Cover

Health and Wellbeing Board

Worcestershire Health and Wellbeing Board

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

How have you gone about involving these stakeholders?

Ongoing discussions and system wide meetings have enabled a range of key stakeholders to be involved in the preparation and review of proposals that sit within the BCF 22/23 plan. Information and data are shared across the system to inform the BCF planning to consider how organisations and providers are meeting the BCF outcomes and metrics. Stakeholders include but are not limited to Herefordshire & Worcestershire Health & Care Trust, NHS Herefordshire & Worcestershire ICB, Primary Care Networks, Worcestershire Healthwatch, voluntary and community organisations, members of the Worcestershire Strategic Housing Officers Group along with Worcestershire council stakeholders. Engagement and involvement has been through a variety of system and internal meetings, including the Integrated Commissioning Executive Officers Group as part of developing the Integrated Care System in Herefordshire and Worcestershire.

Executive Summary

This should include:

- *Priorities for 2022-23*
- *Key changes since previous BCF plan*

The Better Care Fund guidance 2022/2023 sets out national conditions which are the key requirements for the Better Care Fund Plan 2022/2023.

1. A jointly agreed plan between local health and social care commissioners and signed off by the health and wellbeing board.
2. NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution.
3. Invest in NHS commissioned out – of – hospital services.
4. Implementing the BCF policy objectives.

The BCF guidance also sets out the national metrics to be included within the BCF 22/23 plans.

Avoidable admissions to hospital	Unplanned hospitalisation for chronic ambulatory care sensitive conditions
Residential Admissions	Older adults (65 and older) whose long-term care needs are met by admission to residential and nursing care per 100,000 population.
Effectiveness of reablement	Proportion of older people (65 and older) still at home 91 days after discharge from hospital into reablement or rehabilitation services
Discharge to usual place of residence	Improving the proportion of people discharged home, based on data on discharge to their usual place of residence

Key System Priorities and ambitions for 2022/2023:

- Hospital Discharge and Flow
- Development of an Integrated Care System
- Care Market Development
- Management of Social Care Demand
- Intermediate Care

1. Although Length of Stay (LOS) is no longer a metric within the BCF plan, it is still a priority to maintain acute trust LOS performance, continue to improve Community Hospital LOS and achieve best practice Pathway 1 LOS. The system is to agree targets where not achieving best practice and communicate and link to delivery of actions in overall plan.

2. To agree the future of an intermediate care service with all system partners.

3. Capacity planning for 22/23 for Pathway 1, ensuring capacity meets predicted demand aligned to discharge requirements. Also to complete a review of the wrap around care service pilot which supports people to return home from hospital with a period of 24/7 wrap around care. It aims to provide people with the opportunity to make decisions about their long-term service needs whilst in their home environment.

4. To embed pathway 3 and effective use of the Intensive Assessment Rehabilitation Unit (IAR) beds to ensure maximum use of reablement opportunities for those still requiring use of bed-based care.

5. Analyse flow across the system and identify opportunities to deliver integrated approaches where there is benefit to flow and efficiency and supports a home first approach.

6. Development of a long-term homelessness pathway.

The system priorities are interlinked and rely on each partner to work collaboratively for success throughout the system.

Within the 21/22 BCF plan, it was highlighted that a significant level of funding had been committed to support the removal of delay and within the D2A pathways. The system continues to focus on these areas throughout 22/23:

- Continuation of of the council's reablement service (Home-first). This is to meet the increased demand for 22/23 for Pathway 1 to enable people to be discharged within 24 hours in line with the National Discharge Targets. The emphasis on supporting people to go home and to remain at home should have an impact on reducing admissions to long term care. Following the pilot of the Wrap Around Care Service, this will require consideration for long term investment to support discharge to usual and residential admissions.

- Sustaining the delivery of the Onward Care Team. The team is in place and continues to practice a multi-disciplinary approach to identify the correct discharge pathway and care and support plan. This will continue to improve length of stay in the acute hospital and ensure national hospital discharge targets are achieved.

- Further development and review of Pathway 3 to reduce the use of care home provision through the Intensive Rehabilitation and Assessment (IAR) Unit. This will continue to support people who require bed-based reablement to return home.

- Development of a long-term Intermediate Care Service which facilitates effective partnership working and the ability to analyse flow across the system. This will identify opportunities to integrate services where there are benefits to flow and efficiency, following a short-term model of delivery.

Improved Better Care Fund Allocation:

In addition to the main BCF resources and plans, the improved better care fund (iBCF) allocation for Worcestershire Adult Social Care in 2022-2023 includes funding to be spent for the following purposes:

a) meeting adult social care needs
b) reducing pressures on the NHS including seasonal winter pressures
c) supporting more people to be discharged from hospital when they are ready
d) ensuring that the social care provider market is supported

The formal allocation of the iBCF is established as part of the BCF budget setting process, £1m of the total contribution has historically been transferred to the Herefordshire & Worcestershire Clinical Commissioning Group (CCG). This continues to be transferred to NHS Herefordshire & Worcestershire ICB to assist with pressures on the NHS in the relevant areas. The remainder of the grant is used to meet adult social care needs and ensuring that the market is supported, examples of these include:

- Financially supporting the domiciliary care market with the aim to avoid hospital admissions (metric 8.1), and increasing patient flow across the system
- Funding permanent recruitment within the Onward Care Team streamlining hospital discharge and reducing DToC
- Additional investment in the community reablement service with the aim of preventing / delaying admission to long term care or hospital. This supports metric 8.5 (Clients remaining at home after 91 days following hospital discharge).
- Use to fund pressure of externally purchased Pathway 3 placements, whilst long term care planning for clients.

BCF funding is used for key core social care and NHS community services - operational social work, integrated discharge, community health and care services short-term and long-term placements in home care and care homes, and discharge to assess; it is central to the delivery of health and social care in the community.

Key changes since the previous BCF Plan

Overall, the BCF plan remains focussed on supporting hospital discharge but it is evolving to bring in more activities to prevent admissions to hospital and to long-term care placements. As outlined above, there will be a review on the Wrap Around Care Service and the impact it has on supporting discharge to usual residence and avoiding residential admissions. This will require further consideration for long term investment. Also, there will be development of the long-term plan for intermediate care services within Worcestershire. Recruitment has been a national challenge which has had an impact on the entirety of the adult health and social care sector. The recovery and stability of the care market following Covid 19 will continue to have an impact on services funded through the BCF and will be an area of increased focus.

Governance

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

The Worcestershire Health and Wellbeing Board is responsible for agreeing the BCF plans and for overseeing delivery through quarterly reports.

Oversight and responsibility for the Better Care Fund is embedded within the Senior Leadership Teams of both the People Directorate within the County Council and NHS Herefordshire and Worcestershire ICB formally Herefordshire & Worcestershire CCG. In each organisation, this is led by Chief Officers, who can maintain the profile of the shared agendas and ensure linkages to wider health and social care commissioning and delivery.

The senior leaders of the two organisations formed the Worcestershire Integrated Commissioning Executive Officers Group (ICEOG). The aims of ICEOG is to progress the integration of NHS, social care, public health and related services for the benefit of Worcestershire residents. Review on progress of commissioned services and activity and formal decision making takes place at monthly meetings. ICEOG provides quarterly reports of the progress and ambitions for integration priorities within Worcestershire to the Health & Wellbeing Board.

The governance arrangements continue to support collaborative working between health and social care services to increase joint working and alignment of commissioning arrangements. They seek to develop and implement appropriate and effective integrated commissioning plans in accordance with the priorities, outcomes and budgets set by the respective governing bodies and the Health and Well-being Board.

A Joint Health and Welling Being Strategy is currently in development and with the establishment of a new Integrated Care System for Herefordshire and Worcestershire it brings a timely opportunity for the new strategy to inform and deliver action at both the system and place level.

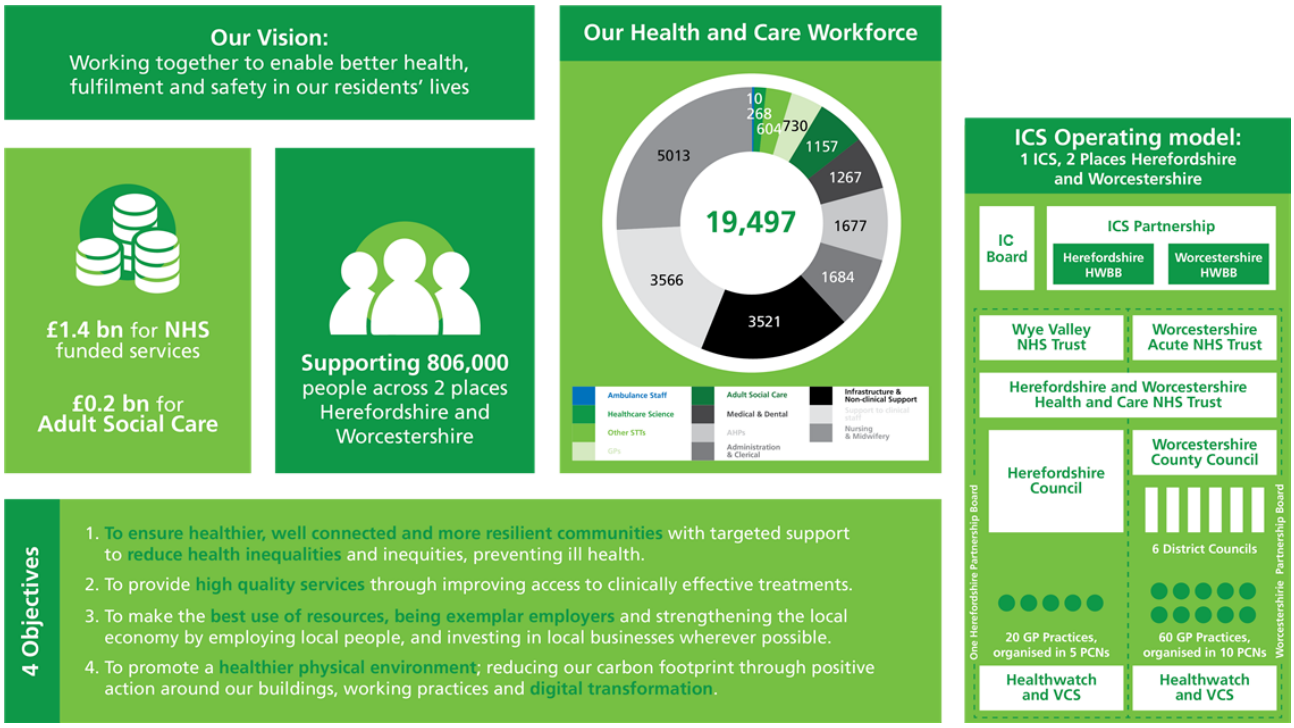
The coronavirus (COVID-19) pandemic has had a profound impact on our health and wellbeing, affecting outcomes across the life course. It has shone a light on some of the health and wider inequalities that persist in our society and it has become increasingly clear that COVID-19 has had a disproportionate impact on many who already face disadvantage and discrimination. A new strategy therefore presents an opportunity to include our aspirations and priorities for tackling inequalities as part of our recovery recognising that many of the causes of ill-health are deep rooted in society.

Indicative timescales for the development of the strategy are summarised below with the aim to publish the final strategy in March 2023 for implementation in April 2023, under the following guiding principles:

- The priorities in the strategy will be based on need, supported by actions based on evidence of effectiveness.
- Prevention (in all its forms) will be at the heart of all we do
- A ‘proportionate universalist’ approach – something for everyone and more for those who need it the most
- The strategy will focus on areas where partnership action adds value and there is commitment across the system
- Narrowing health inequalities as a core aim
- The strategy is developed in close collaboration and consultation with residents and local partners from health, social care, local authorities and voluntary sector.

The Herefordshire and Worcestershire Integrated Care Partnership Assembly will be a statutory committee, bringing together the NHS and local authorities as equal partners to focus more widely on health, public health and social care. The Partnership Assembly will include representatives from NHS Herefordshire and Worcestershire, the two local authorities, and other partners across the two counties such as NHS providers, public health, social care, housing services, and voluntary, community and social enterprise (VCSE) organisations. It will focus on the wider determinants of health, including housing, education and leisure, and will be responsible for developing an integrated care strategy which will set out how the wider health needs of the local population will be met.

he following infographic gives an outline of the composition of our system resources, priorities, and governance:



Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

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

Joint priorities for 2022-23 include: -

-Enhancing and integrating our intermediate care service to ensure a seamless approach to admission avoidance and prevention

-An integrated homelessness pathway for individuals admitted to hospital

-An integrated mental health offer for residents in Worcestershire

During 22/23, work will continue with our health colleagues to look at how we prepare for the proposed Intermediate Care Framework from NHS E/I. The Framework describes how we will support people after a hospital admission or a crisis event in the community (including rehabilitation, reablement and recovery) including the Core20PLUS target population cohort; therefore, it will support both hospital discharge and admission avoidance services. Whilst there are good intermediate care services across Worcestershire, there is room for improvement specifically how we integrate and work more collaboratively regarding hospital avoidance and prevention services, this will result in a seamless approach for our residents and enable us to work more closely to provide the right care at the right time. The key aims we aspire to (in line with the proposed national framework) are:

1. Person-centred and in partnership with carers
2. Home based by default
3. Therapy led
4. 7 days a week
5. Integrated across health and social care – jointly commissioned, based on population needs
6. Includes those at end of life and those with cognitive impairment
7. Truly multi-disciplinary – joint workforce planning
8. Outcomes driven – services focussed on continual improvement through use of local data intelligence
9. Reduces workload for primary care
10. One size does not fit all – local innovation encouraged

For individuals admitted to hospital who have become homeless due to a changing health need or are already a rough sleeper, a pathway is in place, however due to the increased demand and complex need this pathway needs to be expanded and fully integrated across health and social care to support the pressures across the system and enable medically optimised individuals to move into suitable accommodation in a timely manner.

A s75 agreement between health and social care mental health service ended and further work is needed to ensure that whilst this formal agreement isn't in place, residents are still able to access a service which is easy to navigate, utilises the skills and expertise of both health and social care professionals and provides the best possible outcomes for individuals. Work is currently being undertaken with key stakeholders including people who use services to enhance our current offer through the reduction of duplication and improved collaboration. This aspiration over the next year is to combine key policies and procedures, look at co-locating staff and share resources to provide a better experience for individuals.

The collaborative integration approach is evidenced through a number of services or initiatives, which include, but are not limited to the services below.

Integrated Equipment

The Worcestershire Community Equipment Service (WCES) is central to the delivery of the prevention and wellbeing priorities of the ICS and develops its service in line with changing demand in social and health care. WCES provides equipment to support individuals to get home from hospital quickly, rehabilitate once home from hospital, stay home and avoid hospital admission, and increase their function and independence to live well whilst they are at home. WCES delivers the equipment within 24 hours of request if required to meet an urgent need and has adapted its working patterns to meet the time demands of discharge to assess and increased reablement activity. Clinical expertise within the service reviews and changes the type of equipment available to prescribers and offers advice, training and support to our clinical prescribing community to ensure best practice of selection and application of community equipment. Clinical experts scrutinise and assure on all requests for non-standard equipment to ensure only essential purchases of specialist items are made and equipment is re-used wherever possible.

Working directly with clinical prescribers, from provider services in health and care across the county at place and neighbourhood level, WCES sources the best value equipment to meet clinical and functional need, considering quality, and re-use/recyclability. This facilitates patients with increasingly complex health and care needs to remain at home and be supported at home on discharge, having their equipment needs changed and updated as their conditions progress or changes to ensure the right equipment is in place at the right time to support the right care for the individual.

WCES monitors the reason for equipment need from its clinical prescribers and the discharge pathway the equipment is required for if applicable, evidencing the increased demand for rapid access to specialist equipment to support system flow and get people home with the appropriate support. WCES provide standard equipment to clinical teams at their bases, so it is ready to issue immediately to meet an individual need and have systems to restock and replenish that equipment frequently.

The service continues to see an increase in both client numbers and overall equipment spend. The increase evidences the on-going focus to provide equipment to enable people to remain in their own homes, to reduce the need for the interventions of domiciliary care, care home placements and avoidable hospital admissions, whilst facilitating hospital discharge. The service continues to see a shift towards urgent need over routine need, and a change in types of equipment requested to more complex and expensive individual items, including increased bariatric equipment.

WCES provide monthly performance data to its stakeholders to show its monthly activity; number of urgent and routine requests, activity across the discharge pathways including end of life and admission prevention, spend on categories of equipment including data on actual purchase versus use of recycled equipment.

Virtual wards

The system is continuing to develop its approach to virtual wards, which is now as part of the National Virtual Wards Programme. The system continues to develop the relationships between NHS providers, including primary care, secondary care, and social care. Scoping is currently taking place in Worcestershire for the implementation of virtual wards for Frailty, COPD, and Heart Failure.

Flow and Discharge dashboard

The system is now using a system wide flow and discharge dashboard for Worcestershire that supports ongoing monitoring and identifies areas for improvement, including the use of SHREWD and the Patient Tracker. This supports targeted intervention, both on an operational basis and also through tactical review to adjust resource distribution across the pathways.

Falls prevention (Digital Technology)

The system is supporting innovative projects, such as the Falls Technology Project. The project involves Worcestershire County Council, Herefordshire Council and NHS Herefordshire and Worcestershire ICB in commissioning, procuring, and delivering technology which will enable professionals to engage in evidence-based conversations about risk reduction in relation to falls. The work will also support the Health and Well-being priority to ensure Worcestershire residents are healthier, live longer and have a better quality of life, remain independent for as long as possible.

Key to the successful delivery of the plan are health and social care initiatives to support admission avoidance and timely discharge, including 2-hour response service and investment in pathways, aiming to provide sufficient support in the community to enable people to remain independent in their own homes for longer, thereby reducing hospital admissions and support discharges.

Implementing the BCF Policy Objectives (national condition four)

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

- *Enable people to stay well, safe and independent at home for longer*
- *Provide the right care in the right place at the right time*

Please use this section to outline, for each objective:

- *The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care*
- *How BCF funded services will support delivery of the objective*

Plans for supporting people to remain independent at home for longer should reference

steps to personalise care and deliver asset-based approaches

implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches

multidisciplinary teams at place or neighbourhood level.

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.

Carry out collaborative commissioning of discharge services to support this.

Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

Worcestershire County Councils People Directorate strategy is a single strategy for people and communities, with a clear aim and a focus on outcomes for people. The strategy was developed and co-produced with people, staff and partners to meet need by maximising the use of assets, resources and the workforce. A central theme is to enable people to stay well, safe and independent at home for as long as possible. The Commissioning strategy is aligned to the Adult Social Care strategy and references developing a Person-Centred Approach, Shaping Services and Shaping an Effective Market. These principles will support and promote people's independence. The Commissioning Strategy and Market Position Statement are directly aligned to the Council's Corporate Plan and Joint Strategic Needs Assessment. Collaborative commissioning is already being delivered through initiatives such as SEND (SEND Strategy), Carers (Commitment to Carers and Carers Strategy) and Assistive Technology (Falls Technology).

Enabling people to stay well, safe and independent at home for longer is delivered through the following services A key service is the Reablement service which offers therapy-led services aligned with a Reablement model. People are discharged from a hospital setting through a fully integrated discharge team who provide a proportionate assessment in line with the Discharge to Assess (D2A) model. Pathway 1 (Home) being the optimum pathway with a £4m investment to expand this service to enable more people to return home, where safe to do so, and reduce the number of people sent to a bed-based facility. Worcestershire County Council have also commissioned the Domiciliary Care sector to deliver a Reablement Focussed Approach which complements the Reablement Service, further enabling people to maximise their independence and enabling optimum flow across the whole system.

There are also 12 Neighbourhood Teams in Worcestershire. These are multi-disciplinary teams comprising of health and social care professionals who work within local communities providing care, support and rehabilitation to prevent hospital admission or in support of people being discharged from hospital. The NICE reablement guidelines have been adopted and the teams also take an asset based, person centred approach wherever possible. The teams are also involved in development of the frailty-based population health approach, in readiness for delivery of anticipatory care framework and are also tasked with the implementation of virtual wards.

Underpinning the wider Reablement service and Neighbourhood teams is the innovative use of the DFG, the reinvigoration of the Worcestershire Community Equipment Service (WCES) and the Independence at Home service, which supports people with low level need. Services such as Suicide Prevention are enabling people to remain safe whilst supporting people to remain well is a key priority of the system and forms a central theme to the new Health and Wellbeing strategy. The BCF in Worcestershire will also continue to fund the delivery of targeted services such as People Like Us (PLUS) which works across Worcestershire to support anyone aged 18 upwards who is experiencing loneliness or isolation, Lifestyle advisors and an Enhanced Weight Management Service.

The system across Worcestershire will continue to develop an Asset based community development (ABCD) approach recognising, identifying and harnessing existing 'assets' where ever possible and will make stronger, system wide, connections in respect of the population health management approach.

Whilst still early days, the Public Health within WCC has been working with the ICS on specific population health management approaches. This includes using population health management approaches to identify and reduce risk in patients with pre-diabetes. A local primary care PHM tool has been produced which will help to understand population health and needs within Worcestershire. The ICB datalake is a system which will pool health and social care data from across the ICS and will enable even more population health management approaches going forward.

The system is trialed an intermediate care service approach from September 2021 which has a home first focus and we have seen that on the whole, most people have received appropriate levels of care in their own homes in a timely manner, done in a collaborative way with partners across the system to maximise the use of all available resources. At an operational level the service is working with services users and their carers to promote their strengths, making sure people are valued and have meaningful input into arrangements for their discharge plans. We have also introduced multi-agency triage hubs to agree timely discharges which has helped to eliminate delays in allocating capacity and reduced length of stay in hospital. This collaboration has enabled us to move and flex resources around the system to target key areas of pressure in the system to maximise flow.

The trial has enabled collaboration between partners and providers to create a single trusted assessment document, with an emphasis on a description of care needs, not prescription of pathways to encourage the promotion of the discharge to assess model, recognising that people are best assessed in their own environments which tailors to their strength. The trusted assessment has enabled us to streamline the processes and reduce hand-offs between partner organisations, ensuring ownership and accountability for decision making and care provision, which in turn has supported us to improve communication with service users and families, and providers.

As part of the intermediate care trial, we have reviewed our discharge home to assess model (Pathway 1), and are now able to not only look at supporting people home with a standard reablement/care offer, but also a wraparound care service, 24/7 to enable people to go home who would ordinarily have remained in hospital. This trial underpinned by a collaborative leadership approach which has enabled us to break down barriers between organisations and come together with a shared focus on home first. This has also helped to change behaviours and cultures which have previously been a barrier to consistently achieving the right outcomes for people.

Over the course of the trial, the discharge to assess model for patients unable to return home (Pathway 3) has also been reviewed, and we are now looking at making changes to the offer to ensure patients are able to have long term care planning assessments done in an environment most conducive to their needs. We also have a pathway that supports patients with very complex care needs to leave hospital care to have their assessments completed.

There is system agreement to continue with the collaborative approach and the scope of the service is set to be broadened to include all areas of intermediate care service provision funded via the BCF, including preventing admission to hospital, with the aim of aligning them under a single leadership framework with associated budgets and clear governance arrangements to provide accountability at system level. The transformation programme, which will include a review of the current service against the high impact change model is being worked up for agreement with system leaders.

The system has been following the '100- day challenge' to adopt national processes to make a significant difference on facilitating a timely and effective discharge and improve the care for patients. The 10 initiatives of this challenge align with the outcomes of the High Impact Change Model for managing transfers of care. The 100-day challenge will lead to recommendations for the ongoing improvement and monitoring that Worcestershire may need around discharge. Following a self-assessment, Worcester has reported a good level of maturity across a lot of the areas. There are areas highlighted where the system is still developing and establishing plans to meet these outcomes and recommendations for improvement.

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

Replacement Care

BCF funding is used within adult replacement care for block purchase arrangements with care homes. This is to the value of just over £1.5m pa. This includes individuals who are older people, who have mental health needs, learning disabilities, physical disabilities, and sensory impairments as well as some specific dementia replacement care beds. Worcestershire County Council also fund replacement care which is not within care homes but is within the individuals home provided by domiciliary care agencies and personal assistants. Care can also be provided outside the home. Care can be paid for and organised by adult social care, or the individual can organise it via choice of a direct payment, so the DP recipient can manage their own personal care budget.

Replacement care enables unpaid carers to have a break from time to time to enable them to recharge, this has been a real issue to achieve during lock down and covid. It is important to take a break and to care safely, so carers don't put themselves at risk in any way. This type of provision also contributes to reducing carer breakdown, enables the carer to have a life of their own and time to look after their own physical and mental health and wellbeing.

Carer Direct Payments.

Worcestershire County Council (WCC) contracts with the Carers Hub to carry out Carer Assessments on behalf of the council. There is an entitlement for the assessment of carers needs and to establish how these needs can be met. An approach is used called the 'Three Conversations Model' which uses a 'strength-based approach'. This means carers are put at the centre of the process, identifying a carers' own skills and strengths and what support is available to them in their community. This helps to inform the plan of how to meet the needs of both the carer and the cared for.

The 3 Conversations model will help identify which areas of a carer's life are being significantly impacted because of the necessary care they provide, and the best way to meet those areas of need. Universal services, direct support to the cared for and support for the carer (via the Carers Hub) will meet the carer needs. However, for some carers there may be other unmet needs. A Personal Budget can be allocated to meet eligible needs, which is paid for by Adult Social Care and is predominantly taken as a Carer Direct Payment. BCF fund contributes to the Carer Direct Payments to the value of £71,200 pa. This funding contributes to meeting eligible needs in line with the Care Act.

Disabled Facilities Grant (DFG) and wider services

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

In Worcestershire, the DFG is passported out to the District Councils to meet their statutory housing duties. Each District Council is responsible for their own Housing Assistance Policy to make local needs and DFG is used in accordance with these policies.

The 6 District Councils and the County Council have jointly procured a Home Improvement Agency. The countywide home improvement agency service promotes independent living by providing information and advice, adaptations and improvements in the home environment which enable older and disabled people to remain living independently using mandatory grants, discretionary grants, financial assistance, advice and support. In 2021/22 the service received 4225 enquiries and assisted 224 households with a major adaptation, plus a range of other services and grants to enable people of all ages to regain or retain their independence and carry on living in the community which contributes directly to Objectives in the BCF Plan: Enabling people to stay well, safe, and independent at home for longer. These services include:

- **Housing options**: for customers where a move to more suitable accommodation may be appropriate. This service has saw an 80% increase in referrals in 21/22.
- **Mandatory Disabled Facilities Grant** (DFG): adaptations to homes range from a stairlift to an extension providing a ground floor bedroom and bathroom.
- **Ceiling Tracking and Hoists:** in a recent change in policy, the district councils now fund all installations rather than just those where it is part of larger grant works.
- **Home Repair Assistance**: financial assistance to ensure that vulnerable persons remain in their homes in safe, warm and healthy conditions.
- **Hospital Discharge Scheme**: there was a 46% increase in referrals to this fast-tracked and non-means tested works to the home to enable earlier hospital discharge where problems in the home are identified necessary adaptations/equipment/deep clean as a possible reason for delayed discharge which directly contributes to Metric 4: Discharge to usual place of residence.
- **Dementia Dwelling Grant**: assistance providing items such as night lamps, touch lamps, dementia clocks, illuminated switches and key safes to help people with memory loss or a diagnosis of dementia to manage their surroundings, retain their independence and reduce feelings of confusion.
- **Trusted Assessor trained staff**: The service has trained their staff to Trusted Assessor Level 4. This will enable the trained staff to assess low level major adaptations and free up the time of the Community Occupational Therapy team to focus on the more complex cases. The agency and the districts are currently working with the Occupational Therapy team to put the necessary processes and oversight into place which will enable the Trusted Assessors to start work.

In addition to the service elements funded through the Better Care Fund, the home improvement agency also provides the following services.

- **Information and advice**: This Worcestershire County Council funded service provides promotes independent living through information, advice and signposting to provide solutions in the home to meet a disabled person's needs in a timely way.
- **Minor adaptations/handyperson**: funded by Worcestershire County Council to provide adaptations which are easily installed and do not require structural changes to the home. Theses can include items such as grab rails, stair rails and external rails.
- **Able to pay customers**: Award winning research undertaken by Worcestershire County Council highlighted that there were 63 self-funding pick-ups for the financial year through to end of September 2019. These are people placed in residential care whose own funding runs out during

their placement and this then being taken over by social care funding at a cost of £32,922.50 pw (£1.7m per year). The new service being launched this year enables customers to privately fund adaptation works to their property with the full support of the agency. https://adaptivehomesolutions.co.uk/

- **Health through Warmth**: The agency has again been successful in securing funding from Foundations Independent Living Trust which benefits customers with specified health conditions to assist them with heating when funding cannot be found elsewhere.

The district councils have employed a new Collaboration Manger to lead work on work to develop a long term strategic plan co-designing a collaborative approach across housing, health and social care to create a single service pathway for customers who need assistance with aids and adaptations to live independently.

The service has a 95% target for improving customer wellbeing. Customers are asked whether they felt that there had been an improvement in their wellbeing as a result of the adaptation/assistance. For 21/22 the service achieved 97.37%, and for Q1 22/23 this rose to 100%.

The service is also targeted on the number of customers who had their housing difficulty resolved after receiving housing advice with the target set at 80%. The 21/22 figures show a 70% success rate and in the first quarter of 22/23 this rose to 82%.

The service achieved the following outcomes in 2021/22

Facilitate timely discharge	192
Prevent an unplanned admission to hospital	184
Reduce pressure on informal carers	268
Reduce or delay increase in package of care	253
Reduce/prevent falls	2608
Remain/promote independence	2436
Enable to remain in own home	353

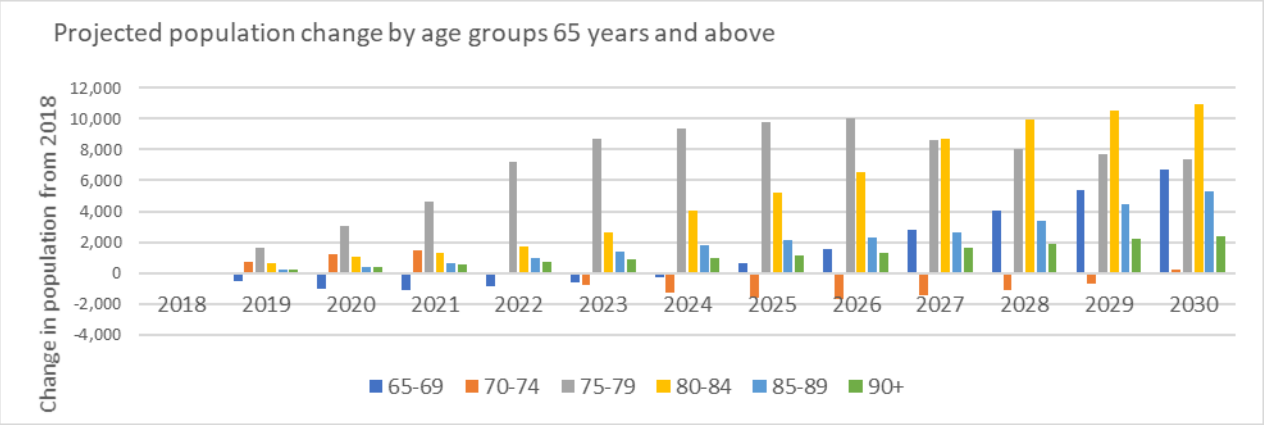
Equality and health inequalities

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 BCF funded services*
- *Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered*
- *Any actions moving forward that can contribute to reducing these differences in outcomes*

In general, the population of Worcestershire is healthy and there are many health-related measures where Worcestershire performs better than the national average. However, there are often smaller places in Worcestershire where people's health is not good, and the average measures reported at County and district council level mask the differences in health outcomes experienced by some communities.

Worcestershire has a growing and ageing population. It is projected that the population is set to increase from 592,100 in 2018 to 638,800 in 2030. Most of the projected growth in the population is amongst those aged 65 and over, with this group overall projected to increase by 32,900 or 25% by 2030. There is particularly large projected growth for those aged 75 and over, with this group projected to grow. The growing and ageing population presents challenges in an increased likelihood of a lengthier stay in hospital and an impact on hospital discharge destination. The BCF plan aims to address these challenges through improved integrated discharge through the onward care team as part of the overall integrated care team. There is a focus on integrated and expanded community services and continuing reablement through discharge to assess and a home first approach and interventions to reduce hospital admissions.



(Source: Office for National Statistics, Subnational population projections for England: 2018-based projections by 26,100 or 44% by 2030)

The HWB and its Health and Wellbeing Strategy sets the strategic direction for many other strategies, forums, and committees across the Integrated Care System to ensure we can work together to achieve better health and wellbeing for Worcestershire. The new Strategy is currently out to public consultation and will set out a vision and key priorities for our partnership work to improve health and wellbeing and reduce inequalities in Worcestershire over the next 10 years. The Strategy will be a 'living document' that will evolve and adapt to changing needs and be implemented through shorter term action plans. The action plans will include appropriate outcome measures to monitor progress.

As part of the biggest legislative change impacting the NHS in the last decade, 42 Integrated Care Boards (ICB) / systems (ICS) have been created across England with a wide remit based on the idea that collaboration – between hospitals, GPs, social care, and others – is needed to improve local services and make the best use of public money. ICSs have been tasked with leading efforts to identify and reduce health inequalities in their area, alongside broad objectives to improve population health and contribute to social and economic development.

Herefordshire and Worcestershire ICB was established and commenced operation on 1st July 2022 and has ambitious plans to identify and reduce health inequalities. As part of this the NHS in Herefordshire & Worcestershire are implementing a number of plans focused on delivering the national ambition known as 'CORE20PLUS5'. This means we are working with communities to improve health outcomes in the most deprived 20% on the national population as identified by the national index of multiple deprivation (CORE20 component), identified local priorities of rurality, health literacy, people who are not registered with a GP and

mental health (PLUS component), within the 5 clinical areas of maternity, severe mental illness, respiratory disease, early cancer diagnosis and cardio-vascular disease.

The ICB is investing resources into these key areas, with delivery being through primary care working with partners from the district and county councils, voluntary sector, community groups and wider partners to understand the barriers in accessing health and care services and adjusting services accordingly. This approach has worked within the COVID vaccination programme, where Worcestershire has achieved one of the lowest uptake gaps across England between the least and most deprived communities at under 10%. The programme has been nominated for prestigious parliamentary and HSJ awards for this work with the approach being applied to address wider inequity in access out outcomes.

Progress against achievement of these aims will be held at the ICS board, with the aim of continually striving to embed the needs of underserved communities in all our services and ensure the ICS plays a significant part in reducing health inequalities.

Worcestershire County Council and its partners are committed to the Public Sector Equality Duty (and General Duties outlined in the Equality Act 2010) to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations between people who share a relevant protected characteristic and those who don't. Ensuring we can evidence 'due regard' in our decision making in the design and delivery of services. It is not envisaged that the content of this plan will negatively disadvantage the following nine groups with protected characteristics: age, disability, gender reassignment, marriage and civil partnerships (in employment only), pregnancy and maternity, race, religion or belief, sex and sexual orientation.

It is fundamental that individuals and groups are represented, involved and engaged in our activities and services. Partners will work to enable people to access services within the scheme/funded projects, and that support and guidance are provided where necessary to meet all needs, empowering individuals to be independent in the community wherever possible.