Cover

Health and Wellbeing Board

Worcestershire Health and Wellbeing Board

Bodies involved strategically and operationally in preparing the plan.

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 2023/2025 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 Worcestershire County Council (WCC), Herefordshire & Worcestershire Health & Care Trust, NHS Herefordshire & Worcestershire ICB, Primary Care Networks, Worcestershire Healthwatch, voluntary and community organisations, Worcestershire Association of Carers, members of the Worcestershire Strategic Housing Officers Group. Engagement and involvement has been through a variety of system wide and internal meetings, including the Integrated Commissioning Executive Officers Group (ICEOG) as part of developing the Integrated Care System in Herefordshire and Worcestershire. WCC has recently developed and launched their Building Together policy, this supports co-production to ensure thoughts, ideas and suggestions of people who use services are utilised to develop and shape provision. Prior to this, services supported by the BCF have always sought to involve people who use services and worked in a collaborative way in addition to working with key partners such as Health Watch. There are some groups which are more difficult to engage with such as people who are homeless or rough sleepers due to the transient nature of their accommodation and potential needs therefore, it is imperative that services are measured by outcomes. The homeless in hospital pathway for example, is developing an outcomes framework to evaluate the effectiveness of the service, involvement and engagement will be undertaken by liaising directly with people who have used the service but also through links with partner organisations such as St.Paul's hostel and District housing authorities. Other services supported by BCF, for example the reablement service, collates user experience and outcome at the end of each intervention to inform and shape the service as it evolves. Worcestershire's BCF 2023-2025 plans have been shared with the ICB Executive Leadership Team and Strategic Commissioning Committee. The plans have been jointly agreed at ICEOG and circulated to Worcestershire Health and Wellbeing Board for virtual sign off ahead of formal ratification at the next board meeting in September 2023.

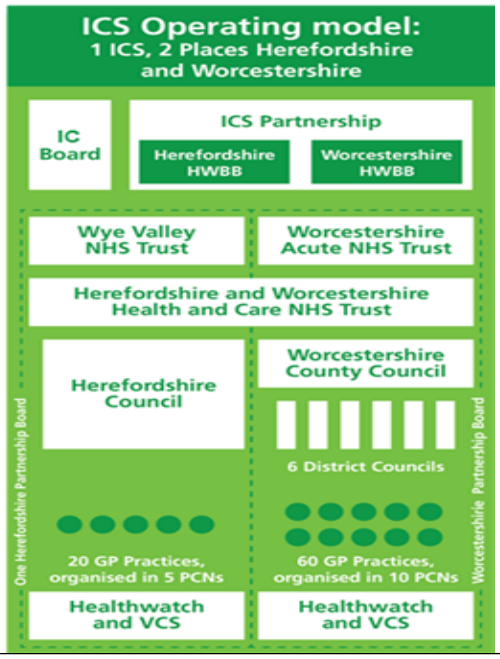
Governance

The Worcestershire Health and Wellbeing Board is responsible for agreeing the Better Care Fund plans and for overseeing delivery through quarterly financial monitoring reports. Oversight and responsibility for the Better Care Fund is embedded within the Senior Leadership Teams of both the People Directorate within WCC and NHS Herefordshire and Worcestershire ICB. 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 Integrated Commissioning Executive Officers Group (ICEOG) in Worcestershire. ICEOG meet monthly and its aim is to progress the integration of NHS, social care, public health and related services for the benefit of Worcestershire residents. This will be achieved through:

- The development of strategies that support the integration of care across adults and children's services – in the context of the Integrated Care System, Joint Strategic Needs Assessment, Joint Health and Well-being Strategy, the Children and Young People's Plan and other relevant strategic plans across the Council and the Integrated Care Board (ICB)
- Ensuring effectiveness, safety and improved experience of services commissioned under the Section 75 (S75) agreement.
- Supporting the development of new models of care, focussing specifically upon integration and improvement of health and social care, and ensuring synergy with the place-based governance through Worcestershire Executive Committee.

ICEOG provides 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. The group seeks 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.



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Executive Summary

- *Priorities for 2023-2025*
- *Key changes since previous BCF plan*

Key System Priorities and ambitions for 2023- 2025:

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

1. To agree an extension to the pilot integrated intermediate care service in 2023/2025, with a view to finalising the operating model and specifications of the service with all system partners as the 2-year pilot draws to a close in quarter 3 2023/2024.

2. Some changes to capacity within the pathways was required in 2022/3 leading to a decision to undertake more detailed demand and capacity planning for Pathway 1 and Pathway 3 based on learning over the previous 18 months, ahead of winter 2023/2024, to ensure that planned hospital discharges can continue to be supported in a timely manner.

3. Following a 4-month review of the wraparound service pilot, in 2022/2023 it was agreed to extend the pilot from the original 6 months to 18 months with the pilot drawing to a close in quarter 2, 2023/2024. The wrap around care service pilot supports people to return home from hospital with a period of 24/7 wrap around care, enabling a slightly long assessment period prior to determining any future care needs.

4. To review how the Intensive Assessment Rehabilitation Unit (IAR) beds were opened and embedded into the pathway services with the aim of ensuring maximum reablement opportunities for those still requiring use of bed-based care.

5. Partners continued to analyse flow across the system and identify opportunities to deliver integrated approaches where there is benefit to flow and efficiency and support for a home first approach. This has been particularly challenging during the winter months exacerbated by ongoing industrial unrest within the health service.

6. Implementation 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 2021/2022 BCF plan, and throughout 2022/2023, 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 continued to focus on these areas:

- Continuation of the council's reablement service (Home-first) and the wraparound care service. This has met the significant levels of demand for Pathway 1, enabling people to be discharged from hospital within 24 hours in line with 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.

- The onward care team continues to practice a multi-disciplinary approach to identify the correct discharge pathway and care and support plan. This positively impacts length of stay in the acute hospitals and ensure national hospital discharge targets are achieved.

- A review of Pathway 3 to reduce the use of care home provision through the Intensive Assessment and Rehabilitation (IAR) Unit.

- The Integrated Intermediate Care Service which facilitates effective partnership working and the ability to analyse flow across the system was extended until September 2023. This will identify opportunities to integrate services where there are benefits to flow and efficiency, following a short-term model of delivery and allow for a longer-term view on the service and its future operation to be taken.

Key changes since the previous BCF Plan

Overall, the BCF 2023-2025 plan largely remains focussed on the continuation of schemes, services and work force investments that support the two national conditions; providing care in the right place at the right time and enabling people to stay safe well and independent for longer and supporting unpaid carers. Following the successful 18-month pilot of the Pathway 1+ (wrap around) service, the opportunity for further investment is under discussion, with the service potentially increasing capacity to support additional people in the next two years, following the positive impact the service has had over the pilot period. This service supports a timely hospital discharge for people who otherwise may not have been able to return home due to complexity of need and/or requiring intensive care and support for a transitional period and a full assessment carried out at home.

Implementation of the homelessness in hospital pathway is a key change in the 2023-2025 plan. The BCF 2023-2025 plan contributes towards expanding this service to support people who are or become homeless upon access to hospitals in the county due to a multitude of reasons with an integrated approach across health, social care and housing where necessary.

Recruitment has continued to be a local 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 2023-2025 plan and will be an area of focus. In Worcestershire we have seen some improvement with workforce capacity within domiciliary care, which could be linked to the annual fee review from the local authority. Commissioners continually analyse the local workforce needs and plan with providers how to build sufficient capacity alongside developing the skills, knowledge and values required for the workforce. Through our Independence Focussed Domiciliary Care contracts we are now able to work more closely with a selection of providers to more effectively shape the market and take a whole system approach. Understanding the future demand for services, provides clear information to inform our long-term plans through our Market Position statements (in relation to the size, skills and values of the workforce).

National Condition 1: Overall BCF plan and approach to integration

Approach to embedding integrated, person-centred health, social care and housing services. Changes to the services commissioned through the BCF from 2023- 2025 and how they will support further improvement of outcomes for people with care and support needs.

Worcestershire Health and Wellbeing Board have developed the Health and Wellbeing Strategy 2022-2032. The Joint Health and Wellbeing Strategy focuses on good mental health and wellbeing with a particular steer and focus on prevention and tackling health inequalities to improve health and wellbeing outcomes for Worcestershire's residents. This priority will be supported by:

- Healthy living at all ages
- Safe, thriving and healthy homes, communities and places
- Quality local jobs and opportunities.

Herefordshire & Worcestershire ICS are in the latter stages of developing its ten-year Integrated Care Strategy in Herefordshire and Worcestershire. The strategy utilises the Joint Strategic Needs Assessment that identifies the key shared priorities for improvement of outcomes for the local people.

- Providing the best start in life
- Living and ageing well
- Reducing ill health and premature deaths from avoidable causes

The two strategies are aligned and instil a shared approach to delivering better outcomes for local people. Worcestershire's Better Care Fund 2023-2025 plan continues to promote integration between health, social care and housing within Worcestershire and in support of the priorities outlined within the system-wide and place-based strategies. The schemes and services jointly commissioned through the BCF continue to develop partnership working and integration to support people with care needs, ensuring residents receive care in the right place at the right time and remain independent at home for longer. Also, to continue support unpaid carers in line with the Worcestershire All Age Carers Strategy.

Joint priorities for 2023-2025 include: -

- Reviewing the performance of the extended Integrated Intermediate Care Service pilot against need and determining the longer-term operational structure and operational service requirement 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 2023-2025, work will continue across the wider health and care system to develop the Intermediate Care Framework. 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

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

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 wide flow and discharge dashboard for Worcestershire is embedded and working well, providing one data set that also measures performance and identifies areas for improvement, including the use of SHREWD and the Patient Tracker. This supports targeted intervention at pace, both on an operational basis and through tactical review to adjust resource distribution across the pathways.
Key to the successful delivery of the 2023-2025 plan are health and social care initiatives to support admission avoidance and timely, well-planned discharge, including via the 2-hour response service and in the discharge pathways, aiming to provide sufficient support in the community to enable people to remain independent in their own homes for longer, thereby reducing hospital (re-) admissions and supporting hospital flow.

National Condition 2: BCF objective 1: Enabling people to stay well, safe and independent at home for longer.

Approach for 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.

Worcestershire County Councils (WCC) 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 and both will be refreshed during 2023/2024. 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).

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

Public Health within WCC have continued working with the ICS on specific population health management approaches. This includes using population health management approaches to identify and reduce risk in people with pre-diabetes. A local primary care PHM tool has been produced which will help to understand population health and needs within Worcestershire. It is recognised that there is further work to be completed regarding the housing tenure and stock condition data. Currently this data is collected by responsible districts but is not always joined up, accurate or accessible to all partners. Through the work supported by the ICB, datalake is a software being explored to look at an integrated and seamless approach to data collection specifically focussing on housing tenure data and stock condition, this would enable quicker discharge from hospital for those who have a housing need and a more integrated approach for individuals living in the community. The ICB datalake will pool health and social care data from across the ICS and will enable even more population health management approaches going forward.

The BCF in Worcestershire also supports the system to cater for an increase demand for services following the implementation of the Care Act. This contribution includes funding towards domiciliary care to meet Care Act duties and support people to stay well, safe and independent at home for longer. Since the previous BCF 2022/2023 Plan, the Council has identified the provision of a comprehensive high quality domiciliary care service which includes independence focused domiciliary care as fundamental to achieving this. Therefore, the County Council has decided to offer a new contract to domiciliary care providers who are able to deliver a service with a focus on outcomes, maintaining and where possible regaining independence with individuals, as well as to continue domiciliary care where required. This became partly operational in quarter 4 of 2022/2023 and will continue across the length of the BCF 2023-2025 plan.

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 (re-) admission, increasing function and independence to live well whilst they are at home. WCES delivers the equipment within 24 hours of request 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 people 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 ongoing 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. The extent to which urgent need could be reduced by improved and earlier discharge planning may be explored. WCES provide monthly performance (activity) data to its stakeholders to show the 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.

Alongside statutory and local commissioned services, unpaid carers play a key role in enabling people in Worcestershire to stay well, safe and independent at home for longer. The Worcestershire Carers Strategy seeks to place carers at the heart of Worcestershire's families and communities. The strategy includes four outcomes which carers have identified as being important to them:

- Being recognised and valued
- Having a life of my own
- Being supported to maintain my physical and mental wellbeing
- Caring Safely

Worcestershire Association of Carers and YSS have been contracted to support the delivery of this strategy for all carers across Worcestershire and all partners are delivering work which supports Worcestershire's ambition of being a carer friendly county.

WCC also commissions the provision of bed based 'replacement care' (also known as respite care or short breaks) from local care home providers, the objective being, to support a carer to have a break from caring to help them to continue in their caring role and/or to provide care in the event of the carer being unable to continue care provision on an unplanned or emergency basis for example due to their own hospitalisation or illness. Planned Replacement Care provides a short term / temporary placement to give the carer a break

from their caring role, as far as is possible on dates of their choosing e.g., for a family holiday. Emergency Replacement Care provides a short term / temporary placement that is required urgently to cover such eventualities as; risk of the individual remaining in their own home, breakdown of a homecare package, a change in the person's needs or carer breakdown.

Using a categorisation of low, medium and high care needs, placements are made with a range of care homes, including those which have are specialised in providing care for individuals with dementia.
During 2022 (January – December) over 8,700 nights of replacement care for older people were delivered in Worcestershire. This equates to an average of 24 individuals being in receipt of bed-based replacement care every night. The need for bed-based replacement care for older people is expected to remain broadly consistent in 2023/2024 and 2024/2025, although the long-term trend for an increase in placements to support people with dementia is expected to continue.

There are 12 community-based, multi-disciplinary Neighbourhood teams (NTs) within Worcestershire. This service is delivered by Herefordshire and Worcestershire Health and Care NHS Trust. The teams deliver planned care, intermediate care for both hospital admission prevention and supported hospital discharge, urgent community response and end of life care. This is provided 24/7, 365 days of the year with full geographical coverage of Worcestershire. The new frailty virtual wards are also now live and in their "learning phase", delivered via a multi-disciplinary approach.

The NICE reablement guidelines have been adopted and the teams ensure people have person-centred care plans that where appropriate aim to maximise independence and quality of life. This is delivered through therapy-led reablement, rehabilitation and provision of minor equipment and adaptations. Referrals for major adaptations and specialist equipment are made where reablement potential has been exhausted. NTs work in partnership with the Local Authority's Reablement service, to support the delivery of Pathway 1. Also identifying people who would benefit from further reablement with the LA's community reablement service.

Unpaid carers play an essential role in supporting the step-down of NT service provision through supporting the independence and strengths-based approaches. Likewise, timely housing adaptations enable the timely implementation of reablement and step-down of service provision. This is supportive of the proactive and wider hospital admission prevention agenda. Neighbourhood team Leads work closely with the ICB and Primary Care colleagues to develop clinical pathways that support a proactive approach to care. Population health data is utilised to inform service changes and innovations.
Work has started to implement Fuller recommendations through collaborative working with PCN and ICB colleagues. Frailty Virtual wards have provided a good opportunity to integrate the Advanced Clinical Practitioner and Medical Leadership elements of Virtual Wards.

National Condition 2 (cont.) Rationale for the estimates of demand and capacity for intermediate care to support people in the community.

Neighbourhood teams in Worcestershire usually support up to 23 community-based people who no longer meeting the criteria to reside') at any one time across the county. These are broken down to CHC, Social Care and Self-Funding – usually in a 25%, 50% and 25% split respectively. There is consideration for how the increased capacity in the domiciliary care sector and swifter referral pathways could increase capacity within Neighbourhood teams. This could improve patient flow, ensuring that reablement resources are equitably accessible for all who need them. It is understood that rural areas in Worcestershire have higher rates of people who no longer meet the criteria to reside. Therefore, people in these areas may not access reablement services at the earliest opportunities due to the knock-on effect to the available capacity in these localities although the new contracts for home care, once fully operational will greatly improve this situation.

NTs have been working with system partners to improve the step-up process to Community Hospitals to avoid unnecessary acute admissions. Infection control measures can often be a barrier due to patients needing to go into a side room from the community. Ring-fenced beds are currently being explored. In addition, the night sitting service has been aligned with the urgent community response hub to support admission avoidance where possible. Further work is planned with the Local Authority (LA) to consider realigning night services to support a system-wide approach.
The system is confident that the demand and capacity modelling supplied is sufficient for the 2023/2024 period.

Throughout the 2022/2023 period the system participated in the 'National Discharge Challenge'. This series of deep dives within individual systems looked at process, both within acutes settings, community and the functionality of each system's individual 'complex discharge function '. Throughout this period the Worcestershire system consistently performed well and received appropriate feedback from regional colleagues confirming this.

We regular monitor capacity and demand within our intermediate care services and down-stream bedded capacity. We have further growth built into our 'at home 'pathway and within our bedded settings there is some opportunity to generate further capacity by increased utilisation of the 'at-home 'pathway rather than bedded settings.

An independent review of the intermediate care service / bedded capacity has been undertaken, which is managed by our Community Trust via the Onward Care Team and Capacity Management Team. The review highlighted general good practice and recommended some 'efficiency' process changes and pathway modifications. These changes do not alter the demand and capacity modelling but are aimed instead at appropriate pathway identification and utilisation.

The Urgent Community 2-hour response is also managed by the Community Trust. This service has gathered significant momentum in the last twelve months, with the significant increasing referrals and improved response times which are correlated to reduce ambulance activity.

The main challenge with respect to flow into our Intermediate Care Services / complex discharges into the pathways / demand and capacity modelling, relate to levels of simple and timely discharge activity. To help address this the system commissioned a long length of stay and flow review which was led by Dr Ian Sturgess. The final report has been delivered and work is currently underway to translate this review into a forward action plan. This will identify the main area of work during 2023/2024.
Worcestershire have region leading levels of criteria to reside and low length of stay measures.

National Condition 2 (cont.) Impact on 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 whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population*

Community hospital provision continues to work across the health and social care system to increase patient numbers admitted directly from home to avoid unnecessary A&E attendances. As outlined above, there are 12 community-based, multi-disciplinary Neighbourhood teams (NTs) within Worcestershire managed by Herefordshire and Worcestershire Health and Care NHS Trust. The teams deliver planned care and intermediate care for both hospital admission prevention and supported hospital discharge. The work NT's, the community equipment service, Pathway 1 + (Wrap Around) and the reablement services deliver across the county has impact upon the unplanned admissions to hospital for chronic ambulatory care sensitive conditions. Their approach within the community and upon hospital discharge also will continue to impact on the number of people aged 65 and over who have an admission into residential and or nursing care homes.

There is innovative work in place across BCF funded services that strive to have impact on hospital admissions following a fall for people over the age of 65. Joint working with Platform Housing ensures that people who have fallen are referred to Neighbourhood Teams for a multi-factorial falls assessment, urgent occupational therapy and/or physiotherapy assessment. Guidelines have been developed jointly to support implementation of this operationally. NTs and LA reablement clinicians now have access to lifting equipment. These teams are working closely with the Ambulance service to identify people who have fallen, don't have injuries and are responding as part of a 2-hour urgent community response (UCR). The people will then receive therapy and Reablement as required. If people do present at the Emergency Department (ED), the UCR hub is supporting with in-reach to try and facilitate a return home rather than an unnecessary hospital admission. The UCR hub is working closely with same day emergency care at the Acute Trust to support with diagnostics and a return home rather than an unnecessary hospital admission. Organisations have worked together to ensure there is a robust offer regarding aids and adaptations. Examples of this can be found in the falls prevention workstream, where work with local providers such as nursing and residential homes have quick access to community services and equipment. Within the hospital, the community equipment stores are available for professionals to refer into, the community OT service provides quick access to routine aids and equipment to either facilitate a discharge home or prevent falls where appropriate. Referrals to this service can be made by any professional to expedite provision in a seamless and effective way. There are some challenges due to resources (OT) in undertaking assessments for individuals in the community, however, Districts are working closely with acute colleagues to further utilise the trusted assessor model and expedite provision through DFG money. Additional work has been undertaken to align policy and procedures to create a more seamless approach to provision. OCT have direct access to refer to all services as do other professionals across place. This does not sit within the homeless in hospital pathway but is an accessible service for all providers to access and utilise as required for the benefit of individuals.

National Condition 3: BCF objective 2: Provide the right care in the right place at the right time.

Approach for integrating care to support people to receive the right care in the right place at the right time. Including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge.

The system has commissioned an integrated intermediate care service approach via a 2-year pilot which has a home first focus. The pilot ends in September 2023.

Worcestershire has seen that overall, most people have received appropriate levels of care in their own homes in a timely manner. This has been achieved through planning 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 people and their carers to promote their strengths, making sure people are valued and have meaningful input into arrangements for their discharge plans. Multi-agency triage hubs agree timely discharges which has helped to eliminate delays in allocating capacity and reduced length of stay in hospital. This collaboration has enabled us flexibly utilise resources around the system to target key areas of pressure in the system to maximise flow.

The collaboration between partners and providers created 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. This is recognising that people are best assessed in their own environments. The trusted assessment has enabled the system 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 the system to improve communication with people, their families, representatives and other care providers.

Community Hospitals take a proactive approach to onward care planning for the most vulnerable people in Worcestershire's health economy. Undertaking regular multi-disciplinary teams' meetings, board rounds and ward rounds with system partners, to ensure effective plans are in place to support people to remain at home.

The Onward Care Team (OCT) is an integrated health and social care service that provides a service into the Acute Trust to support the transfer of care onto community pathways. A person's care needs are described by the ward team and the OCT prescribe the pathway the person is allocated to. The service adopts the home first approach, and most people are supported to return to their own residence (PW0: 11%, PW1: 50%, PW2: 25%, PW3:14%).

The OCT is responsible for managing complex discharges including:

- Repatriation for out of area patients
- CHC funded and fast track discharges
- Nursing and care home placements
- Housing issues and homelessness.

The OCT ensure that discharges are safe and are responsible for managing safeguarding concerns. Complex patients that are ready for discharge are reviewed daily at the discharge cell. The OCTs ensures complex issues are worked through in a timely manner therefore tackling the pressures related to delayed discharge. The enablers for achieving discharges earlier in the day will be through the successful delivery of the

ongoing OCT review actions. Additionally, earlier discharge activity will be achieved through the successful delivery of recommendations from Worcestershire's Dr Ian Sturgess long length of stay review.

Pathway 1 in Worcestershire 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, returning home, remains the optimum pathway with a previous significant investment to develop further capacity within this service. This is with the desired outcome to enable more people to return home, where safe to do so, in a timely way and reduce the number of people inappropriate occupying a bed-based facility and to benefit from reablement services. Worcestershire County Council have also commissioned the Domiciliary Care sector to deliver a Reablement Focussed Approach which complements the Reablement Service described above, further enabling people to maximise their independence and enabling optimum flow across the whole system.

Following the successful pilot, the Wrap Around service, also known as Pathway 1+, health and care executives are currently discussing the future requirements for the service. The aim of the service is to support people to recover and gain confidence in their own home following a stay in hospital, and to remain at home by delivering 24/7 care in the persons own home for a brief period post discharge. This also allows time to assess and identify any on-going or future care and support requirements. The service focusses on supporting people who are discharged from Acute and Community hospitals and is part of a suite of services for discharge, most especially following a long in-patient stay.

The principles of the service align with:

- Home First
- Focus on people's strengths
- Outcomes

The service is offered on a county-wide basis within Worcestershire. The capacity of the service during its pilot phase was limited to 4 carers initially. There was a staggered start to the pilot service with a two-week lead to ensure time to identify people who are suitable for the service. The service can now support up to 6 people at one time unless 2 carers are required. The duration of care is on average 16 days with significant benefits for the people who have received the service. It has demonstrated a significant reduction in people requiring a care home service once the wrap around service has finished.

Funded through the BCF, the discharge to assess model for people unable to return home under Pathway 3 ensures people can have long term care planning assessments completed in an environment most conducive to their needs. Within this pathway social work colleagues and hospital teams work collaboratively to support people with very complex care needs to leave hospital care to have their long-term assessments completed. The progress of the assessments is regularly monitored and length of stay managed. This ensures that people access the appropriate longer-term care placements as quickly and safely as possible. The collaborative leadership approach has enabled us to break down barriers between organisations and come together with a shared focus. This has also helped to change behaviours and cultures which have previously been a barrier to consistently achieving the right outcomes for people.
A contribution from Worcestershire's BCF is allocated towards packages of care for adults with Learning Disabilities who are eligible for s.117 aftercare. This is for individuals who were previously detained in hospital under the Mental Health Act s3 but have subsequently been discharged into the community. This funding promotes the support to individuals in an environment that ensures they receive the right care at the right time, as a step down from mental health hospital care and support. This could be support provided

within residential care or supported living, dependent on the personalised care and support assessed for the individual.

Worcestershire's BCF also contributes towards the expanded Homeless in Hospital Pathway. This pathway aims to embed the home first approach by early identification of homelessness or housing related issues preventing discharge, whether people are admitted to an Acute Hospital or whether they present at Emergency Departments. Working with the District Councils and their duties under the Homeless Reduction Act 2017 and Worcestershire's Home Improvement Agency which delivers the aids and adaptations service as well as other discretionary services funding via the hospital discharge grant. This this supports discharging people to their usual place of residence and finds alternative accommodation where this is not achievable. Through this pathway, data is being gathered to identify housing related issues that have led to admission and in order to better understand how services can be improved to prevent these admissions. This data will also inform whether step-down accommodation provision is required in the County and what type of units would meet the needs to those unable to return to their usual place of residence on discharge but could do so, longer term, with an interim option. The pathway supports the multi-agency discharge cell work. In turn, this has broadened the cohort of people identified as homeless or with housing related issues preventing discharge. The service also supports hospital teams with people who have complex housing related issues delaying discharge. Correct advice and guidance on what support is available and early identification of these issues will increase system flow over time.

Within the hospital, the homeless in hospital pathway service will be the single point of contact for all housing related discharge referrals. This includes but is not limited to where it is considered the person cannot return home for 'housing' reasons or is homeless. The support provided includes: -

- Early identification within the hospital setting to ensure that the person's housing needs are assessed and acted upon at the earliest opportunity.
- Face-to-face assessments with the person and relevant professionals to establish what is required to safely discharge the person.
- Identification of and access to suitable accommodation which meets their needs but might not necessarily meet all their wishes.
- Identification of need and provision of equipment, furniture and fittings, or anything else that would enable the smooth transition from hospital to the arranged accommodation.
- Signposting/advice/access to complete forms etc to ensure the individual is financially secure regarding income/benefits to cover ongoing accommodation costs, utilities, and day to day provisions.
- Referrals to appropriate agencies across Place to support with health and wellbeing needs and attendance at follow up health appointments to reduce the likelihood of re-admission.
- Facilitation of effective and efficient discharge and prevention of re-admissions for housing needs.
- Oversight of all planned interventions, within agreed timelines.
- Adoption of Consent, Information sharing, Data protection and Freedom of information requirements by all agencies.
- Partnership and collaboration across a wide range of agencies, including but not limited to acute and community hospitals, adult social care, Primary Care colleagues, Care providers, Neighbourhood Teams, District Council Housing and Benefits Teams, Housing Providers, Voluntary and Community Social Enterprise Organisations.

National Condition 3 (cont.) Rationale for the estimates of demand and capacity for intermediate care to support discharge from hospital.

Referrals into the Homeless in Hospital Pathway service in 2022-2023 and improved joint working practices with partners highlighted that only those without an accommodation option were being considered as homeless and requiring support from the previous service. The new pathway increases the number of people eligible to receive the service. This is including those who are unable to return home due to issues with their properties such as cleanliness issues which prevents social care entering the home, hoarding and aids and adaptations such as stairlifts and ramp access.

The cost of living crisis has seen an increase in the number of properties that adult social care identifies as uninhabitable due to damp and mould within the home. Data is being collected around this as District Councils and Housing Associations are asked by the Department for Levelling Up, Housing and Communities to address this. The pathway gathers this data to identify how earlier identification and prevention could prevent hospital admissions.

With the broadening of the definition of homelessness and housing related issues within the pathway this led to a predicted increase in the number of referrals into the service and April 2023 saw a significant increase coming through. At present there is capacity within the inpatient pathway, however, the situation will be monitored and reviewed monthly.

The approach to modelling in this area is based on internal system capacity and demand profiling. Initially the approach was based on that described by Carnall Farrar (External NHS Consultancy) and this has now been adapted for local use.

Modelling is reviewed regularly. Daily and weekly reporting is in place, to allow for immediate actions should significant anomalies occur. Low Levels of outstanding Pathway work, low levels of Criteria to Reside and low LOS measures are all evidence that the basis of the modelling is sound.
The outstanding challenge relate primarily to PW0 activity and actions to rectify this are highlighted above on Pages 10-11.

National Condition 3 (cont.) Impact on Metrics

- *Discharge to usual place of residence*

As detailed above, the Onward Care Team manages the transfers from a stay in hospital to the discharge destination. They are particularly focused on supporting people through a home first approach to impact on the discharge to usual place of residence. This aligns with the direct work by the community equipment service, reablement and Pathway 1 services to support Worcestershire residents to regain their independence, returning and remaining at home.

Pathway 1+, also known as the wrap around service has been expanded and extended during 2022/2023 and future arrangements (for 2023 – 2025) are under discussion. There is potential to increase the capacity to be able to provide support for up to 6 people at one time and for the service to be formally contracted for a 2-year period from September 2023, with a further option for an additional 1-year extension. The purpose of this service is to support people to return to their usual place of residence with an intensive level of care and support for a temporary period. Evidence suggests that people with this level of need would have remained in hospital or, other care and support options would have been considered, delaying the discharge and/or resulting in this cohort of people being unable to return to their own home.

The Neighbourhood Teams provide a 2-hour urgent community response. This is mainly for people in their own homes but if people do present at ED, the UCR hub is supporting with in-reach. This is to try and facilitate a return home rather than an unnecessary hospital admission. The UCR hub is also working closely with SDEC at the Acute Trust to support with diagnostics and a return home rather than an unnecessary hospital admission. The investment into Neighbourhood teams for Pathway 1 in 2021 increased capacity to support an additional 9 patients per week across the county home from hospital. NTs work collaboratively with the LA's Reablement service daily to agree which patients would benefit most from health led Reablement. In addition, should a person deteriorate once home, NTs can support to prevent a potential re-admission and take over the care/reablement as appropriate.

The Homeless in Hospital Pathway aims to gather the data to inform how we change services to provide the right care, in the right place, at the right time in relation to those experiencing housing related issues or homelessness, so delaying discharge. It will identify the housing tenure of people admitted which has not been gathered previously to understand gaps in provision of other services such as those who are ineligible for grants for aids and adaptations but who decline assistance for financial reasons. The pathway aims to support individuals in discharge to their usual place of residence whilst learning from those who are unable too. Having specialist support around the housing and homelessness legislation has increased referrals into the service. It is anticipated that as the pathway is embedded it will support the ambition to improve the waiting time in relation to discharge to usual place of residence.

National Condition 3 (cont.) Implementing the High Impact Change Model for managing transfers of care.

Current Sit Rep on Transfer of Care Hub:

- The Transfer of Care Hub is delivered by our Onward Care Team whose workforce is multidisciplinary from across the system
- It is delivered by the Herefordshire & Worcestershire Health & Care Trust and provides a service across Worcestershire
- Its processes 10 to 15% of total discharge activity from the Acute Trust
- It has an executive senior responsible owner from Herefordshire & Worcestershire Health & Care Trust
- It has agreed local governance
- It receives and process PID
- Decisions are based on real time data
- It is the system's source of demand and capacity information relating to complex pathways
- The Hub facilitates transfers of people between 08:00am and 17:00pm 7 days per week – as part of the recent review into the service it will broaden this functionality to 08:00am to 20:00pm 7 days per week
- The Hub operates with a Trusted Assessor Process and its team are actively involved in discharge planning at a ward level

Areas of development for 2023/2024:

- Improved co working and utilisation with Third Sector Partners
- Left shift from P2 activity to increasing P1 activity
- Improve the 17:00 to 20:00 functionality

National Condition 3 (cont.)

Use of BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered.

In addition to the main BCF resources and plans, the improved Better Care Fund (iBCF) allocation for Worcestershire Adult Social Care in 2023-2025 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 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 dual aims of avoiding hospital admission and increasing patient flow across the system
- Funding permanent recruitment within the Onward Care Team supporting the streamlining of hospital discharge and reducing the number of people who no longer meet the criteria to reside.
- Additional investment in the community reablement service with the aim of preventing / delaying admission to long term care or hospital.
- The funding of externally purchased Pathway 3 placements, whilst long term care planning for clients.

BCF and iBCF funding is used for key core social care and NHS community services. This includes 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. There is a funded provision for out of hours / enhanced duty social work to provide a rapid response from adult social care in responding to crisis in the community for residents with Worcestershire GPs. This is to deliver a timely response to change of needs of an individual at home who requires an urgent social care assessment to avoid an admission to hospital. Using an enhanced duty service allows referrals to be screened throughout the day, providing an urgent response based on level of urgency and risk. Health colleagues have a point of contact to discuss social care needs when they have urgent concerns causing potential risk of hospital admission. Also, to ensure there is social work capacity to respond to any urgent concerns after office hours to prevent and reduce risks of admission to hospital in the evenings and weekends prior to emergency duty team hours.

Supporting Unpaid Carers

BCF funding is used within adult replacement care for block purchase arrangements with care homes and a newly commissioned care home framework. The framework, which will be the focus of sustained development during 2023/24, is intended to ensure individuals and their carers have access to local, bed-based replacement care, which through working in partnership with providers, develops to meet the needs of older people and their families. The framework is to the value of just over £1.5m p.a. and is currently primarily for older people. However, this provision also includes replacement care for people with physical disabilities and sensory impairment and some specific dementia replacement care beds, (with providers who are registered to support these needs). Replacement care for people with a learning disability, mental health or autism is still on a block contract basis. However, this is being reviewed.

Worcestershire County Council also funds replacement care to enable carer breaks which is not within care homes but is within the individual's home. This care is provided by domiciliary care agencies and personal assistants. Care can also be provided outside the usual residence. Care can be paid for and organised by adult social care, or the individual can organise it via a direct payment. The direct payment 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 was a real issue to achieve during Covid and will be in future, as we learn to 'live' with Covid. This type of provision 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.

The framework for replacement care is more cost effective than block purchasing for older people, as there was an under-utilisation of the block beds. This model of replacement care is one choice for the carer and cared for. Carers informed the council that the way replacement care is provided can be a restrictive option. This is because not all carers want or need a full week or 2-week break at one time. In response to this feedback, a change was made to the service specification to enable carers to book several days, rather than a full week or two weeks. Providers are given a minimum payment for very short stays to make this a financially viable option for them.

Worcestershire County Council (WCC) contracts with Worcestershire Association of Carers to deliver Worcestershire's 'Carers Hub'. Researched shows the benefits of having a provider independent of the council to provide carer support, encouraging carers to come forward seek support in some circumstances.

WCC delegates the statutory duty of carer assessments out to this voluntary sector provider. 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 support network or community (where possible). This type of assessment helps to inform the plan of how to meet the eligible needs of both the carer and the cared for.

The three 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 collectively 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 provided 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 p.a. This funding contributes to meeting eligible needs in line with the Care Act 2014.

Carers also informed the council that they like the variety of options WCC offer including domiciliary care and personal assistants both at home and away from the home. If existing domiciliary care packages are in place, the carer break comes from a temporary increase in their domiciliary care package or their direct payment for their personal assistant care hours. The advantage of this is that the carer break can be person centred, for as long or as little as the carers requires and can be within or outside of their home. The carer can choose to remain living at home or go away.

Disabled Facilities Grant (DFG) and wider services

Worcestershire Place is committed to making sure that people admitted to hospital who are homeless, rough sleeping or at risk of becoming homeless are supported with their accommodation needs under The Housing Acts. As part of this commitment, key stakeholders from local authorities, health colleagues and the voluntary and housing sector have come together to develop a seamless pathway to identify individuals at the earliest opportunity and fulfil their duty to refer and provide support/accommodation as appropriate.

The aim of an outcome-based approach is to move the focus from 'tasks' to 'outcomes' and from processes to the way services affect individuals. Success in achievement of outcomes will be evidenced primarily but not exclusively by an improvement of an individual's overall health and wellbeing needs, environmental impact, and satisfaction levels of the individual and their family/carer/advocate as well as service reviews. Services are designed around the individual needs of the person.

Achievement of the individual outcomes should ensure that regardless of an individual's age, circumstances or complexity of their needs, everyone is:

- Valued, this involves being listened to, given options and choices, being kept informed and up to date and that decisions are made about them, with them.
- Supported through change, particularly when moving house, adapting to different support, community, networks.
- Supported to remain safe. Services are coordinated and provided by staff who are well trained and who understand about person-centred approaches to support care and support.
- Treated as an individual. Services are tailored to individual need and offer flexibility and understanding regarding complexities/individual circumstances

Worcestershire's Housing Strategy 2023-2040 (currently being adopted) sets out the shared commitment for collaboration with partners to better integrate with health and care. Health and Wellbeing is one of four key priorities within the strategy and recognises housing's key role in the delivery of health and wellbeing services.

The strategy is overseen by the Housing Board which is attended by a wide range of organisations including health partners. The Housing Board has links to Health and Wellbeing Board which has a representative from housing at the district council and voluntary housing services.

This collaborative approach informs the range of assistance and services offered in the Housing Assistance Policy. The Policy outlines the consistent countywide approach on how we will use the BCF to provide grants and services to enable people to remain safely independent in their own home and avoid unnecessary admissions to hospital, residential and care homes. These services include Dementia Dwelling Grants, Home Move grant assistance, assistance to address fuel poverty and advice on housing options.

These services are delivered through a jointly commissioned home improvement agency integrated with the Worcestershire County Council funded services providing information and advice service on how to remain independent at home and minor adaptations such as grab rails. The home improvement agency also has the support of an in-house occupational therapist.

Where a person needs assistance after a hospital admission, a Heath and Care Trust funded Hospital Discharge worker (employed by a local housing authority) helps to establish a housing pathway and enable swift links to assistance, such as a hospital discharge grant, to facilitate timely discharge from hospital.

Next steps (2023-2025):

- Implement the actions from the Health and Wellbeing priority, in the Worcestershire Housing Strategy, through a new multi-agency task group
- Work with partners and use best practice to develop assistance which efficiently and effectively utilises Worcestershire's additional DFG allocation to support vulnerable people to live well at home.
- Use the home improvement agency recommissioning process to strengthen partnerships and develop our collaborative approach.

Additional information: Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services?

Yes

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

The Home Improvement Agency has a flexible DFG funding allocation to meet demand. This is closely monitored to ensure that the districts are able to fulfil their statutory duty. All six district councils within Worcestershire use the funding for discretionary services. In 2023/2024 the spend is projected to be £1m for discretionary services

Equality and health inequalities

How the BCF plan contributes to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics.

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 an older age structure than is seen nationally, and the number of older people is increasing. This has consequences for the county in terms of access to services including primary and secondary care settings, general health of the population, ratio of full-time workers to people of retirement age and levels of resources. Malvern Hills, Wyre Forest, and Wychavon all have particularly high levels of older residents. Based on the 2021 census data, almost 22% of the population in Worcestershire are aged 66-plus, with almost 3% aged 85-plus. Proportions of older people are particularly high in Malvern Hills, Wychavon, and Wyre Forest.

Worcestershire has a higher proportion of one-person households where the occupant is of retirement age than is seen nationally, and a lower proportion of lone-parent households. The number of one-person households in which the occupant is of retirement age is increasing. The high proportion of older one-person households could contribute to social isolation and loneliness, as well as potential lack of mobility and access to services and health care, potential increased health concerns and future requirements of access to social care.

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 through the Neighbourhood Teams.

Since the previous BCF plan, Worcestershire's Health and Wellbeing Board has published its Health and Wellbeing Strategy 2022-2032. For the 2022 to 2032 Strategy, the Health and Wellbeing Board identified good mental health and wellbeing as the main priority, supported by action in areas that we all need to 'Be Well in Worcestershire'. The strategy outlines the Health and Wellbeing Board's commitment to improving mental health and wellbeing, supporting people to live well in good health for as long as possible, particularly those who have poorer health outcomes. The Health and Wellbeing Board will champion collective action to ensure children have the best start in life, young people will have hope and aspiration for the future, and residents live longer, more independent lives in good health, with fewer people going on to need care and support which is vital to supporting good mental health and wellbeing.

The BCF plan is an important vehicle for the Worcestershire Health and Care system to support a reduction in unwarranted variation in outcomes. Partners across the system have come together at the Herefordshire and Worcestershire Integrated Care Partnership Assembly to develop and agree an Integrated Care Plan which will share the vision for integrated care, improved health and care outcomes and a reduction in unwarranted variation in outcomes. Underpinning this strategy are the joint strategic needs assessment (JSNA) which provides an assessment of the health needs of the population and focused work to reduce unwarranted variation in outcomes. In Herefordshire & Worcestershire, health provision is working to CORE20PLUS5, an approach to reducing health inequalities and unwarranted variation developed and used across the NHS in England. This focuses efforts to increase tailored support to those living in the most deprived 20% of the national population (CORE 20) and locally define groups including unregistered

populations and those experiencing barriers due to health literacy. The key clinical areas of variation are Maternity, Severe Mental Illness, Chronic Respiratory Disease, Early Cancer Diagnosis and Hypertension.

The health and care system has commissioned and funded a range of services which directly respond to unwarranted variation, as described in the core20plus5 strategy, as well embedding reducing health inequality through prevention and personalisation through all commissioned services. These principals flow through district collaboratives which bring together district council, county council, health and voluntary sector partners to understand and address local variation. Primary Care are funded to deliver plans focused on reducing unwarranted variation, driven through the district collaboratives. In support of these mechanisms Herefordshire & Worcestershire ICB and Worcestershire County Council have brought funding together to deploy an outreach service. This service will directly work with district collaboratives and communities to provide additional resource and capacity to deliver increased GP registration, health checks and screening within the most deprived communities. The aim is to provide early intervention through a personalised care approach which will see a longer-term reduction in variation and adverse outcomes within key clinical areas such as heart attacks, strokes as well as a range of long-term conditions.

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.