Better Care Fund Narrative Plan
2023-2025
Buckinghamshire Health & Wellbeing Board

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils). How have you gone about involving these stakeholders?

Buckinghamshire has a joint (NHS Integrated Care Board and Council) Integrated Commissioning Executive Team (ICET). ICET is made up of Health, Social Care and Housing senior leaders. ICET also has representation from clinical leads in Mental Health and LD, CYP, Integration and Primary Care as well as representation from Public Health, Business Intelligence, and the lead commissioner for the Disabled Facilities Grant.
ICET holds the delegated responsibility for overseeing the BCF plan and through monthly meetings, leads the BCF development and planning. In addition to this, the BCF planning is taken to establish integrated boards and meetings as both executive level and at operational levels to get input from a wider group of stakeholders including the Trusts.
In addition to this, Buckinghamshire uses the established mechanisms to gather input. Some examples include:

- Within hospital discharge, commissioners, Home First representatives and hospital discharge representatives meet with Home First home care providers (monthly) and care home providers (weekly). The feedback and discussions contribute to the BCF planning.
- The Carers Board has representatives from all key stakeholders including health and social care leaders, carers and the VCS. This reports into the Buckinghamshire Council Transformation Board which contributes to BCF planning.

Information collected through routine contract and quality monitoring of BCF scheme providers and feedback from service users is shared via ICET and informs the BCF planning process.

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

Buckinghamshire has joint governance arrangements in place for the BCF. The Health and Wellbeing Board (HWB) hold overall responsibility for the BCF plan but has delegated the responsibility for the development and oversight of the plan and expenditure to the Integrated Commissioning Executive Team (ICET).

ICET is made up of Health and Social Care senior leaders and is co-chaired by the ICB Executive Place Director and the Council's Service Director for Integrated Commissioning. Membership includes the ICB Finance Place Lead and the Council's Head of Finance, representation from the Council's Social Care Housing lead, clinical leads in Mental Health and Learning Disabilities, Children Young People, Integration and Primary Care as well as Public Health, Business Intelligence, and the lead commissioner for the Disabled Facilities Grant.

ICET has representation from all areas of Joint Commissioning. The joint commissioners routinely engage with care providers and the Voluntary and Care Sector organisations through a variety of mechanisms including routine visits and monitoring, the care association network meetings, care providers registered managers network, home care provider forums, hospital discharge provider forums and there is a dedicated integrated commissioning email address for provider queries and feedback. Information collated via these routes is brought to ICET via the commissioners reporting and this enables care providers and the VCS to influence the plan.

The BCF Plan is endorsed by the ICB Accountable Officer who has delegated authority from the ICB and by the Local Authority Corporate Director and DASS and the Cabinet Member for Health and Wellbeing prior to going to the HWB for final agreement.
Following approval and submission of the BCF 2023-25 Plan, the BCF Section 75 agreement will be updated.

Executive summary
This should include:

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

The Priorities for 23-25 are:

1. Hospital discharge
2. Admission avoidance
3. Inequalities

The key changes are increased investment in the Health and Care Integrated Programme which is a joint Council, ICB and NHS Trust programme. The programme has an initial focus on hospital discharge but will also incorporate admission avoidance during 23-25. The additional BCF funding and discharge fund for 23-25, alongside the existing funded schemes, will enable Buckinghamshire to implement new models of working for hospital discharge and admission avoidance. The first phase of the programme in 23-24 will focus on hospital discharge and admission avoidance will be the second phase.

The previously funded schemes continue to be funded but some will be reviewed during the 23-25 period as contracts end or as outcomes and impact are reviewed.

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.

The BCF priorities broadly align to those of the Buckinghamshire Executive Partnership which draws upon the Health and Wellbeing strategy to shape its priorities. For 23-25 the BCF priorities are:

1. Hospital discharge
2. Admission avoidance
3. Inequalities

Buckinghamshire has an Integrated Commissioning model. There are Integrated Commissioning Teams which are hosted by the council, but health and social care funded to jointly commission services. There are s75 agreements to formalise the integrated commissioning arrangements including for Integrated Therapies, s117, Integrated Community Equipment, Continuing Health Care, Hospital Discharge and BCF. Through ICET, there is shared oversight of commissioning plans to steer and monitor joint priorities.

There are integrated approaches to broader commissioning functions such as the management of care sector quality with a formal integrated Quality Surveillance Group and an integrated Care Home Outbreak Risk Group. There are integrated workstreams for key areas including the integrated hospital discharge programme, Mental Health, Learning Disability and Autism.

An integrated approach is now embedded at every level of the system. From the Buckinghamshire Executive Partnership, which is the place-based partnership of the Chief Executive Officers and their senior colleagues within the Council, the NHS Trust and the ICB through to daily integrated operational meetings. There are an increasing number of joint funded integrated posts, many of which are funded via the BCF, and any new initiatives and workstreams are used as an opportunity to further embed integration.

For 23-25, there is significant additional investment into the Health and Care Integrated Programme which has a number of joint funded workstreams and schemes and joint funded integrated programme team and joint funded schemes which will drive forward the new models of working for hospital discharge and admission avoidance. The programme will deliver a range of initiatives within a new model, including Trusted Assessors, an Integrated Discharge Team, A transfer of care hub, a community hospital intermediate bedded care hub, a care home hub bed model for complex cases and a short-term care home interim bedded care hub. Together, this will ensure people get out of hospital as soon as they are medically ready and will, wherever possible, return home. Anybody requiring ongoing care will be able to access the right care, in the right place, at the right time.

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.
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.

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

Adult Social Care is supported with BCF funding to deliver the Buckinghamshire Council Better Lives Programme which is a strengths-based model of care. The programme seeks to enable more people to live longer, independent lives in their communities and ensure more high cost, high dependency care in residential and nursing homes is only used when absolutely needed.
The programme has delivered a shared model of prevention, agreed by partners across Buckinghamshire. The Better Lives Programme aims to keep people healthy and in their own homes and communities for longer.
BCF funded schemes which support this include:

- Advocacy – ensuring the voice of the individual is heard and the rights of individuals are protected.

- Integrated Carers Service – provides support to carers and helps to identify carers
- Supported Living – provision of housing which enables people to live at independently whilst within a supported environment and helps them to sustain their tenancies
- Direct Payments – supporting service users to make choices over the care and support they receive
- 'Home from Hospital' service which also includes a community service which provides low level support to enable people to remain at home and prevent admission to hospital.

The BCF also funds a Memory Support Service which supports early diagnosis and delivers intervention for people with mild to moderate dementia. It provides individuals with a person-centred service, which empowers people with dementia or memory concerns and their carers to make informed decisions about care and which helps maximise quality of life. The service aims to reduce the risk of crises later in the illness and enable the person to be cared for at home for as long as possible while this is the preferred place of care.

In Buckinghamshire, the BCF is used to fund integrated community health services. This is being used to support Primary Care Networks (PCNs) as part of a culture of shared ownership for improving the health and wellbeing of the population. In 23-25, these integrated neighbourhood teams, through collaboration and joint working will seek to streamline access to care and advice and provide more proactive, personalised care with support from a multidisciplinary team of professionals ensuring healthy communities are created and the incidence of ill health is reduced.

The Rapid Response and Intermediate Care (RRIC) service is also funded via the BCF contribution to the Buckinghamshire Health Trust Community Services contract. RRIC provides Urgent Community Response (2 hour and 2 day response, rehabilitation and intermediate care, improving function, clinical outcomes, maximising independence and preventing deterioration to remain at home, community physiotherapy, hospital discharge support through community physiotherapy or intermediate care on discharge.

The BCF is also used to fund the Home Independence Team via social care which provides a hospital discharge and community reablement service which also supports individual to return home or to remain independent in the community for longer.

If step-up care is required, the current model is admission to a community hospital if there is an identified health need and admission to a spot purchased care home bed if there is a social care need. Although capacity is currently meeting demand, the additional BCF funding and discharge funding is contributing to the Health and Care Integration Programme which is a joint Council, ICB and NHS Trust programme. The programme has an initial focus on hospital discharge but will also incorporate admission avoidance during 23-25 as the second phase of the programme. The additional BCF funding and discharge fund for 23-25, alongside the existing funded schemes, will enable Buckinghamshire to implement new models of working for admission avoidance which aim to make a more efficient use of resources and improve the individual's journey.

The BCF is used to fund Immedicare to support care homes. Immedicare is a clinical healthcare provider that operates on a 24/7/365 basis and enables clinicians and others involved in healthcare provision to respond and assist patients remotely in real-time, via the use of video-based technologies. Our data is showing us that in 22-23, if Immedicare was not in place, more than 70% of calls would have resulted in a GP call and 6% of callers would have called for an ambulance. There is evidence that immedicare is helping to keep people in the community for longer and prevent admission to hospital.

The BCF is used to fund a falls prevention service which aims to prevent repeat falls through education and therapy input, enabling people to remain independent and living in the community for longer. It also supports preventable hospital admissions. There was a reduction in falls related admissions to hospital in 2022-23 compared to the previous year.

The number of people entering long term care in residential and nursing homes has increased and exceeded our estimate for 2022-23. Although the data does not explain why, we know that approximately two thirds of the new admissions came through hospital discharges. The new models for hospital discharge are aiming to reduce any possibility the system has contributed to this figure. This will be done through robust mechanisms to ensure bed-based care is used when it is the only suitable option to safely meet an individual's need but also to reduce length of stay in bed-based care to prevent any deterioration that might lead to the need for a permanent admission to a care home.

In 2021/22 Buckinghamshire Council established a specialist accommodation steering group to maximise the benefit of becoming a unitary authority by co-ordinating activity across Adult Social Care, Children's Social Care, Housing, Planning and Property. As part of the 2022/23 action plan this group worked together to support the completion of an Adult Social Care Market Analysis to estimate the demand for accommodation-based care over the next 20 years. This analysis is being used to inform the local plan and to explore opportunities to work with planning and property within the Council to bring new developments to market. The market analysis has identified that Buckinghamshire needs to particularly focus on increasing capacity in nursing care beds, supported living and extra care (including private as well as Council funded). The work is also promoting the need for general housing to support people with care needs. To support this work the group has also developed design principles for supported living accommodation (which are also adaptable for other settings) to help develop design briefs for specific cohorts of clients. This will assist the Council in working with developers. Children's accommodation priorities are also being explored within the specialist accommodation steering group, which will also support activity around transition to adult services.

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.
- 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.

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.

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

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.

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?

During 22-23 Buckinghamshire set up 'The Health and Care Integration Programme' which is a joint Council, ICB and NHS Trust programme. The programme has an initial focus on hospital discharge but will also incorporate admission avoidance during 23-25. The additional BCF funding and discharge fund for 23-25, alongside the existing funded schemes, will enable Buckinghamshire to implement new models of working for hospital discharge and admission avoidance. The first phase of the programme in 23-24 will focus on hospital discharge and admission avoidance will be the second phase. Management of the programme has dedicated

integrated posts funded through the BCF and is jointly funded but the BCF will also contribute to schemes that align to the domains in the High Impact Change Model. Buckinghamshire was previously assessed as established or planning in most areas. The new models and schemes for 23-25 aims to move all areas to mature or exemplary.

Change 1: Early discharge planning – the new model will have an integrated discharge team which will include hospital based social workers. There will be early discussions about discharge with both patients and family members within 48 hours of admission. There are carers support workers based within the hospital which are BCF funded. An early screening process to identify any potential complexities or circumstances which might present a barrier or delay to discharge will be implemented so issues can be addressed prior to individuals being ready for discharge.
Change 2: Monitoring and responding to system demand and capacity – the demand and capacity planning in previous years, alongside the additional discharge funding has enabled the trial and evaluation of different approaches including the flexing of the workforce. Based on the learning, the 23-25 plan includes a planned increase in the number of beds over the winter period through the temporary opening of a bed based intermediate care facility on the hospital site for the winter surge from October to March, as required. The change of the operational model to include the co-located multi-agency integrated discharge team and a new transfer of care hub will enable live monitoring of capacity across the system so that available capacity can be used effectively.
Change 3: Multi-disciplinary working – the creation of an integrated discharge team with hospital staff and social workers becoming one team and working together with patients on the ward to plan their discharge from the point of admission. Discharge plans will be simplified, based on the strengths of the patient, and developed with residents and their families. Better planning of discharge will reduce the likelihood of readmission, enabling people to remain at home. The integrated discharge team will work alongside a new co-located multi-agency transfer of care hub which will co-ordinate the patient's journey through the system with hospital, social work, therapy, and commissioning staff co-located and working together in an integrated team to achieve this. The ToCH will also track and manage capacity within the discharge pathways and will include input from housing and the VCS as well as the statutory partners.
Change 4: Home first – the Home First model of assessing people at home has been successful in Buckinghamshire and this will continue for 23-25. However, the bed based D2A model had long lengths of stay and was not achieving the ambition to get people home in a timely way, which was resulting in many temporary beds becoming permanent. The bed-based model is changing in 23-25. There will be the re-introduction of more hospital based assessments to enable more people to go straight home from hospital. There will also be the introduction of a new bedded hub model which will each have multi-disciplinary teams attached to them ad include:

- A 22 bedded intermediate care hub within Buckinghamshire Community Hospitals. These beds will complement the intensive rehabilitation beds (35) that are currently provided in Buckinghamshire's Community Hospitals.
- A complex case bedded care home bed hub providing 20 beds for people who need a longer period in a bed to support complex health needs such a being non-weight bearing or with delirium

- Two short term interim care home bed hubs providing a total of 20 beds which can be used to flexibly support discharge from acute hospitals. This will include people who will be assessed in line with a D2A but can be flexible to be used for people who could be delayed in hospital for other reasons.

Change 5: Flexible working patterns – the new multi-agency transfer of care hub will operate across seven days and for extended hours not the evening. The care home hub beds will have seven-day assessment and admissions within their contracts.

Change 6: Trusted assessment – the discharge fund enabled the development of a Trusted Assessor model. In 23-24, two new full time trusted assessors have been appointed and will work within the hospitals to undertake assessments on behalf of care providers. This will be piloted and expanded if successful.

Change 7: Engagement and choice – the establishment of a multi-agency integrated discharge team within the hospitals will enable earlier conversations with individual and their families. The BCF also funds a brokerage offer within the hospitals to support self-funders and funds carers support to be present within the hospitals. Communication and associated information materials are being reviewed as part of the programme of work for 23-25.
Change 8: Improved discharge to care homes – as part of the new care home hub model, care homes will have in-reach MDTs to support the hospital discharge beds which includes dedicated GP support.
Change 9: Housing and related services – Council housing representatives have been involved in the development of the transfer of care hub model. Housing will form part of the ToCH support to ensure timely discharge from hospital. The integrated discharge team will also identify any housing issues, including the need for small adaptions or equipment, prior to the person being medically optimised for discharge. The ToCH will facilitate any equipment, technology or housing adaptions required for discharge.

The model has been driven from previous learning. Up until the end of 22-23, Buckinghamshire had a Discharge to Assess model. We know that elements such as the Home First model have been successful in getting people home. Home First was improved through 22-23 and people are now discharged to this pathway very quickly and consistently assessed within 28 days.

However, the D2A bedded model was not as successful. This was due to there being a large number of beds distributed across a high number of care homes over a wide geographical area. The therapy and social care resource could not be used efficiently due to this, and it contributed to long lengths of stay in these beds. In addition to this, the beds had a very wide eligibility criteria which meant that some people who needed a further non-acute period in bedded care for health reasons would go into the D2A beds but were not able to be fully assessed within a 4-6 week period. The combination of these factors resulted in the average length of stay in the service being over 100 days. This may have resulted in deconditioning which could be one of the factors in the number of new permanent admissions to care homes increasing beyond our estimate.

During 22-23, the number of general D2A beds has been reduced with a focus on improving length of stay and ensuring only people requiring bedded care will go to a care home. The reduction in the number of D2A beds has also increased the market capacity for longer-term placements.

Barriers to assessing patients in hospital are being removed, and the system has started delivering more assessments in this setting. The discharge fund has supported the social work resource to enable this. This will mean that where a patient requires a relatively simple assessment, this can be done quickly in hospital, meaning they can be discharged directly to their long-term care arrangement, minimising the potentially disruptive effect of multiple moves for people.

Buckinghamshire residents may be treated and discharged from many hospitals including Stoke Mandeville, Wexham Park or Milton Keynes Hospitals. There is now stronger partnership working with neighbouring systems. The Frimley system (which treats the largest proportion of Buckinghamshire residents after Stoke Mandeville Hospital), have representatives on the key groups that govern the County's integration programme (including the Buckinghamshire Executive Board), and are key participants in the design of our future model for discharge and intermediate care.

Housing partners are involved in the integrated programme and are involved in the new discharge models. During the winter of 22-23, six new short-term housing units were available to facilitate discharges where residents were waiting for longer term housing. The units acted as a 'bridge' between hospital care and returning home for Buckinghamshire residents who were waiting to be housed. The learning from the initiative will inform the future model.

The BCF also funds a VCS provider to deliver a 'Home from Hospital' service which provides transport and low-level support to settle individuals in at home on discharge from hospital on Pathway 0.

The HICM will be used as regularly one of the evaluation tools during 23-25 to assess the impact of the new model and ways of working.

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.

Buckinghamshire commissions a VCS organisation, Carers Bucks, to provide an All Age Integrated Carers Support Service and the adult element of this service is fully funded by the BCF. In line with Care Act duties, Adult Social Care have a tiered system to identify support needs for carers

with a focus on improving wellbeing, as well as supporting the Carer in their role. The conversations range from signposting or providing information and advice through to a full assessment leading to an agreed outcome-based care plan.

The Care Act 2014 sets out that Local Authorities must protect carers. The Act identifies a range of wellbeing principles and recognises that a carer's wellbeing is to be protected equally to the person/s that they care for. The Carers Bucks contract enables the council to meet their duty to:

- Provide carers with support to meet their needs, according to national eligibility criteria
- Provide information and advice, to promote wellbeing and to prevent the carer developing their own care needs because of being a carer.

Carers Bucks have worked with the Council and partner organisations to develop innovative and creative solutions to meet carers needs. Over the course of the contract the number of carers known to the service has increased significantly. At present, 28.4% of the 41,773 unpaid carers (identified in the 2021 census) in Buckinghamshire are registered with Carers Bucks. This is significantly higher than neighbouring authorities but there is a plan to build upon this. Over 70% of carers registered with Carers Bucks are caring for more than 50 hours per week in contrast to 25% of carers overall in Buckinghamshire. This would indicate that Carers Bucks is effective at reaching carers providing high numbers of hours of care. Carers Bucks offer a range of support to carers at different levels ranging from advice and information through to an intensive crisis support service. They also support carers via primary health environments by developing their investors in GP award, working with surgeries across the County. The award requires that all staff within GP primary care settings are trained in recognising the needs of carers and that flexibility is offered where possible to promote carer wellbeing. Carers Bucks also have support staff located in the acute hospitals to support carers, with a particular focus on hospital discharge.

Buckinghamshire has a Carers Transformation programme (2022 – 2024). During 22-23, an integrated Carers Board was established which has senior leadership representation from Adult Social Care, Cabinet Members, ICB, Buckinghamshire Healthcare Trust, the voluntary and community sector (VCS) and Carers. The Board will use a co-production approach to oversee the carers transformation workstream to deliver improved outcomes for carers in Buckinghamshire. During23-25, the joint Carers Strategy will be refreshed, and the Carers Support service will be recommissioned.

Buckinghamshire Council has well established Direct Payment options and carers breaks are funded through Direct Payments. In addition to this, work is being undertaken in 23-24 to review the planned overnight respite offer within Buckinghamshire which forms part of the Community Opportunities transformation workstream.

Disabled Facilities Grant (DFG) and wider services

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

In 2021/22 Buckinghamshire Council established a specialist accommodation steering group to maximise the benefit of becoming a unitary authority by co-ordinating activity across Adult Social Care, Children's Social Care, Housing, Planning and Property. The aim of this group and work is to maximise the potential to develop accommodation solutions that will meet the future needs of people with adult social care needs, aligning the strategic objectives of both housing and adult social care. Included in this is accommodation that can support delivery models that focus on maintaining independence and maintaining wellbeing. As part of the 2022/23 action plan this group worked together to support the completion of an Adult Social Care Market Analysis to estimate the demand for accommodation-based care over the next 20 years. This analysis is being used to provide evidence to incorporate adult social care accommodation needs into the Local Plan and will inform future commissioning activity. The workstream is also promoting the need for general housing to support people with care needs and work has been undertaken to develop design principles for different types of adult social care need to support independence at home.

Through collaboration between Council departments (Adult Social Care, Children's Social Care, Housing and Planning), and in consultation with recipients of DFG, the Council intends to enhance the delivery of DFG to better meet the needs of its residents whilst aligning with the various strategies in place (and in development). This will include ensuring adults are supported to remain independent in their own homes for longer, ensuring children are given the best start in life and ensuring that people are living in homes that support them to have positive health and social care outcomes.

In Buckinghamshire, access to DFG is administered by a single, dedicated Grants and Adaptations Team within Housing while the assessment of need is undertaken by Occupational Therapists within Adult Social Care. The funding is now retained by the single unitary council and a policy review began in 2022 and is currently going though governance processes for adoption.

To enhance the delivery of DFG the council is working across all departments and in consultation with recipients of DFG, to better meet the needs of its residents. This will include ensuring residents are supported to remain independent in their own homes for longer, ensuring children are given the best start in life and ensuring that people are living in homes that support them to have positive health and social care outcomes.

Opportunities for 23-25 include:

- Reducing 'handoffs' between social care and housing to improve client experience and speed up delivery by creation of a single grants and adaptions team.
- Aligning operational practices to abolish the nuances between the former district councils' approaches, where possible, in some cases, this is outside of the Council's control e.g., different housing organisations have different approaches to adaptations
- Reviewing the referral criterion to determine how we can make improvements to access
- Reviewing and extending the support available to applicants in making a DFG application
- Reviewing procurement processes for DFG works, to streamline application timelines

- Bringing DFG closer to the Integrated Community Equipment service to allow greater access
- Closer working with registered provider landlords and the housing options team to enable mutual exchanges/swaps to take place where suitable properties for adaptations can be identified
- Evolving discretionary use of the grant to further support hospital discharge and preventative measures

As well as capital funding to support permanent adaptations to homes, the DFG is also currently used for some minor discretionary approaches that serve a preventative purpose. These are outlined below:

Healthy Homes on Prescription – Seeks to prevent hospital admissions and assist with managing timely discharge from hospital by funding essential works to address health and safety hazards in homes. This could range from installing and repairing heating and other minor repairs, to installing electrical points for medical equipment and widening doorways to accommodate wheelchairs.

Better Housing, Better Health – seeks to prevent or reduce cold related illness by providing grants for heating and insulation measures for those residents with a health condition impacted by the cold.

DFG currently runs in parallel to the Integrated Community Equipment Service (ICES). The ICES service within Buckinghamshire is delivered by NRS through a joint funding arrangement between health and social care and encompasses several service elements including provision of simple and complex aids to daily living, minor adaptations, technology enabled care, continence products, long term wheelchair provision, sensory equipment, and domestic lift maintenance. The service plays a key role in supporting discharge of people into their own homes, preventing avoidable admissions to hospital and maximising service user independence.

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

Yes, 8% of the budget is for discretionary services. Buckinghamshire is a Unitary Authority.

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.

Local Authorities and NHS organisations have a duty to consider the impact of decisions on people with protected characteristics. In Buckinghamshire any new services or any changes to services, including commissioned and directly delivered services, must have an Equalities Impact Assessment carried out and this includes the BCF schemes. For 23-25, there is a plan to take this further and review schemes funded via the BCF to not just ensure that they are not having a negative impact on equalities but to identify what positive impact they are having on addressing inequality. This work has started with a multi-agency workshop, facilitated by the BCF leads, in April 2023 to review the impact individual schemes are having on addressing inequalities. There will be further discovery work and then ICET will review and determine any improvements that can be made.

Buckinghamshire JSNA has identified that the number of people being admitted to hospital due to a fall, is more prevalent in deprived areas, with a particular focus on the south of the county, as it has a higher figure than the overall average in England. The BCF funds a Falls Prevention service in Buckinghamshire via the NHS community contract and primarily works with older adults. However, the service focuses on people who have already had a fall in order to prevent further falls. The falls prevention service is being reviewed during 23-25 to ascertain if it is the most effective way to get outcomes for older people.

Cardiovascular disease and smoking are current HWB priorities. There is a focus on smoking cessation as this is the number one cause of health inequalities in Buckinghamshire and has been identified within the CORE20PLS5 approach as having a positive impact on all five identified key clinical areas. THE BCF funds the NHS Integrated Community Services which delivers some of the workstreams addressing health inequalities. The workstream includes:

- Improving referrals and access to smoking cessation services
- Prioritising long term conditions reviews for cohorts of patients who smoke and are an ethnic minority
- Developing smoking cessation support for acute inpatients, maternity services, and mental health services
- Ensuring pathways and services are culturally appropriate
- Improving the cultural competence of the workforce

- Focusing on the most deprived practice areas including Aylesbury and High Wycombe

It is evidenced that people with SMI are more likely to die prematurely and individuals with SMI are 3 x more likely to smoke. BCF funding is used for Annual Health Checks for people with SMI to reduce the inequalities this cohort faces, in line with the CORE20PLUS5 approach. The work has increased the proportion of patients receiving all six elements of the physical health check.

The JSNA shows rates for people with dementia in Buckinghamshire are estimated at 7,000 people aged 65+ having been diagnosed. A Dementia Needs Analysis has been carried out in 22-23 and this has identified that Buckinghamshire's low dementia diagnostic rate (56.9%, or 4,061 people diagnosed out of estimated prevalence of 7,142, as per NHS Digital report from March 2022) illustrates the underdiagnosis of people living with dementia in the area, which results in people not accessing the appropriate dementia support. It has been suggested that the gap is not within the current diagnostic pathways but instead around increasing awareness, reducing stigma, and encouraging people to come forward to be diagnosed. In Buckinghamshire, the BCF funds a Memory Support Service which as well as providing diagnosis and intervention, it seeks to raise awareness and reduce stigma relating to dementia which disproportionately impacts older people.