Halton Better Care Fund Plan 2023 - 2025

Halton Health and Wellbeing Board

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

With being a year of transition for the NHS, the involvement of stakeholders is particularly paramount, in ensuring a system-wide plan. Some plans are still under development following the establishment of the NHS Cheshire and Merseyside Integrated Care Board (ICB) including the overarching NHS Cheshire and Merseyside Integrated Care Partnership (ICP) and the Integrated Care Strategy (in line with the Health and Care Act 2022 amending the Local Government and Public Involvement in Health Act 2007), which will be evidence-based and focussed on system-wide priorities and will be an over-arching document which will feed in to all other plans.

A new One Halton Health and Wellbeing Strategy from autumn 2022 – 2027 has been developed and approved for improving health and reducing health inequalities.

A number of stages to the development of the Strategy have taken place, involving various stakeholders, based around a shared ambition to:

"To improve the health and wellbeing of the population of Halton by empowering and supporting local people from the start to the end of their lives by preventing ill health, promoting self-care and independence, arranging local, community based support and ensuring high quality services for those who need them".

With partners being fully involved with the development of the Health and Wellbeing Strategy, as described in our previous plan, the BCF plan for 2023 - 25 runs parallel to this and all members of the Health and Wellbeing Board (HWBB) will approve the plan and the ambitions for the metrics, which for this current year, the targets are aligned to the NHS Cheshire and Merseyside: Halton ICB agreed planning assumptions. The main trusts that we work alongside and that are members of the HWBB are:

- Bridgewater Community Healthcare NHS Foundation Trust
- Merseycare NHS Foundation Trust
- St Helens and Knowsley Teaching Hospital NHS Trust
- Warrington and Halton Teaching Hospitals NHS Foundation Trust

In addition to the above Trusts, Halton Borough Council and NHS Cheshire and Merseyside ICB – Halton place also involves the following organisations within Halton:

- Cheshire Constabulary
- Cheshire Fire and Rescue Service
- Runcorn and Widnes Primary Care Network
- Halton Children's Trust
- Halton Housing Trust
- Halton and St Helens Voluntary and Community Action
- Healthwatch Halton

How have you gone about involving these stakeholders?

A series of workshops have taken place to identify key areas of need from data, intelligence and local knowledge, and identified a set of potential interventions. Along with engagement with frontline staff, operational and strategic leads to support the key elements requiring transformational change and development to inform the development of the One Halton Strategy. Development of an engagement plan for public/patient groups aligned with Digital strategy. Consultation completed with small numbers responding.

Work continues as part of two hospital system footprints to reduce key performance metrics, as detailed in the BCF Plan, including Admission Avoidance and Lengths of Stay. Contract meetings with the respective Trusts take place on a regular basis.

Governance

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

New internal governance arrangements have been implemented with effect from 1st April 2023 in respect to the development and monitoring of the BCF Plan, associated Pooled budget and joint working arrangements, as detailed below:-

Joint Senior Leadership Team (JSLT)

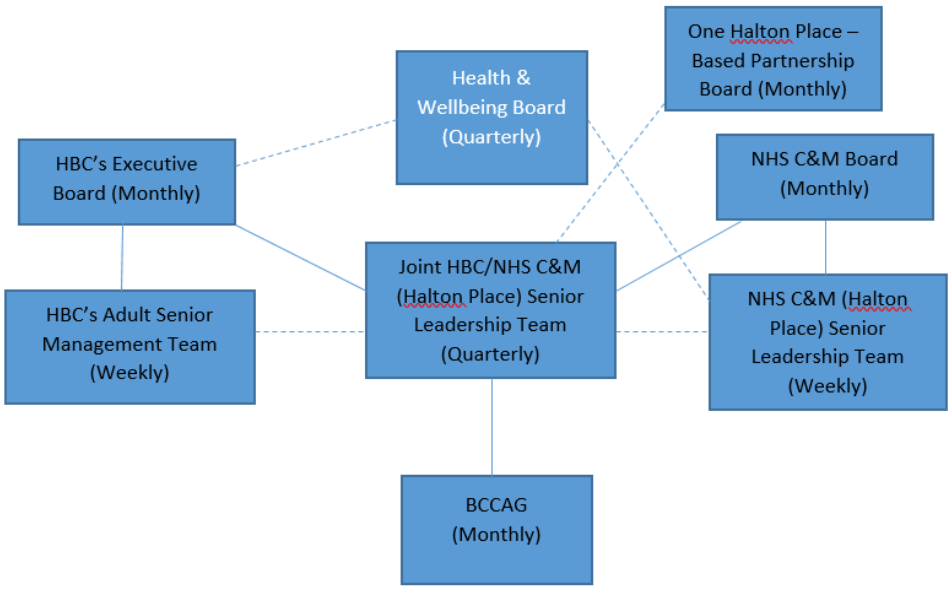
The JSLT is responsible for the direction, oversight, monitoring of the BCF Plan and associated Pooled Budget. The JSLT is supported in this duty via the Better Care Commissioning Advisory Group (BCCAG). The BCCAG reviews in detail information pertaining to BCF Plan, impact of the Pool Budget, quality, performance, activity and finances, and make recommendations to the JSLT on remedial action plans or future use of the Pool as appropriate.

Better Care Commissioning Advisory Group (BCCAG)

Key responsibilities of the BCCAG include (list not exhaustive):-

- To monitor performance of the Better Care Fund plan, including achievement of the Plan's aims and ambitions, and overall plan and service performance, quality, activity and finance measures.
- To develop and prepare the performance management framework, incorporating, BCF mandated measures alongside Place-specific outcome, performance quality, activity and financial measures, identifying and recommending remedial actions to address under performance.
- To identify, develop and make recommendations to the JSLT on the alignment of budgets, focusing on the overall aim of improving the local health and care system to deliver better outcomes for Adults in Halton.
- Based on financial and performance information available, develop and make recommendations to the JSLT, impacting on the strategic, commissioning and operational direction of Adult Services in Halton.

See governance diagram below:-



The BCF Plan is signed off by the HWBB and regular update reports are provided to the Board on progress of the BCF Plan priorities and associated schemes.

Executive summary

This should include:

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

During 2022/23, with the establishment of Place Based Systems and Boards across the country, in line with the White Paper Integrating Care: Next Steps to Building Strong and Effective Integrated Care Systems across England, published in February 2021, we continue to work together to transform services across the health and social

care system to deliver sustainable change with maximum benefits to communities, residents and patients/users of services and their families and carers. This includes joint accountability and decision-making, improved commissioning and a move to integrated service delivery.

The BCF aligns to the wider integration landscape including One Halton which is a local system partnership whereby all priority areas are shared and prioritised via a structured governance process. One Halton's vision is:

"Working together to improve the health and wellbeing of the people of Halton so they live longer, healthier and happier lives".

The Integrated approach for the BCF enables the local commissioners and providers to develop plans that support local placed-based delivery and system-wide strategic transformation. The development of the NHS Cheshire and Merseyside ICB - Halton place supports the place and programme developments and creates an opportunity to work on tactical, operational and strategic approaches.

A Section 75 Joint Working Agreement (JWA)[i] has been in place between HBC for a number of years (now formerly with the NHS Cheshire and Merseyside ICB and previously NHS Halton CCG). The current JWA sets out our Partnership Flexibilities in respect of Integrated, Joint and Lead Commissioning with principles that underpin this.

The Health and Wellbeing Strategy 2022 – 2027 encompasses four main themes of:

- Tackling the wider determinants of health;
- Support our community in Starting Well;
- Support our community in Living Well; and
- Support our community in Ageing Well.

During the pandemic we were able to focus resources and services to support people to remain at home and return home from hospital (Home First). The BCF has been aligned to this and services have been reconfigured to reflect this approach.

Priorities for the BCF in 23-25 are in line with those for 22/23. These are:

- Support Local Authorities duties within the Care Act – namely resources to support care homes and domiciliary care provision
- Maintain and expand the home first / D2A approach with additional resource to support hospital discharge and trusted assessment
- Support community health and social care community, intermediate care and equipment services
- Maintain and improve support for carers through investment.

National Condition 1: Overall BCG 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 integrated of health and social care. Briefly describe any changed 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.

Through the One Halton Board and the key sub groups executive lead officers and key officers across the place drive our approach to embedding integrated and person-centred health, social care and housing continues to improve. The shift towards strategic commissioning and a more collaborative approach to planning and improving services continues in 2023-25. This means that, instead of focusing on procurement and contract management, the role of commissioners is to work closely with key partners across the system (including with providers) to understand population needs, determine key priorities and design, plan and resource services to meet those needs, so the structures being introduced in respect to One Halton and the provider collaborative will support and enhance this way of working.

During the pandemic we were able to focus resources and services to support people to remain at home and return home from hospital (Home First). The BCF has been aligned to this and services have been reconfigured to reflect this approach.

The 2023-25 Delivery Plan sets out the key areas of opportunity for the JSLT and BCCAG to move forward with an integrated pathway approach. The areas identified are those in a shared space across health and social care, with a clear interface between health and social care.

There are two priority aims from 2022/23 which will help inform the work of the BCCAG and JSLT these aim are to support people to:-

- live an independent life; and
- regain independence following a change in circumstances.

Performance frameworks and monitoring of the BCF plan continue to be developed

National Condition 2: 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 asses-based approaches

- Implementing joined-up approached 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 visit set out in the Fuller Stocktake
- How work to support unpaid carers and deliver housing adaptations will support this objective.

Locally in Halton, the Intermediate Care review implementation has progressed, incorporating the work and learning from the pandemic and work undertaken from the frailty service. Detailed planning work has focused on both the available evidence of utilisation, incorporating current and future requirements of community services and staffing capacity and skill mix. Several departments within Bridgewater Community NHS Foundation Trust, Halton Borough Council, NHS Cheshire and Merseyside ICB – Halton place (previously NHS Halton CCG) and Warrington and Halton Teaching Hospitals NHS Foundation Trust and St Helens and Knowsley Teaching Hospitals NHS Trust have undertaken this work. Work across Cheshire and Mersey ICB on intermediate care, led through the provider collaborative, will support this work

In 2022/23 Halton maintained the level of people receiving, interventions in their own homes. This has continued to be achieved through the focused work of all staff, and maintaining capacity in long term services (notably the domiciliary care), simplified processes for hospital discharge, and focused multi-disciplinary / multi-agency work to improve pathways through short term services utilising nationally endorsed models (ECIST et al) concentrated on day-to-day caseload management. Both acute trust footprints plan to undertake further analytical work to improve hospital discharge and D2A processes in 2023/24.

This demonstrates that investment in the right community resources can improve outcomes for individuals, reduce reliance on short-term community bed-based services (and therefore reduce the number required), reduce the utilisation of acute hospitals (with potential to reduce admissions, readmissions and length of stay) and enable further investment in the community infrastructure. The capacity and flexibility to meet demand across services supported by the BCF and discharge funds in 2022/23 will be increased in 2023-25 particularly in relation to hospital discharge processes where the need for additional staff in the discharge process has been identified.

Another key collaboration that contributes steps to personalise care and deliver asset-based approaches and multi-disciplinary teams at place level is the Neighbourhood Teams project with the aim of defining and developing the culture, systems and pathways in which Community Multi-disciplinary teams in Halton will work and communicate in a continuous and integrated way. The main scope of the project includes a needs-based approach encompassing the whole population (adults, children, families, care homes). A strengths and asset-based approach will be adopted throughout all partner organisations operating in Halton, and we will define what place means at delivery level (i.e. different levels of place e.g. Borough, Town, neighbourhood levels).

The ICB is developing and rolling out the national virtual ward programme, with ARI virtual ward already receiving early supportive discharges on to remote monitoring and now progressing for step up access from primary care and community teams. The frailty virtual ward are due to start to test their process and open beds in July 2023 with both step down, prior to admission to an acute ward and step up pathways from the community. Learning for the level of remote monitoring that can be utilised is still being gathered from across the country.

Primary Care in Halton is now seeing more patients both face to face and with virtual appointments than pre-pandemic, and the system is looking to transform the way same day primary care is offered, in collaboration with the Urgent Treatment Centres and community teams.

Public Health is leading targeted work to tackle fuel poverty through their winter warmth and cost of living programmes as well as continuing to offer their sure start to later life services to reduce deterioration and ill health, and provide training to care homes and community teams in keeping residents active and managing falls.

National Condition 2 (cont) – rationale for estimates of demand and capacity for intermediate care to support 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 reduced demand of 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 demands?
    - How have estimates of capacity and demand (including gaps in capacity) been taken on board and reflected in the wider BCF plans.

The service capacity delivered in 2022/23 mostly met demand in terms of bed and community support services. Use of transitional care bed capacity was low and focused mainly on people with care and support needs where housing issues prevented a return home directly from hospital. Processes through hospital and to discharge have been identified as a key area to work on and will be the subject of further detailed work with external support in 2023/24. Additional resource has been allocated to support discharge planning in 2023-25.

The 2023-25 demand and capacity assumptions have utilised real time data from 2022/23 where available. This has been pathway information from one hospital and extrapolated based on population for the other; utilisation of intermediate and

transitional care in 2022/23; demand analysis across the year; flow through community services. Based on 2022/23 data, demand for Pathway 1 Hospital Discharges fluctuated throughout the year. These fluctuations did not significantly vary throughout the year. As the 2023-25 demand assumptions have been based on the 2022/23 data available, we anticipate seeing a peak in demand during July 2023 and a trough in February 2024. The development fund will enable flex of capacity throughout the year, in particular during peak times and where we see an increase in Length of Stay during the winter, due to the complexity of cases.

National Condition 2 (cont) – describe how BCF funded activity will support deliver 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 admission 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

Across the three main Mid Mersey boroughs around the catchment of St Helens and Knowsley Hospitals there is a collaborative workstream to focus on admission avoidance, with a specific aim to reduce ambulatory care sensitive condition admissions, a workshop has been held, lead by Aqua, with partners to analyse and review respiratory admissions, particularly COPD, Asthma and acute respiratory infections. The work will also go on to review admissions for cellulitis, UTIs and gastrointestinal complaints that all have similar presentations in older people that could be care for in the community.

Halton Adult Social Care support 3091 people age 18 and over per 100k population in the community and 399 per 100k population in residential and nursing care; this equates to 13 per cent of the overall population of people who receive services. During 2022/23 we had 595 people per 100k population over the age of 65 placed in residential and nursing care, which is below our target and those who received a Reablement service on discharge from hospital, were able to remain at home with support or independently in 84.7 per cent of cases in 2022/23.

The HICaFS service provides an MDT response within 2 hours and same day to assess and provide diagnostics, treatment, support and rehabilitation to maintain people in their own homes to prevent hospital admission. This supports the developing virtual ward approach to the management of frailty within the community. Additional BCF resource will be utilised in 2023-25 to strengthen this approach.

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 commission will support this and how primary, intermediate, community and social carer services are being delivered to support safe and timely discharge, including:

- Ongoing arrangements to embed a home first approached and ensure that more people are discharged to their usual placed or residence with appropriate support, in line with the Governments hospital discharge and community support guidance.
- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.
- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

The focus of the delivery plan is on ensuring sufficient resources for both hospital discharge and community response. The approach to D2A and the capacity and demand assumptions have informed the investment strategy for the BCF, iBCF and discharge grants. Domiciliary care, intermediate care and wider community services are the main features of the investment plan, with additional investment in hospital discharge processes.

During 2022/23, capacity to support hospital discharges effectively met demand, through the use of discharge funding made available at Place. This funding, in the main, was used to fund Transitional Care beds and additional hours to support Pathway 1 discharges.

When the national discharge fund was announced in the autumn 2022, partners worked collaboratively to identify numerous schemes where it was felt that they would have the most positive impact in freeing up the maximum number of hospital beds and reducing bed days lost, including from mental health inpatient settings.

Due to the time limited nature of the funding made available last year, a number of schemes didn’t come to fruition but the funding that this freed up was used instead to deliver more Intermediate Care provision, along with funding additional packages of care.

When drawing up plans for the use of the Discharge funding for 2023/24 we reviewed the outcomes from the previous schemes and the impact that this had had on capacity to deliver more hours of care/packages, speediness of discharges etc. As a result of this it was agreed between partners that the most effective use of the funding for 2023/24 would be on the provision of Intermediate Care, both within the community and bed based in being able to support discharging more people in a safe and timely manner.

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support 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 reduced demand of 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 demands?
    - How have estimates of capacity and demand (including gaps in capacity) been taken on board and reflected in the wider BCF plans.

The service capacity delivered in 2022/23 mostly met demand in terms of bed and community support services. Use of transitional care bed capacity was low and focused mainly on people with care and support needs where housing issues prevented a return home directly from hospital. Processes through hospital and to discharge have been identified as a key area to work on and will be the subject of further detailed work with external support in 2023/24. Additional resource has been allocated to support discharge planning in 2023-25.

The 2023-25 demand and capacity assumptions have utilised real time data from 22/23 where available. This has been pathway information from one hospital and extrapolated based on population for the other; utilisation of intermediate and transition care in 2022/23; demand analysis across the year; flow through community services. Based on 2022/23 data, demand for Pathway 1 Hospital Discharges fluctuated throughout the year. These fluctuations did not significantly vary throughout the year. As the 2023-25 demand assumptions have been based on the 2022/23 data available, we anticipate seeing a peak in demand during July 2023 and a trough in February 2024. The development fund will enable flex of capacity throughout the year, in particular during peak times and where we see an increase in Length of Stay during the winter, due to the complexity of cases.

National Condition 3 (cont)

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

- Discharge to usual place of residence

Additional investment in 23/24 will support additional capacity to further strengthen our home first / D2A approach. Work across the 2 hospital footprints on processes through and out of hospital to home in 23/24 will support improved pathways and processes to reduce length of stay and no right to reside numbers. The development fund will support changes of approach throughout the years as well as provide additional flexible capacity as demand patterns change.

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.

A self-assessment of implementation of the High Impact Change Model has been completed and agreed actions for improved future performance have been identified as follows:

Impact change	Action	How will you know it has been successful?
Change 1: Early discharge planning	The 100 day challenge for the high impact changes needs to be reviewed prior to winter and early discharge planning has been identified as a priority area to work on. Planned – Plans in place Emergency – Plans in place Red bag scheme – the red bag scheme is not being used (it has previously and will be reviewed) Working with partners and in line with guidance for elective care all patients discharge is planned prior to admission. For non-elective care Halton is working with the local trusts to identify patients upstream that may require ongoing care after discharge to allow the collection of information and assessment of need to begin at the earliest opportunity. The hospitals have implemented the where best next principle to consider the right care and right place approach.	The percentage of patients with no right to reside will reduce to the national target of 10% and average lengths of stay will improve overall Halton is monitoring the lead times between when a patient no longer has the right to reside, the time assessment commences and the time to discharge with the aim to optimize the discharge process to avoid unnecessary delays. There will always be complicated cases that have protracted care planning and the lessons learnt from long stay patient will help inform further developments
Change 2: Monitoring and responding to system demand and capacity	System and partnership working needs to be part of the CMAST and Out of Hospital provider alliance workplans in collaboration with the Place Based delivery programmes. Winter preparations need to make the necessary capacity available for any increased demand and be able to be flexible to ensure escalation is possible if threshold triggers are reached.	Improved system partnerships and less congestion in set points of the pathway Patient tracking through the discharge process allows ongoing undertaking of the journey for each individual. There is any single consistent bottle neck within the local systems but a

	Responsive capacity – Mature Improving how the system flows – plans in place Effective information sharing – Established Daily and weekly system pressure calls are undertaken with partners to understand the demand across the sectors and to identify gaps and opportunities. Venn modelling has previously been undertaken, and consideration for Newton demand and capacity analysis is being held with one acute provider and an internal audit process with the other main acute provider.	series of small variables that disrupt flow, but the common feature is the collection and sharing of the relevant information to allow a safe discharge. Both acute providers are striving to ensure discharge information is complete and accurate. Currently demand at the emergency departments, admissions and acuity of patients is greater than anticipated, and all partners have responded to this prolonged surge through escalation and collaborative solutions.
Change 3: Multi-disciplinary working	Improvements have been made and capacity has been increased but there are still challenges and barriers to effective communication between the teams. Halton has a discharge steering group in place to review the current processes and make improvements. Without system interoperability there will be a limitation on the full extent to shared records. MDT working – Established Discharge planning and assessment – Plans in place Daily discharge tracking meetings are undertaken between health and social care. VCSE aren't part of the assessment of need but are part of the operational discharge. Social workers are present on the ward to undertake assessments of need and carry out best interest meetings with patient, families, advocates, ward staff and wider teams as required. Patients with differing ongoing needs have different requirements for their assessment and planning with simple cases being able to be carried out with purely with the patient, while complex patients requiring multi agency planning meetings.	Reduction in the time to gather all the information required to discharge a patient, and improved timeliness of social worker involvement in the discharge planning, which will reduce the time taken to arrange a care package and clear the hospital beds. Ongoing improvements in MDT working has reduced the frequency of differing opinions of need and the over prescribing of ongoing care. The management of patients expectations is a joint role between health and social care to provide the patient centered care meeting their best interests.
Change 4: Home first	All boroughs across Mid Mersey have different processes and are at different positions to be able to move to a home first and discharge to assess model. There needs to be agreement on a joint framework to move to a discharge to assess model. Discharge to assess – not yet established Reablement and pathways – Mature Embedding and home first mentality – Mature The principles of home first and Reablement	Increased decisions about patient needs and care plans being made in their own home with their families. Reduced levels of patients remaining in hospital who no longer have the right to reside. The aim is to continue to increase the number of patients discharged to their normal place of residence, with reduction in any readmissions.

	first are fully embedded within the borough, including when patients require community rehabilitation or transition their ultimate aim is to return to their usual place of residence. True discharge to assess is not in place for all patients as it is often clear that their, and their families, needs can not be met in their own home. If a patient is placed in 24 hour care their continue to be assessed for the next 4 weeks to determine if there is a improvement and they care return to their home. In Halton there is a single point of access to intermediate care through the Halton Intermediate Care and Frailty Service	
Change 5: Flexible working patterns	Continue the existing arrangements for seven day working and support the hospitals to increase the pathway 0 discharges over the weekends. Assessment and decision making – not yet established Discharge services – Plans in place Care Packages – Established Hospital decision making for discharges is still heavily focused on 5 day working, with a smaller element of pathway 0 discharges at the weekend for patients that don't require higher levels of services. There are limited capacity for TTO preparation and equipment Weekend PTS is in place and will be increase in the next year. Many services for patients that require ongoing care will accept patients at the weekend, while the planning will have been undertaken during the week, and a few care home will admit at the weekend but generally during the weekdays.	Improved continuous processes would reduce the variations between the peaks and troughs over the week. The focus is on improving the pathway 0 discharges at the weekend that don't require high input from multiple partners. Improved processes are aimed to reduce the variation and cycles that are seen during the week to move to a consistent decision making and discharge across the weekdays.
Change 6: Trusted Assessment	Independent care sector assessment – not yet established Within hospital – established Adult social care – N/A Local care home do require to undertake their own assessment of patients before acceptance and admission. Therapy and clinical assessment undertaken in the hospital are utilized for their patients ongoing needs without further reassessment by community providers. Access to intermediate services it carried out be the patients social worker assessment and process through the single point of access. There is sufficient capacity within the social worker teams to undertake a timely assessment	Improvements in the quality, accuracy and timeliness of discharge information will improve the assessment processes allowing a lighter touch approach and a reduction in delays for clarifications.

	and third parties are not required.	
Change 7: Engagement and choice	Information and support decide care – established Choice protocol – Mature VCSE provision - ??? On admission patients are provided with information about the process that will be undertake to plan their discharge, with recognition of the importance of a timely discharge for the flow in the acute sector and to their recovery. Choice protocols are in place within each acute provider with joint decision between health and social care on how they are escalated when required. Patients that require advocacy to act on their behalf when they lack capacity and IMCA is provided.	Home first principles are in place and all partners work to the best interest and wishes of the patients. If patients do not have capacity, their families and person with LPA are fully engaged with the best interest decisions. The aim is to support patients who chose to return to their own home to do so with the necessary support required.
Change 8: Improved discharge to care homes	The Enhancing Care in Care Homes plans should be in place by the end of the current financial year. Discharge support – Established Enhanced primary care – Exemplary Access to out-of-hours/urgent care – Established The Halton Care Home steering group and liaison provide a supportive roll in working with care home to improve the acute discharges, admissions, capacity, occupancy and care for residents. All care homes have an aligned GP practice that providers medial support to the home with ward round and MDTs. The HICAFs service includes the community rapid response service to provide a 2 hour response to patients that require assessment and care. There is limited provision out-of-hours but there is a consistent offer to residents in a care home as to residents in their own home.	Reduction in patients being conveyed to hospital to receive care. Improved experience of residents in care homes. Further development of the EHCH, UCR and virtual ward programs will aim to support care homes to maintain patients in their beds without the need for conveyance to an acute setting. If a patient is admitted to hospital, there is also an aim to return their to their home through early supportive discharge to reduce the risks of acute decompensation and cross infection.
Change 9: Housing and related services	Continue to monitor the situation and review if there are issues identified. Systematic response and demand/capacity – established. Early needs assessment and response – established Integration/joint working – established Home adaptations, equipment, telecare and health – mature	Reduction in delays to discharge due to waiting for home adaptations to be undertaken.

	The housing status of patients is recording at the point of admission. Assessment of the patients ability to cope within their home is undertaken Environmental and home visits are undertaken when required Patients requiring equipment, adaptations, downstairs living, telecare etc. is part of the assessment and discharge planning process	

National Condition 3 (cont)

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

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid cares 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.

Our whole system approach is delivering to improve outcomes supporting unpaid carers. Our Carers Strategy group (a multi-agency partnership) provide strategic oversight of our approach and has membership from health and social care sectors, including representation from both adults and children's services, alongside third sector representation.

In delivering against our Care Act duties there is a jointly commissioned service with our Halton Carers Centre, with service specification and performance monitoring jointly reviewed between NHS and Social Care commissioners.

Halton Carers Centre are the primary point of contact for all carers', including young carers and young adult carers, to access a wide range of universal and targeted services that will support them to improve their quality of life throughout all stages of their caring role. This is delivered via services to meet these objectives including:

- Identification of carers
- Provision of information, advice and guidance
- Signposting carers to appropriate advice and support
- Advocating on behalf of carers
- Providing short term intensive support to carers where there is significant risk of carer breakdown
- Expanding and diversifying provision of activities and peer support for carers
- Supporting carers to take part in education, training or work opportunities

We are supporting unpaid carers through BCF funding allocated to Halton Carers Centre to deliver a Carers' Personalised Break Fund to enable carers to have a break from their caring role. This provides support to a range of carers that works towards

the prevention, reduction and delay of the need for care and support for individuals and to improve people's wellbeing.

Further funding is allocated to support provision of a home-based respite care service, which provides breaks for carers and to assist people to live in their own homes to remain independent for as long as possible. This service provides home care normally provided by the unpaid carer and allows that carer to have respite from their role. BCF funding supports the provision home based respite care in Halton to unpaid carers. The LA also have a budget for carers' breaks, respite and direct payments.

Disabled Facilities Grant (DFG) and wider services

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

Halton's Home Assistance Policy describes how we use our powers under the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 to provide home adaptations for disabled people. The policy aims to ensure that residents with disabilities are provided with support to adapt their home so that it meets their needs and they are able to continue living safely and independently at home. The assistance offered through this policy is funded through the Disabled Facilities Grant (DFG) allocation.

The DFG is used as a means of financing a wide range of equipment and adaptations within and around the home to ease accessibility, aid independence and promote wellbeing. As a result of transformation the fund can be allocated in a variety of ways including grants, loans, equity release, subsidies or a combination of these. Halton has schemes in place such as the 50/50 funding agreements (a joint working arrangement between the council and housing associations). The Council works collaboratively with service users in a person-centred way to meet their care and support needs.

Halton have traditionally used mandatory grants for:

- External access - to get into and out of the home e.g. widening doors, ramps, rails
- Safety – e.g. improved lighting, a room made safe so a disabled person can be left for a period unattended
- Internal access – to make it easier to get into the living room
- Washing/bathing/cooking/sleeping - to provide/ improve access to the bedroom/kitchen/toilet/ washbasin/bath/shower e.g. by altering the layout, installing a stair lift, providing a downstairs WC or putting in an accessible shower
- Heating – improving/providing a heating system suitable to the disabled person's needs
- Ease of use – e.g. adapting heating or lighting controls to make them easier to use
- Facilitate caring - to enable the disabled person to care for someone else who lives in the property, such as a spouse/partner, child or other person

- Garden access – this was added in 2008 with the aim of providing access to and from a garden or to make a garden safe (in practice this may only cover a limited amount of larger gardens).

As part of the developments and transformation of the fund we now also use it to cover repairing, improving, extending, converting or adapting housing accommodation. This creates schemes that help disabled people in a more responsive and accessible way and can include:

- Providing a 'fast track' scheme for low level adaptations not requiring a full social care assessment or a means test or for those facing end of life.
- The effective utilisation of new technologies to support independence e.g. telehealth care.
- Provision of relocation grants to help people to move to a more accessible home.
- Dealing with small repairs and heating problems, allowing people to live well in their home for longer and/or helping people to return to their home faster (e.g. hospital discharge)
- Issue of aids and equipment which allow people to maintain their independence for longer – including mobility aids and personal care equipment.

The scope for use of the DFG is aligned to schemes and facilities which support prevention of more complex intervention, promotion of independence and delay transfers into care.

This grant and associated capital expenditure are also being used to improve the range of specialist accommodation available in the borough, notably in respect of Adults with LD/Autism, and also care home provision for older people.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2022 (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?

£518,890

Equality and health inequalities

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

- Changes from previous BCF plan
- How equality impacts on 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, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5,

The One Halton Health and Wellbeing Strategy 2022 – 2027 sets out how, as a system, we are aiming to work together to develop pro-active prevention, health promotion and identifying people at risk early, when physical and/or mental health issues become evident, will be at the core of all our developments, with the outcome of a measurable improvement in our population's general health and wellbeing. The BCF is considered as part of the wider borough work on health inequalities, and will contribute to the following actions to reduce inequalities in Halton:

- Supporting a community development asset-based approach and community-led initiatives that build capacity for local people to become more informed and involved in decision about their health.

- Improving access to services for people and groups most at risk of poor health.

- Developing the health and social care workforce to ensure they have the knowledge, skills and understanding about how to identify and respond to need and inequalities, signposting and referring appropriately.

- Delivery of Core20PLUS5 NHS initiative supported by partners and the community.

- The Core20PLUS5 NHS approach is designed to support Integrated Care Systems to drive targeted action in health inequalities, and to address health inequalities for the population in the 20% most deprived areas, according to IMD, along with specific population groups experiencing poorer than average health access, experience and/or outcomes. For the BCF, this will focus specifically on Older People, and resulting actions will redefine services to reduce differences.

The Local Authority and the NHS Cheshire and Merseyside ICB - Halton place are also working together to develop services centred around care homes, including medication and dementia screening and strengthening clinical nursing support for residents and staff alike.

Choice, partnership and control will continue to be developed based on integrated approaches to needs assessment. Bringing care out of acute settings and closer to home will be an essential part of providing health and social care over the next five years. We also use a Choice Protocol in both Trusts to proactively challenge people.