will be some future engagement with town/parish councils over the findings of the recent survey of secondary schools, and importantly, sharing the views expressed by young people to help inform local decision making on facilities.

Future Actions

- The Partnership Chair, Nigel Lynn, and Vice-Chair, Supt Helen Kenny, will give the annual local crime and disorder presentation to the Councils Overview and Scrutiny Management Commission on 14 September 2023

- Martyn's Law (formerly Protect Duty) – sector webinars have been attended and a Task and Finish Group to be convened when more guidance is available

Children's Early Help & Prevention Partnership

Update for HWB Steering Group – September 2023

Current Activity

Early Help Best practice: ongoing exploration of what works in early help and prevention through research and learning from best practice in other areas is ongoing, including how the My Family Plan is used as a tool in the Early Help arena.

Data analysis: undertaking exploration of the nature of referrals coming to the Early Response Hub, Family Hubs and those requiring My Family Plans – seeking to identify patterns trends and areas of focus.

Digital Referral Form for the Early Response Hub (ERH), was discussed as an alternative to the current telephone call referral process. It was agreed to trial a digital referral form by 10 identified schools but with a view to rolling this out more widely if the pilot is successful. The ERH digital referral form as well as all of the connecting links to relevant information has now been built by WBC Digital Team, however, the outstanding actions are around ensuring that the digital referral tool either cannot be used out of hours for urgent safeguarding concerns or to ensure that there is a referral pathway including EDT for any referrals where the author identifies that they are very concerned about the child/family.

Supporting Families: oversight of the work of the operational group, looking at some of the challenges with the new outcomes framework, data sharing, the next steps with the Better Together Project.

Parenting: a mapping exercise was undertaken to understand what parenting provision was available across West Berkshire, currently there are 49 parenting courses/groups being run in a variety of different settings with many different focuses. Work in underway to ensure they are more visible and easy to access for parents who require support.

Early Help Self Assessment: the group examined the self-assessment which is required to be completed by the Department of Levelling Up Housing and Communities to ascertain how the Early Help System is functioning across five domain in the local area. This was submitted in July.

Schools and Universal Offer Working Group (SEND): there is ongoing work on the SEND Strategy and there is a significant overlap between the working group and the work of CEHPP therefore ongoing collaboration was agreed.

Future Actions

The CEHPP are continuing to drive the actions and agenda around Early Help building on the activity outlined above. Specifically:

- Pilot the Early Help Digital Referral Form
- Establish a robust dataset around Early Help indicators
- Drive forward actions stemming from the Early Help Self Assessment
- Develop the accessibility and visibility of existing parenting courses

Health Inequalities Task Force

Update for HWB Steering Group – September 2023

Current Activity

The group has not met since the last HWB Steering Group meeting as per the direction from the Service Lead, Zoe Campbell. The Terms of Reference have been updated. Progress has been made on writing up a summary of the desk-top analysis for the Task Force and stakeholders, using the Marmot policy areas as a framework. This summary will be shared with the Task Force and will be published to the Observatory. Conversations have been held with John Ashton (Director of Public Health) and the new interim Pubic Health Consultant Mike Bridges about the development of the programme to address health inequalities in West Berkshire e.g. using the Marmot policy areas and collaborating with Reading.

Future Actions

The Task Force are due to meet again in September (chaired by Mike Bridges) and will be asked to:

- sign-off the updated Terms of Reference
- agree whether Community Participation is required to address gaps in the data & intelligence following the desk top data analysis
- consider proposals from Mike and John on the way forward for the programme to address health inequalities in West Berkshire, including a Marmot policy framework and possible co-production with residents to develop an action plan .

Locality Integration Board

Update for HWB Steering Group – September 2023

Current Activity

- At June meeting, LIB reviewed Proposed Health and Inequalities Model for West Berkshire (Inequalities and prevention funding from ICB) – this will come back to September meeting with an update and hopefully agreement to proceed.

- 10/8/23 - SE region were pleased to recommend West Berkshire's BCF plan for approval. Now being considered by National Partners for formal sign off, which should be received in September. There were some areas of improvement suggested:
    - Build a strategic alignment between Housing and BCF; and
    - Review High Impact Change Model.

- Meeting in August was cancelled to due to number of people being away.

Future Actions

- Next meeting in September

Mental Health Action Group

Update for HWB Steering Group – September 2023

Current Activity

The Mental Health Action Group has not met since the last meeting of the steering group. However, work has continued on the issues raised then, as well as on some other matters.

Much of that work has been following up issues on financial problems and mental health which are due to be reported to the next Health and Wellbeing Board, in September. They include:

- Research on Council Tax Reduction Schemes and debt collection arrangements and discussion with the WBC Revenues and Benefits Manager about ways of reducing the burden of council tax on the most vulnerable groups, and current debt collection arrangements
- Discussion with the WBC, Health and Wellbeing in Schools Coordinator about how to support teachers enhance education on personal financial management
- Meeting planned with the Environment Delivery Manager
- Meeting planned with Sovereign on their debt collection arrangements
- Chasing up other actions

Other activities include:

- Discussions about the place of the MHAG in the Berkshire West Place Based Partnership
- Discussion with the interim Director of Public Health about a possible workshop with key stakeholders to develop a public mental health approach.
- Obtaining feedback from MHAG on proposed strategy delivery plan outcome indicators relating to adult mental health.
- Participating in the Health and Wellbeing Strategy Delivery Review Group
- Supporting the Volunteer Centre with a series of workshops exploring people's experiences of mental health services
- Collating poems received as part of the Poetry in Mind campaign led by Public Health
- Closure of Surviving to Thriving Fund and diverting remaining funds into a new "Let's Get Mindful" fund to support mental health. To be launched along side "Let's Get Active", led by Greenham Trust.

Future Actions

The next meeting of the Mental Health Action Group is to be held on 13th September. It is intended to use this meeting to plan the programme of activity for the next year. This will be the first MHAG meeting held face-to-face (on request) since the pandemic.

Skills and Enterprise Partnership

Update for HWB Steering Group – September 2023

Current Activity

The SEP met on the 15th June 2023 and received updates on each of the actions identified in the Delivery Plan.

	Planned Actions	Progress at June 23
1	Public Awareness campaign to promote the sustained employment of people from under-represented groups	Nicky Bhatoey-Turnbull from Groundwork is planning a further activity, after the success of last year's event in September 2022.
2	Extension of the 'Delivering Life Skills' programme	The H&WB approved funding for this programme, which was delivered in secondary schools by the EBP. All sessions were completed by July 23, with a significant increase to 250 participants. A further funding bid for 2023/234 will now be submitted to the HWB Board.
3	Implementation of the Supported Employment Strategy 2020 - 2024	Paul Coe has confirmed that a new approach for Supported Employment has been agreed by the WBC Corporate Board and, therefore, the SEP will no longer have a specific role in the implementation of the Supported Employment Strategy.
4	Enhanced delivery of a Work and Careers Fair – including participation by local schools and supporting the work on employment opportunities for people with learning disabilities	The second annual Work & Careers Fair (the 'Destinations Expo') was successfully delivered on 13th October 2022 at Newbury College. Over 800 young people from local secondary schools attended, with around 50 employers and other organisations exhibiting. There was a strong focus on careers for students with disabilities, with over 100 attending and all employers attending a briefing on supported employment. The EBP projected managed the event, with financial support from the Greenham Trust. The 2023/24 event will be held on 12th October 2023, with a planned increase in the number of exhibitors and the numbers of young people attending.

5	Support small businesses to promote mental health and wellbeing practices in workplaces (e.g. mental health awareness training, the Mental Health at Work Commitment)	WBC were unsuccessful attracting enough small businesses to the mental health awareness training, but the sessions were successfully delivered to a number of voluntary organisations.
6	Commission services to support people who are in contact with mental health services to find or stay in work (Supported Employment Strategy)	The SEP does not have a specific role in relation to the commissioning of services, but this is achieved through WBC's commissioning of Groundwork (for adults) and Ways into Work (for young people). Groundwork updated the SEP on their work at the June meeting.

Future Actions

The SEP has two identified actions which it is now supporting on an annual basis – the 'Delivering Life Skills' programme and the 'Destinations Expo', as reported above.

The SEP will be discussing potential actions for 23/24 and 24/25 at its next meeting in November 2023, in order to meet its key purposes:

- Promote economic development by ensuring the widest possible pool of talent for local employers
- Support people from groups who are under-represented in employment to acquire skills and overcome barriers in order to enter, or re-enter, employment

  Under-represented groups include:
  - People with physical disabilities
  - People with mental health problems
  - People with learning disabilities
  - People with long-term health conditions
  - Young People

- Support employers in providing and sustaining employment for people in under-represented groups in order to increase diversity
- Help to close the employment gaps in West Berkshire, with a focus on the development of supported employment services.

Substance Misuse Harm Reduction Partnership

Update for HWB Steering Group – September 2023

Current Activity

The next partnership meeting is on Thursday 14th September

We have not met over the summer but have been busy in the background with the combatting drugs partnership and actions related to this and service delivery.

Via have recruited a new acting manager. Having struggled with retaining a manager over the delivery of the contract they have recruited a former team leader with local connections and are investing in training and support to strengthen the stability of the team.

The service like others in the area are still struggling with retention and recruitment of staff but appear to be in a stronger position and have found some innovative solution to fill vacant posts.

Combatting drugs partnership- CDP is holding a Stakeholder day on Friday 29th November at Reading Town Hall. This will be an opportunity for us to look together at our Berkshire west strategy and action plans and to plan ahead to meet the targets set by the Dame Carol Black review and the grant funding attached.

There is a big emphasis on increasing Numbers in treatment services and we are working locally on networks to enable us to do this.

Drug related Death meeting- We held the first drug related death meeting over the summer and intend to hold these meetings quarterly. This forum enables us to look at any trends in deaths relating to alcohol or other substances, look at individual cases and any system failures that need to be addressed or improved and to identify good practice. The next meeting is due to take place in October. Date to be confirmed

LDIS- (local drug information systems) This is in place and is led by Jason Kew (Consultant working with Berkshire East and West councils to support Dame Carol Black funding requirements)- the network is set up to identify any trends with substance use particularly where they are leading to hospitalisations overdose and deaths. We meet monthly and also as required when there is a substance of concern. Recent alerts have been in relation to synthetic opiates which have been added to heroin.

We now have a range of network meetings regarding mental health, prison leavers, police and probation meetings at a strategic level that feed into the local work taking place and improve on partnership working.

Future Actions

Future actions to be identified to link with CDP actions. Via have been doing a lot of work around local pathways and referral routes into treatment and this is relevant work that will continue for adults and young people.

To work more closely with community organisations and Via are looking to provide more sessions in the community settings and development of these networks will be a role for the SMHRP.

Work with BHCFT to develop training package for November and hold a Berkshire wide Drug awareness and training week.

Suicide Prevention Action Group

Update for HWB Steering Group – September 2023

At a meeting of the Suicide Prevention Action Group on the 28th July we received a report from our outreach worker. Our worker is employed for 1 day per week.
During the past 4 months we have managed to secure funding for this post for a further year from 1st August. Circa £6500 from Greenham Trust and £1000 from Public Health.

The purpose the SPAG is to provide information and resources to front line workers, managers, small businesses, sports clubs and the voluntary sector in particular. The SPAG is operated by Volunteer Centre West Berkshire and attended by stakeholders and lead by its Director Garry Poulson who established the group in May 2017 with support from the HWBB.

In the year to date we have trained 110 people in Suicide Prevention. Our next course is in September with 15 people booked in so far.

Current Activities

We delivered a Suicide First Aid Courses face to face during April, May and June. Attendees included Street Pastors, Healthwatch, Solicitor, Citizens Advice, Handybus, Soup Kitchen, Sport in Mind and Time 2 Talk
The worker attended 2 CPD events "Suicide and Self Harm" and a Tutor drop in event,
The worker has attended regular support meetings with the director Garry Poulson and a fellow Tutor to discuss issues which is important supervision.
She also attended Grassroots Suicide Intervention Skills Training (ASIST) a 2-day interactive workshop on Suicide First Aid n Brighton- a tough but thoroughly enjoyable course, which added knowledge to the skills already learnt

The worker also qualified in RSH Level3 Award in Mental Health First Aid in May.
We have continued to visit and leave information , or email information to Pubs, hairdressers, barbers, Tattooists, Social and Sport Clubs amongst others. We have had useful meetings Andrew Spaak West Berkshire Injury Clinic who is very keen to book courses for local Rugby Clubs.

Our Director has visited and sent information to the Fire Station in Theale and Swift local delivery firm, both wishing to explore possibly booking courses.

Continuous development for the outreach worker by attending the ASIST course, she had to deliver a Suicide Intervention to tutors and group peers, this was then critiqued by all, a nerve-wracking experience. However, the feedback received boosted her confidence and as such she felt the course was a great success.

Our worker will be attending a virtual conference in September NCEPET Virtual Conference 2023- Suicide Prevention: Working Together We will continue to plan monthly face to face training courses, and have booked room space until the year end. The worker has been invited to spend a shift with the Street. Pastors.

SOBS At our last stakeholder meeting in July the topic of support for people who are bereaved by suicide. West Berkshire does not have a post suicide bereavement peer support group. It was resolved to seek to establish a SOBS (Survivors Of bereavement due to Suicide) group for the district. The outreach worker has now made contact with Nationals SOBS to create a template for West Berkshire.

Health & Wellbeing Board – 3 October 2023

Item 16 – Members' Questions

Verbal Item

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Health and Wellbeing Board Forward Plan (All meetings are on a Thursday, starting at 9.30am in the Council Chamber except where otherwise stated)

Item	Purpose	Action Required	Date Agenda Published	Lead Officer(s)	Those consulted
Hot Focus Session - Children's Early Help and Prevention Partnership (date TBC)					
7 December 2023 - Board Meeting					
Health Inequalities Needs Assessment	To present the Health Inequalities Needs Assessment fo the Helath and Wellbeing Board.	For discussion	29/11/2023	Zoe Campbell	Health and Wellbeing Steering Group
Berkshire Suicide Prevention Strategy	To provide an update on the Suicide Prevention Strategy	For discussion	29/11/2023	John Ashton	Health and Wellbeing Steering Group
Local Response to the Cost of Living Increases	To provide updates on the impacts of the cost of living on local residents	For discussion	29/11/2023	Sean Murphy	Health and Wellbeing Steering Group
Safeguarding Adults Board for Berkshire West - Annual Report for 2022/23	To present the annual report from the Safeguarding Adults Board	For information	29/11/2023	TBC	Health and Wellbeing Steering Group
Berkshire West Safeguarding Children Partnership - Annual Report for 2022/23	To present the annual report from the Safeguarding Children Partnership	For information	29/11/2023	TBC	Health and Wellbeing Steering Group
Health and Wellbeing Board Annual Conference 2024	To agree the date and theme for the next HWB annual conference	For decision	29/11/2023	April Peberdy	Health and Wellbeing Steering Group
Better Care Fund Monitoring Report - Q2 2023/24	To approve the BCF quarterly monitoring report for Q2 2023/24	For decision	29/11/2023	Maria Shepherd	Health and Wellbeing Steering Group
Delivery Plan Progress Report: Priority 3	To update on progress in implementing the actions set out in West Berkshire's Delivery Plan, focusing on the third priority to: *'Help children and families in early years'*	For discussion	29/11/2023	April Peberdy	Health and Wellbeing Steering Group
Hot Focus Session (topic and date TBC)					
22 February 2024 - Board Meeting					
Local Response to the Cost of Living Increases	To provide updates on the impacts of the cost of living on local residents	For discussion	14/02/2024	Sean Murphy	Health and Wellbeing Steering Group
Delivery Plan Progress Report: Priority 4	To update on progress in implementing the actions set out in West Berkshire's Delivery Plan, focusing on the fourth priority to: *'Promote good mental health and wellbeing for all children and young people'*	For discussion	14/02/2024	April Peberdy	Health and Wellbeing Steering Group
Hot Focus Session (topic and date TBC)					
2 May 2024 - Board Meeting					
Health and Wellbeing Board Peer Review	To present the findings from the Health and Wellbeing Board Peer Review	For decision	24/04/2024	April Peberdy	Health and Wellbeing Steering Group
Local Response to the Cost of Living Increases	To provide updates on the impacts of the cost of living on local residents	For discussion	24/04/2024	Sean Murphy	Health and Wellbeing Steering Group
Delivery Plan Progress Report: Priority 5	To update on progress in implementing the actions set out in West Berkshire's Delivery Plan, focusing on the fifth priority to: *'Promote good mental health and wellbeing for all adults'*	For discussion	24/04/2024	April Peberdy	Health and Wellbeing Steering Group

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