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.

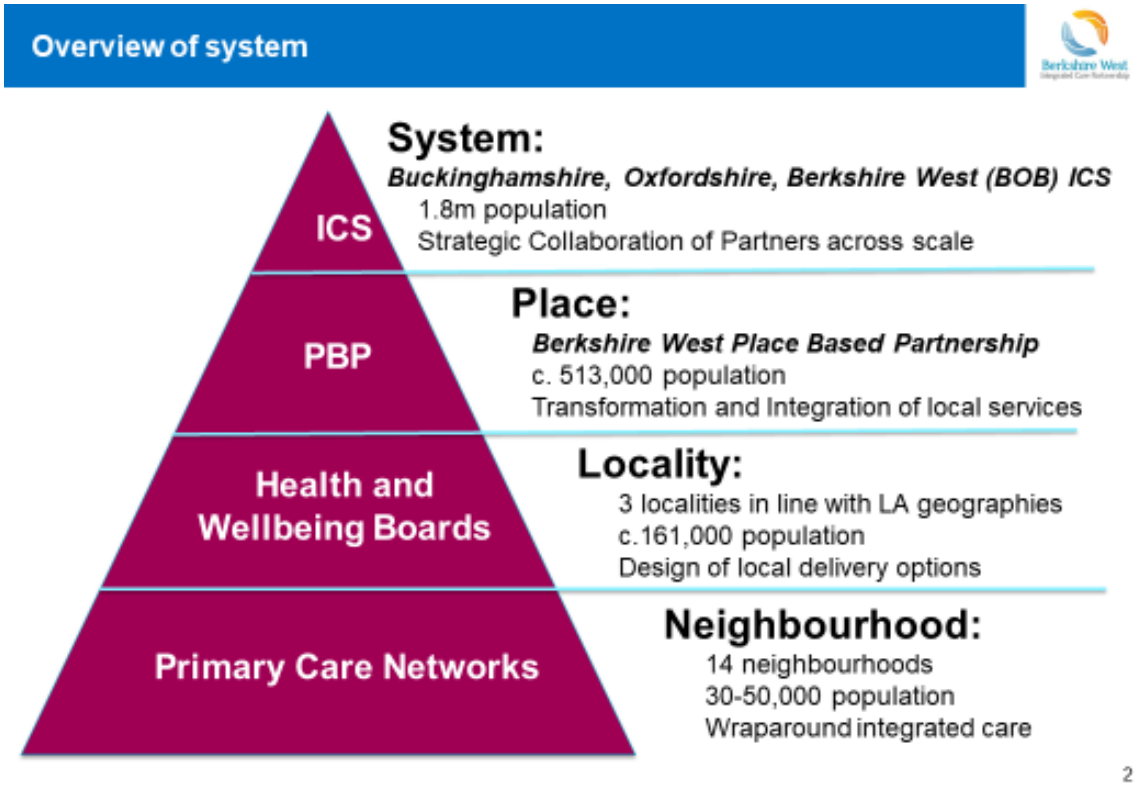
The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board was formally established on 1 July 2022.

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.

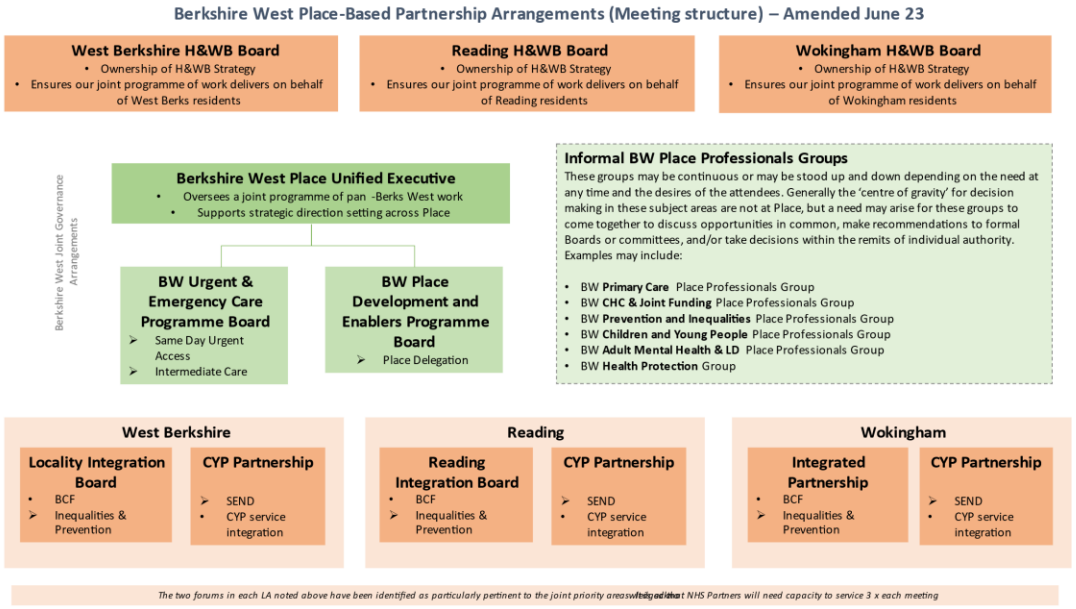
While the ICS and PBP are committed to strong joint working at place level, they recognise that there remains a need to design local delivery options to meet their strategic objectives.

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.

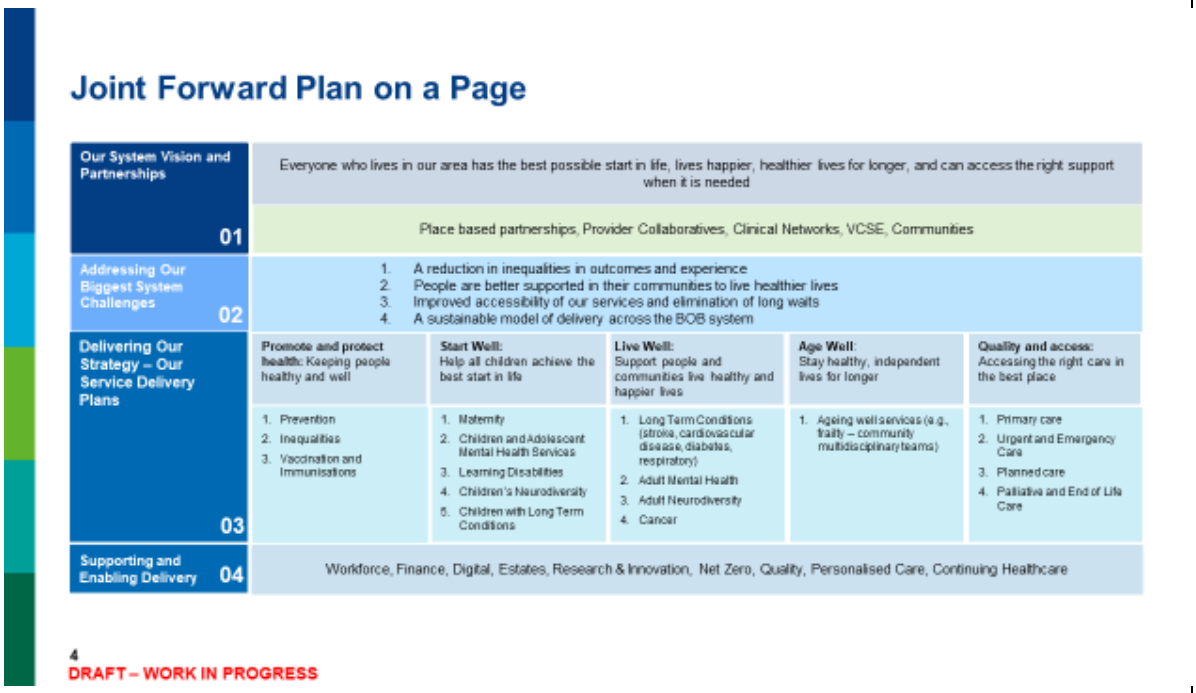
We remain committed to delivering against the national metrics as well as supporting both the Health and Wellbeing Board, the Integrated Care Partnership and the BOB ICB to deliver its priorities through a number of local and national initiatives through the PBP flagship priority programme boards, urgent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



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.

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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.

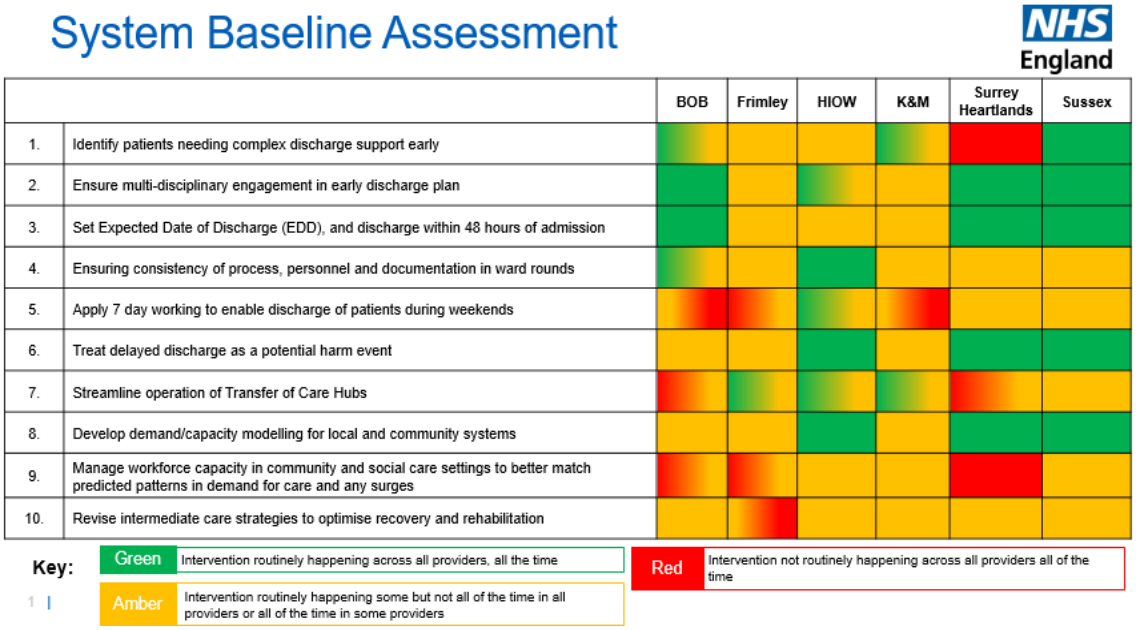
9. Introduction of care Home 'Clinic' in May 2022 -A new concept in which key Care Homes are invited to join the Care Home Forum attendees to share concerns, good news stories and learning in general. It is felt that any unmet training needs can be picked up and addressed in this forum.

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.