Better Care Fund Plan for 2022-23

West Berkshire Health and Wellbeing Board

Bodies involved 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)
- 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 Health and Wellbeing Strategy, Urgent and Emergency Care Board Priorities and the NHS 5 year forward plan.

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 the HWB with a quarterly update on progress against the plan and meet with colleagues from the ICB to report on spend within the BCF budgets.

Our priorities for 2022-23 were agreed at Locality Integration Board towards the end of 2021-22 and two align with the Core20plus5 approach outlined by NHS England to support the reduction of Health inequalities.

Executive Summary

This should include:

- Priorities for 2022-2023
- key changes since previous BCF plan

West Berkshire's BCF plan for 2022-23 builds on previous plans, National Guidance and a review of our priorities for 2022-23, which are: -

- **Risk Stratification** – we plan to 1) employ or utilise a data analyst from across the system to develop the Connected Care platform for use by GP practices, ASC, BHFT and Public Health 2) put in place a common criteria to identify patients for MDT's and 3) an understanding of inequalities in practice populations and identify groups which may need targeted work in the future.

- **Service User Experience** – we plan to 1) Map current methods of capturing and integrating the service user voice in services, including MDTs 2) Identify any gaps and commission work to address needs and 3) Explore ways in which service user voice is integrated into MDTs.

- **Multi-Disciplinary Team Development** – we plan to embed a Multi-Disciplinary Team (MDT) approach across Health and Social Care aligned to Primary Care Networks building on the work started in 2019-20 and 2020-21. The project will utilise a Population Health Management (utilising Berkshire West's Connected Care System, an integrated Health and Social Care System) approach in identifying a segment of the population and shifting primary care service delivery from reactive to proactive management to ultimately avoid unnecessary hospital admissions.

  Locality Integration Board has taken the decision to put this project on hold but it will be refreshed once requirements of the NHS's long term plan for anticipatory care model are known.

- **Reducing inequalities** – This project aligns with the Core20plus5 approach outlined by NHS England to support the reduction of health inequalities. We are supporting PCN projects to improve the take up of LD and SMI health checks. People living with a learning disability (LD) and or serious mental illness (SMI) often have poorer physical health and a shorter life expectancy than other people. Annual health checks offer general practice an opportunity to provide appropriate health and lifestyle advice to patients and to help identify preventable illnesses early (this is also sits in the HWB action plan).

- **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.

In addition to our priorities we have a number of actions that sit within the HWB plan as follows: -

Objective	Item	Description	Update
1.4: Address the variation in the experience of the wider social, economic and environmental determinants of health	1.4.3: Support PCNs to tackle health inequalities	1.4.3: Support PCNs to tackle health inequalities through identifying and engaging with a population experiencing health inequalities	The four West Berkshire PCNs are working jointly on a project to support patients with learning disabilities and sever mental illness to take up the offer of an annual health check. A project brief outlining the identified interventions has been presented to the LIB and regular updates are being provided.
2.6: Improve the mental and physical health of rough sleepers and those who are homeless through improved access to local services	2.6.1: Increase GP registration among rough sleepers	2.6.1: Increase GP registration among rough sleepers and those in temporary accommodation: work with CCG to develop a process for registration (placeholder)	Discussed at LIB in June. A process is already in place to promote GP registration through a locally commissioned service. A meeting is needed between LIB, HSG and PH representatives to identify a baseline and any further actions required.
2.6: Improve the mental and physical health of rough sleepers and those who are homeless through improved access to local services	2.6.4:Homeless patients in hospitals	2.6.4: Develop a clear process from admission through to discharge from hospital settings, to ensure homeless patients are discharged with somewhere to go with support in place (placeholder)	A meeting took place with Hospital Discharge Team and Housing Colleagues in April 2022. Hospital Discharge Policy shared and reviewed , housing leaflets have been placed in elective wards at RBH and Rough Sleeper Prevention Officer has been put in contact with Therapy Lead at RBH. High Impact Change Model to be reviewed with Housing colleagues as part of BCF Plan for 22/23.

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 is unchanged. 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 seven 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

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.

Governance

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

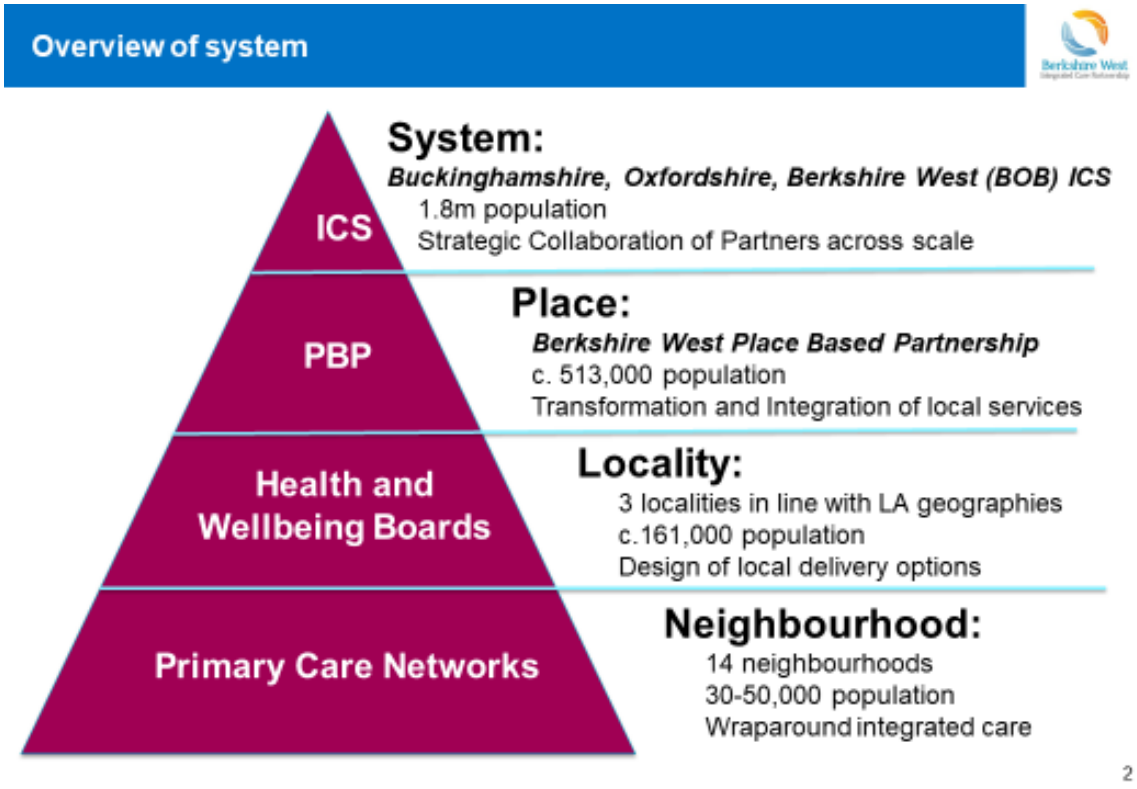
The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System takes strategic decisions at scale for the benefits of its 1.8 million population.

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.

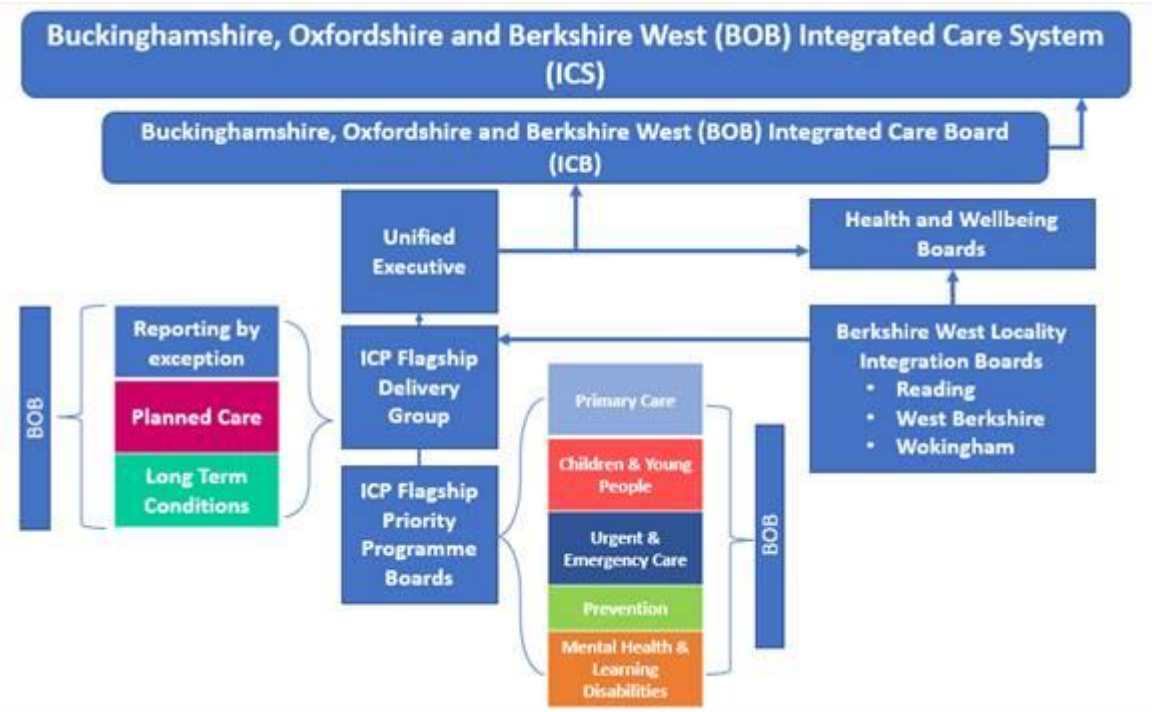
While the ICS and PBP are committed to strong joint working at place level, they recognise that there remains a need to design local delivery options to meet their strategic objectives.

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.



Overall BCF Plan and approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- Joint priorities for 2022-23
- Approaches to joint/collaborative commissioning
- How BCF Funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.

In 2019 the three Health and Wellbeing Boards for Reading, West Berkshire and Wokingham took the decision to develop a shared Health and Wellbeing Strategy with the (then) ICP to make even more improvements in health across Berkshire West.

The Berkshire West Health and Wellbeing Strategy 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 the 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 report (in anticipation of a delivery plan being finalised) for each of the three Local Authority areas, describing how the strategy will be implemented in each area.

The Locality Integration owns a number of the actions within the plan for West Berkshire and will be an enabler to support a number of the other actions within the plan.

With closing health inequalities and recovery from Covid-19 at its very heart, the Berkshire West Health and Wellbeing Strategy 2021-2030 establishes our priorities for the system, and aims to enable all of our residents to live happier and healthier lives.

The Council has been working with partners to co-produce an integrated community wellbeing model. The aim of the model is to bring together new provision (NHS link workers) and existing provision that supports individuals to self-care and strengthen community assets.

Adult Social Care operates on a number of guiding principles the first of which is to support its residents to maintain or develop their independence. This is seen in a number of services, one of which is funded through the BCF, the Reablement Service. 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 support 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.

Housing are represented on the 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, 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, 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 also have a range of offers for adults with Learning Disabilities and Mental Health. We are working on another scheme, which will offer up to 12 units of supported accommodation for adults with Learning Disabilities and Mental Health by 2020/21.

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 Funding – support for young people with dementia, Alzheimers Dementia Advisor & Stroke Association.
- 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.
- 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. West Berkshire are represented on the programme board and working together with health partners to implement this programme across the BOB ICS.

Implementing the BCF objectives national condition four

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- Enable people to stay well and independent at home for longer
- 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: -

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Adult Social Care's first commitment to its residents is to support them to maintain or develop their independence. This is seen as a range of services, including Reablement, sensory needs 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 support 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.

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 committed to a number of local priorities to help avoid hospital admissions: -

- MDTs
- Risk Stratification
- Targeted Community Health Checks

Across Berkshire West we continue to fund a number of schemes to help reduce avoidable admissions: -

- Rapid Response and Treatment Service for Care Homes
- Mental Health Street Triage
- Falls and Frailty

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 call to discuss hospital discharges with partners including: Local Authorities, RBH, BHFT, BW CCG 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% has been awarded to providers operating in West Berkshire.

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.

Following the creation of the Rapid Community Discharge Group last year a number of initiatives/projects were created and remain in place: -

- Promotion of single handed care – this project will end in August 2022 but there are plans to submit a bid for further development of this programme through the community hospitals
- 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.
- A dedicated phone helpline was put in place for care homes to contact the acute hospital following a hospital discharge to raise any concerns.
- A bariatric/plus size forum was created to take a system-wide approach and standard operating procedure
- Medicine Discharge Service to support vulnerable individuals and those with multiply medications

A self-assessment review of the Hospital Discharge and Community Support Guidance, published on 31st March 2022 was conducted in May 202, 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:

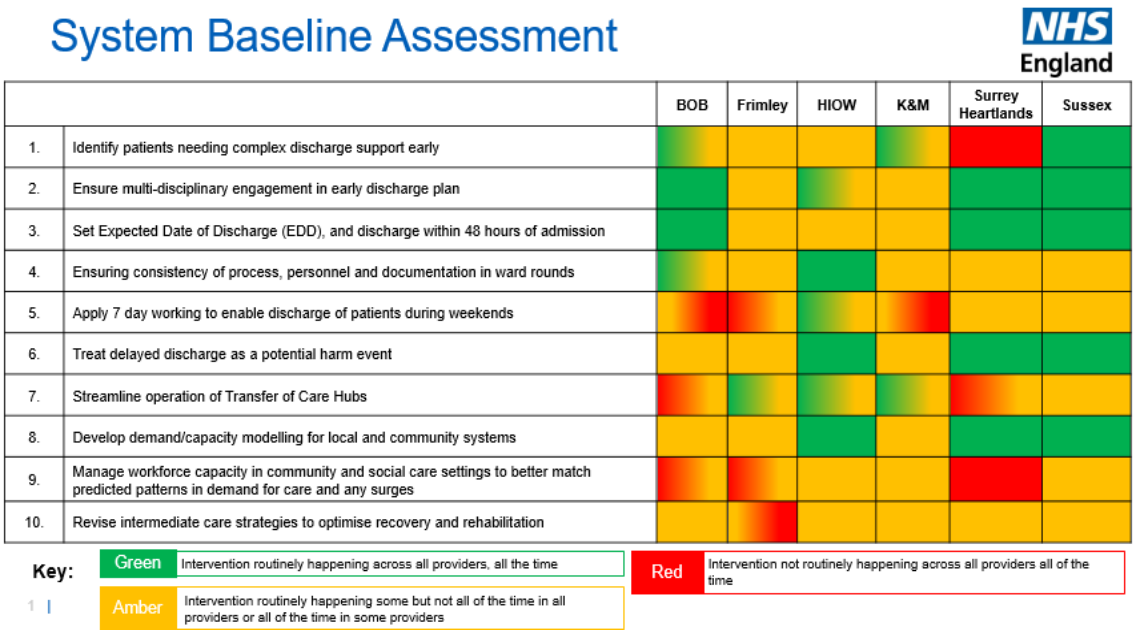
1. The predominant issue to address is the delay in discharges to Care Homes.
2. RCD Project -aims to improve liaison and communication with Care Homes in order to streamline transfers and repatriation.
3. Care Home Forum -A monthly forum in which concerns and processes needing improvement can be raised. 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. Plans are in progress to revitalise it.
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.
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: -



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 2022/23.

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:

£72.5k per annum is used to commission a Carers Information and Advice service, currently delivered by TuVida.

The contract is jointly commissioned with the BOB 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. TuVida 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.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

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 revised Grants and Loans policy 2021 sets out West Berkshire Council's approach in terms of how we manage and allocate the Disabled Facilities Grant through the Housing Service's Home Improvement Agency Team (HIA). The HIA Team have systems in place to process Disabled Facilities Grant applications 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 Officer 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 DFGs and our recent customer satisfaction survey returned 100% satisfaction rate. 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

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 Local Authority has invested a further £150K into this area of work in 2022/23 and we are in the process of re-scoping this work to explore smarter technology in our in house care provision and increasing the prevention of falls within Adult Social Care to avoid hospital admissions.

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.

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.

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.

In West Berkshire a Health and Inequalities task group was established in February/March 2021 to develop this delivery and action plan to reduce the differences in health between different groups of people.

The Task group communicates between stakeholders and group members and monitors actions to support the whole system. For example: -

- The Locality Integration Board owns actions to increase GP registration among rough sleepers and those in temporary accommodation and to develop a clear process from admission through to discharge from hospital settings to ensure homeless patients are discharged with somewhere to go with support in place.

  These actions have been incorporated into the BCF Monthly highlight report which is updated and shared with partners.

- The Chair of the Health and Inequalities group is also a member of the Locality Integration Board.

The Health Inequalities Task Force will have a Health Inequalities Needs Assessment, completed by the end of December 2022 as per the Action Plan for 2022/23 that will provide: -

- a set of agreed priorities to address current health inequity in West Berkshire based on data, research and community participation (with a focus on disproportionately impacted and under-represented residents)

- 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 enable us to develop and implement a Health Inequalities Delivery Plan, to address the prioritised health inequality issues, incorporating the wider (or social) determinants of health – see figure 1 and 2 below.

Figure 1. Adapted Labonte model (source: Place-based approaches to health inequalities

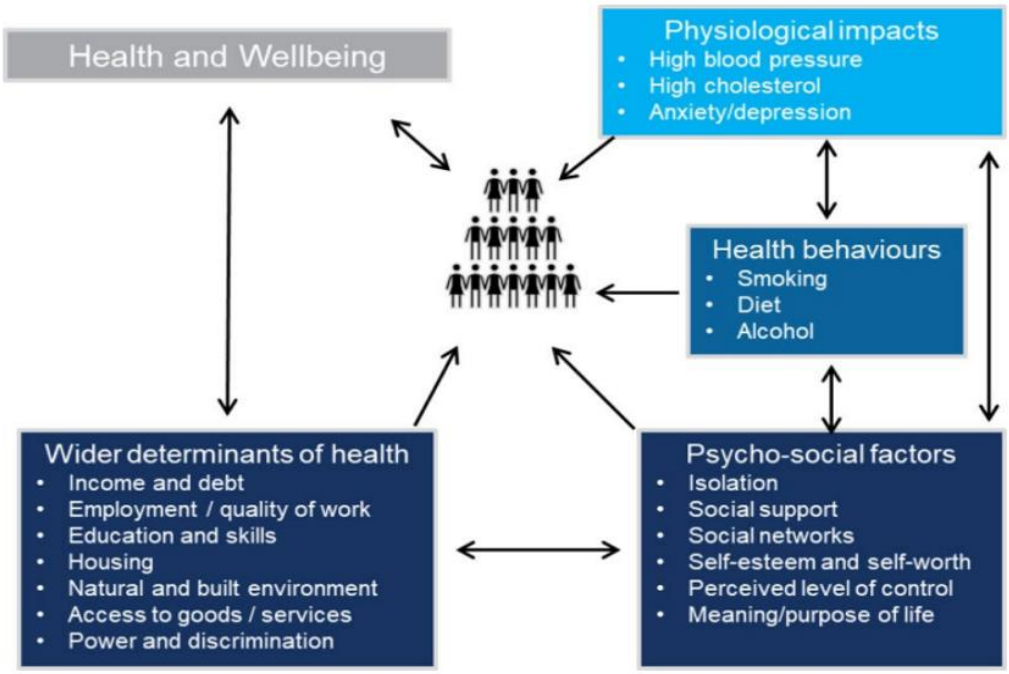


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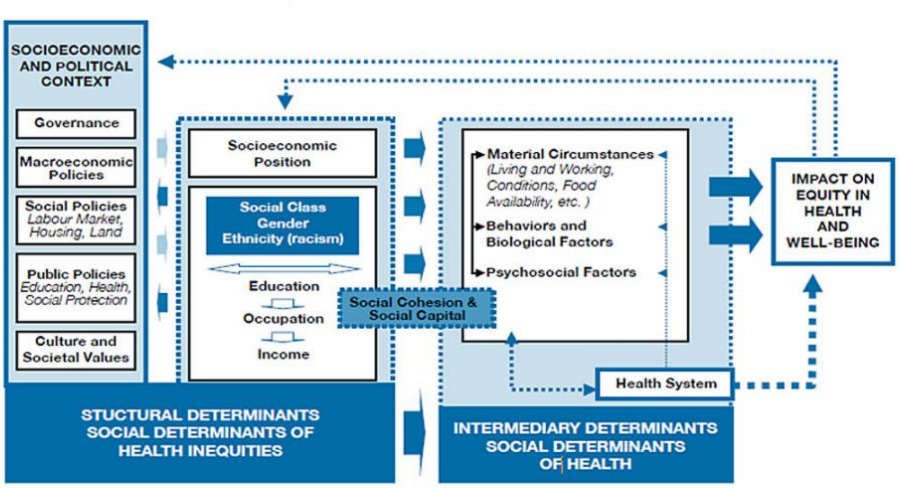
Figure 2:



Ref: Solar O, Irwin A. *A conceptual framework for action on the social determinants of health. Social Determinants of Health* Discussion Paper 2 (Policy and Practice). Geneva, WHO, 2010

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 NHS Health Checks, illustrating 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.

- Provide support and information to service users of the risks associated with CVD, and encourage behavioural lifestyle changes for the patient's wider physical and mental health as well as additional lifestyle services where required

- Provide regular updates on progress made in relation to KPIs.

In addition the Council is continuing to embed inequalities with all the work it does and is incorporating inequalities into all its policies.