HM Government

NHS England

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s).

Wirral **DRAFT PLAN**

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

The following bodies whose services are partially or fully funded by the BCF have been involved in preparing this plan:

- Wirral Council,
- The Cheshire and Merseyside ICB, Wirral Place
- Wirral University Hospitals NHS Foundation Trust (WUTH)
- Wirral Community Health and Care NHS Foundation Trust (CT)
- The Cheshire and Wirral Partnership NHS Foundation Trust (CWP)
- A range of social care providers including the voluntary sector
- A range of people with lived experience
- Primary Care
- Extra care housing developers and providers
- Liaison with the Place Based Partnership Board will be reinforced enabling partners, including providers, to contribute to in year BCF investment and reviews for all appropriate schemes.

How have you gone about involving these stakeholders?

The Wirral Place Based Partnership Board, chaired by Wirral's Place Director and which includes representatives from all key organisations has had oversight of this draft submission.

Involvement of people with lived experience in key projects, for example the development of a PA register and the reablement strategy.

The executive led discharge hub has given a system focus on escalations and removing obstacles between organisations and has influenced the design of several schemes.

Attendance from Trust colleagues at residential and care at home forums to build relationships, support discharge and inform and advise on the emerging Transfer of Care Hub.

Involvement of housing colleagues in the development of an escalation policy (further engagement with PCNs planned).

Extra care housing developers and providers.

Governance

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

The governance of the BCF currently sits within the jurisdiction of the Joint Health and Care Commissioning Executive Board (JHCCEG).

Wirral's Place Director and the Director of Adult Social Care and Commissioning seeks local stakeholder endorsement of Wirral's Plan via the Wirral Place Based Partnership Board (WPBPB).

The plan will be validated by the Health and Wellbeing Board.

Overall approval of the plan will be via NHS Cheshire and Merseyside ICB Executive Committee.

Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

The BCF will be a key enabler in achieving the outcomes of the Healthy Wirral Plan and any other priorities identified by the Wirral Place Based Partnership Board (See principles below)

1. Create a place that supports the Health and Wellbeing of everyone living in Wirral in the places that they live.

2. Through understanding our populations health we enable more people to remain healthier and independent for longer and live well

3. Families and communities are empowered and supported to raise healthy and resilient children and young people and give them the best start in life.

4. Wirral people and their families feel informed and involved in managing their health and in accessing their care seamlessly from organisations that talk to each other

The plan describes our progress and ongoing investment into Home First Services. Our priority is to ensure all pathway 1 patients are assessed at home. This will reduce over-prescription of care and a risk averse approach to discharge. The discharge/transfer hub will curate a person's journey from admission and will ensure people are discharged onto the right pathway, adopting an asset-based approach, and optimising the CVFS offer.

A key priority is to offer sustainable ongoing support and reduce reliance on commissioned services. Our Reablement operating model will support admission avoidance and enable people to recover and thrive post-discharge.

The Wirral Health and Care system has had some of the highest levels of 'no criteria to reside' (NCTR) on our wards at Arrowe Park Hospital.

Our BCF plan aims to reduce the historical level of NCTR of 220 to below 80 before autumn.

Our other 23/25 priorities including some metrics are set out below:

a. Avoidable Admissions (ACS): Reduce below 22/23 rate of 190 per 100,000 population.

:

b) Continued investment to support the care market in line with the Market Sustainability Plan.

c) Reduce the number of avoidable NEL Admissions (ACS) to below the 22/23 rate of 190 per 100,000 population

e) Reduce the number of emergency Admissions due to Falls (65 and over) to below the 22/23 baseline

f) Increase the number of people discharged home or to their normal place of residence to 94% from 93% baseline.

g) Increase % of People still at home 91 days after discharge from hospital or reablement/rehabilitation settings. Currently 84.4%

h) Focus on improved LOS in D2A bed bases to 21 days and improved outcomes.

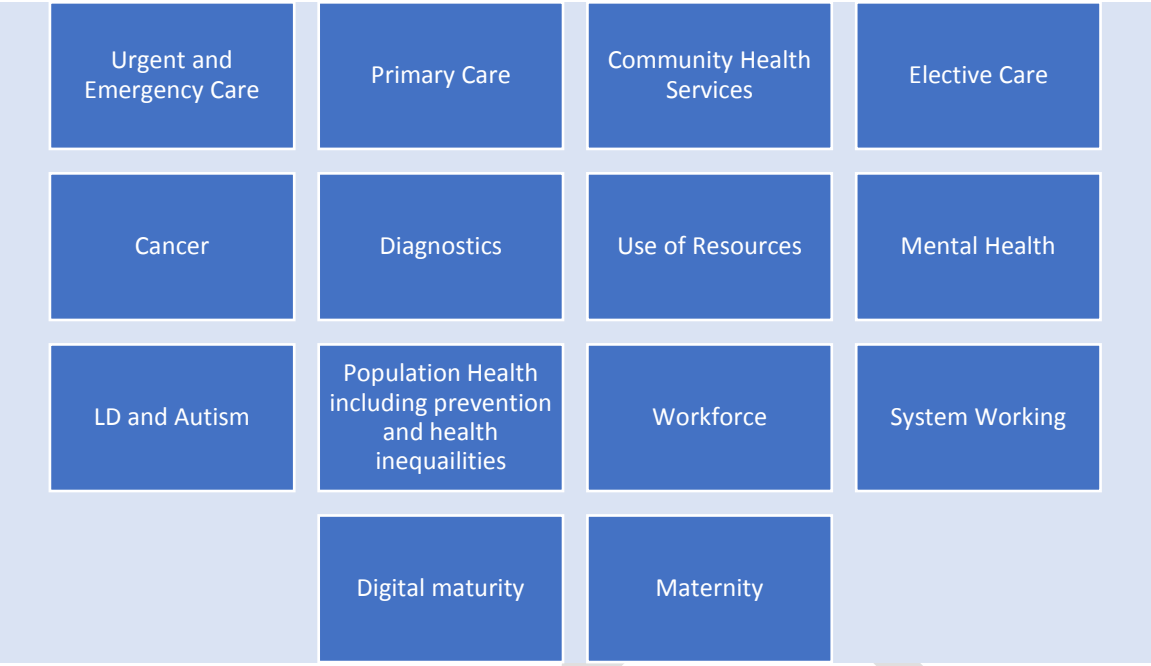
i) Increase capacity in the Frailty and Respiratory Virtual Ward to above 22/23 baseline.

j) Expansion of ACS Admission Avoidance and Same Day Emergency Care access with a focus on Respiratory and Cardiovascular Disease

k) Urgent Crises Response – Increase in capacity and enhanced links with other UEC services such as 111 and Falls Level 2 response.

l) Increase the number of crisis beds (4) for people with mental illness

m) Enable more people to die at home


Urgent and Emergency Care
Primary Care
Community Health Services
Elective Care
Cancer
Diagnostics
Use of Resources
Mental Health
LD and Autism
Population Health including prevention and health inequailities
Workforce
System Working
Digital maturity
Maternity

National Condition 1: 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 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

Joint Priorities for 2023/25

Wirral Place in 2023/25 will be building on the current governance arrangements and placing a greater emphasis on collegiate commissioning. A review of the Terms of Reference for the monthly BCF Joint Oversight Group will be completed and a BCF Dashboard will be developed mapping schemes against core metrics and our wider Health and Care Plan deliverables. The review will ensure National Conditions are met and value for money outcomes against cost assessments are demonstrated.

1) Liaison with the Place Based Partnership Board will be reinforced enabling partners, including providers, to contribute to in year BCF investment and reviews for all appropriate schemes.

2) Ensure the system is equipped with services that support business continuity and resilience during periods of high pressure.

3) There will be an improved focus on reducing inequalities, using the work at neighbourhood level and the Core20+5 principles both of which will form key metrics to measure the impact and define deliverables for new commissioning. Equality Impact Assessments of current schemes will be reviewed and completed for and any new schemes.

4) There will be greater collaboration to share learning and best practice across other Cheshire and Merseyside Places

5) Reablement is a system priority, and a model has been developed which will be partially mobilised in 2023 and fully in 2024/5 The model will better integrate a range of services at a place level and will support the aims of the Wirral Health and Well-being Strategy and the exponential increase of the Home First service.

6) Work in tandem with children and families' services to ensure an holistic approach to care and support is maintained.

7) Embed the 3 conversations asset-based approach to assessment ensuring conversations with individuals and their families begins on admission to hospital,

this approach is already embedded within community teams, will be a key enabler for the reablement strategy.

8) The integrated offer to carers and young carers will be enhanced

9) Increased investment into Frailty services aiming to provide a triangulated approach to care:

- Urgent Crises Response (2 hour) response to patients in the community
- > Older Peoples Rapid Access Clinic for acute ambulatory care
- > Step up/down care in Frailty Virtual Ward beds as an alternative to admission.

10) A review of the Discharge to Assess bed-based service will seek evidence that there is reduced length of stay and in line with the 21-day target.

11) Increase the number of crisis beds and develop of a supported housing model for people with learning disabilities/mental illness and an increase in the number of step-down beds.

12) Capacity in the Urgent Crises Response service will be increased and link with other UEC services such as 111 and Falls Level 2 response. This will include a review of the falls prevention services, and the equipment and enabling technology offer.

13) Ensure that system and provider estates reflect current and emerging health trends including bariatric care supported by DFGs in the community.

14) Implement recommendations following on from the review of The Community Intermediate Care Centre (CICC).

Joint Commissioning programmes in Wirral linked to BCF priorities include:

1. SEND

2. Neurodevelopment

3. SALT – Speech and Language Therapies

4. Mental Health Initiatives: Happy Minds, Alliance, Companearos

5. Home First

6. D2A

7. Reablement

8. Health and Wellbeing Plan

9. Ageing well

10. Frailty

National Condition 2

Use this section to describe how your area will meet BCF objective 1: Enabling people to stay well, safe and independent at home for longer.

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches.
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

Wirral has very well established, collaborative commissioning relationships in place across Health and care which is a key enabler to delivery.

Wirral has developed a neighbourhood model which strives to support communities to think differently and focus on what is important to them. This asset-based approach is in its infancy in Wirral however it is anticipated that this approach, will lead to a reduction in inequalities and health inequalities. As the key priorities are identified by neighbourhood leaders, BCF schemes will be considered to assess how they can support these priority areas.

The 3 Conversations approach compliments the above model and delivers a person-centred strengths based approach to assessments. This will be rolled out across the system equipping social care and clinical staff with the confidence to support people to design their own solutions to how their support needs will be met. See a story of difference below:

“A family member who works away contacted Social Care in relation to his 22-year-old brother living with his mother in her rented property. The young man has a diagnosis of dyslexia and ADHD. His mother passed away two weeks previously but as the rental agreement was in his mother’s name the landlord wanted to evict him. The young man does not have a bank account, benefits, or income. He was adopted and the only ID he had was a birth certificate in another name.

The Social Worker was unable to access Housing Options or open a bank account with him as the ID was not enough. ‘Connect Us Northwest’ were able to open a bank account in his name without ID and support him apply for a passport.

A one-off payment was paid for his Sky subscription to reconnect his landline and broadband, enabling him to remain in contact with his social worker and the other agencies supporting him. The Army welfare fund and Housing Options agreed to cover his rent for two months. He also received food parcels.

When his benefits started Housing Options found him a temporary place in a self-contained flat in Pembroke House with some support. The staff in Pembroke will support him access courses so he can find a job.

The difference

Due to using Conversation 1 the young man was able to access support that he may not have received previously unless he became homeless. The social worker was able to work more flexibly with him, taking him to appointments and remaining involved with the other agencies working together."

The following BCF schemes contributing to this BCF objective are.

a. WIS including Community Equipment Service, Falls Prevention & Assistive Technology

b. Urgent Crisis Response Service – joint funding via BCF and Ageing Well – recent service expansion – established pathways with NHS 111, 999 and care homes to support admission avoidance.

c. IV antibiotics – OPAT service provided collaboratively by WUTH, WCHC and Community Pharmacy – admission avoidance and ESD

d. UCAT – GP advice and support to paramedics to avoid conveyance / admission.

e Inception of the Discharge Hub.

f. Home First

g. Early onset dementia support and dementia local enhanced service

g. Mental Health Crisis Response Service

h. Third sector support: including an SPA in the hospital.

i. Implementation of the Reablement Service.

j. The PA Register

Wirral Place has MDTs embedded across the system. A few examples are provided below with a focus on promoting independence and support to remain at home for longer:

a. Virtual wards – newly established in 22-23 operate an MDT approach with support from the BCF funded integrated response service.

b. The Urgent Crisis Response Service was expanded in 22/23 utilising ageing well funding with the core service funded by BCF. MDT includes Nurses, Therapists, Paramedics, Social Workers, HCA's

c. Integrated teams based within neighbourhoods.

d. A local ambition during 23-24 is to enhance our Single Point of Access offer to provide a more comprehensive clinical navigation service centred around the needs of the person.

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Our Intermediate Care System includes the following key components:

1. CICC – 71 Beds (p2)

2. Leighton Court – 22 beds (p2 beds

3. Park House 15 bed (p1)

4. Home First (50 patient capacity for p1a)

Typically from a community perspective re-admission rates from D2A services to hospital average around 17%.

Overall occupancy for D2A services has exceeded 85% for 22/23 with continued ongoing waiting lists to access services although this is reducing. Correspondingly our NCTR rate has been consistently averaging 220 this too has now reduced. The capacity constraints across home based intermediate care combined with our system ambition to ensure all patients on Pathway 1 has promoted the development of Home First over the last 12 months, and the planned expansion during 23-24. In terms of community step up to intermediate care bed bases, there hasn't been an unexpected increase in demand and as such it is not believed that there is unmet need in this area. This cohort of patients continue to take priority for discharge to assess capacity if a hospital admission would otherwise be required.

In addition, the LGA will support Wirral place with capacity and demand modelling in 23-24 to support recovery against key challenged areas, most notably our non-criteria to reside numbers.

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

Wirral in 23-25 will further invest in a range of services to reduce Ambulatory Care Sensitive Conditions including.

1. Community and Acute Heart Failure Services

2. OPAT

3. Integrated Respiratory Service

4. Dementia Nurse / Early Onsert Services

5. New SDEC service offering from WUTH

6. Virtual Wards for Frailty and Home First

The increased investment into CVD and Respiratory ACS services aims to further reduce admissions below the 22/23 baseline of 925 per 1,000. This includes greater capacity for early supported discharge/front door admissions avoidance components of the pathway.

A Falls Group leads Wirral's strategic approach to improving the care of those who have fallen or at risk of falls. The recent year on trend of reduced hospital conveyances will be further improved by interventions including Falls Level 2 prevention/pick up, equipment to care homes & poly pharmacy reviews.

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered 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, in line with the Government's hospital discharge and community support guidance.

Wirral place has accelerated its work around 'right care, right place, right time' over the last 12 months with further expansions planned for 23-24. Respiratory and Frailty virtual wards are in place supporting both admission avoidance and accelerated discharge. Whilst it is acknowledged that, with our non-criteria to reside numbers consistently high, we are falling short of achieving this objective, our system focus is on recovering this position.

The discharge hub (see model below) will curate a person's journey from admission to discharge and provide full visibility of patient flow. Initial outputs are demonstrating improvement in this area with increased utilisation of support services available, including those commissioned via BCF e.g., IV Antibiotics and the Age UK Going Home Service.

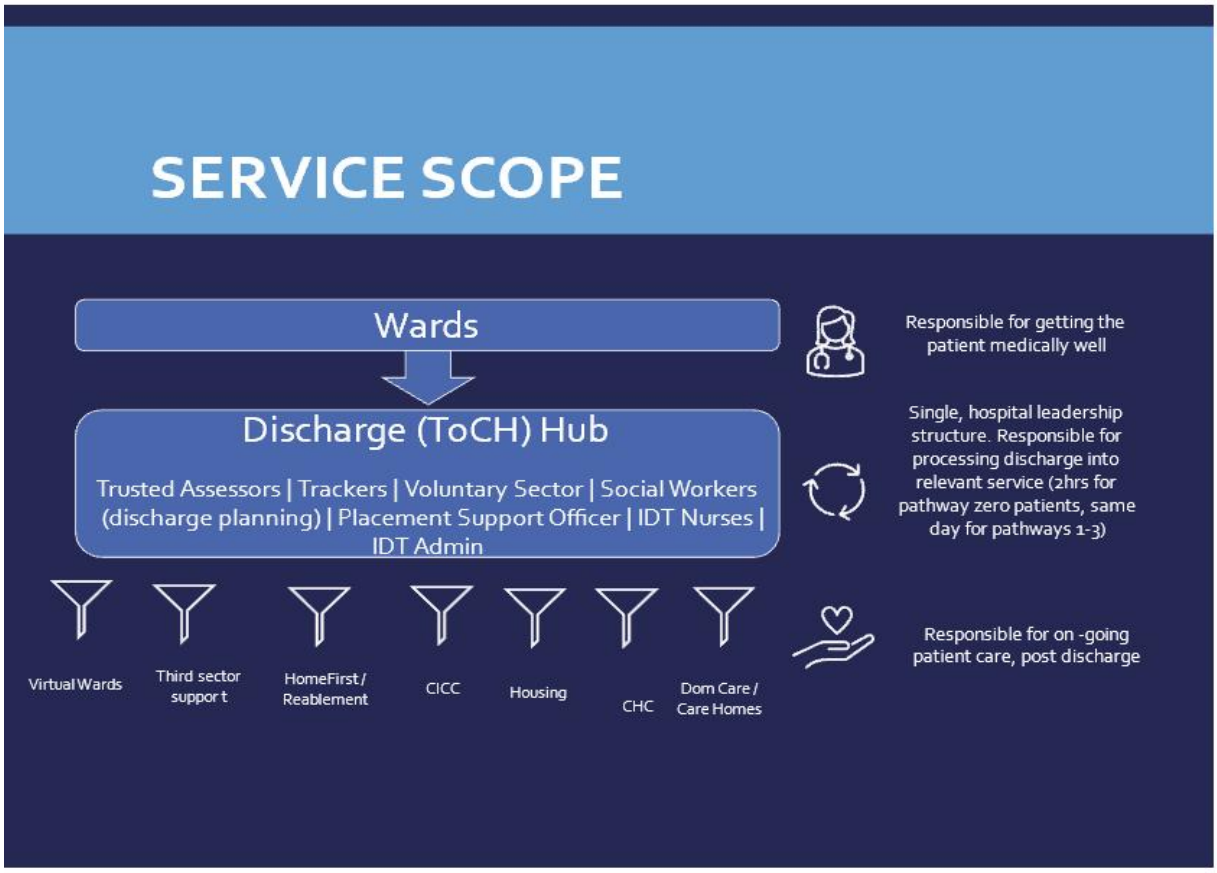
The acute discharge policy has been updated and re-launched across the trust with an emphasis on home first and early identification of additional support needs via the 'notification to assess' function. This will enable the integrated discharge team to provide early, proactive support and assessment ahead of discharge.

The Home First service (see model below) supports acute discharge and is reducing non criteria to reside numbers and supporting patients to return home and be assessed at home with the appropriate wrap around support. The expansion of home first will utilise discharge funding and will invest in the workforce (additional 104 WTE staff).

Both services will be supported by the adoption of the 3 Conversations asset-based approach to assessment and with support from the CVFS. The Community Intermediate Care Centre (CICC) supports earlier discharges out of our D2A base to ensure the average length of stay of 21 days or less is achieved allowing flow through the service.

Testimonials from people utilising the service highlight the improved outcomes experienced for people able to return home as early as possible.

SERVICE SCOPE



In partnership:
Wirral Community Health and Care NHS Foundation Trust
Wirral University Teaching Hospital NHS Foundation Trust
Wirral Council

NHS

Current

Full assessment on ward including determination of pathway based on available information

For people determined as Pathway 1, prescription of:

1. Short Term Assessment & Reablement (care, reablement) for up to 6 weeks, or
2. Domiciliary Care package

IDT arranges packages based on availability

Discharge home with agreed support

STAR package may become dom' care package if needed

Future

Simple assessment on ward – 'is someone medically fit for discharge and safe to go home with visiting services?'

Same day handover to arrange same / next day visit from Home First team

Therapy and/or care (with assessment if needed) for up to 6 weeks

For those who need it, handover to domiciliary care

Hospital may be where you get treated, but home is where you get well.

HomeFirst
Why not home, why not today?

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
    - how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

As referenced in the section above, in relation to intermediate care in the community, previous capacity and demand modelling has been undertaken. It was anticipated at the time, based on current and pre-pandemic activity, that the CICC discharge to assess facility would be sufficient to meet our demand for intermediate bed-based care. Due to several factors, length of stay within the service failed to meet the required 21 days and as such capacity was insufficient to meet demand.

This led to the need to extend transitional D2A capacity in Leighton Court Nursing home (x22) and commission additional beds from Elderholme nursing home (x9). MDT provision was provided by the Community Trust ensuring social work and therapy input. Despite this additional provision, there has remained a reliance on wider spot purchases to manage the demand on the system

This imbalance of capacity and demand has also impacted intermediate care provision at home following hospital discharge. As a result of domiciliary care delays, (this is exponentially reducing at pace), several residential beds have been commissioned utilising ASC monies. These beds are utilised by patients who no longer require acute care but are awaiting a package of care. Over the period of the contract, there have been periods of underutilisation. This is in part due to failure to identify suitable patients. As a result of this, the commissioned beds have been incrementally reduced with the initial 25 beds reduced to 15 and then 10.

These factors have led partners to work together to develop the new home first service which supports patients to return home following a hospital admission. If a patient does require a short period of bed based intermediate care, the home first service and the integrated community teams will ensure the time spent in a bed is minimised as far as possible.

Wirral currently discharges XX% of patients on pathway 0 and 1, XX% on pathway 2 and XX on pathway 3. It is anticipated that through the developments and additional investment in home first and virtual wards, at least 95% of patients will be able to return home.

The total Wirral population is 324,336 (Office for National Statistics (ONS) mid-2020 data). The 65+ population is 71,289. ONS projections indicate that the population is estimated to increase by 4.1% to 336,300 between 2018 and 2043. This hides large variations when looking at specific age groups, with the population of children and young people (0-14) decreasing by 8.2%, while the population of older people (90+) is projected to increase by 96.3%

There are 71 care homes for people 65+ in Wirral, with a maximum capacity of 2,766. The average occupancy level for all homes is 88%. Engagement with the discharge/transfer hub and the care home market is underway to optimise the use of these beds.

Whilst there is sufficiency of supply for standard residential and nursing care, there is a shortage of dementia provision (residential and nursing EMI); there is a risk that Wirral could be oversubscribed by winter 2023, and commissioners are working with Integrated Care Board colleagues to improve capacity in Residential and Nursing EMI categories for complex cases. The ongoing development of Older Peoples extra care units, growth of the domiciliary care market, (3 new providers were mobilised in May 2023) and the strategic direction to provide added support for independence through new technologies, is intended to mitigate this risk.

There are 28 contracted care at home providers in Wirral which is an insufficient supply to meet local demand. South and West Wirral are the most challenged areas for delivery. Most providers in Wirral are small, local organisations and there are challenges around recruitment and retention for domiciliary care staff. The Council has been working with providers to attract people to the sector and to retain existing staff. Discharge funding has been used to fund incentives such as increased hourly rates during periods of high pressure and support initiatives such as the ‘Care Friends’ App, E-bikes have been made available and the Skills for Care ‘Finders Keepers’ approach to finding and keeping the right people with the right values. Recruitment events have been held in local areas in partnership with the university and Local NHS providers.

In March 2023, Wirral Council approved funding to continue to support all community care market providers to take up the Real Living Wage (RLW) increase rates for domiciliary care to pay front line staff a wage above the Real Living Wage ie £12 per hour.

In March 2023, Wirral Council approved funding to continue to support all community care market providers to take up the Real Living Wage (RLW) increase rates for domiciliary care to pay front line staff a wage above the Real Living Wage ie £12 per hour. This allocation of funds has supported recruitment and retention in the care at home market and will support to maintain and grow the market moving forward to meet local demand. Personal assistants employed by direct payment recipients have had their hourly rate aligned with the rest of the sector. The Council has considered the cost of living challenges when allocating financial resources.

The number of hours support offered is returning to pre-covid levels, but the number of packages is smaller due to the complexity of need. In April 2023, 3 new providers joined our framework and the combination of the extra support and using off framework providers is having a positive impact on flow.

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

The following initiatives will support this objective:

1) The Discharge Hub currently under development coupled with the expansion of the Home First service will support this objective.

2) The 10 step down beds at Park House care home will support people waiting for care at home services in a more appropriate environment reducing the risk of de-conditioning.

3) The exponential increase of care at home services to pre-Covid levels of support

4) The realisation of the DFG targets supported by an increase in enabling technology.

5) The rollout of the 3Conversations model will reduce reliance or supplement commissioned packages of support

6) Additional BCF funded social work posts to ensure reviews are undertaken in a timely manner and discharge legacy packages are appropriately adjusted.

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

1) The discharge hub and the Home First Service will be the model for managing transfers of care, supported by a responsive care market please see above.

More details of capacity and demand will be added here

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

A large proportion of the ASC monies was invested in the care at home and care home services to further support market sustainability but the short-term nature of the funding did prove to be an impediment to recruitment although the incentives to encourage staff to work additional hours during periods of high demand were effective. The availability of early intervention and prevention services have supported people and carers to remain independent at home and expedite discharge.

Community based Trusted Assessors will continue to ensure packages of support are adjusted appropriately and improve flow.

Additional mobile night runs will continue to be funded as this has previously been an area of high demand.

IBCF funded equipment and enabling technology enabled 604 people to be supported home. This included an additional 42 deliveries during Dec & Jan. Moving with dignity principles were applied leading to packages being right sized, reducing reliance on the care market.

.Funding will continue to support flexible working patterns (7 days for social care staff sitting within NHS Trust)

The Personal Assistants register will enable more people and families to access a direct payment.

The focus on recruitment of social workers and apprentice social workers will continue.

The alliance of voluntary sector providers will continue to be funded, to support early intervention and prevention, they will be a key pillar of the reablement strategy.

Funding to support carers will continue, be increased and reflect the outcomes of the Carers' Strategy.

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.

The Carers' co-produced strategy has identified a range of priorities including the provision of

1) Information, Advice and Training

2) Improve the health and wellbeing of carers

3) Support with finances and benefits

4) A PA register

5) Increased carer breaks (additional respite beds will be commissioned)

6) Support young cares (Current offer will be reviewed)

7) Improve identification of carers including at point of admission to hospital.

We will support these priorities and continue to work with all health and social care sector organisations to improve support for carers. We will optimise use of the shared lives scheme and increase the number of respite beds available. The PA Register will enable carers to access appropriate and flexible support.

We will support and promote the Primary Care Carers Quality Standards to include:

- Carers Health Checks
- Carers vaccinations
- Flexible appointments
- Mental Health support
- Contingency and emergency planning
- We will promote improved ways to support Carers in Primary Care and other health settings.
- Support people to access Carers Support Groups and networks for specific health conditions
- Improve the Primary care role in identifying Carers whose health and wellbeing would benefit from Short Breaks
- We will promote improved ways to support Carers in Primary Care and other health settings.
- Support people to access Carers Support Groups and networks for specific health conditions

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

Wirral Council's Home Adaptations Team will continue to evolve its client centred approach through the expansion of the rapid Home Adaptation Grants (none means tested adaptations with a target of installation within 50 days) to prevent falls, enable independence and reduce readmission into hospital. The service will look to review the Handyperson Service in line with recent government guidance but will continue its focus on minor adaptations (within 48hrs of referral for priority cases such as those awaiting hospital discharge).

More complex DFG's will be closely monitored to ensure delivery is as efficient as possible and the role of Client Liaison Officers will be developed further to improve the customer journey. Efficient use of OT resources and the use of trusted assessors (currently used for Assisted bathing assessments) will ensure resources are targeted where they are needed most.

New performance measures will strategically align to the living well strategy and will be implemented from 1st April 2023 onwards. The new measures reflect the customer journey through the various stages of the DFG process. As well as minor works and adaptations to support hospital discharge. The current drive is to accelerate waiting times while managing increasing demand for the service and over the next 2 years improving transparency and clarity of the process for the customer.

This will be closely monitored over the next 2 years. The Council's financial assistance policy complements this activity by addressing dangerous, cold, and damp housing conditions and dovetails where required with home adaptations to ensure the most vulnerable can remain living independently in their homes for longer. The DFG element of BCF has been used flexibly to support the wider strategic priorities around assistive technology and an investment programme is underway.

The use of technology enabled care (TEC) will be embedded into day-to-day assessment and reviews, shifting towards a "Digital First" philosophy to support the 3Conversations approach in particular, understanding how to support people to live more independently, make more use of the technology they already use in and around their homes and what a good life could look like for them as they consider their futures.

From July, a project to introduce more TEC options to individuals in receipt of Supported Living services will commence. This will be part of an NHS Digital programme called Strengthening Independence Through Technology (SITT). This will provide an opportunity for the proposed TEC Champions across social care to discover more about the technologies available and the impact they can have on an individual's ability to live more independently.

The number of adaptations completed.

The target for the total number of adaptations was 2550 for 2022/23 although the service achieved 3198 in total. This performance is 25% higher than previous years and although there has been a smaller, but steady increase in referrals in previous years, it is not known whether this level of demand is likely to be sustained. It is therefore suggested that a realistic but improved target of 2750 adaptations be introduced for 2023/24 and this be reviewed at year end.

DFG Allocation for 2023/24 and 2024/25

23-24 confirmed allocation of DFG grant for Housing is £4,723,627, which is the same as the 2022-23 allocation, with an additional amount due to be announced later this year providing an increase in the total allocation nationally from £573m - £623m.

Additional information (not assured)

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? (Y/N)

Funding flexibilities under the RRO has enabled more adaptations to be fast tracked without the need for means tests that slows down the process. The discretionary element is now a substantial element of adaptations assistance and includes Time Critical Adaptations Grants (fast tracked adaptations to provide dignity and flexible assistance for patients needing end of life care) and the Home Adaptation Grant (50-day target for completion of grant).

These products provide for greater support for carers, helping to prevent carer breakdown through a faster process (target of 50 days) and aligning to the national priority to ensure people stay well, safe, and independent at home for longer. This has been aligned with additional grant funding such as the Public Health funded Healthy Homes assistance to tackle wider determinants of health and the Energy Saving Trust funded programme of energy advice and assistance for those receiving adaptations.

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

£2.83m

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these.
- Any actions moving forward that can contribute to reducing these differences in outcomes.
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

Our BCF and overall, Health and Care Plan for Wirral now has equality and health inequalities as core delivery priorities. In Wirral life expectancy can differ as much as 12 years depending on where you live. Although social economic determinants of health are the principal factor, we recognise the health and care system design also plays a very important role. The BCF plan supports the outcomes as defined by the health and Wellbeing Plan, neighbourhood strategy (Core 20+5). An Equality Impact assessment will be completed for all new commissions and will be included as part of service reviews. There will be a focus on services provided locally, to increase social value. We expect all schemes to have identified key metrics to determine their impact on health inequalities.

For example, for respiratory conditions our BCF investment aims to provide better access to services in areas of higher prevalence and corresponding poorer health outcomes. Our Neighbourhood Model, which will be co-produced with our communities, will form the foundation for how we on Wirral and our health and care system will tackle health inequalities together and improve the health outcomes of our population. Each of our 9 neighbourhoods, which are a defined geographic area, will have a core group which will be led by community leaders to improve health outcomes.

The aim of the Model is to link population health data with local intelligence with a focus on deep local insight. Each neighbourhood will use this combined information to identify a priority area for improving health outcomes. When a priority area has been identified, the Model will be to enable change that will be co-produced with communities and health and care services. The focus of changes will be on prevention of ill health, both in terms of the wider determinants impacting negatively on health and on clinical prevention that can help to promote good health. The plan for 2023/24 is to begin with two neighbourhoods initially and utilise improvement methodology to test out new ways of tackling health inequalities.