Integration and Better Care Fund

Better Care Fund 2025-26 HWB submission

Narrative plan template

	HWB area 1
HWB	**West Berkshire**
ICB	**Buckinghamshire, Oxfordshire and Berkshire West**

Introduction and guidance

Section 1: Overview of BCF Plan

This should include:

- Priorities for 2025-26
- Key changes since previous BCF plan
- A brief description of approach to development of plan and of joint system governance to support delivery of the plan and where required engage with BCF oversight and support process
- Specifically, alignment with plans for improving flow in urgent and emergency care services
- A brief description of the priorities for developing for intermediate care (and other short-term care).
- Where this plan is developed across more than one HWB please also confirm how this plan has been developed in collaboration across HWB areas and aligned ICBs and the governance processes completed to ensure sign off in line with national condition 1.

The Priorities for 2025-26 are as follows:

- **Workforce:** Recruitment and retention of Social Workers and Occupational Therapists to support Better Care Fund (BCF) policy objectives. This will support a wide range of activities including support to discharge people from hospital with care, and support to avoid admission.

- **To improve efficiency using technology:** For example, by using Artificial Intelligence (AI) to speed up the assessment process and ensure that managers receive documentation more quickly in order to make earlier decisions about need and care. This could also include reviewing falls prevention technologies.

- **Falls Pathway:** Continue work with partners to reduce the risks of falls, including providing assessment and advice activities. This includes exploring best practice models used in other systems. This will avoid admissions and support earlier intervention.

- **Self-Care Programmes:** Working with system partners to encourage self-care as part of a wider preventative agenda. Data on the health needs of the local population indicates some groups who require support to live healthier lifestyles. This will support longer-term management of demand.

- **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. This will keep pathways clearer for discharge.

- **Care market:** Undertake work to support the local care market to meet the needs of the local population. This will include advice and support to maintain capacity and quality. This will enable discharge and avoidable escalation of need.

- **Community Wellness Outreach Service:** A programme of delivering NHS Health Checks, wellbeing and lifestyle advice and support in community settings to reach vulnerable groups and reduce the risk of poor health outcomes. *(**Note**: this scheme is funded through the Inequalities Fund from the ICB and not through BCF, but this is included in our Section 75 Framework Agreement as a supportive prevention activity).*

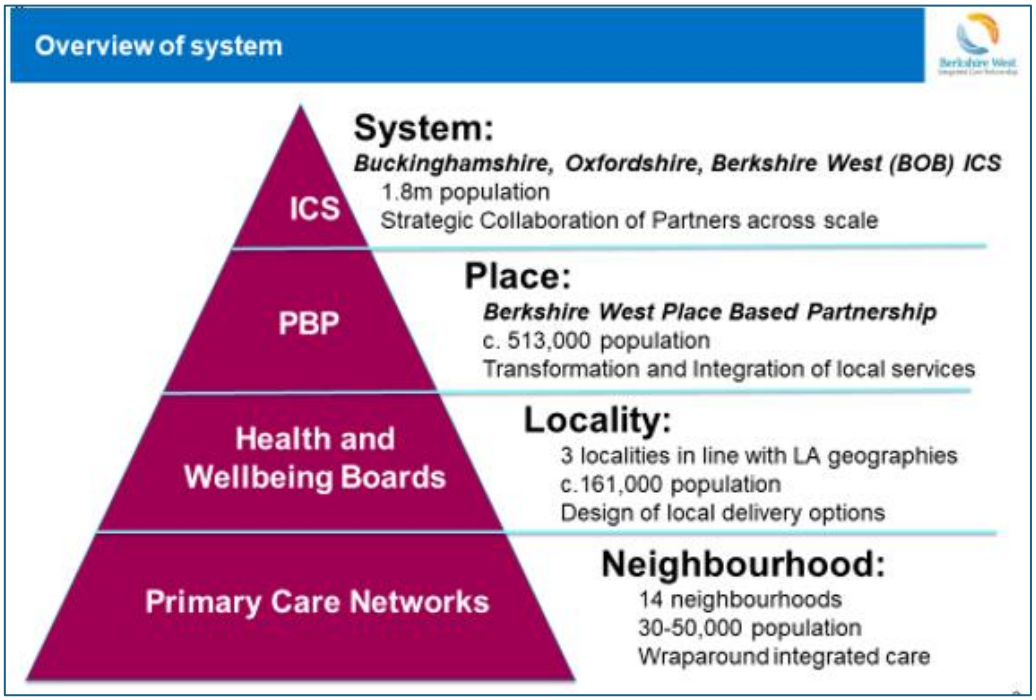
There is significant continuity from last year's plan, with relatively minor additions to reflect new opportunities. Performance has been broadly positive given the contextual challenges. These include a significantly ageing population in West Berkshire. In addition, there have been significant price increases for services, especially in the care sector. The workforce challenges are also significant, with shortages in key disciplines leading to both gaps and high cost requirements for cover arrangements. Whilst it is noted that some targets have been missed, the view is that this is largely due to that combination of challenges.

The Plan has been developed at pace, reflecting the national timelines. Consequently, there has been limited formal consultation. Nonetheless, it has incorporated the required checks and balances to reflect the multi-agency context. Throughout the year, there is work to understand the position of stakeholders regarding pressures and opportunities which have informed our Plan. Both the Locality Integration Board (LIB) and the Health and Wellbeing Board are key forums for sharing intelligence, agreeing priorities and reviewing performance. The draft plan was presented to and discussed at LIB on 20th March 2025 and a wide range of stakeholders were in attendance including representatives from the VCSE sector, our own internal services, health partners and Health and Wellbeing Board chair.

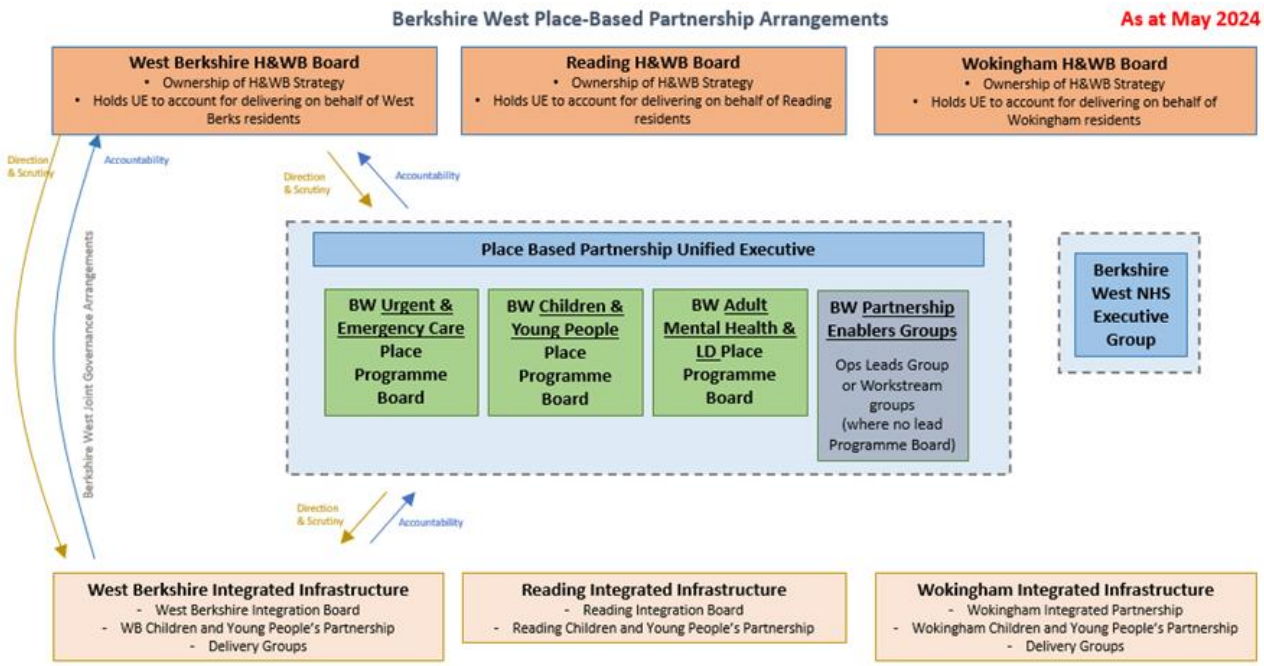
Governance arrangements for the delivery of the BCF Plan are as follows:

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.



The priorities for intermediate care are as follows:

In – patient and flow priorities.

For those patients requiring hospitalisation it is important that lengths of stay are minimised to prevent decompensation and risk of hospital acquired infection. This is particularly important for the vulnerable cohorts of patients requiring ongoing social care support post discharge. The BCF plans will help support a reduction in the number of patients not meeting the criteria to reside for patients on pathways 1 and 3.

Areas of focus include:

- Strong home first ethos.
- Hospital Liaison teams aligned to the Hospital Discharge Team.
- Effective reablement pathways.
- Early notification of complex discharges.
- Support and development of the Care Market.
- Bariatric pathways.
- Delirium and mental health.

Berkshire West (BW) is also looking at how the Urgent and Emergency Care (UEC) Programme Board and the Integration Boards can be more effectively aligned to ensure BCF

Plans continue to be developed in support of the UEC improvement programme. Priorities already reflect the issues identified through the UEC Programme Board relating to admission avoidance, expediting discharges, workforce, the care market, etc.

Length of stay will be a breakthrough objective for 25/26 with data reported to Executive monthly.

Bed days lost work will continue to be monitored, themes will continue to be identified and discussed with relevant parties to work in a collaborative manner to reduce the impact that bed days lost cause to the system.

Weekly Quality improvement methodology work to continue with acute partners to maximise utilisation of community beds.

Reviewing opportunities to skill mix roles. Safe staffing work planned, new dependency tools to be implemented from April 2025, linking with IT to understand how these tools can evidence acuity more clearly in services to better inform community OPEL.

Principles of Martha's Rule to be implemented across all wards.

Urgent Community Response

To continue to work in collaboration with acute, community, South Central Ambulance Service (SCAS) and Primary Care providers to ensure that all patients are treated in the most appropriate care setting to reduce the need for hospital admission.

To support the education and upskilling of clinical staff to ensure the workforce can adapt to evolving patient needs.

To strengthen partnerships with voluntary and 3rd sector services to provide ongoing support to patients.

To maximise skill mix and implement 7 day working for support staff.

Intermediate Care – rehabilitation pathways

Focus on the application of any outstanding actions in line with the Intermediate Care framework for rehabilitation, reablement and recovery following hospital discharge (2023).

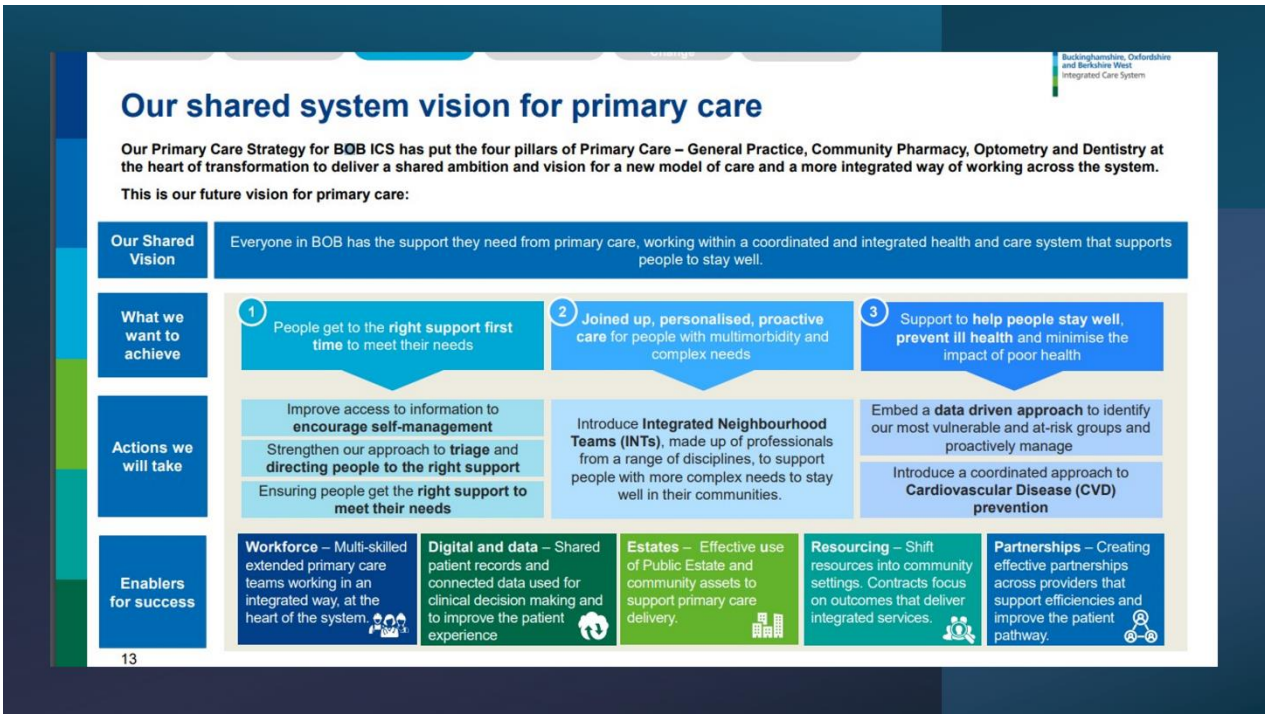
Improve workforce utilisation through implementation of the new community rehabilitation and reablement model - working with professional leads to explore how we can maximise the use of skill mix across all pathways, consistently in BW.

Effective performance monitoring - with a focus on improving flow into intermediate care pathways through careful monitoring and management of the length of stay on service.

Enhancing current outcome measures in use across our intermediate care pathway – adding in the introduction of patient reported outcome measures, alongside patient experience and clinician reported outcome measures.

To work with systems colleagues to develop a single performance scorecard for rehabilitation, reablement and recovery pathways across all providers enabling comparative data to be reviewed and utilised for quality improvement initiatives.

Please see infographic for Shared Vision for Primary Care across BW:



The vision complements our BCF Plan through targeted work which supports admission avoidance and wider preventative work, for example, through the Community Wellness Outreach Service which targets people at risk of Cardio Vascular Disease (CVD), provides wellbeing and lifestyle advice, and raises awareness of CVD in the wider community. The focus on good data is reflected in our ongoing commitment to Connected Care.

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.

Section 2: National Condition 2: Implementing the objectives of the BCF

Please set out how your plan will implement the objectives of the BCF: to support the shift from sickness and prevention; and to support people living independently and the shift from hospital to home. This should include:

- A joint system approach for meeting BCF objectives which reflects local learning and national best practice and delivers value for money
- Goals for performance against the three national metrics which align with NHS operational plans and local authority social care plans, including intermediate care demand and capacity plans
- Demonstrating a "home first" approach that seeks to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care
- Following the consolidation of the Discharge Fund, explain why any changes to shift planned expenditure away from discharge and step-down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.

The Locality Integration Board and Health and Wellbeing Board both support collaborative work across the system to develop initiatives and review the impacts of the BCF according to key metrics. Both boards include statutory partners, the voluntary sector and commissioned services. The metrics and financial performance are reviewed regularly.

The key learning from our performance over the last few years is brought forward into this year's Plan. Performance against the key metrics is relatively strong. This is against a backdrop of significant growth in the population aged 65 years and above. Additionally, the impact of cost-of-living challenges and price inflation have created additional pressure in the workforce and care market. Despite these pressures, performance has remained positive indicating that the measures we have in place are effective and impactful. On that basis, there are high levels of continuity from previous years' Plans.

A key area of challenge is ensuring that non-elective admissions do not increase, which we will seek to address through the plan, including the investment in the workforce and technology.

Boards take a preventative approach routinely, especially with contributions from Primary Care, Public Health, Adult Social Care, Housing and Children's Services.

Multiple lines in the plan support a preventative approach, e.g. by facilitating earlier contact and better joint working.

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.

Our work with key integration system partners in West Berkshire also crosses over into neighbouring areas, particularly with our 'Berkshire West' neighbours (Reading and Wokingham) where there are shared services/providers and in those cases we aim to provide a consistent approach as far as possible. The BCF leads for each area meet with ICB leads on a regular basis (at least monthly) in order to ensure collaboration and alignment of Plans, including alignment with the NHS planning submissions, and Market Sustainability plans for the Local Authorities.

Performance against the national metrics have been broadly positive in a very challenging context. As above, the challenges consist of an ageing population, workforce challenges and price inflation especially in care services. Within that context, the view is that continuity with last year's plan is appropriate. There is investment in workforce, technology and the provider market.

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

- **Berkshire Health Foundation Trust (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 Stations 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 (BCES):** Jointly commissioned across 6 Local Authorities in Berkshire and their Health Partners. BCF monies are used in West Berkshire to fund this provision.
- **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. The Ageing Well Programme supports people to maintain their independence and only attend hospital when absolutely necessary, including virtual wards and virtual care. West Berkshire are represented on the programme board and working together with health partners to implement this programme across the BOB ICS.

'Home First' is supported throughout the hospital discharge process. Reablement is provided where there is a view that it can be impactful. The BCES responds quickly to need and facilitates return to home where possible. In keeping with Principle 5 of the NHS

Improving Hospital Discharge guidelines, Royal Berkshire NHS Foundation Trust work with Local Authority agencies to operate a 'Home First' approach, working first and foremost to return patients to their home with support at home. Wherever possible, we request patients to be supported to return to their home for ongoing assessment. The BW System recognises that accurate description of care is difficult when patient assessments are undertaken in hospital. Improvements have been made in West Berkshire relating to care home admissions. We need to make further improvements to performance relating to discharge to normal place of residence. This focus will continue.

A proportion of people that come through the discharge pathway to the local authority do not result in a reablement package of care but still require significant amounts of work for LA staff in terms of coordinating the restart of an existing package or navigating the care system.

Please describe how figures for intermediate care (and other short-term care) capacity and demand for 2025-26 have been derived, including:

- how 2024-25 capacity and demand actuals have been taken into account in setting 2025-26 figures (if there was a capacity shortfall in 2024-25 what mitigations are in place to address that shortfall in 2025-26)
- how capacity plans take into account therapy capacity for rehabilitation and reablement interventions

All available data has been reviewed in order to develop the BCF Plan. Some areas of performance have been kept under review, especially where there have been concerns. We have seen an increase in the number of discharges under Pathway 1. This is linked to bringing forward contractual arrangements with providers of care at home.

We have reduced the total amount of reablement hours delivered as we recognised 'over-prescription' to people without achievable reablement goals. This is reflected in the Capacity and Demand template (tab 3.1 Step-down). It should be noted that we receive a number of referrals through to the Pathway (Demand) which do not result in a new reablement package of care. These could be restarts of existing packages of care and a care co-ordination role by the duty team, and/or social worker involvement in care navigation that may not result in a package of care. This equates to over 300 referrals over a year which creates a significant amount of work for the social care hospital discharge team. Numbers within the Capacity and Demand template relate to activity which we track over time with a percentage increase based on trends seen over time. The data reflects demand from across the Local Authority sector, which includes two acutes which are not in the Local Authority area (Great Western

Hospital, Swindon, and North Hampshire Hospital, Basingstoke). With regard to 'Average LoS/Contact Hours per episode of care', we are now targeting reablement to those that have the greatest potential of recovery. These initial packages are often quite intensive but our aim is to reduce them to minimise ongoing support. We have added in UCR Demand and Capacity into the 3.2 Step-up of the Capacity and Demand template as we see this as a significant part of the service. We have used combined data for Pathways 1 and 3 for 3.1 C&D Step-Down, and data from RBFT for Pathway 2. Gaps remain as follows: C&D 3.1 Step-down LoS for Pathway 2, C&D 3.2 Step-up Contact hours or LoS, Social support (including VCS). We are working with our acute partners to identify this data.

Our goals for performance against the 3 national metrics reflect both our recent performance and the priorities for system partners. Performance has been achieved despite a very challenging backdrop of an ageing population, market pressures and workforce challenges. On that basis, targets are still broadly in line with the current picture. An ongoing commitment to prevention remains and to supporting people to manage their own needs through the provision of intermediate care. Targets have been informed by data shared by partners including the acute settings.

Section 3: Local priorities and duties

Local public bodies will also need to ensure that in developing and delivering their plans they comply with their wider legal duties. These include duties:

- to have due regard to promoting equality and reducing inequalities, in accordance with the Equality Act 2010 public sector equality duty.
- to engage or consult with people affected by the proposals. For ICBs, trusts and foundation trusts this includes their involvement duties under the NHS Act 2006.
- for ICBs, to have regard to the need to reduce inequalities in access to NHS services and the outcomes achieved by NHS services.
- for ICBs, to have regard to the duty to support and involve unpaid carers in line with the Health and Care Act 2022

Please provide a short narrative commentary on how you have fulfilled these duties

The Local Authority is committed to promoting equity and reducing inequity in a number of ways. We apply an Equity and Inclusion Policy to all of our activities, and key decisions are always informed by an Equity Impact Assessment (EIA). Public Health take a leadership role in undertaking work or commissioning services which contribute to the reduction of health inequalities, and work continues to adopt a Health in All Policies approach across West Berkshire Council.

Due to the tight timescales, we have not conducted formal consultation. However, throughout the year, there is work to understand the position of stakeholders regarding pressures and opportunities which have informed our Plan. The Locality Integration Board is a vital vehicle for consultation and engagement. The membership of the Board includes Housing, Children's Services, Health providers, Primary Care, Pharmacy, Public Health, the voluntary sector and more. The chairmanship is shared by the Local Authority and the ICB. BCF metrics data is regularly reviewed. The Health and Wellbeing Board is another key forum for sharing intelligence and agreeing priorities.

Equality

In planning services delivered through the Better Care Fund, the Local Authority and ICB have regard to the General Duty of the Equality Act 2010 Public Sector Equality Duty, and in particular ensuring that services advance equality of opportunity between people who share and people who do not share a relevant protected characteristic. To this end, Equality Impact Assessments will form part of the decision-making process for any change in the use of Better Care Fund investment and continuation or ceasing of services or projects funded

through the plan, to be reviewed by the Locality Integration Board prior to any recommendation being made to the Health and Wellbeing Board. No such service change has been proposed in the refresh of the plan for 2025/26.

Consultation and Engagement

The Better Care Fund is managed through the Locality Integration Board which is a partnership group involving Healthwatch and members of the voluntary sector, reporting to the Health and Wellbeing Board. The views of the public are sought in respect of specific initiatives and service changes but we have not engaged with the public on the plan refresh itself as the vast majority of schemes are rolling forward for 2025/26.

As partner organisations we are however committed to engaging with the public to support co-production of service change. Public engagement informed the development of the BOB Integrated Care Strategy, which aligns with the Berkshire West Joint Health and Wellbeing Strategy on which the objectives of our Locality Integration Boards (see below) and Better Care Fund plans are based. The ICB is now refreshing its approach to patient engagement as described in our recent Board paper. This describes the importance of involving the public to identify specific needs and co-produce services tailored to them, build trust and improve patient experience by ensuring services continually improve in response to feedback. The paper describes how we will establish an ongoing dialogue with the public and community leaders to ensure all groups can make their voices heard and provides information on engagement activities undertaken during 2024/25.

Reducing inequalities

The BCF plan contributes to the delivery of the objectives of our Joint Health and Wellbeing Strategy, which are as follows.

1. Reduce the difference in health between different groups of people
2. Support individuals at high risk of bad health outcomes to live healthy lives
3. Help families and children 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 Locality Integration Board is charged with delivering these priorities, reporting into the Health and Wellbeing Board in both cases. Providers of BCF services are expected to work to address any potential inequalities in access and a number of schemes are also targeted at groups who may potentially be affected by inequalities in access or outcomes, for example Carers funding, Mental Health workers and Mental Health Street Triage.

Through the Locality Integration Board we also work with partners to address the wider determinants of health which may impact different groups inequitably, for example in our voluntary sector.

Unpaid carers

Both the ICB and the Local Authority are committed to supporting unpaid carers, with £821,635 of BCF investment focussing specifically on carers. This includes Carers Information and Advice, respite care, direct payments to carers, sitting services, Stroke Association, Young People with Dementia, and Dementia Care Advisors. We have a Carers group which informs our planning.