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Monitoring Officer
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Agenda

Name of meeting	**HEALTH AND WELLBEING BOARD**
Date	**THURSDAY 20 JULY 2023**
Time	**9.30 AM**
Venue	**COUNCIL CHAMBER, COUNTY HALL, NEWPORT, ISLE OF WIGHT**

Participants
Councillor Lora Peacey-Wilcox (Chairman)
Michele Legg, IW CCG (Vice-Chairman)
Councillor Debbie Andre
Norman Arnold, IW Economic Development Board
Simon Bryant, Isle of Wight Council
Darren Cattell, IW NHS Trust
Emma Corina, IW Voluntary Sector Forum
Michaela Dyer, IW CCG
Stuart Ashley, Director of Children's Services
Laura Gaudion, Director of Adult Services and Housing
Gill Kennett, Healthwatch
Councillor Karen Lucioni
Terry Norton, Police and Crime Commissioner for Hampshire & Isle of Wight
Wendy Perera, Isle of Wight Council
Colin Rowland, Isle of Wight Council
Robert Mitchell, Police and Crime Commissioner Representative for Hampshire and Isle of Wight
Maria Bunce, Age UK Isle of Wight
June Davison, IWALC Isle of Wight Association of Local Councils

Democratic Services Officer: Sarah Philipsborn
democratic.services@iow.gov.uk

Details of this and other Council committee meetings can be viewed on the Isle of Wight Council's Committee website. This information may be available in alternative formats on request. Please note the meeting will be audio recorded and the recording will be placed on the website (except any part of the meeting from which the press and public are excluded). Young people are welcome to attend Council meetings however parents/carers should be aware that the public gallery is not a supervised area.

1. **Apologies and Changes in Membership (if any)**

   To note any changes in Membership of the committee, made in accordance with Part 4B, Paragraph 5, of the Constitution.

2. **Minutes** (Pages 5 - 10)

   To confirm as a true record the Minutes of the meeting held on 26 January 2023.

3. **Declarations of Interest**

   To invite Members to declare any interest they might have in the matters on the agenda.

4. **Public Question Time - 15 Minutes Maximum**

   Questions may be asked without notice but to guarantee a full reply at the meeting, a question must be put including the name and address of the questioner by delivery in writing or by electronic mail to Democratic Services at democratic.services@iow.gov.uk, no later than two clear working days before the start of the meeting. Therefore the deadline for written questions will be Monday 17 July 2023.

5. **Chairman's Update**

   The Chairman to give a verbal update to the Board.

6. **Joint Strategic Needs Assessment JSNA Update** (Pages 11 - 28)

   The Director of Public Health, Isle of Wight Council, to present the Joint Strategic Needs Assessment (JSNA) update.

7. **Terms of Reference of the Health and Wellbeing Board** (Pages 29 - 30)

   The committee to discuss the Terms of Reference of the Health and Wellbeing Board. The Monitoring Officer to assist in the discussion, and to advise on the process that needs to be followed regarding any proposed changes to the Board Membership and any other points arising regarding the Terms of Reference.

8. **Mental Wellbeing Plan and Suicide Prevention Action Plan 2023 - 2028** (Pages 31 - 108)

   The committee to receive an update on the Isle of Wight Mental Wellbeing Plan 2023-2028 and associated Suicide Prevention Action Plan 2023-2028.

9. **Better Care Fund** (Pages 109 - 180)

   The committee to be presented with the Better Care Fund 2023-2025 Plan for approval.

10. **Health Inequalities - Place base and its link to outcomes affecting health.** (Pages 181 - 184)

To explore the themes of place, deprivation and regeneration and their effect on health.

11. **Members' Question Time**

To guarantee a reply to a question, a question must be submitted in writing or by electronic mail to democratic.services@iow.gov.uk no later than 09:30am on Tuesday, 18 July, 2023. A question may be asked at the meeting without prior notice but in these circumstances, there is no guarantee that a full reply will be given at the meeting.

CHRISTOPHER POTTER
Monitoring Officer
Wednesday, 12 July 2023

Interests

If there is a matter on this agenda which may relate to an interest you or your partner or spouse has or one you have disclosed in your register of interests, you must declare your interest before the matter is discussed or when your interest becomes apparent. If the matter relates to an interest in your register of pecuniary interests then you must take no part in its consideration and you must leave the room for that item. Should you wish to participate as a member of the public to express your views where public speaking is allowed under the Council's normal procedures, then you will need to seek a dispensation to do so. Dispensations are considered by the Monitoring Officer following the submission of a written request. Dispensations may take up to 2 weeks to be granted.

Members are reminded that it is a requirement of the Code of Conduct that they should also keep their written Register of Interests up to date. Any changes to the interests recorded on that form should be made as soon as reasonably practicable, and within 28 days of the change. A change would be necessary if, for example, your employment changes, you move house or acquire any new property or land.

If you require more guidance on the Code of Conduct or are unsure whether you need to record an interest on the written register you should take advice from the Monitoring Officer – Christopher Potter on (01983) 821000, email christopher.potter@iow.gov.uk, or Deputy Monitoring Officer - Justin Thorne on (01983) 821000, email justin.thorne@iow.gov.uk.

Notice of recording

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If you wish to record, film or photograph the council meeting or if you believe that being filmed or recorded would pose a risk to the safety of you or others then please speak with the democratic services officer prior to that start of the meeting. Their contact details are on the agenda papers.

If the press and public are excluded for part of a meeting because confidential or exempt information is likely to be disclosed, there is no right to record that part of the meeting. All recording and filming equipment must be removed from the meeting room when the public and press are excluded.

If you require further information please see the council guide to reporting on council meetings which can be found at http://www.iwight.com/documentlibrary/view/recording-of-proceedings-guidance-note

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Minutes

Name of meeting	**HEALTH AND WELLBEING BOARD**
Date and Time	**THURSDAY 26 JANUARY 2023 COMMENCING AT 9.30 AM**
Venue	**COUNCIL CHAMBER, COUNTY HALL, NEWPORT, ISLE OF WIGHT**
Present	Cllrs L Peacey-Wilcox (Chairman), D Andre, Brothers, S Bryant, D Cattell, E Corina, L Gaudion, G Kennett, K Lucioni and W Perera
Also Present	Jamie Brenchley, Ros Hartley, Johanna Jefferies and Sarah Philipsborn
Also Present (Virtual)	Michele Legg
Apologies	Cllr K Love

1. **Apologies and Changes in Membership (if any)**

Apologies from Karl Love and Shirley Smart.

Emily Brothers to substitute for Shirley Smart.

Super Intendent Rob Mitchell to replace Jim Pegler as the Board Member representing the Hampshire and Isle of Wight Police.

Maria Bunce to replace Rachel McKernan as Board Member representing Age UK Isle of Wight.

2. **Minutes**

RESOLVED:

THAT the minutes of the meeting held on 9 November 2022 be approved.

3. **Declarations of Interest**

Cllr Karen Lucioni declared she was a Personal Assistant (PA) on the PA Notice Board.

4. **Chairman's Announcements**

An update was given on the progress of the Mental Wellbeing Plan and the Substance Misuse Partnership Board.

The Chairman stated that the multi-agency Mental Health and Suicide Prevention Partnership had signed off the Isle of Wight's Mental Wellbeing Plan, which set out how improvements could be made to individual and others', mental wellbeing across the Island, over the next 5 years.

The plan focused on the actions required to support people before they needed services or reached crisis point. It identified priorities to drive forward significant improvements in the mental wellbeing of Islanders and to prevent death by suicide, through a commitment to build community resilience, to reduce stigma and discrimination, and to work in partnership to prevent and support people impacted by suicide.

The Chairman explained that in December 2021 the Government had launched its 10-year drug strategy, 'From Harm to Hope' with a clear vision to reduce drug and alcohol related harm. Public Health was working with partners to implement this strategy and to reduce harm for Island residents through the development of a local delivery plan, supported by a substance misuse needs assessment. This was to be overseen by the multi-agency Island Strategic Drug and Alcohol Partnership, which was to be chaired by Simon Bryant, who was also the Senior Officer responsible for this local implementation.

5. **Public Question Time - 15 Minutes Maximum**

None received

6. **The Better Care Fund**

The Better Care Fund Discharge Fund Determination Report relating to the distributing of funds to Adult Social Care, was presented to the Board and the Board was asked to vote on delegated authority be given to the Managing Director of the Isle of Wight Integrated Care Board and the Director of Adult Social Care and Housing, to meet the mandatory deadline for applying for the funding.

It was explained to the Board that the money had been given quickly by Government, but it was only available for a short space of time, and therefore, it was important to act quickly, to be allocated the funds. It was deemed correct for the Board to take this to a vote according to Paragraph 26 (b) of the Report

RESOLVED:

THAT the Better Care Fund be approved by vote.

THAT Delegated authority be given to the Managing Director of the Isle of Wight Integrated Care Board and The Director of Adult Social Care and Housing regarding this matter.

7. **The Integrated Care Plan**

The Integrated Care Plan was reported to the Board by the Director of Partnership for the Integrated Care System (ICS), and it was explained that it was an interim plan with the scope to build on, and that flexibility existed to adapt and change where necessary.

It was an overarching strategy across the Isle of Wight and Hampshire designed to better coordinate care across the whole area.

The Integrated Care Plan looked at the development of a strategy in context with the population, and the issues that affected health and wellbeing.
The joint strategy was designed to better coordinate resources and people, and to be able to take into account context and the power of scale. The aim was to have priorities that focused on making a difference in improving the health and wellbeing of the local population.

The five main priorities of the strategy were outlined in being, Children and Young People, Mental Wellbeing, Good Health and Proactive Care, the Workforce and Digital Solutions.

The delivery of the strategy focused on how to add value across the objectives in service delivery in local places. The work that was being done as the ‘umbrella’ integrated care system across the four areas, supported the work that was being done locally in Hampshire, the Isle of Wight, Portsmouth and Southampton and made best use of combined resources.

RESOLVED:

THAT the (Interim) Integrated Care Plan be supported.

8. **Strategy Priorities 2023 of the HWB**

8a **Health Inequalities**

The Director of Public Health introduced the Health Inequalities report as being part of the major priorities of the Health and Wellbeing Board.

The Associate Director of Public Health presented the paper on the Drivers of Health Inequalities on the Isle of Wight, where it was fundamental to understand that it was necessary to consider the bigger picture to appreciate the range of factors which influenced health and wellbeing, and the differences observed between different groups.

It was explained to the board that the circumstances in which individuals were born, grow, live and work have the strongest influence and biggest impact on health. These were factors outside the control of individuals where actions needed to be taken to achieve the biggest changes in improving health. These factors were referred to as the building blocks of health, on which the Board could formulate policies, actions and community engagement.

The report looked at both the assets and challenges of the Island.
Housing and employment opportunities, food insecurities and lower educational attainment were highlighted among the challenges that faced the Island.

It was noted that the Isle of Wight population had a higher prevalence of a wide range of long-term conditions including heart disease and cancer, compared to local neighbouring mainland areas. There was also a greater number of children with special educational needs and disabilities than the UK average.

Four local geographic areas were identified as having significant health inequalities and were used as case studies to explore the factors contributing to poor health outcomes. These areas were Freshwater South, Freshwater North and Yarmouth; Parkhurst, Hunnyhill, Pan and Barton; Ryde Central Wards and the Bay Area.

The population of the Freshwater wards was identified as having an acutely older population with a level of a limiting long-term illness or disability that was higher than England and the rest of the Isle of Wight.

The Parkhurst and Hunnyhill, Pan and Barton had a younger middle-aged population but suffered more marked deprivation with disability, hospital admissions and early deaths being higher than the national average.
70% of households were regarded as being deprived in one or more of the four dimensions of education, health, housing and unemployment.

The Ryde ward had a larger proportion of primary school aged children with Ryde South East ward having a much younger and more deprived population than the rest of Ryde. The population of the Ryde wards had a significantly worse premature mortality for all causes of death especially cancer, circulatory diseases and conditions seen as preventable, and the data showed higher rates of self-harm and alcohol abuse. The findings suggested that ill health in this area was not driven by an aging population but by preventable conditions, that was shaped by social factors. Poor quality housing, overcrowding, low income and unemployment were also deemed influencing factors with groups experiencing physical and mental health issues in the area.

The Bay showed higher levels of deprivation for older people and children than the Isle of Wight average. Disability, hospital admissions and early deaths were also all higher.

RESOLVED:

THAT the report on the drivers of Health inequalities be noted and further discussed between partners to take action.

8b **Housing and its Relationship with Health**

The Service Manager for Housing Needs and Homelessness presented a report detailing the links between health and housing. This explained the impact of housing on health and demonstrated how housing impacted on the life course of individuals.

The report showed how housing impacted health through three established pathways: quality, security and affordability. Underlying all three were fundamental challenges that related to the shortage of good quality and affordable housing.

Suitable housing that was safe and warm was deemed as being one of the foundations of personal wellbeing whether in childhood or old age.

The Report stated that one in five dwellings did not meet decent standards in England. Insecurity was highlighted as having a significant impact on security with 26% of private renters having lived for less than a year in their home, compared to fewer than 8% of social renters and 2% of owner-occupiers. The link between frequent residential moves and poorer health and mental health was explored.

Housing affordability was deemed as an important factor affecting health both directly and indirectly. Affordability problems were described as having increased in both the private and social rented sectors.

RESOLVED:

THAT the report on the links between housing and health be noted and the subject be further discussed.

9. **Members' Question Time**

None received

CHAIRMAN

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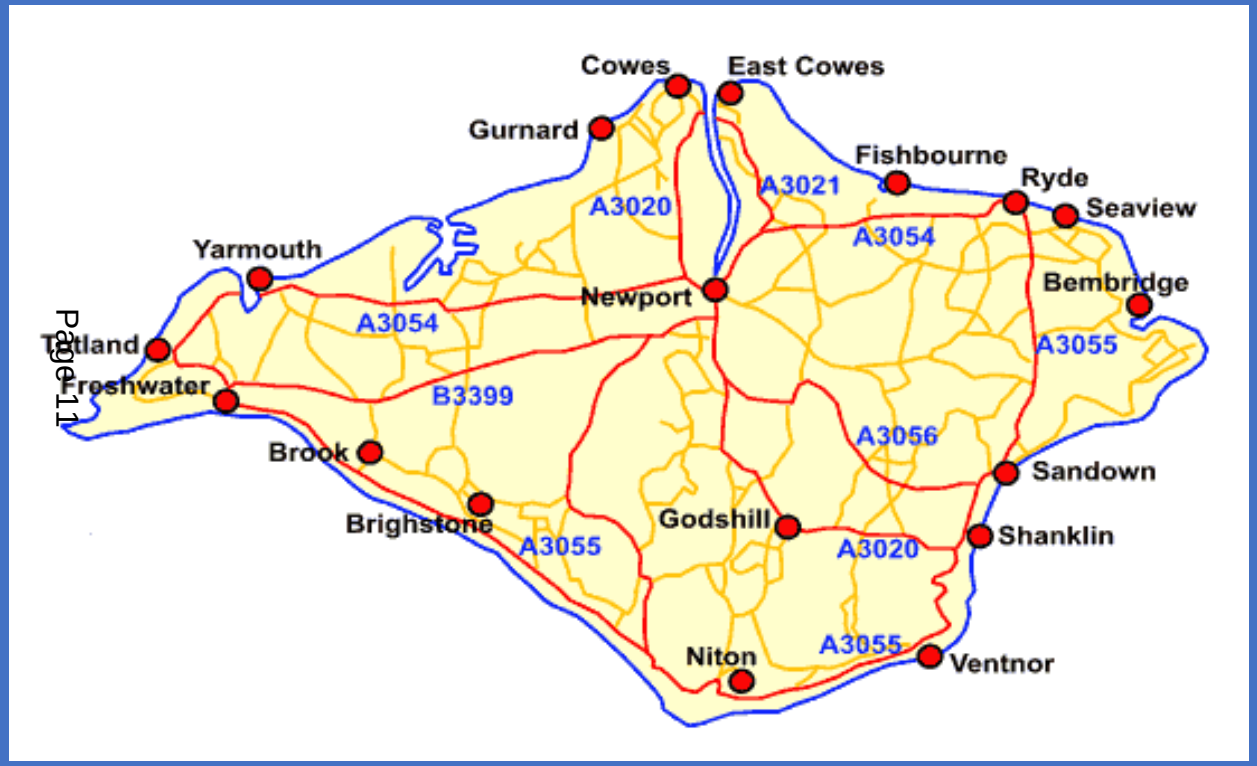


Isle of Wight Population Health

3rd May 2023

Hosted by Isle of Wight Public Health team

A partnership with Hampshire County Council

ISLE of WIGHT COUNCIL

Agenda

Time	Item
12.00-12.05	Welcome and Introductions
12.05-12.10	Setting the scene of the partnership, main opportunities and challenges
12.10-12.25	Health need and population insights
12.25-13.00	Discussion

Context

- Largest English Island Authority 4 miles from the South of England
- Ferry travel is expensive (Bank Holiday cost £300)
- Health Care provision (296 bedded hospital)
- Workforce challenges
- Partnerships with Mainland organisations (including Public Health with Hampshire County Council)

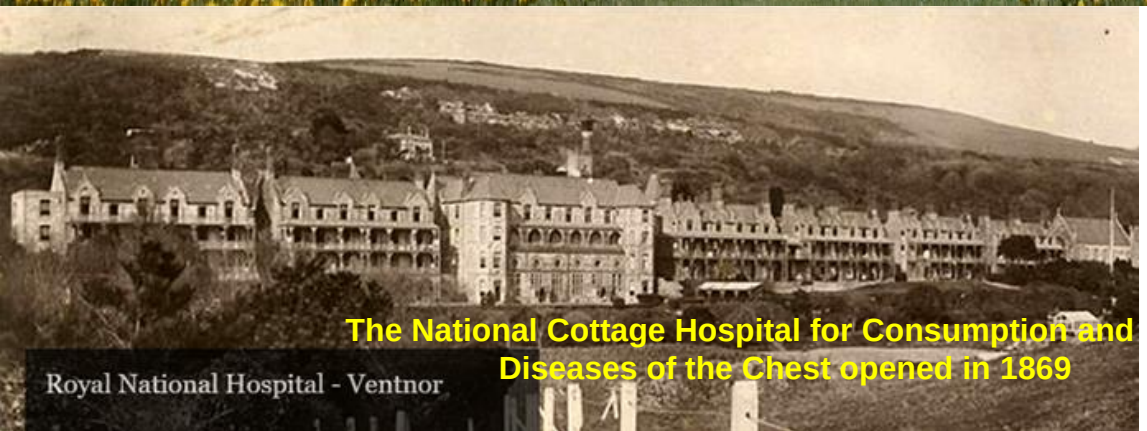
Opportunities

- Engaged voluntary sector e.g. Age UK's Age Friendly Island
- High levels of community participation/ Voluntary sector
- Unitary Authority

ISLE of WIGHT COUNCIL

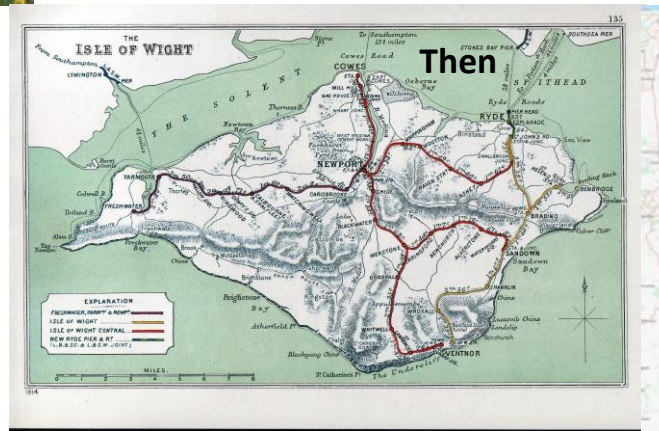
Introduction to the Isle of Wight Population

- Third smallest county in England with a population of 140,500. 22.5 miles east to west, 13.5 miles north to south
- 80% of the island designated to agriculture.
- Half of the island is protected as an AONB, 10,000 people (7% of the population) live in the AONB.
- Ryde and Newport are the largest towns.
- Between 1955 and 1971 a top-secret missile and space rocket development centre was built on the site of old Needles Battery site
- Hovercraft first prototype was developed in East Cowes (1959). The IOW Hovercraft is the last remaining commercial hovercraft service in the world. Operating between Southsea and Ryde.
- Since 2002 Isle of Wight festival has been an annual event, with around 50,000 festival goers. The 1970 festival was one of the last public performances by Jimi Hendrix and the number of attendees reached a record breaking 600,000



The National Cottage Hospital for Consumption and Diseases of the Chest opened in 1869

Up until 1950 the island had 55 miles of railway line. Now there is one main line 8.5 miles long connecting Ryde, Pierhead with Shanklin via 6 stations



Understanding local population - strong predictor of future health and care needs.

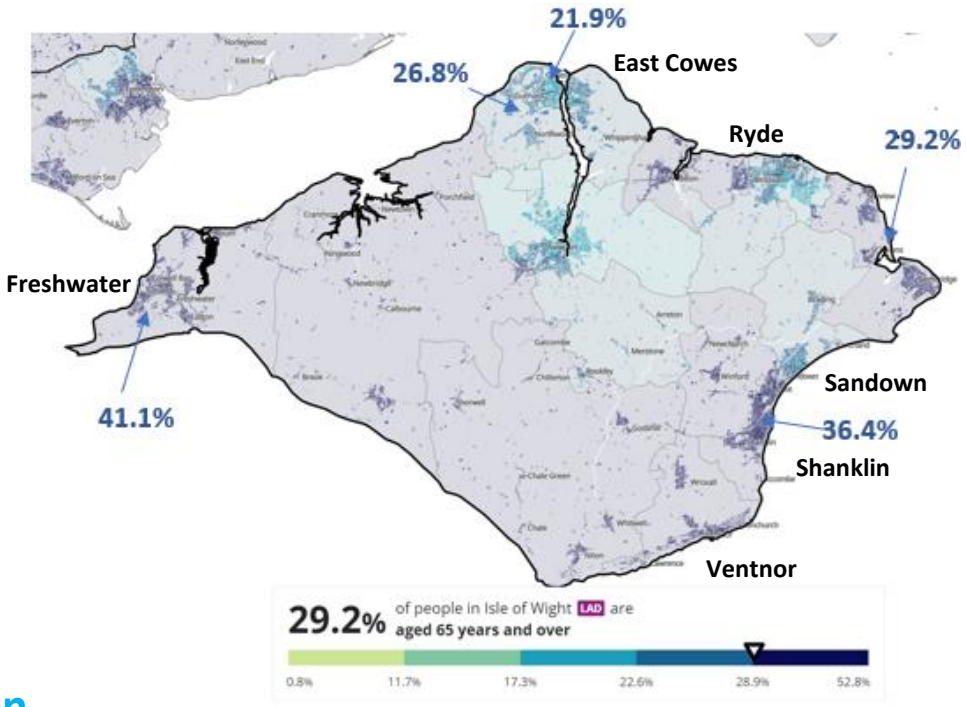
IOW has a significantly older population compared to England

140,500 population
(1.6% increase)

Median age increased by 5yrs
(46 to 51 years).

Joint second-highest median age in the SE and a higher median age than England (40 yrs).

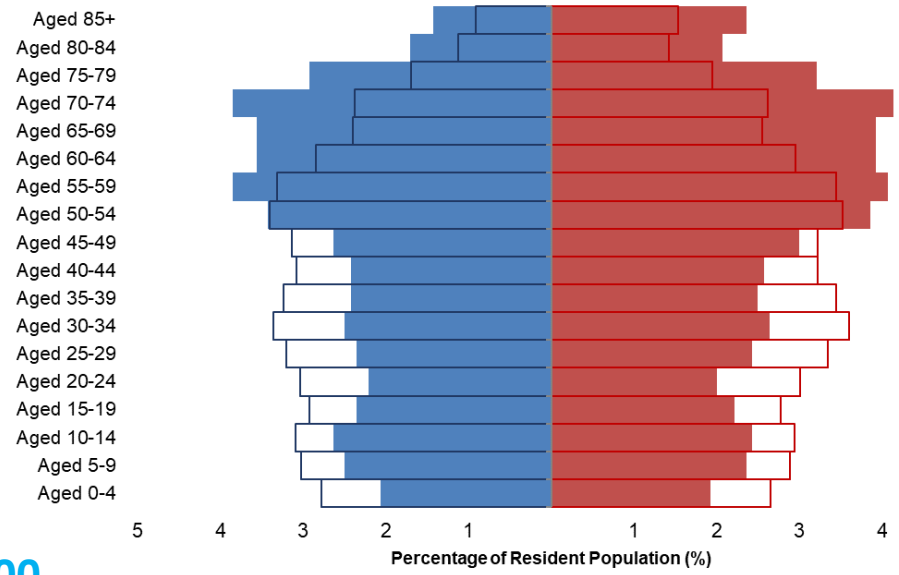
Census 2021: Percentage of the population aged 65 years and over



Data source: Census 2021 Maps

29.2%
Aged 65yrs+
(18.3% England)

Isle of Wight Council district estimated resident compared to England and Wales 2021 by sex.



3.8%
Aged 85yrs+
(2.4% England)

18% one person household aged 66+
(12.8% England)
Increase from 16.5%

4,600
More people aged 65 to 75yrs
(increase of 26.7%)

England & Wales Females 2021 | England & Wales Males 2021
Isle of Wight Females 2021 | Isle of Wight Males 2021

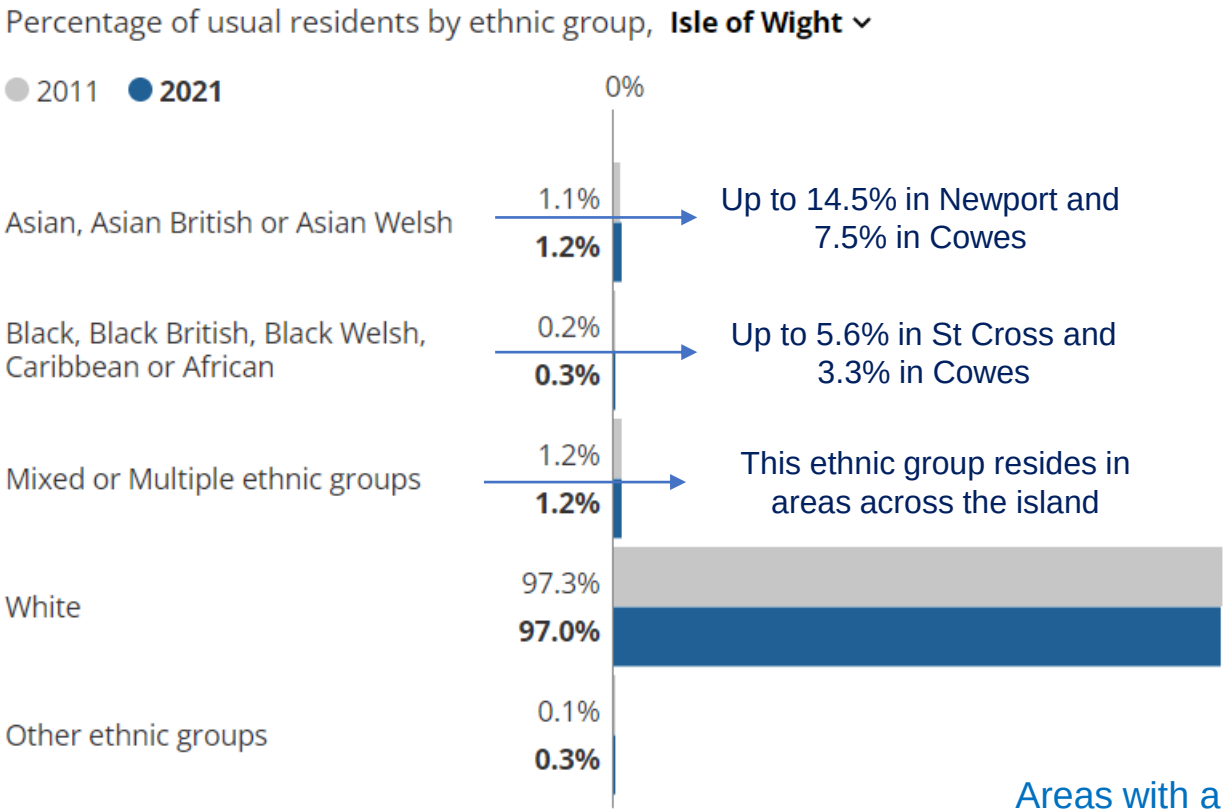
92.7% of the IOW population are living in a coastal community. Over nine out of ten of the island's 65 years and over population live in a coastal area.

[Click to see the Isle of Wight population change from 1861 to 2021 video]

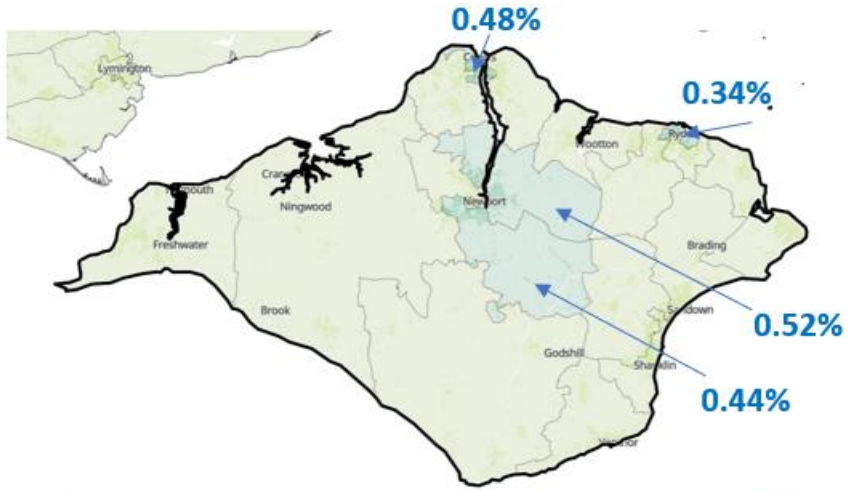
Understanding population diversity

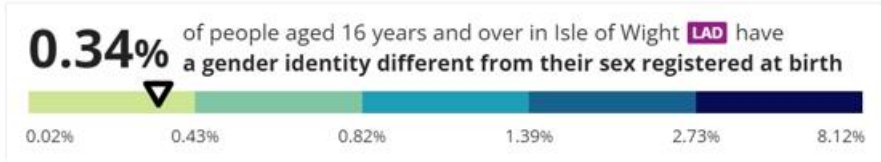
Ethnic diversity increased very slightly
small decrease in White ethnic group

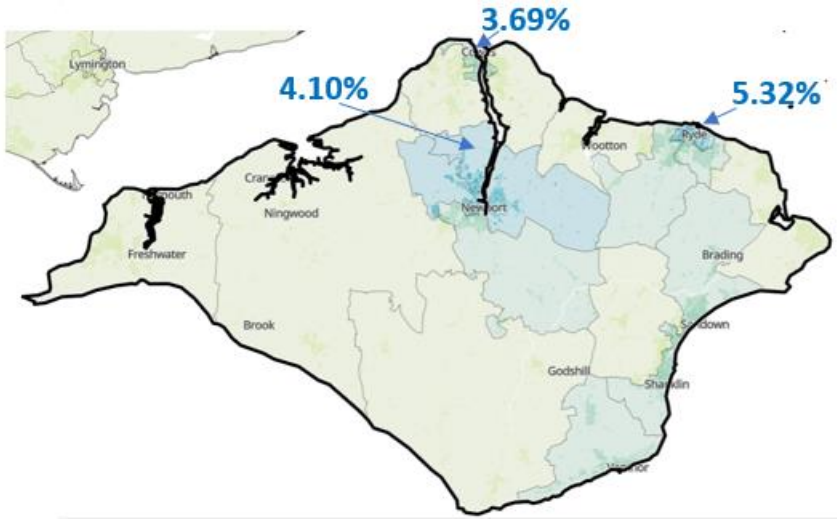
0.1% increase in Asian, Asian British or Asian Welsh and **Black, Black British, Black Welsh, Caribbean or African ethnic groups**

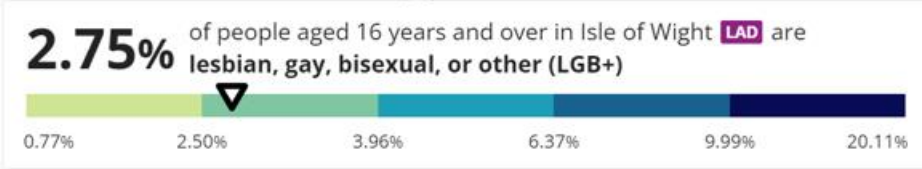


Source: Office for National Statistics – 2011 Census and Census 2021



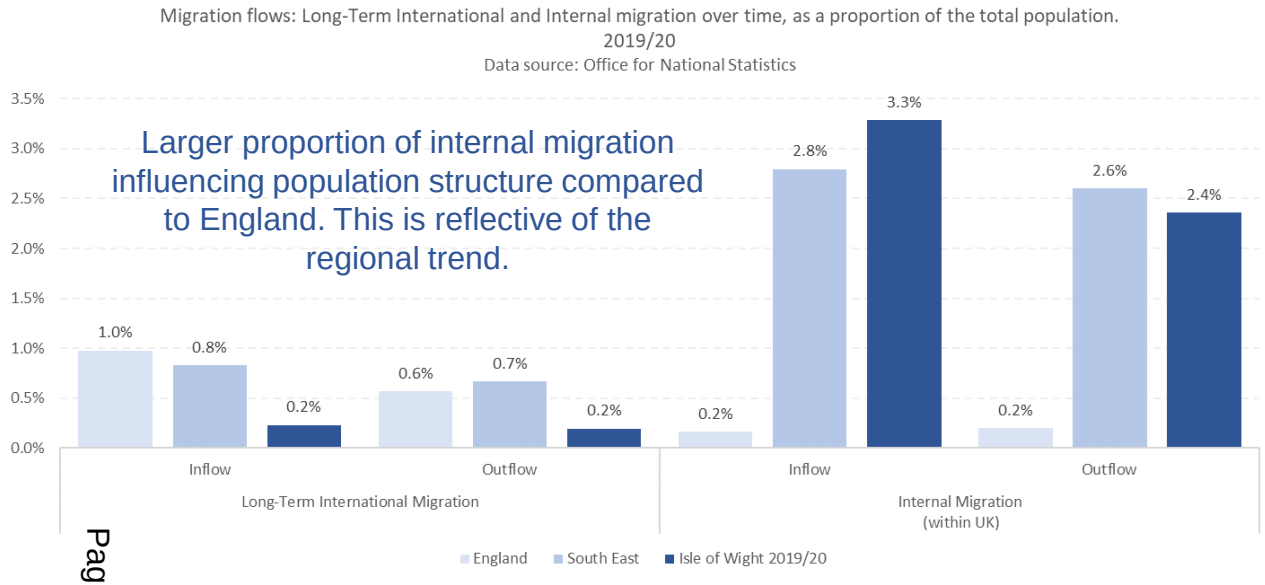


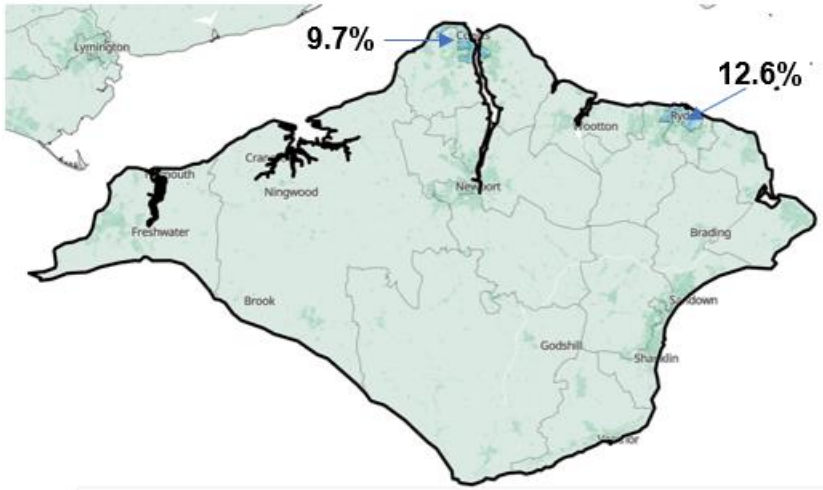




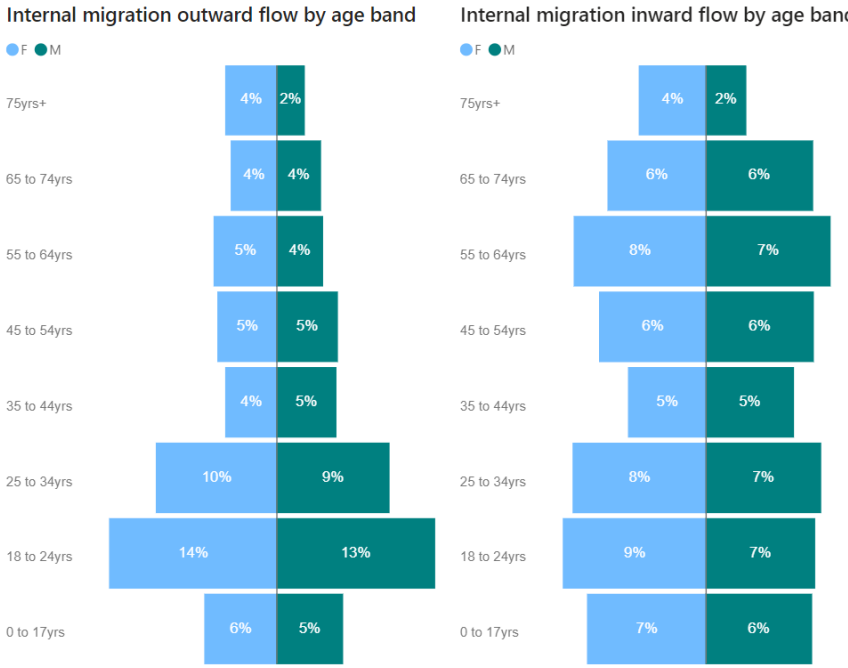
Areas with a relatively younger populations have the greatest diversity

Understanding population change: migration flows.



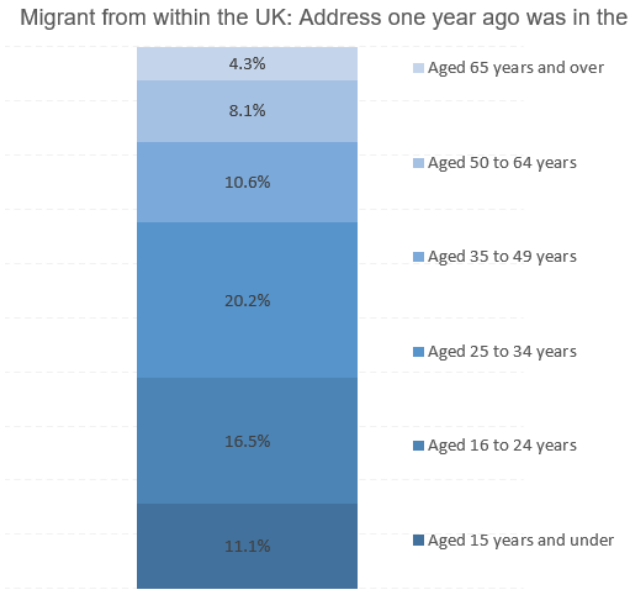


Isle of Wight Internal Migration Flows , 2019



Outward flow
Young university/ working age population

Inward flow
Older working age/older population and possible returning younger population



Migrant indicator show the greatest population movement due to internal migration is in Cowes and Ryde. In some small areas 1 in 8 people did not live there one year ago

Understanding population health: Life expectancy, premature mortality and preventable mortality

Life Expectancy at birth (males) worse than England.

- 77.2 years for males (78.7 years England)

Life Expectancy at birth (females) comparable to England.

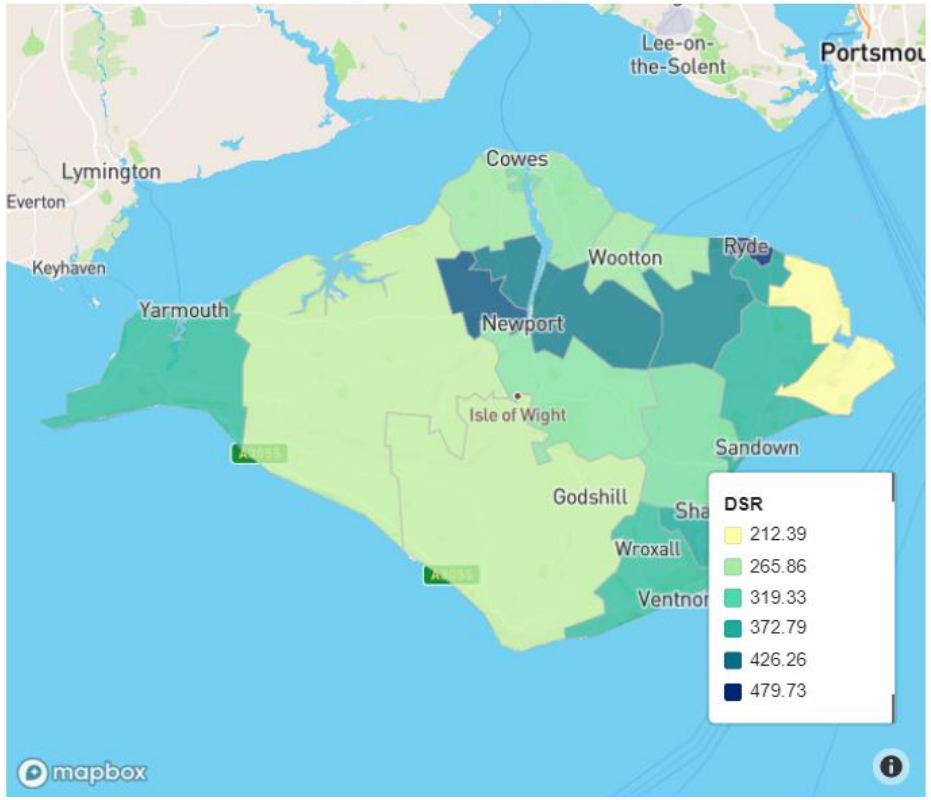
- 82.9 years for females (82.8 years England).

Life expectancy trends up to 2020 have stagnated.

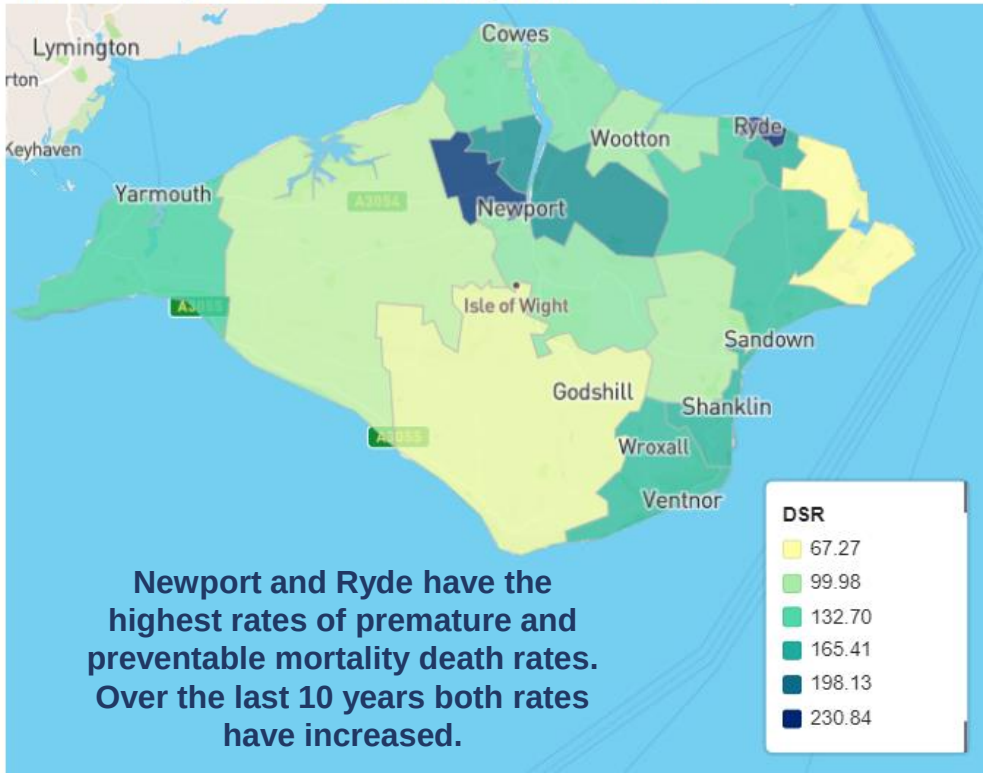
Males born and living in the most deprived areas of the Island could expect to live 6.1 years less than those in the least deprived areas. 9.7 years in England. Increasing trend but not statistically significant.

Females born and living in the most deprived areas of the Island could expect to live 2.3 years less than those in the least deprived areas.7.9 years in England. Improving trend but not statistically significant.

Premature mortality (under 75 years) persons, Isle of Wight, 2016-2020

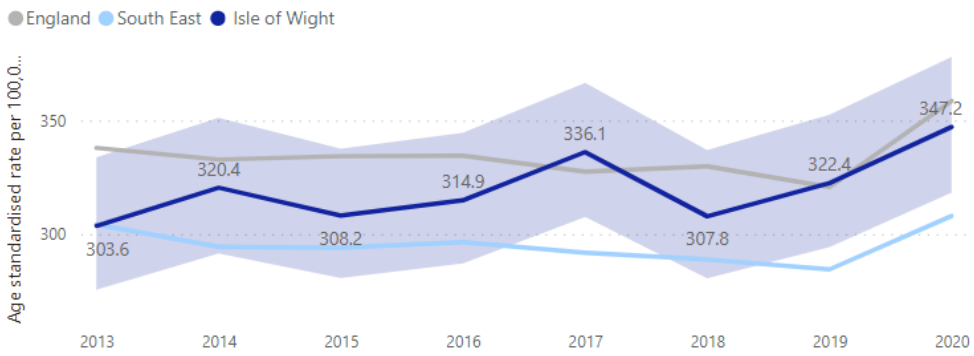


Under 75 mortality rate from causes considered preventable, 2016-2020

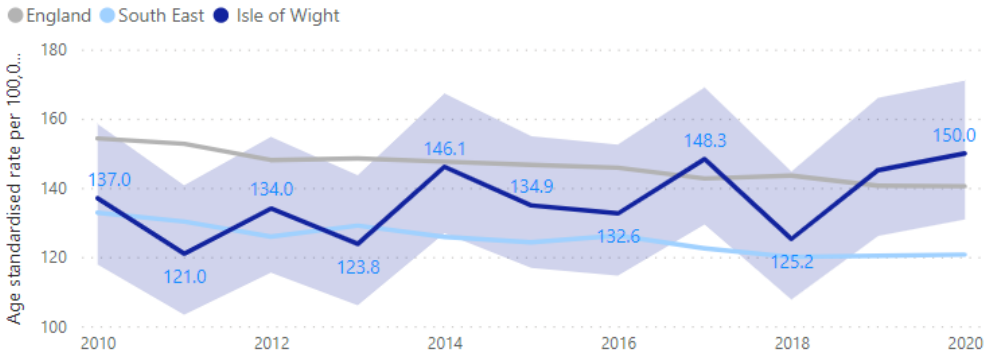


Newport and Ryde have the highest rates of premature and preventable mortality death rates. Over the last 10 years both rates have increased.

Premature mortality (under 75 years) for persons, Isle of Wight



Under 75 mortality rate for causes considered preventable for persons, Isle of Wight



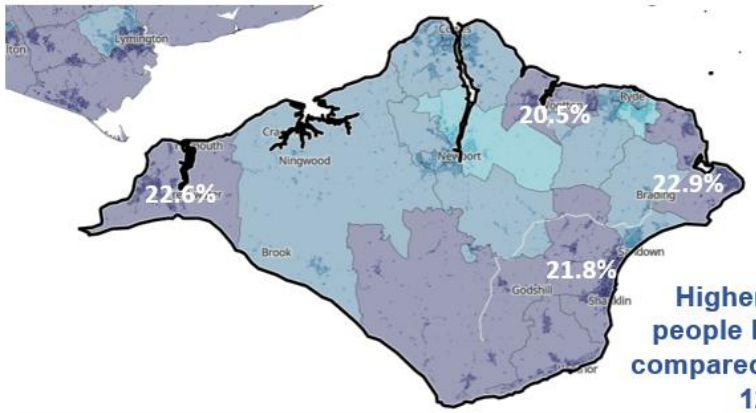
Data source: JSNA Vital Statistics

Older people

Overall older people on the Isle of Wight experience good health.

LE at age 65 for both males and females is statistically similar to England, recent decrease attributable to the pandemic year

HLE at age 65 for both males and females statistically similar to England

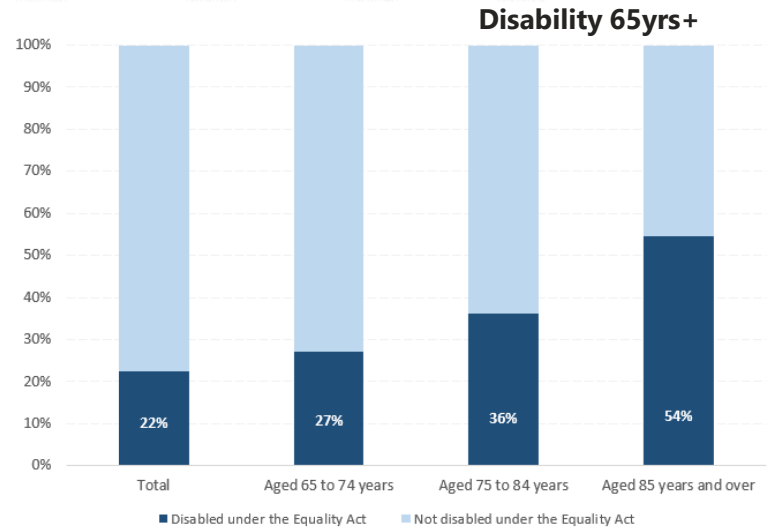


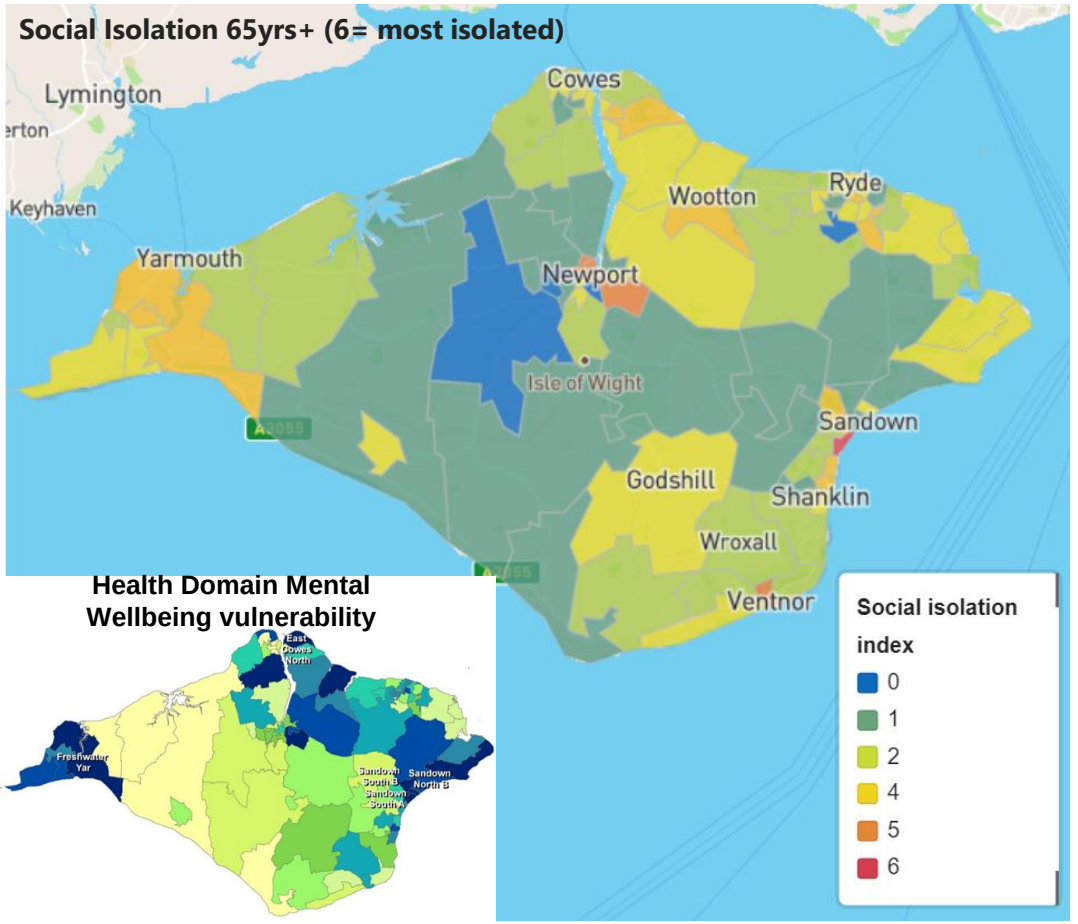
Higher % of old people living alone compared to England, 12.8%

29.2% of the population aged 65+ (40,186 people)
England: 18.4%

12.9% of the population aged 75+ (18,377 people)
England: 8.6%

3.8% of the population aged 85+ (5,378 people)
England: 2.4%





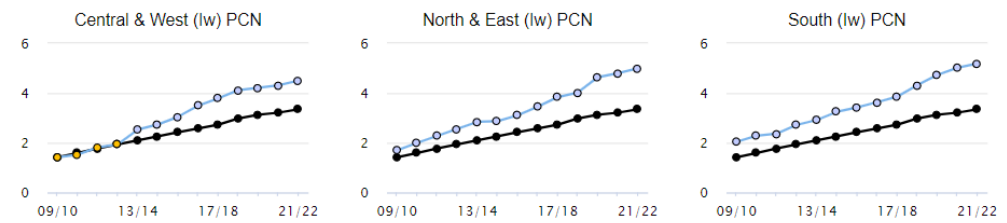
Health Domain Mental Wellbeing vulnerability

The Isle of Wight has a number of areas where people are at increased risk of **social isolation** including Freshwater, Sandown, Newport and Ventnor.

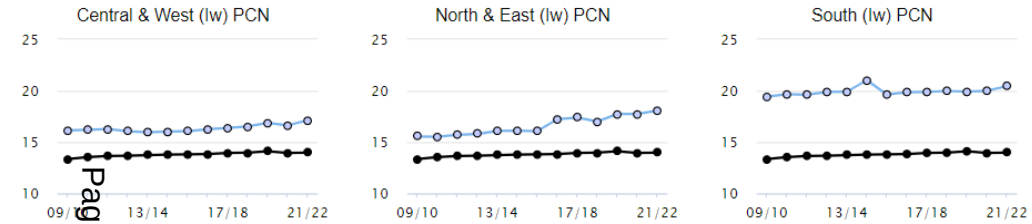
The pattern of mental wellbeing vulnerability in the health domain shows a clear divide between areas on the Island. **There is high vulnerability in the northeast, as well as the West of the Island in the area of Freshwater.** All of the five most vulnerable LSOAs have more people aged 65 years and above with two or more LTC's.

Understanding health and social care needs: Ill Health and Multi-morbidity

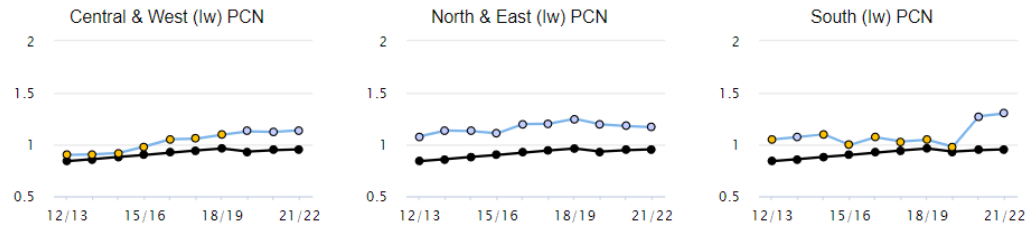
Cancer: QOF prevalence (all ages)



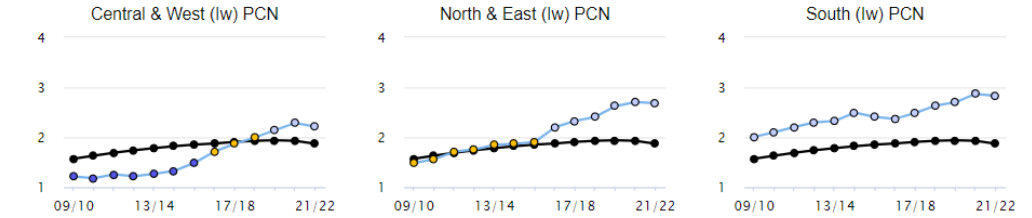
Hypertension: QOF prevalence (all ages)



Mental Health: QOF prevalence (all ages)



COPD: QOF prevalence (all ages)



5.6%
Provide 20+ hours unpaid care a week
(4.4% England)

9.8%
Day to day activities limited a lot
(7.3% England)

13.5%
Day to day activities limited a little
(10% England)

6.8%
Bad or very bad health
(5.2% England)

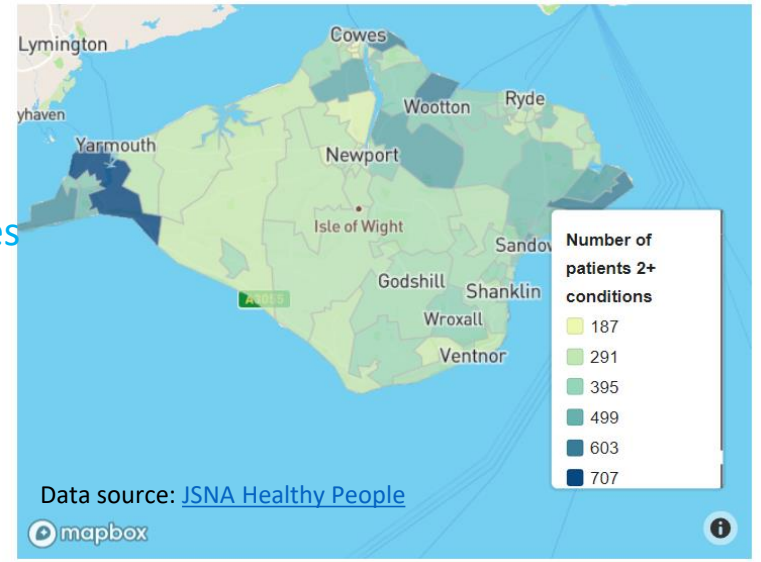
CHD, Hypertension, Stroke, Heart failure, Atrial Fibrillation, Diabetes, COPD, Asthma, Cancer prevalence is above the HIOW ICS, England and increasing.

Estimated number of people with 2+ long term conditions

32,935 people have 2 or more conditions

23.1% of the population have 2 or more conditions

Number of patients with 2 or more long term conditions by resident LSOA



An expanding elderly population with multimorbidity means a rising demand for healthcare services and increasing reliance on access to care from the mainland. At the same time, the contracting working age population to look after and support this elderly population poses significant challenges.

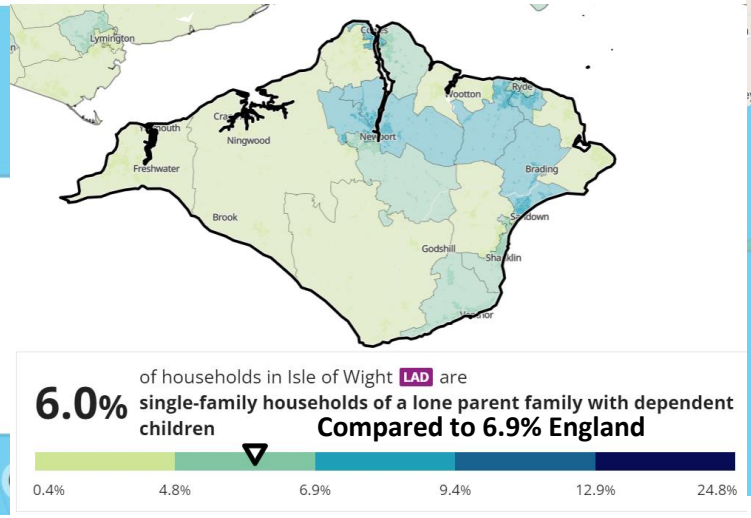
Children & Young People

22.2% of children (aged under 16) are living in relative low-income families, significantly worse than England and continues to increase

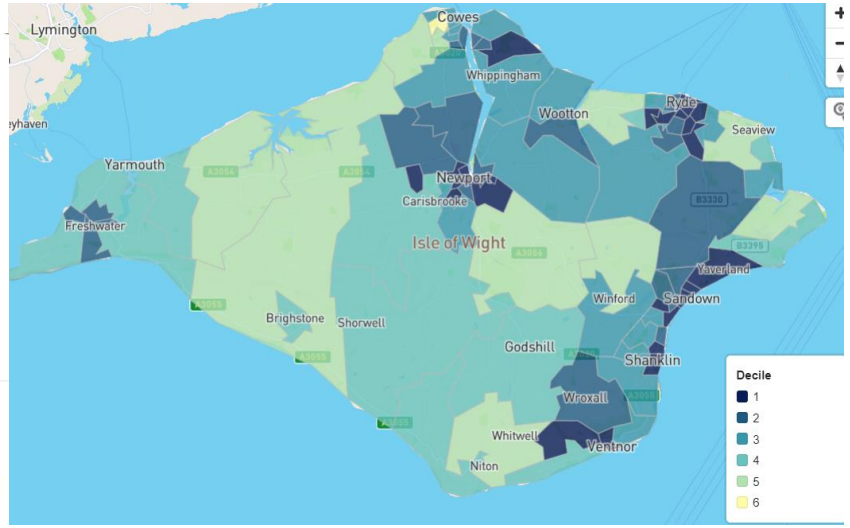
Much higher % of lone parents in Ryde and Newport. Also correlates to areas of higher food insecurity

Child poverty

Lone parent families



Food insecurity – compositional risk



Isle of Wight Mental Health and Wellbeing Vulnerability Index

Those in Urban areas of Parkhurst, Newport, Ryde and Cowes Castle East are vulnerable to poor mental wellbeing due to their demographics; being young, ethnic minorities and also working in industries most affected by furlough. Those in rural areas are vulnerable due to factors relating to their employment and health, particularly in the northeast of the Island.

Risk factors for poor educational outcomes

- In 2021/22 3.8% of school pupils had social, emotional and mental health needs – this trend has been increasing over time similar to the England pattern (3%)
- 16.6% of secondary school enrolments are classified as persistent absentees (missing 10% or more of possible sessions)- – 14.8% for England, 14.1% for South East
- Higher rate (115 per 10,000) of children in care compared to England (70 per 10,000) – 275 children
- School readiness: percentage of children achieving expected level in phonics screening check in Year 1 – statistically worse than England at 62.6% compared to 75.5%

Work, Education & Skills

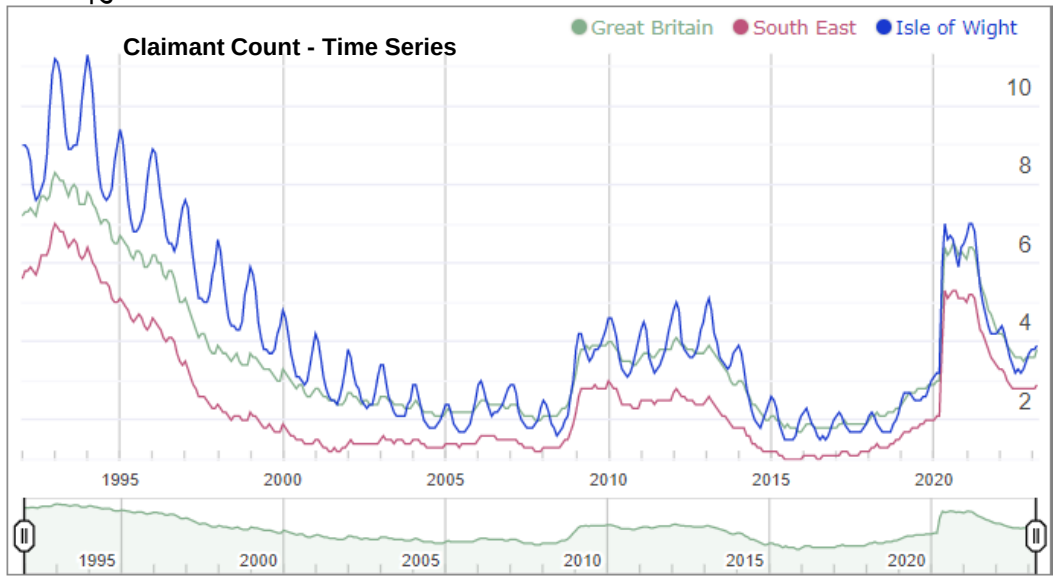
47.5%
Employed
(50.2% in 2011)

Third lowest percentage of people aged 16 years and over (excluding full-time students) who were employed.

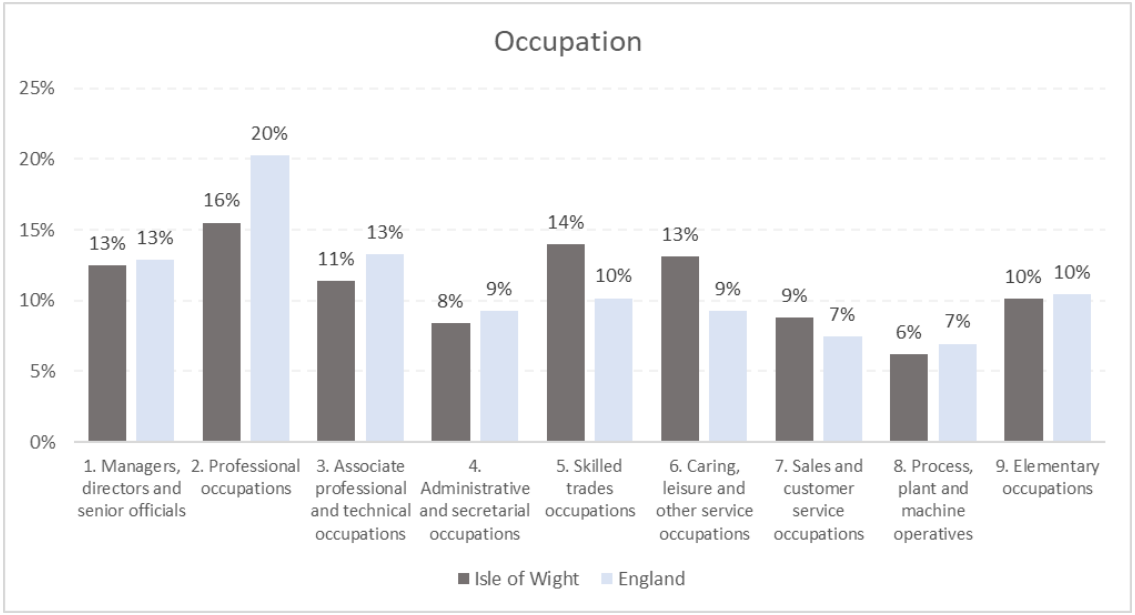
33.2%
Retired
(30.6% in 2011)

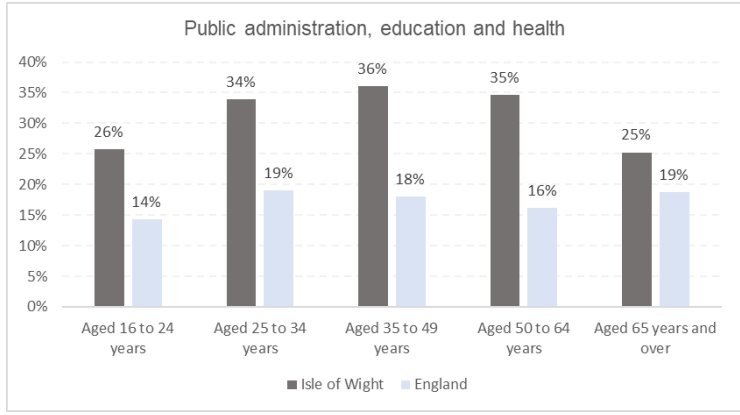
12.5%
Worked <15hrs per week
(11.1% in 2011)

More adults worked short hours.



Census 2021 Occupation & Industry





Occupations are dominated by public service, caring and seasonal tourism related activities

Jobs with lower earnings and prevalence of seasonal and part-time employment opportunities are over-represented

Housing

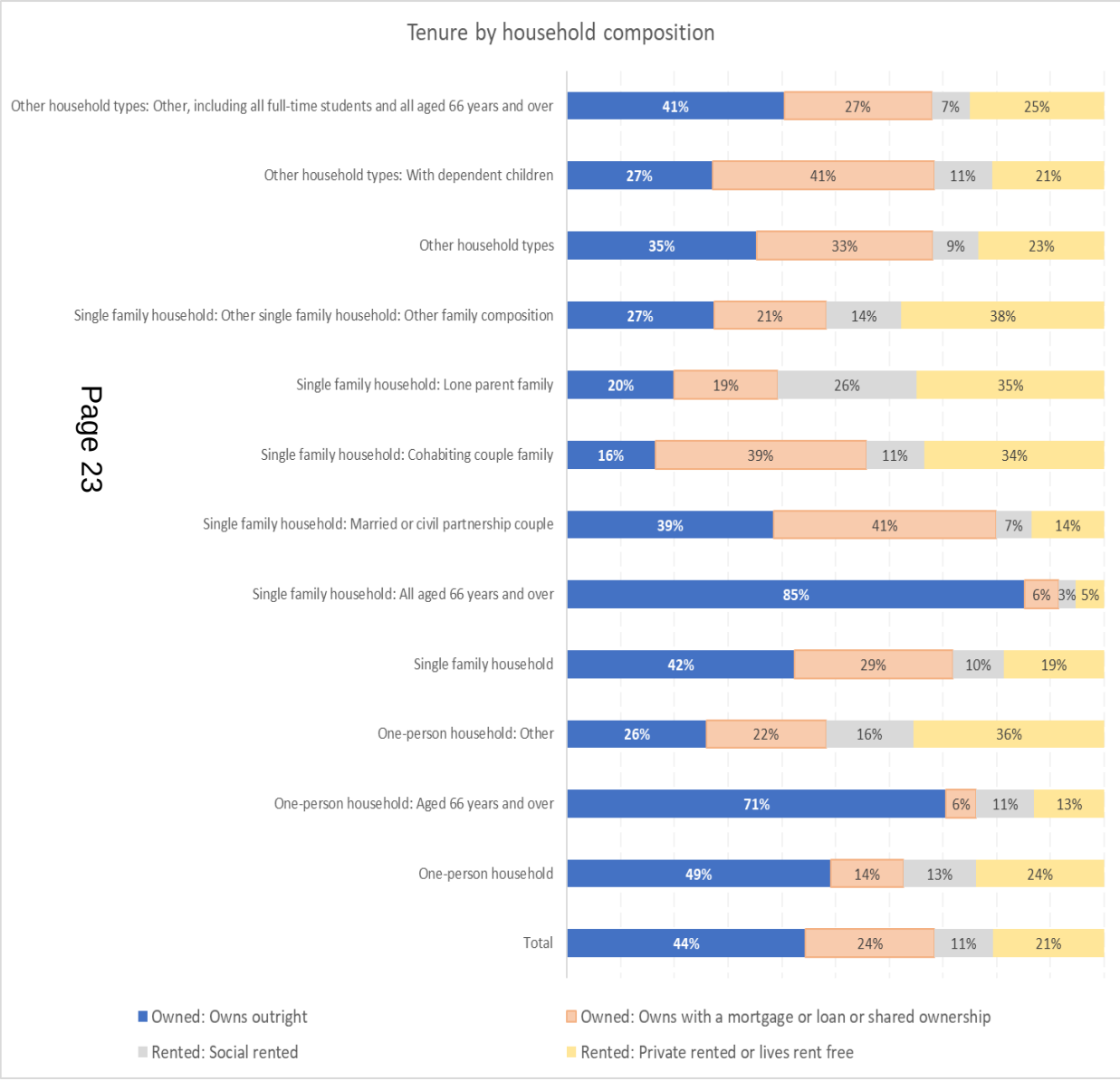
67.6%
Owned
(61.3% England)

44.4%
Owned outright
(32.5% England)

10.9%
Social rented
(17.1% England)

90%
Social rented is not from the council or local authority i.e. other social rented. (51% England)

20.7%
private rented and mainly rented from private landlord or letting agency - (20.5% England)



Housing affordability

Across the Isle of Wight homes have become less affordable since 2002

Housing availability

3,008 homes (4%) are classed as second homes compared to 1% in England. 1.2% of houses are empty (2% England).

Housing quality

Private Rented Sector (PRS) has the worst housing conditions. The English Housing Survey (EHS) estimated that in 2021, 23% of PRS homes did not meet the Decent Home Standard. This compares with 13% of owner-occupied and 10% of social-rented homes.

% of households in fuel poverty highest in areas in Newport and Ryde which also has high % of PRS housing.

Properties with D to G energy rating in Isle of Wight, 2022

Area in Newport
75% of housing is privately rented, 11.8% do not have central heating

Place: Food, Family, Friends & Community.

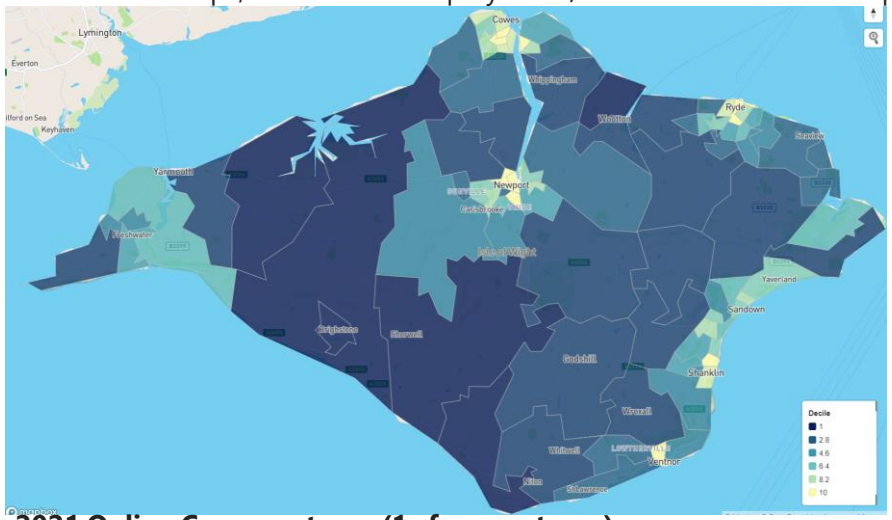
Food insecurity on the Island is high due to high levels of deprivation and additionally reduced access to shops for large areas of the Island.

There is also low **access to leisure facilities**, higher levels of social isolation and low internet engagement. Internet user classifications suggest large populations who experience poor digital infrastructure and slow speeds and groups with limited or no engagement.

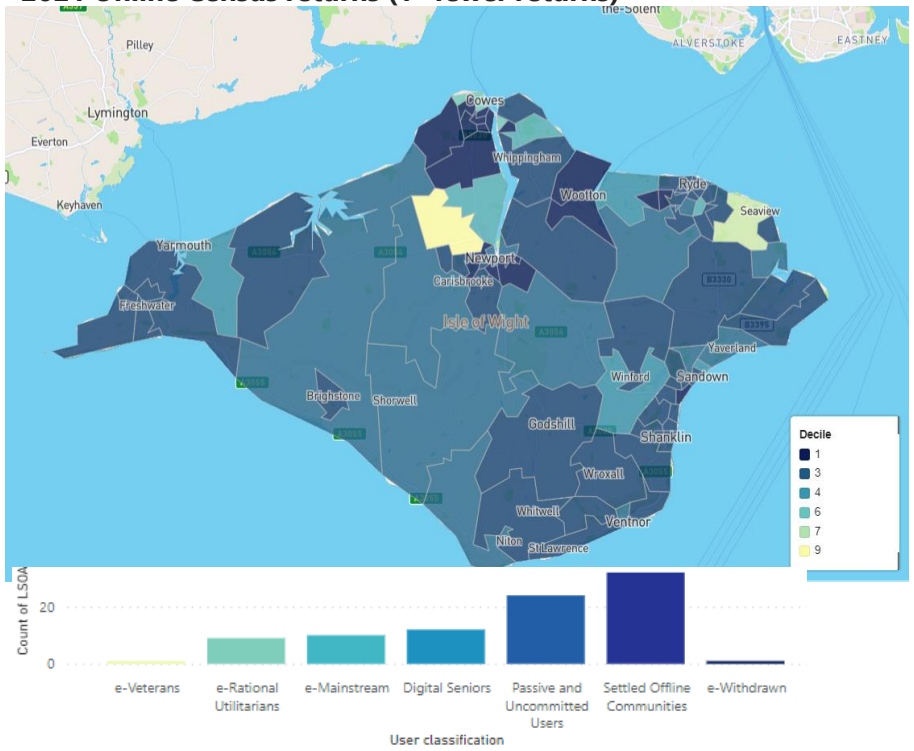
Settled Offline Communities: Limited use, elderly, White British, semi-rural.
Passive and Uncommitted: Limited or no engagement, suburbs / semi rural, semi-skilled or blue-collar occupations.

The Isle of Wight showed low rates of electronic census returns across the island which suggests that alternative modes of engagement should always be considered by service providers and information campaigns.

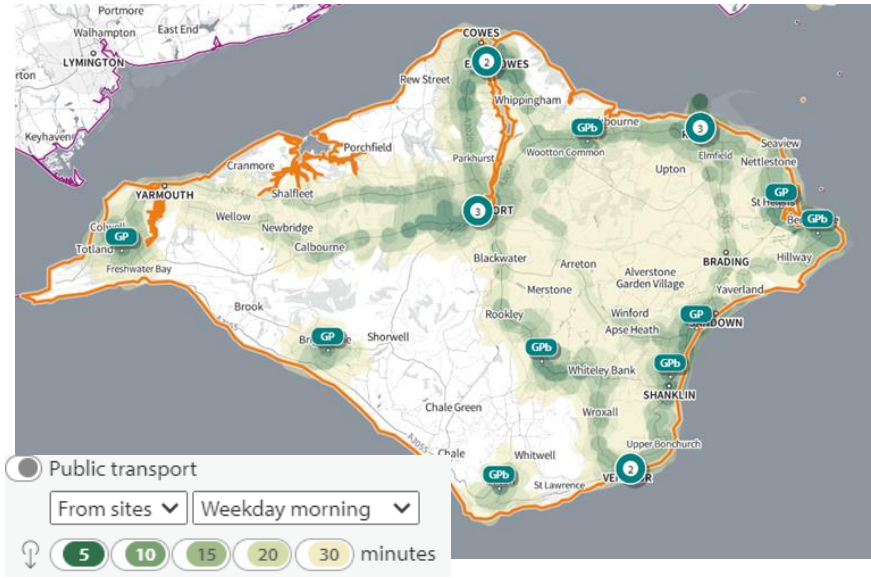
Food Insecurity: Structural index
Includes bus stops, distances to employment / food stores & internet speeds



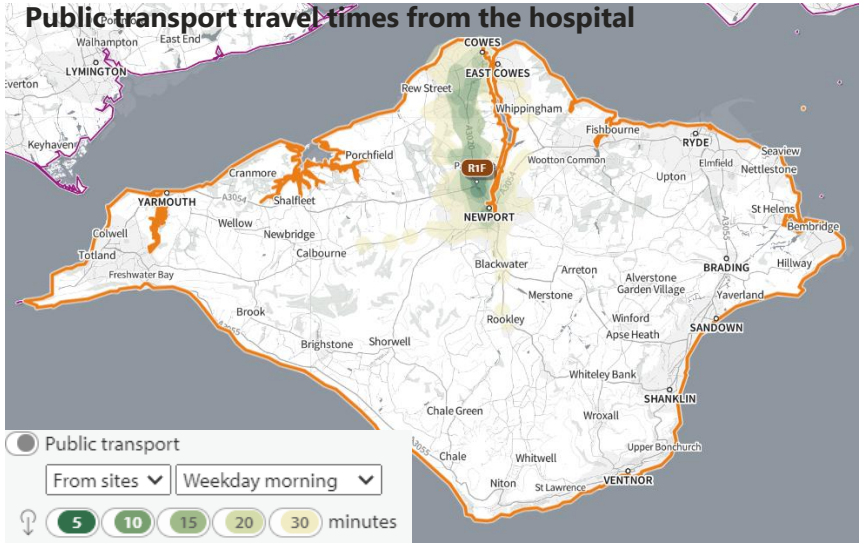
2021 Online Census returns (1=fewer returns)



Public transport travel times from GP practices



Public transport travel times from the hospital

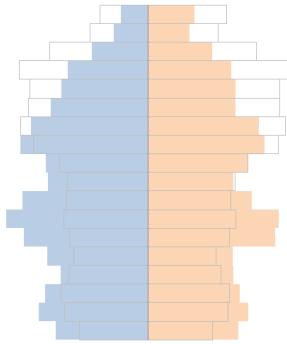


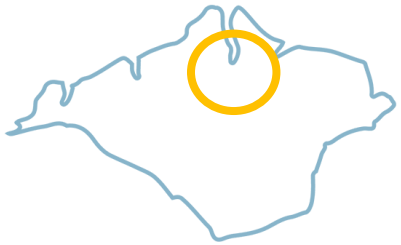
39% of people aged 66+ who live on their own do not own a car - higher than England (27%)

Data source: JSNA Healthy Places

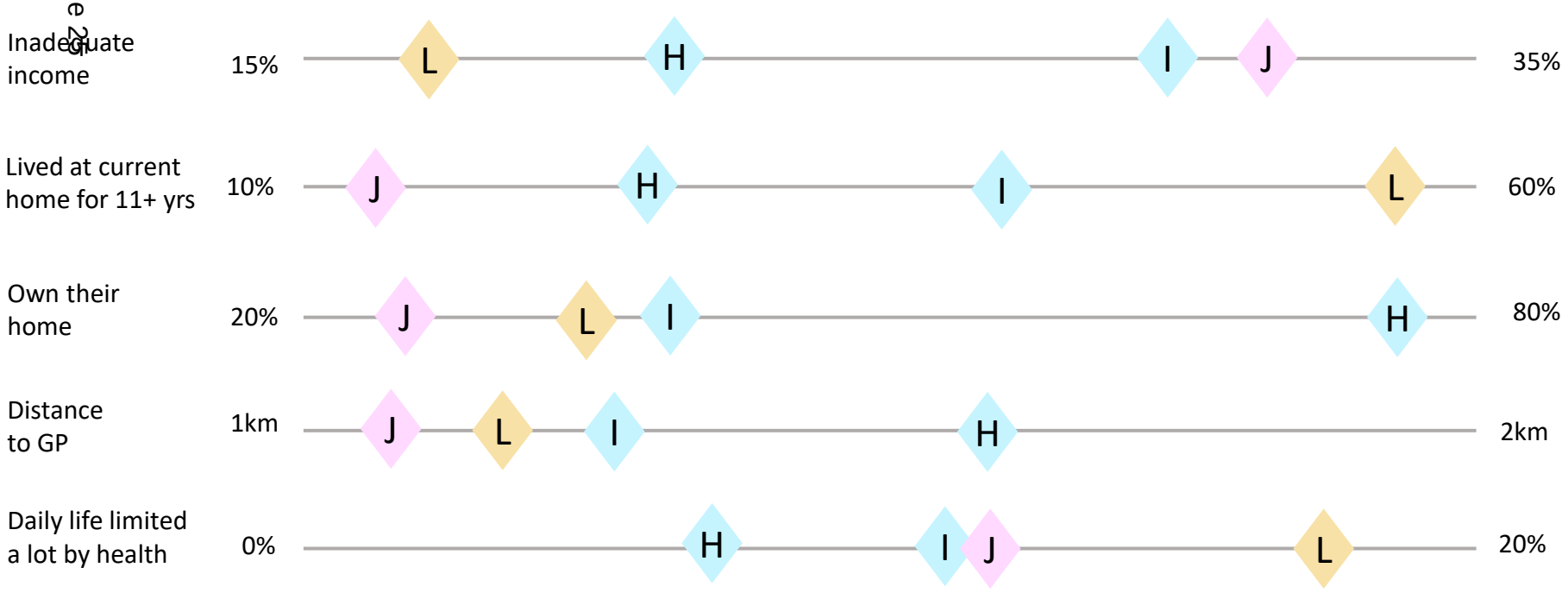
Parkhurst, Newport, Pan & Barton

Total population 17,529
18.2% aged 65yrs+



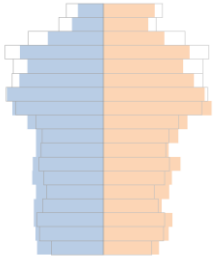


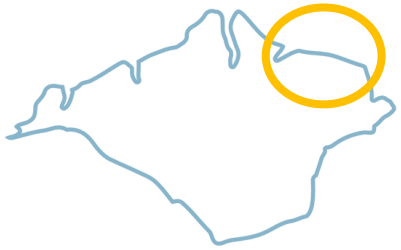
Group	% of population	Brief description
H Aspiring Homemakers	21.9%	*Younger households settling down in housing priced within their means*
J Transient Renters	16.5%	*Single people renting low cost homes for the short term*
I Family Basics	15.2%	*Families with limited resources who budget to make ends meet*
L Vintage Value	12.6%	*Elderly people with limited pension income, mostly living alone*



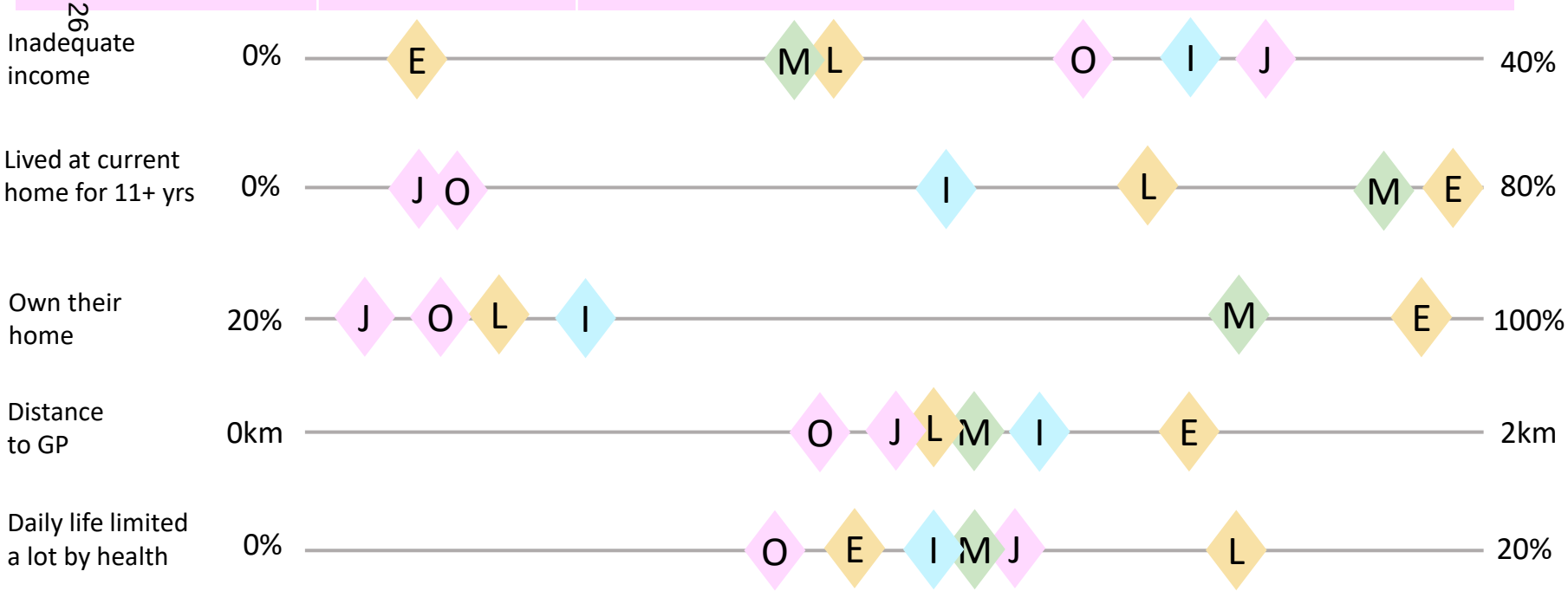
Ryde

Total population 19,342
23.4% aged 65yrs+



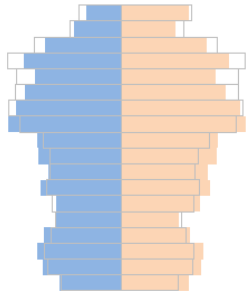


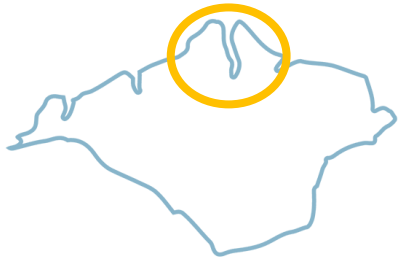
Group	% of population	Brief description
O Rental Hubs	19.5%	*Educated young people privately renting in urban neighbourhoods*
E Senior Security	13.8%	*Elderly people with assets who are enjoying a comfortable retirement*
I Family Basics	13.8%	*Families with limited resources who budget to make ends meet*
M Modest Traditions	12.9%	*Mature homeowners of value homes enjoying stable lifestyles*
L Vintage Value	10.4%	*Elderly people with limited pension income, mostly living alone*
J Transient Renters	10.3%	*Single people renting low cost homes for the short term*



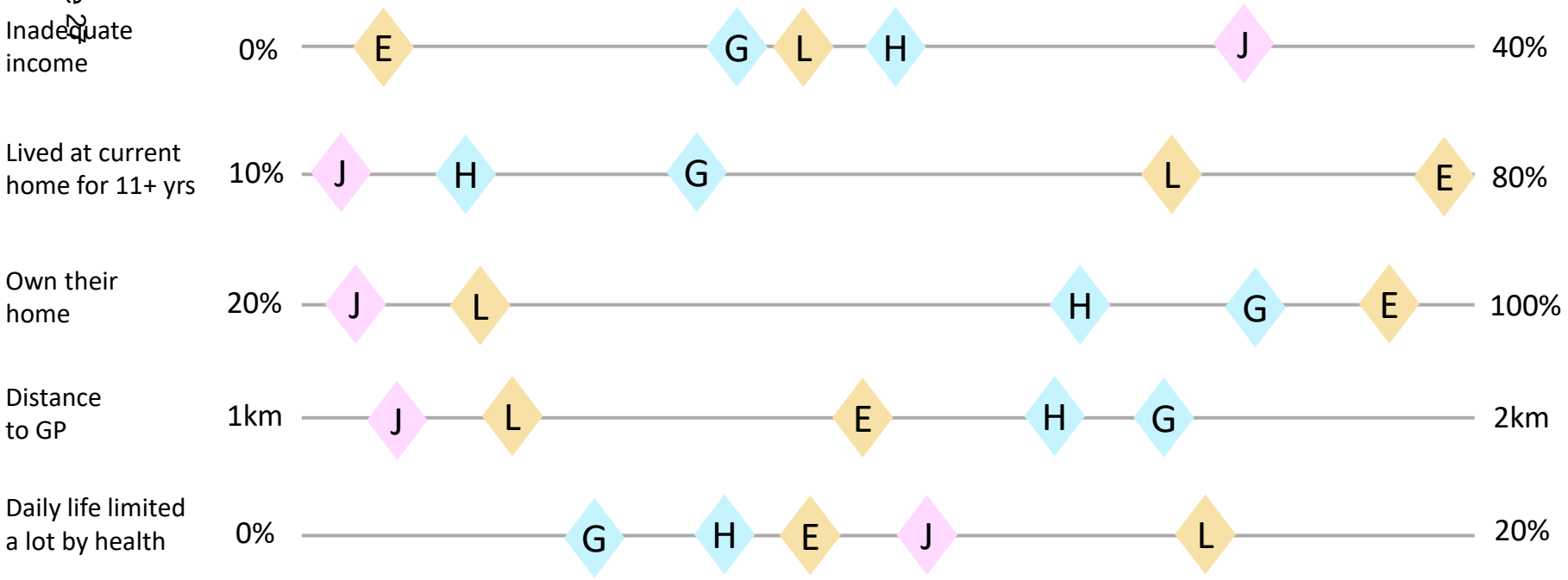
Cowes

Total population 14,813
25.3% aged 65yrs+



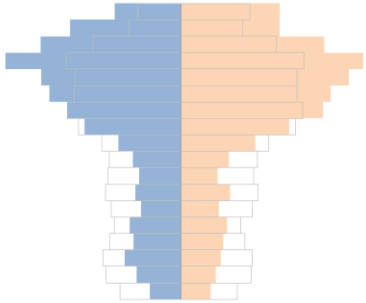


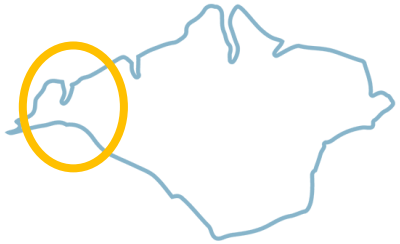
Group	% of population	Brief description
G Domestic Success	16.0%	*Thriving families who are busy bringing up children and following careers*
H Aspiring Homemakers	14.8%	*Younger households settling down in housing priced within their means*
J Transient Renters	14.5%	*Single people renting low cost homes for the short term*
E Senior Security	14.4%	*Elderly people with assets who are enjoying a comfortable retirement*
L Vintage value	9.2%	*Elderly people with limited pension income, mostly living alone*



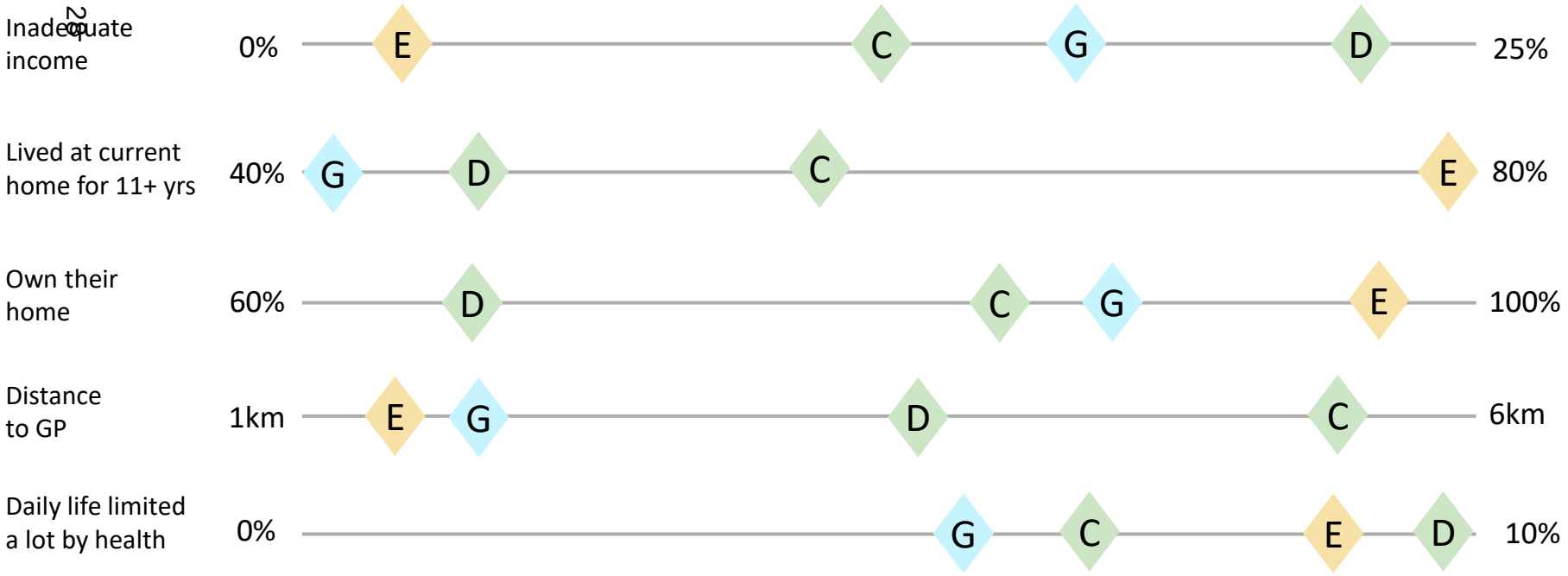
Freshwater

Total population 4,662
44.6% aged 65yrs+





Group	% of population	Brief description
C Country Living	48.7%	*Well-off owners in rural locations enjoying the benefits of country life*
D Rural Reality	35.3%	*Householders living in less expensive homes in village communities*
E Senior Security	12.7%	*Elderly people with assets who are enjoying a comfortable retirement*
G Domestic Success	0.4%	*Thriving families who are busy bringing up children and following careers*



THE ISLE OF WIGHT CONSTITUTION

CHAPTER 2:8

JOINT ARRANGEMENTS.

Health and Wellbeing Board (HWBB)

Health and wellbeing encompasses key partners to improve the health of the island population this include the Isle of Wight Council, NHS services, community safety partners, economic development links and people who improve our environment.

The purpose of the HWBB is to build strong and effective partnerships, which improve the partnership working for health outcomes alongside the joining up of commissioning and delivery of services, leading to improved health and wellbeing for local people.

The HWB leads and advises on work to improve the health and wellbeing of the people of the Isle of Wight. This is achieved through joined up commissioning across the NHS, social care, public health and other services directly related to health and wellbeing in order to:

(a) secure better health and wellbeing outcomes on the Island
(b) reduce health inequalities and
(c) ensure better quality of care for all people and care users

In accordance with the Health and Social Care Act 2012, the HWB is constituted as a formal committee of the council under s.102 of the Local Government Act 1972, and answerable to its scrutiny functions with the following terms of reference:

(a) Encourages all those who arrange for the provision of any health or social care services to work closer together for the purpose of advancing the health and wellbeing of the people of the Isle of Wight.
(b) Develops and endorses a Joint Strategic Needs Assessment (JSNA) including the Pharmaceutical Needs Assessment, for the Isle of Wight, sharing within own organisations
(c) Commissions and endorses a Joint Health and Wellbeing Strategy (JHWS) to meet the health and social care needs identified in the JSNA, subject to final approval by relevant partners that will consider how it compliments and informs the Islands Health and Care Plan needs, if required.
(d) Can receive the reports of both the Safeguarding Children Partnership Board (SCPB) and Safeguarding Adults Board (SAB), including their annual reports.

The HWBB agendas and work will be closely linked with the Island Health and Care Partnership which has similar membership with a distinct focus. The HWBB alongside the HWBBs for Hampshire, Southampton and Portsmouth provide the basis, information and local picture for the Integrated Care Partnership (ICP) for Hampshire and IOW.

The membership of the HWBB is as follows:

(a) Executive Leader - Chairman

(b) Cabinet member for Children's Services, Education and Lifelong Skills

(c) Cabinet member for Adult Social Care, Housing and Public Health
(d) Cabinet member for Community Protection, Regulatory Services and Waste
(e) Council Chief Executive
(f) Council Director of Children's Services
(g) Council Director of Adult Services
(h) Council Director of Public Health
(i) Council Director of Regeneration
(j) Council Director of Neighbourhoods
(k) Clinical Chair of the Hampshire and Isle of Wight ICB – Island Place – Vice-Chairman
(l) Managing Director of the Hampshire and Isle of Wight ICB – Island Place
(m) Representative NHS England
(n) Chief Executive of Isle of Wight NHS Trust
(o) Chief Constable representative for Hampshire and IOW Constabulary
(p) Police and Crime Commissioner representative for Hampshire and the Isle of Wight
(q) Healthwatch Isle of Wight representative
(r) Isle of Wight Association of Local Councils (IWALC) representative
(s) Chairman of the Isle of Wight Voluntary Sector Forum

The quorum is at least two Cabinet members, one statutory officer of the council, a representative of the ICB and four other members of the Board or their representatives present.

Voting is by show of hands. A simple majority prevails and in the event of a tied vote the chairman shall have a second or casting vote. The recording of votes and the right for an individual vote to be recorded will follow the council's Constitution procedure rules.

The HWBB meets four times a year with additional meetings arranged in agreement with the Chairman, as required. The chairman determines, in consultation with the clerk, the agenda for each meeting.

All meetings of the HWBB are held in public unless there are grounds for excluding the press and public, as set out in the Access to Information rules (see Part 5 Section 2) or in accordance with legislation. Members of the public have the right to ask questions at each meeting.

The HWBB is supported by sub-groups, if needed. Both the SCPB and SAB can bring issues and concerns to the attention of the HWBB and, in turn, the HWBB needs to be confident that these fora are operating effectively to discharge their responsibilities.

Committee:	Health and Wellbeing Board
Date:	20 July 2023
Title:	Mental Wellbeing Plan and Suicide Prevention Plan
Report From:	Simon Bryant, Director of Public Health

1. Formal details of the paper

1.1. Isle of Wight Mental Wellbeing Plan and Suicide Prevention Action Plan (2023 to 2028)

1.2 General publication

1.3 Date of Board: 20 July 2023

1.4 Author of the Paper and contact details: Sharon Kingsman
sharon.kingsman@iow.gov.uk

2. Summary

2.1 **Key messages for Board members**

2.2 The purpose of this report is to provide an update on the Isle of Wight (IOW) Mental Wellbeing Plan (2023-28) and associated Suicide Prevention Action Plan.

2.3 This report seeks to:

- Provide an overview of the IOW Mental Wellbeing Plan, which was launched this year. The plan has been developed collectively with partners of both the multi-agency Isle of Wight Mental Health and Suicide Prevention Partnership and Mental Health Alliance. It emphasises a preventative approach to address the wide range of factors that influence mental health and wellbeing.

- Provide an overview of the IOW Suicide Prevention Plan, which aims to deliver on the Suicide Prevention priority within the Mental Wellbeing Plan of ensuring that Islanders will feel assured that all partners are working together on suicide prevention and supporting those lives that are impacted by suicide.

- Update the board on the associated governance arrangements.

2.4 Contextual Information

The Isle of Wight Mental Health and Suicide Prevention Partnership is a multi-agency partnership that works collaboratively and strategically to prevent mental ill health, promote positive mental wellbeing, and reduce death by suicide for people living on the Island.

The partnership includes a range of key stakeholders who can provide prevention-focused leadership across the wider public and voluntary sector system. A key function of the partnership is to oversee the delivery of the Isle of Wight Mental Wellbeing Plan (2023 to 2028).

2.5 Isle of Wight Mental Wellbeing Plan (2023 to 2028)

The plan was launched in Spring 2023 and demonstrates how partners across the system will work together to promote mental wellbeing and support Islanders to have the best mental wellbeing they can and reduce inequalities in mental wellbeing across certain groups. It focuses on the mental wellbeing of all adults, whilst recognising the importance of working across the life course, and of ensuring that mental and physical wellbeing are given equal importance.

2.6 The plan takes a two-pronged approach to support mental wellbeing on the Island and focuses not on mental health services, but on the actions required to support people before they might require services or reach crisis point. This will be achieved through a:

- Universal approach to encourage good mental wellbeing, emotional resilience and self-care across all age groups and populations on the Island.
- Targeted approach to tackle mental wellbeing inequalities to reach, engage and improve the mental wellbeing of those at an increased risk of the worst outcomes.

2.7 Within the plan, five specific priorities have been identified alongside partners as follows:

- Islanders will live, work, and thrive on a unique island where partners are committed to working together and differently to ensure positive improvements to mental wellbeing are made. (Focus on partnership working)

- Islanders will benefit from the positive aspects of being part of their community and know where to access information and support to build both individual and community resilience. (Focus on and building resilience)

- Islanders will be comfortable talking about their mental health and wellbeing and be able to challenge prejudice around poor mental health (Focus on reducing stigma and discrimination)

- Islanders will feel assured that all partners are working together on suicide prevention and supporting those lives that are impacted by suicide (Focus on suicide prevention)

- Islanders will experience positive mental wellbeing, irrespective of their background, where they live or their life circumstances and value their mental wellbeing alongside their physical health (Focus on reducing inequalities and wider determinants)

2.8 The following multi-agency partnership groups support the Mental Health and Suicide Prevention Partnership in delivering the Isle of Wight Mental Wellbeing Plan:

- The Isle of Wight Mental Health Alliance (MHA) brings together key stakeholders from across the Island to;
    - Reduce the stigma of mental ill-health;
    - Improve emotional and mental resilience, including through support in building community resilience;
    - Ensure prevention and early intervention is central to work around mental wellbeing and suicide prevention on the Island;
    - Enable partnership working across statutory and voluntary sectors to ensure improved mental and emotional wellbeing for Island residents and break down barriers to accessing appropriate support.

- The Mental Health Alliance Communications Group is a sub-group of the MHA. It brings partners together to set out and agree a cohesive approach to communication and engagement within the context of improving mental health and wellbeing, including suicide prevention, across the Island. It aims to;
    - agree a joint messaging approach around the topic of mental health and wellbeing, including suicide prevention.
    - ensure a continued cohesive approach to communication and meaningful engagement with wider partners, service users and Island residents around mental wellbeing and suicide prevention.
    - promote positive messages and support available as well as self-help across the Island, defined by the mental wellbeing communications plan

2.9 **Isle of Wight Suicide Prevention Action Plan 2023 - 2028**
The IOW Suicide Prevention Action Plan outlines how we will work with system partners to support earlier intervention and prevention of suicides. It is the main mechanism for coordinating actions identified under priority four within the IOW Mental Wellbeing Plan; Islanders will feel assured that all partners are working together on suicide prevention and supporting those lives that are impacted by suicide. This plan will also serve to refresh the previous IOW Suicide Prevention Strategy 2018-2021.

2.10 The refreshed IOW Suicide Prevention Plan (2023-28) aligns with the six areas for suicide prevention action identified within the National Suicide Prevention

Strategy. It will take an iterative approach, with specific actions and priorities identified and reviewed on an annual basis. The plan identifies the following areas for action, which have been developed in partnership with the Mental Health Alliance and approved by the Mental Health and Suicide Prevention Partnership;

1. Take action on the wider determinants that influence suicide and suicide prevention. Suicidal behaviours are shaped by the social, economic, and physical environments in which we live. Key actions within this theme include the delivery of money and mental health training for frontline staff, delivery of workforce suicide prevention training to housing staff and voluntary organisations who support people experiencing multiple vulnerabilities.

2. Tailor approaches to suicide prevention for particular groups, including through improved data and intelligence. While everyone is at risk of suicide, that risk is not distributing equally amongst the population. Using both national and local insight and intelligence we will target interventions, signposting and communications at those with the greatest need. Priority groups include middle-aged men, those in touch with the criminal justice system, people misusing substances, victims and perpetrators of domestic abuse and veterans.

3. Embed early intervention and prevention through ensuring a comprehensive training offer, promoting mental wellbeing and improving communications around support available. Mental Health First Aid and Suicide First Aid training is now being offered to professionals, voluntary sector and communities. In collaboration with IOW Citizens Advice the Isle find It website has been developed to include comprehensive signposting to early help and support.

4. Reduce access to means of suicide by promoting suicide safer communities. The National Institute of Clinical Excellence published an evidence review in 2018 which highlighted effective measures for reducing access to means. We will work closely with planning, landowners and primary care to implement appropriate measures in line with the evidence base.

5. Ensure appropriate and sensitive communications of suicide and suicidality across all sectors on the Isle of Wight. Sensitive and appropriate use of language can help to reduce the stigma that prevents people from seeking help. Within this area for action, we will continue to develop our workforce development and training offer, work with local media outlets to ensure responsible reporting of suspected suicides and develop a postvention communications toolkit to be used by multiagency partners following a suspected suicide death. This will help support frontline staff, volunteers, and members of the public to feel confident and equipped to intervene and signpost people to the right support where necessary.

6. Work in partnership to provide the ‘right support’ at the ‘right time’ for those individuals and communities affected by a suspected suicide death. Providing guidance and support in a timely manner for those affected by a suspected suicide death is an important aspect of local suicide prevention plans. Actions

within this theme include the refresh of the education postvention protocol, promotion of the Amparo bereavement support service, and use of the real time surveillance system to identify those affected in a timely manner.

7. Improve research, data sharing and monitoring. Since 2013 IOW Public Health has conducted a local suicide audit which enables valuable insight into local needs. This work is now being supported by a Real Time Surveillance System, enabling data to be collected in a timely manner and enabling an appropriate, joined-up postvention response across partners. Further work is planned to enhance this system and to further support engagement with people impacted by suspected suicide.

3. Decisions, recommendations and any options

3.1 The Health and Wellbeing Board is asked to:

1. Note the priorities within the IOW Mental Wellbeing Plan (2023-28) and key mechanisms for delivery.

2. Note the areas for action within the IOW Suicide Prevention Plan and key mechanisms for delivery

3.2 Relevant information

3.2.1 Performance

The Mental Wellbeing Strategy and accompanying suicide prevention plan have identified key areas for action, that have been categorised as ‘now’ and ‘next’. This demonstrates the commitment by all partners to ensure focused action is taken at the right time and that a clear direction has been mapped out for the next five years.

These actions will be regularly assessed by the IOW Mental Health and Suicide Prevention Partnership and the Mental Health Alliance to ensure they are addressed in a timely manner. Actions identified as ‘now’ are those where work is already underway.

Updates and progress on both plans will be presented to the IOW Health and Wellbeing Board annually.

3.2.2 Co-Production

The Mental Wellbeing Plan was co-produced with a range of partners who are represented on the Mental Wellbeing and Suicide Prevention Partnership and Mental Health Alliance. This included a task and finish group to oversee the development, consultation, writing and final document design.

The Suicide Prevention Plan was developed from priority four of the Mental Wellbeing Plan and in collaboration with the Mental Health Alliance. It has been approved by the Mental Health and Suicide Prevention Partnership.

3.2.3 Conclusions

The IOW Mental Wellbeing Plan and IOW Suicide Prevention Plan demonstrate how partners across the Island will work together to promote mental wellbeing and support Islanders to have the best mental health they can and reduce inequalities in mental wellbeing across certain groups.

Governance has been updated to support the ambitions of both plans.

Implementation of key actions will be reviewed by the IOW Mental Health and Suicide Prevention Partnership and the Mental Health Alliance will ensure delivery of both plans. Annual updates will be presented to the Health and Wellbeing Board.

4. Important considerations and implications

4.1 Legal – no legal implications but the plan has been shared with legal.

4.2 Finance – no financial implications but the plan has been shared with finance.

4.3 Performance information and benchmarking - High level performance and monitoring has been considered during the development of the plan. The detail regarding key performance indicators and benchmarking is now being considered with partners and will be defined in the annual action plan.

4.4 Equalities and Diversity - An Equality Impact Assessment has been carried out and is attached.

4.5 Future Proofing / Exit strategy
The plan will be reviewed on an annual basis. It will be in place until 2028 unless there is a need to refresh the content prior to this time. A detailed annual action plan is being developed, which will be overseen by the Mental Health and Suicide Prevention Partnership.

4.6 Health, social care, children's services and public health and other partners who may be affected by the report – Colleagues from health, social care, housing, children's services were involved in the development of the plan.

4.7 Key PIs that will be monitored and why
The detail regarding key performance indicators is now being considered with partners and will be defined in the annual action plan.

5 Supporting documents and information

Appendices

Appendix 1: IOW MHWB Plan FINAL for HWB
Appendix 2: MWB Plan EIA
Appendix 3: IOW SP Action Plan May 2023 Final

- It is not necessary to include any works published elsewhere (including legislation, other Committee reports and Minutes), but this may be extremely helpful to anyone reading the report and their inclusion is welcomed.

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SIMON BRYANT *Director of Public Health*	*COUNCILLOR IAN STEPHENS* *Cabinet member for Adult Social Care, Public Health*

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Isle of Wight mental wellbeing plan

2023 to 2028

ISLE of WIGHT COUNCIL

Contents

Foreword

We are delighted to present the Isle of Wight's mental wellbeing plan, which sets out how we can improve our own and others' mental wellbeing across the Island. This plan identifies priorities where the Mental Health and Suicide Prevention Partnership (MHSPP) believe that we can drive forward significant improvements in Islander's mental wellbeing and prevent death by suicide, by working together. It sets out the achievable steps we will take as a partnership to get there.

Everyone has mental health and wellbeing, just as we all have physical wellbeing, and everyone has the right to positive mental wellbeing. However, we know that some groups of people are more likely to experience poorer mental wellbeing compared to others. This plan will focus on the mental wellbeing of adults on the Island, whilst recognising the importance of working across the life course, and of ensuring that mental and physical wellbeing are given equal importance. The plan will focus not on mental health services, but on the actions required to support people before they require services or reach crisis point. It will set out the partnership's commitment to working collaboratively to prevent mental ill health, promote positive mental wellbeing and reduce death by suicide, irrespective of anyone's circumstances.

Chair of the Mental Health and Suicide Prevention Partnership
On behalf of the Isle of Wight Mental Health and Suicide Prevention Partnership

Introduction

This plan has been developed in partnership across both the Mental Health and Suicide Prevention Partnership and the Mental Health Alliance. The combination of both these groups means a true multi-agency strategic and operational view has been incorporated from the many key players that contribute to improving the mental health and wellbeing of the Island's population. Additionally, the voice of local people has steered the direction of the development of this plan through the recent community resilience survey and continued voluntary and community sector involvement, ensuring a continued emphasis on listening and responding at a local level.

We recognise that different approaches and ways of working will suit different groups of people. Adapting how we work, individually as partners as well as collectively, means adopting new ways to ensure the people who need support most are getting it in a way that is relevant and appropriate to them. It is important for all the Island's partners to take a positive approach to mental health and wellbeing and not to focus on merely the absence of a mental illness or the provision of acute mental health services.

This plan aims to take a preventative approach, recognising the wider factors that influence mental wellbeing, such as the natural environment and employment. It reinforces the links between people's mental and physical wellbeing, as well as the interrelationship with deprivation and financial anxiety. It summarises information about the differences in wellbeing across various population groups and areas on the Island and shows how we will work in partnership to address these inequalities. The plan also seeks to reduce death by suicide through a partnership approach to prevention, by raising awareness and listening to those affected by suicide. It is key that learning is taken from every death by suicide to prevent suicides and build stronger, more connected communities.

"The Isle of Wight Council's public health department are committed to ensuring this plan makes a real difference to the lives of people on the Island. We are focused on developing an approach that not only listens to the experience of people but also works with our communities and builds our assets. These assets include our vibrant voluntary sector, our community hubs and local community groups as well as our natural environment. We will continue to work in partnership with others on the Island to drive progress on the priorities set out in the plan, making sure we work together to improve mental wellbeing in ways that make a difference to local people."

Simon Bryant, Director of Public Health

"Isorropia Foundation is committed to improving the Isle of Wight community's mental health and wellbeing through the delivery of our organisational activities whereby Islanders can self-refer to our unique model of transformation, based on learning new skills and empowerment, facilitated by our team of wellbeing coaches with lived experience."

Isorropia Foundation CIC

"Hampshire and Isle of Wight Constabulary are looking forward to working with partners and key stakeholders in delivering the Mental Wellbeing Plan for residents of the Isle of Wight."

Hampshire and Isle of Wight Constabulary

"As a voluntary sector partner we are committed to supporting this plan, to ensure that the older people on the Isle of Wight can enjoy and live a better life that will lead to improved mental wellbeing."

Age UK Isle of Wight

"We are committed to the collaborative and co-produced approach set out in this plan. We are developing trauma informed services and continue to foster a culture of thoughtfulness and compassion, flexing and adapting to the diverse needs of the individuals we work with. We will work in partnership with Island based organisations to ensure that the priorities set out are addressed, and hold each other to account, to ensure that actions bring about positive change."

The Isle of Wight Trust's Mental Health and Learning Disability Division

Glossary

We all use different words to describe our mental wellbeing. We have clarified the intended meaning of the words used in this plan below.

Mental wellbeing includes both our feelings, such as contentment and enjoyment, our ability to function well in our lives and to engage with the world. It could be summarised as living in a way that is good for ourselves and for others. 'No health without mental health' defines mental wellbeing as: 'a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment.'[1] Positive mental wellbeing is more than the absence of mental illness. 'Mental wellbeing' and 'mental health' are often used interchangeably, though mental health is more often used in a context where mental illness is being discussed, for example, to describe treatment or support services.

Happiness and contentment

Feelings of happiness, joy and pleasure are characteristic of someone who has a positive experience of their life, contentment is an ease of one's situation.

Emotional resilience

Emotional resilience is about the ability to react positively to adverse events. It is the ability to cope with upsetting or difficult life events, to learn from or accept mistakes and bad experiences and move on. Another description of resilience is 'doing better than expected in the face of adversity'. Strong emotional resilience doesn't preclude feeling sad or upset but it does enable us to cope better with the challenges we face. Feeling connected and able to contribute to our community is an important aspect of this.

Mental illness or ill health

Mental illness refers to all diagnosable mental health conditions – they can involve both small and significant changes to thinking, emotion, and behaviour. Some common conditions include anxiety and depression, more severe conditions can include schizophrenia and bipolar disorder.

Inequalities

Everyone in society should have the opportunity to make healthy choices, live healthy lives and access high quality health and social care services, however, inequalities in power, money and resources at local and national levels can make people's daily lives more challenging. In turn, this can make people more vulnerable to poor health.

Inclusion

Giving equal access and opportunities, getting rid of discrimination and intolerance.

Diversity

Respecting and appreciating what makes people different.

Trauma

Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual wellbeing.

Adverse childhood experiences

Adverse childhood experiences (ACEs) are known as traumatic events occurring before the age of 18 years old. High or frequent exposure to ACEs, without the support of a trusted adult can lead to toxic stress. These can include various forms of abuse, neglect, witnessing or otherwise experiencing violence, having one's parents separate and living with parents who are afflicted by mental illness or addiction, among other adversities. Survey findings indicate that multiple ACEs can impact into adulthood with those experiencing four or more ACEs more likely to have poorer mental wellbeing, have a limiting long-term condition, smoke, be obese and be less physically active[2], with further research indicating an increased likelihood of being a high-risk drinker or drug taker, committing violence or be the victim of violence[3].

No Wrong Door

No Wrong Door (NWD) is the adult community mental health transformation programme across Hampshire, Southampton, Isle of Wight, and Portsmouth. It is aligned to the delivery of the Community Mental Health Framework outlined in the NHS Long Term Plan.

Suicide prevention

Deaths from suicide are tragic and have a devastating effect on families, friends and communities. They are often the end point in a complex history of events and risk factors. Suicide prevention requires work across a range of settings targeting a wide variety of audiences. Given this complexity, the combined knowledge, expertise and resources of organisations across the public, private and voluntary sectors is essential. No single agency is likely to be able to deliver effective suicide prevention alone.

Vision

The Isle of Wight Mental Health and Suicide Prevention Partnership have come together to formulate a shared vision for the Island over the next five years. The partnership will work together to put people and prevention at the heart of this plan, promoting mental wellbeing and supporting all of us on the Isle of Wight to have the best mental wellbeing that we can.

We will:

- work together to improve the mental wellbeing of all Isle of Wight residents and ensure prevention of mental ill health is at the heart of what we do;
- enable all Islanders to seek support when needed, without judgement; to feel enough resilience to cope and to experience joy and contentment;
- acknowledge the major influence that outside factors (such as our jobs, housing, life etc.) have on mental health and wellbeing and endeavour to make these aspects part of the solution.

Aim

Delivery of this plan will happen in partnership; through many layers of activity and a range of organisations being involved, coordinating action to improve mental wellbeing on the Island.

The drive to achieve a shared understanding of our Island's mental wellbeing, enhance our ability to self-care and improve mental health interventions at the right time, in the right place, focusing on those with the greatest need is central to many of the Island's strategies and work programmes. This plan will sit alongside these strategies[4] and aim to pull this work together, enabling the required focus to achieve the vision set out above. The plan does not focus on mental health services, however links closely with many other key policies and programmes of work across the Island which are being used to create resilient services, including aspects of transformation that are currently happening to improve mental health support for local people.

The Isle of Wight Mental Health and Suicide Prevention Partnership will remain committed to ensuring that work to promote positive mental wellbeing and prevent mental ill health takes place in a coordinated way, and that strategies outlining work on mental health and wellbeing co-exist and overlap as part of a broad network that affect the way we live, how we take care of ourselves and our families, and our access to support from professionals. The partnership view this as a unique strength of the Island's ability for effective partnership working.

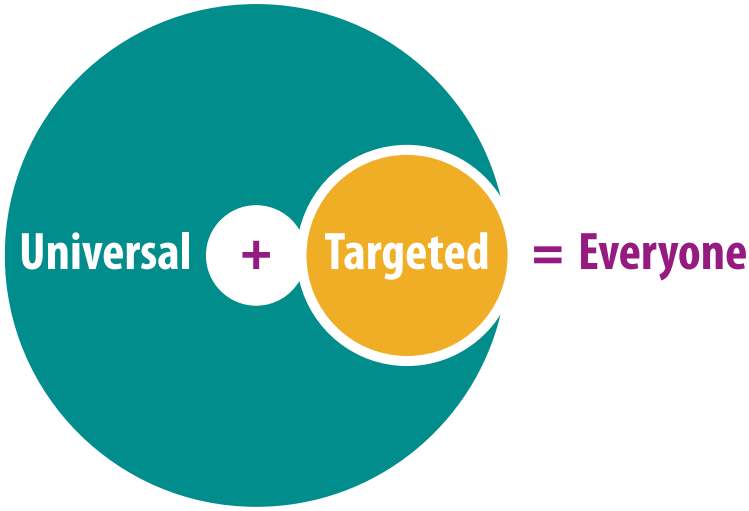
This strategy will adopt a two-pronged approach:

- **Universal approach** to encourage good mental wellbeing, emotional resilience and self-care across the whole Island population.

- **Targeted approach** to tackle mental wellbeing inequalities to reach, engage and improve the mental wellbeing of those at an increased risk of trauma and those at risk of poor mental health and wellbeing outcomes.

Underlying principles

All partners have committed to a number of principles that underpin this strategy and the actions within it. Each partner adopting these principles as part of their business-as-usual work, enables the Isle of Wight system to achieve sign-up to the Mental Wellbeing Prevention Concordat which focuses on achieving strategic and system-wide engagement and delivery.



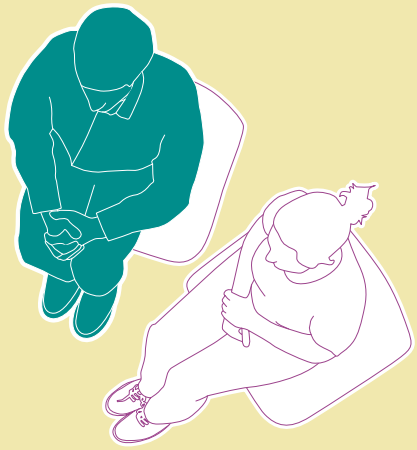
As a mental health and suicide prevention partnership we will:

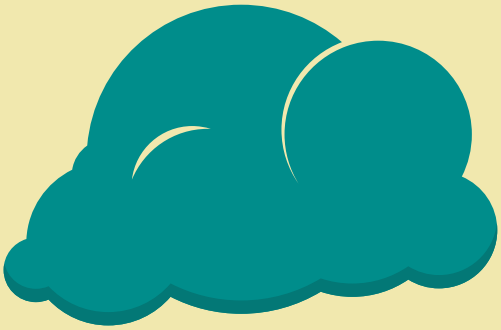
- recognise the **wide range of social and economic factors** that affect an individual's mental wellbeing and resilience such as connectedness, housing, income, education and employment;
- recognise **inequalities** in mental health and wellbeing, experienced by different groups and that different groups require **different approaches**;
- value mental wellbeing **equally** to physical health and recognise they are interlinked;
- engage with the **whole person** by listening and responding in a way that respects their experiences and state of wellbeing;
- focus on **partnership and cross-organisational working** to ensure the right support at the right time, recognising the value and expertise of the **voluntary and community sector** alongside statutory services as integral partners;
- prevent and reduce the impact of **trauma** and break the cycle of **adversity** on people's mental health and wellbeing, building on existing trauma informed and restorative practice;
- proactively address issues of **inclusion and diversity**;
- use the **latest evidence**, data, professional good practice, living experience and Islanders views to drive decisions and shape local approaches;

- **build protective factors** for mental wellbeing, alongside reducing risk factors;
- challenge **stigma and prejudice** at all levels by creating an Island where positive and open conversations about mental health and wellbeing are normalised;
- ensure this strategy does not stand alone, but is firmly embedded across the **Hampshire and Isle of Wight (HIOW) Integrated Care System** and links to the Hampshire, Portsmouth and Southampton's mental wellbeing workstreams.

What we know

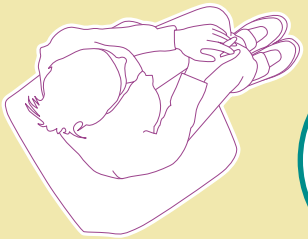
Nationally,
one in four
adults (16 and over) experience a mental health problem of some kind each year[5].





Just over **12 per cent** of the Island's population has depression, equating to around **15,000** people[6]

This equates to around
30,000
adults on the Isle of Wight



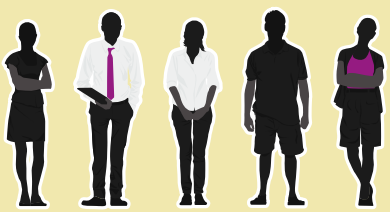
Around **one in ten** people on the Isle of Wight reported a low happiness score[7]

Nearly a quarter of residents self-reported a high anxiety score[8]

Emergency hospital admissions for intentional self-harm is 237.3 per 100,000 and is statistically higher than the national average (181.2 per 100,000)[9]

The suicide rate for the Island Island (2019 to 2021) is
13.8
per 100,000
which is statistically similar to the national average of 10.4 per 100,000[b].

The suicide rate for men in this period was **four times higher than the rate for women[10]**



Being employed is a protective factor for mental wellbeing the Island has a lower than national average employment rate national average.

A wide range of information is available on the risk of poor mental wellbeing associated with demographic variables, geographic wards and life circumstances, including:

- people who are insecurely housed or homeless: homelessness services on the Island saw 1,706 presentations in 2021/22[11];
- older people living alone and socially isolated: over a fifth of the Island's population is aged 70 years and over. People living in rural areas are at an increased risk of limited access to services, fuel poverty and social isolation[12];
- people who identify as LGBTQ+, who are at higher risk of experiencing common mental health problems and poorer mental wellbeing than heterosexual people, particularly those over the age of 55 years old and under 35 years old[13];
- veterans and military personnel, who can face unique risks and challenges to their mental health and wellbeing. Exposure to highly stressful situations, long periods away from home and the difficulty of adjusting to civilian life can all affect mental health and wellbeing[14]. There are around 7,000 veterans living on the Isle of Wight[15];
- carers: Census data indicates that one in ten people on the Isle of Wight (around 13,000 people) are currently providing unpaid support to family or friends[16]. Carers UK 2022 survey found that carers rate their life satisfaction as significantly lower than the national average[17];
- residents involved with the criminal justice system: The prevalence of mental illness and poor mental health is higher in those in contact with the criminal justice system, compared to the general population, and they are more likely to have other risk factors for poor mental health such as adverse childhood experiences[18];
- residents with a drug and alcohol dependence: National research shows that mental health problems are experienced by the majority of drug (70 per cent) and alcohol (86 per cent) users in community substance misuse treatment services[19];
- residents who are experiencing or have experienced domestic abuse: National research indicates that women are more likely to have experienced domestic abuse in their lifetimes compared to men and this is strongly associated with self-harm and suicidality[20].

The Joint Strategic Needs Assessment[21] (JSNA) presents more information on the distribution of these factors across the Island's geography.

It is noteworthy that one person may fall into all these groups. National research in 2015 found that around 40 per cent of people in England with overlapping problems including homelessness, substance misuse and contact with the criminal justice system in any given year also have a diagnosed mental health problem[22].

The impact of COVID-19 and associated legislation has also affected people's mental wellbeing with loneliness increasing in all ages. This impact was disproportionately experienced by people living in deprived areas, exacerbating existing inequalities in mental wellbeing across the Island[23].

Importantly, the Isle of Wight has many assets. It has a rich and diverse natural landscape, as well as a vibrant creative and modern manufacturing sector. In 2019, it became a UNESCO Biosphere, ensuring the preservation of the unique and diverse ecosystems, and enabling local ways to live harmoniously within them. Access to green spaces is a positive protective factor for mental wellbeing, and this should be celebrated.

Priority outcomes

This section outlines the priority outcomes for the Island, showing how we will work together and focus efforts to improve mental wellbeing, prevent mental ill health and reduce death by suicide for all residents. This is followed by next steps to make sure there is specific focus on what needs to be done to make this happen. This shows the commitment needed to ensure we are always working collectively towards our end goal of improving the mental wellbeing of our Island population.

1. Islanders will live, work and thrive on a unique island where partners are committed to working together and differently to ensure positive improvements to mental wellbeing are made **(focus on partnership working)**.

2. Islanders will benefit from the positive aspects of being part of their community and know where to access information and support to build both individual and community resilience **(focus on and building resilience)**.

3. Islanders will be comfortable talking about their mental health and wellbeing and be able to challenge prejudice around poor mental health **(focus on reducing stigma and discrimination)**.

4. Islanders will feel assured that all partners are working together on suicide prevention and supporting those lives that are impacted by suicide **(focus on suicide prevention)**.

5. Islanders will experience positive mental wellbeing, irrespective of their background, where they live or their life circumstances and value their mental wellbeing alongside their physical health **(focus on reducing inequalities and wider determinants)**.

The Mental Health and Suicide Prevention Partnership understand the dynamic and changing context that we all work in with many competing priorities. For this reason, this plan is framed with actions either as 'now' or 'next'. This provides a direction of travel for the next five years for partners both in the short and longer term, however it is not rigid and encourages regular review by the Island Mental Health and Suicide Prevention Partnership to ensure the right action is being focused on at the right time. Each priority also states the indicators of success, so that the Mental Health and Suicide Prevention Partnership can monitor progress over the five-year duration of the plan.

Next steps to make this happen

Priority 1

Islanders will live, work and thrive on a unique island where partners are committed to working together to ensure positive improvements to mental wellbeing are made.

1.1 – now

We will

Use the Mental Health and Suicide Prevention Partnership to influence change and improve outcomes via existing mechanisms such as the NHS Community Transformation Programme, the No Wrong Door Programme, the Crisis Care workstream, and Isle of Wight Health and Wellbeing Board.

How we'll know when we get there

The Mental Health and Suicide Prevention Partnership will enable alignment of this plan with key strategies and workstreams across Isle of Wight Council, the NHS and the community and voluntary sector.

Who?

Mental Health and Suicide Prevention Partnership

1.2 – now

We will

Continue to strengthen the Mental Health Alliance, providing a forum for a range of organisations supporting mental wellbeing to share good practice and increase awareness.

How we'll know when we get there

- Increased awareness of support available and greater links forged.
- Improvements in the skills and knowledge of the wider workforce.

Who?

Mental Health and Suicide Prevention Partnership

1.3 – now

We will

Promote, increase access to and enable currency of Mental Health First Aid and other appropriate mental wellbeing and suicide prevention training for all partners, to raise awareness, enable conversations and provide tools for managers, elected members, employees, and volunteers.

How we'll know when we get there

- Increased number of people attending mental health and wellbeing training activities.
- System-wide awareness of available prevention and mental wellbeing support.
- Increase in confidence to discuss mental health and wellbeing and signpost on to further support, if required.
- Number of organisations integrating mental health and wellbeing into their service delivery.
- Outcomes recorded by health and care professionals using the Everyday Interactions: measuring public health impact.

Who?

Partners human resources and training leads
Mental Health Alliance members
No Wrong Door

1.4 – now

We will

Encourage continual professional learning and networking to update mental wellbeing knowledge and local opportunities via a new MHSPP e-bulletin to be cascaded widely.

How we'll know when we get there

Organisations represented in the Mental Health and Suicide Prevention Partnership and Mental Health Alliance will have a mechanism to share good practice and transfer learning.

Who?

Isle of Wight Council public health

1.5 – now

We will

Work with People with Living Experience of Suicide as an integral part of developing new polices, work programmes, for example as guest speakers on training courses

How we'll know when we get there

- Increased understanding of mental ill health and suicide, the impact this has on people's lives and how to better support people.
- Evidence that people's voices and experiences are influencing learning, policy, services, and actions.
- The existing People with Living Experience of Suicide Voices Collaborative will include specific representation from the Island.
- Bi-annual 'Voices' input to Mental Health and Suicide Prevention Partnership.
- Increase links with current NHS led service user groups.

Who?

People with Living Experience of Suicide
No Wrong Door

1.6 – now

We will

Embed multi-agency approach in the communications plan to increase consistency using insight, and co-produced with People with Living Experience and those from groups identified as most at risk of poor mental health and wellbeing (priority 5).

How we'll know when we get there

- Continue to refresh multi-agency communications plan.
- Feedback surveys used to inform understanding of communications effectiveness demonstrate that Islanders have increased awareness in how to protect their mental wellbeing utilising the Island's assets, can identify when a mental health need arises and feel empowered to access appropriate early help or support themselves.

Who?

Multi-agency Mental Health Alliance communications group

1.7 – now

We will

Partners lead by example, promoting and protecting the mental wellbeing of their workforce, both paid staff and volunteers.

How we'll know when we get there

- Partner organisations audit themselves against a set of workplace mental wellbeing standards, such as NICE Mental wellbeing at work
- Partner organisations have a plan to promote and protect workforce mental wellbeing.

Who?

Mental Health and Suicide Prevention Partnership
Mental Health Alliance working group

1.8 – now

We will

Develop a workforce that supports joined-up care delivery between NHS primary and secondary care, and between community resources including 3rd sector and wider community partners

How we'll know when we get there

Increase in delivery of personalised, place based and well-coordinated care.

Who?

No Wrong Door Programme

1.9 – now

We will

Embed trauma–informed and restorative practice across Isle of Wight Council services to promote early intervention and prevention support, working towards becoming psychologically informed services, taking into account the psychological makeup including the thinking, emotions, personalities and past experience of participants.

How we'll know when we get there

Psychologically informed environments self-assessment tool.
Domestic Abuse Housing Alliance accreditation.

Who?

Homeless Improvement Support Team

1.10 – next

We will

Submit an application to the national Mental Health Prevention Concordat

How we'll know when we get there

- Receive the national Mental Health Prevention Concordat
- The Island to be recognised for best practice in promoting mental health and wellbeing in a collective partnership way

Who?

Mental Health and Suicide Prevention Partnership

1.11 – next

We will

Develop a consistent understanding and approach across agencies and partners of what is meant by a trauma-informed approach; setting out the essential knowledge and skills to operate at all practice levels to support and help people affected by traumatic events.

How we'll know when we get there

Numbers trained in trauma informed approach.

Who?

Homeless Improvement Support Team

Priority 2

Islanders will benefit from the positive aspects of being part of their community and know where to access information and support to build both individual and community resilience.

2.1 - now

We will

Build on existing place-based information of support available to Islanders, working in partnership to gain insight, adapt and develop messaging and accessibility where possible.

How we'll know when we get there

Islanders have the knowledge to support themselves, colleagues and family experiencing poor mental health.

Who?

No Wrong Door
Mental Health Alliance

2.2 – now

We will

Develop and deliver a mental health transformation programme which is embedded in the needs of the Isle of Wight's population and the assets available on a place basis across the statutory, voluntary, primary care sectors along with people with lived experience of mental health issues.

These workstreams will include: Delivering the No Wrong Door community mental health framework programme at locality level to ensure an integrated service for people experiencing severe mental illness; improving access to services for children and young people; improved crisis services (linked to the suicide prevention programme); new pathways to support people with neurodevelopmental issues.

How we'll know when we get there

Islanders are supported with both their physical and mental health needs, enabling them to reach their full potential recovery.

New place-based pathways are developed and implemented aligned to ICB priorities and the final year (23/24) of national Mental Health Investment Standard (MHIS) funding which best meet local population need and build on the assets of local partners and stakeholders working together to improve local access to support.

Who?

No Wrong Door

2.3 – now

We will

Work with partners including regeneration, housing, Citizens Advice and voluntary sector to raise awareness of wider support available, as well as signposting to mental health and wellbeing support.

How we'll know when we get there

Frontline services signpost to assets, support, and services available including housing, financial services and support available from the community and voluntary sector.

Who?

Mental Health and Suicide Prevention Partnership

2.4 – now

We will

Embed trauma informed language through:

- links with wider council to update website to ensure that all of the information on there is easily accessible and trauma informed;
- links with the homeless intervention and support team to amplify information to stakeholders from quaterly newsletter;
- partner agencies who will provide a drop-in service for homeless people which has been commissioned by the IWC for those who are rough sleeping and sofa surfing, where they will be able to access advice from numerous professionals under one roof, delivered in an accessible way.

How we'll know when we get there

- KPIs will monitor an increase of people accessing the support available and record the rate people represent to housing with the same needs.
- Website hits.
- Referral numbers.
- The newsletter tracks how many people read and access the publication.

Who?

Homeless Intervention and Support Team

2.5 – now

We will

Strengthen links with libraries, Safe Places, carers support, community hubs and Advice First Aider network to provide information to people who don't have digital access.

How we'll know when we get there

People without digital access are aware of support available in the community

Who?

Mental Health and Suicide Prevention Partnership

2.6 – next

Who?

Targeting communications around resilience and self-help for specific groups (to be identified).

How we'll know when we get there

Insights from campaigns used to inform communications and increase effectiveness of messaging.

Who?

Mental Health Alliance communications

2.7 – next

Who?

Influence the building of local capacity to ensure sustainability of skills and knowledge, building community resilience programmes that promote mental wellbeing on the Island.

How we'll know when we get there

- Community and voluntary sector partners shape plans to improve their capacity to promote mental wellbeing.
- Annual feedback on what is working well and how to improve.

Who?

Mental Health Alliance

Priority 3

Islanders will be comfortable talking about their mental health and wellbeing and be able to challenge prejudice around poor mental health.

3.1 – now

We will

Deliver a co-ordinated multi-agency Mental Health Awareness Week annually to raise awareness for all Islanders (both residents and professionals), which aligns with the multi-agency communications plan.

How we'll know when we get there

People know where to go for advice and support, how to support themselves and others and spot signs of early mental ill health.

Who?

Mental Health Alliance communications group

3.2 – now

We will

Learn from all agencies to share good practice of support for mental wellbeing within the workforce.

How we'll know when we get there

- Workforce feel able to talk about mental wellbeing and know where to go for support.
- Reduction in absence levels due to mental health issues.

Who?

Mental Health and Suicide Prevention Partnership
Mental Health working group

3.3 – now

We will

Roll out Mental Health First Aid and other appropriate training to community leaders and members to help make mental health an everyday conversation.

How we'll know when we get there

- Number of community leaders and members attending mental health and wellbeing training activities.
- Increase in confidence across the community to talk about mental health and wellbeing.

Who?

Mental Health and Suicide Prevention Partnership

3.4 – now

We will

Work with schools and educational settings through the Partnership for Education, Attainment and Children's Health (PEACH), the mental health support teams and other mental health support to reduce stigma and work in a trauma informed way to encourage all to talk about mental wellbeing.

How we'll know when we get there

Findings from school's survey indicating awareness of where to go for support and having someone to talk to.

Who?

Mental Health and Suicide Prevention Partnership (MHSPP)

3.5 – next

We will

Develop a Mental Health First Aider network for the wider workforce across the Island.

How we'll know when we get there

- Meeting bi-annually to share good practice and learn from examples.
- Community feel empowered and supported to talk about mental wellbeing and signpost to support where appropriate.

Who?

Mental Health and Suicide Prevention Partnership

Priority 4

Islanders will feel assured that all partners are working together on suicide prevention and support for those lives that are impacted by suicide.

4.1 – now

We will

Raise awareness that promoting support for positive mental wellbeing will help in suicide prevention.

How we'll know when we get there

People will know where to go for support and will be aware of signs of mental ill health in themselves, friends, family and others.

Who?

Mental Health and Suicide Prevention Partnership

4.2 – now

We will

Have a partnership co-ordinated mental health communications plan which regularly focuses on suicide prevention e.g., marking suicide awareness days, promoting support and working with partners to gain insight.

How we'll know when we get there

People will know where to go for support with preventing suicide.

Who?

Mental Health and Suicide Prevention Partnership
Mental Health Alliance communications partnership

4.3 – now

We will

Support in People with Living Experience of Suicide 'Voices' so that Island voices are heard.

How we'll know when we get there

- People with living experience will feel heard and insights will better inform future delivery.
- The existing Voices collaborative will include specific representation from the Island.
- Bi-annual Voices input to Mental Health and Suicide Prevention Partnership.

Who?

People with Living Experience of Suicide

4.4 – now

We will

Work in partnership with schools and other key partners to support young people who are self-harming, or at high risk such as children in care and care leavers, those who have low mental wellbeing or suicide ideation to learn positive coping skills and know where to go for support. For example, through; the Partnership for Education, Attainment & Children's Health (PEACH) programme; with schools' Mental Health Support Teams; the Suicide Postvention Protocol; Inclusion IOW youth team

How we'll know when we get there

- Young people will know where to go for support.
- Schools will be able to evidence they have embedded the suicide postvention protocol.

Who?

Schools
Mental health support teams
Inclusion IOW

4.5 – now

We will

Promote and increase access to suicide prevention training, so that partners, eg: frontline services, voluntary and community groups, elected members, employees are able to have conversations with people in times of need and signpost to appropriate resources such as Samaritans, Isorropia, NHS services and online support such as Ripple.

How we'll know when we get there

- Number of people attending suicide prevention training activities.
- System-wide awareness of current, readily available information and support for suicide prevention.
- Increase in confidence to support when individuals are in need.

Who?

System training leads
Mental Health Alliance members
Community and MHLD transformation programmes

4.6 – now

We will

Embed and expand the multi-agency HIOW Real Time Surveillance (RTS) of suspected suicides to ensure timely prevention, postvention and ongoing surveillance takes place.

We will:

- develop a HIOW Suicide Cluster Response Plan with strategic sign-up and operational resource from all partners;
- identify and address data gaps to ensure all relevant data is available;
- review the children and young people response pathway for individual suspected suicides to ensure timely and appropriate responses are mobilised.

How we'll know when we get there

- Increase in active partners in Real Time Surveillance Working Group.
- Postvention protocols mobilised for all suspected suicides (both adult and children and young people).
- Identification of Suicide Cluster Response Plan individual by each partner.
- Being system prepared by having the ability to mobilise a multi-agency rapid response to a suspected cluster of suicides if ever required.
- All partners are aware of children and young people postvention response for an individual suspected suicide.
- Co-ordinated communications via the media are agreed and disseminated in a sensitive and responsible manner.

Who?

HIOW Real Time Surveillance Working Group

4.7 now

We will

Integrate suicide prevention updates and emerging evidence via national and regional networks to inform local practice.

How we'll know when we get there

- Updates and emerging evidence are shared with the IOW Mental Health and Suicide Prevention Partnership and the Mental Health Alliance.
- Practice/policy and action plans are evidence based and updated in light of updates.

Who?

HIOW Suicide Prevention Steering Group
Partners who have a lead for suicide prevention

4.8 – now

We will

Monitor the Island utilisation of support set up through joint working across the ICS e.g. the HIOW Suicide Bereavement Support Service, self-harm support to ensure Islanders are accessing adequate support.

How we'll know when we get there

- Numbers of Islanders accessing the services available

Who?

HIOW Real Time Surveillance working group

4.9 – next

We will

Use data to inform work with partners to reduce access and means to die by suicide

How we'll know when we get there

- Reduction in deaths by suicide.

Who?

Mental Health and Suicide Prevention Partnership

4.10 – next

We will

Work with voluntary, private and community sector experts to support in postvention plans roll out

How we'll know when we get there

- Numbers of protocols in place, with evidence that they are embedded in their organisation.

Who?

Mental Health and Suicide Prevention Partnership

4.11 – next

We will

Work with media through awareness raising and training to ensure the importance of language is recognised with ethical and safe reporting of matters around suicide.

How we'll know when we get there

- Media coverage of suicide and suicide related matters are always undertaken in a safe and ethical format.
- Media outlets engaged in comms specific suicide prevention training.

Who?

Mental Health and Suicide Prevention Partnership

Priority 5

Islanders will experience positive mental wellbeing, irrespective of their background, where they live or their life circumstances and value their mental health and wellbeing alongside their physical health.

5.1 – now

We will

Ensure the NHS Community Transformation Programme orientates focused delivery of services to identified groups most at risk of poor mental wellbeing, in conjunction with Mental Health and Suicide Prevention Partnership and Mental Health Alliance.

How we'll know when we get there

Coordinated efforts by different organisations will be focused on vulnerable populations.

Who?

NHS Community Transformation Programme

5.2 – now

We will

Build on data and work with partners to better understand groups most at risk of poor wellbeing and how best to target messages identifying support available – including:

- insecurely housed and homeless people;
- older people who are socially isolated;
- LGBTQ+ groups, veterans, carers;
- those in contact with the criminal justice system;
- those with drug or alcohol dependency;
- those who have experienced domestic abuse;
- young people accessing support services transitioning to adults.

How we'll know when we get there

Vulnerable groups will know how to look after their mental wellbeing and where to access advice and support.

Who?

Mental Health and Suicide Prevention Partnership

5.3 – now

We will

Prioritise engagement with those groups identified at most risk to better understand their needs, assets and barriers to services and support.

How we'll know when we get there

Annual stocktake with the MHA demonstrates improvement in identification of needs, assets and barriers to services and support in those groups identified at most risk.

Who?

Mental Health and Suicide Prevention Partnership
Mental Health Alliance comms

5.4 – now

We will

All homelessness and support services will take a harm reduction approach where people are supported holistically. Staff support individuals who use substances to reduce immediate and ongoing harm to their health, who self-harm to undertake practices which minimise risk of greater harm, support individuals to undertake practices that reduce harm and promote recovery in other areas of physical and mental health and wellbeing.

How we'll know when we get there

Outcomes measured as part of service KPIs:

- Quarterly: Number of people who support needs met within six months.
- Number of people with support needs met within 12 months.
- Number of people who support needs met within 12 or more months.
- Percentage of positive responses on annual survey.
- Percentage of people who have achieved their desired outcomes when cases are closed.

Who?

Homeless Intervention and Support Team

5.5 – now

We will

Work in collaboration with those groups most at risk to adapt interventions to better meet their needs. This includes:

- adapting communications, or developing materials specifically to meet the needs of under-represented groups;
- address barriers to access.

How we'll know when we get there

People in those groups most at risk, feel that they have meaningfully contributed to enable interventions to better meet their needs.

Who?

Mental Health and Suicide Prevention Partnership

5.6 – now

We will

Learn and more widely implement Psychologically Informed Environment (PIE) framework currently used by Homelessness and support services which takes into account the psychological makeup, thinking, emotions, personalities and past experience of both its staff and individuals using their services and recognises the possibility for positive change.

How we'll know when we get there

Monitored as part of positive outcomes in KPI's and via service user services as part of a service review.

Who?

Homeless Intervention and Support Team

5.7 – now

We will

Recognise and build on the Homelessness and support services approach to increase positive social impact on client's lives, their families, and the wider community. The benefits for Islanders will include improved health (physical and mental), stability and social functioning, crime reduction and reducing the organisations carbon footprint. The service should build individual resilience and support networks that will sustain independence in the community.

How we'll know when we get there

Monitored as part service user services as part of a service review, using a newly developed PIE self-assessment tool.

Who?

Homeless Intervention and Support Team

5.8 – next

We will

Ensure alignment with this plan and the Island's children and young people's plans, including the Children and Young People's Mental Health and Emotional Wellbeing Local Transformation Plan (LTP), with an emphasis on transition from childhood to adulthood.

How we'll know when we get there

Children and young people's mental wellbeing plans align with adult plans and the transition between the two is clear.

Who?

Mental Health and Suicide Prevention Partnership

Partners

This strategy has been developed by members of the Isle of Wight Mental Health and Suicide Prevention Partnership and the Isle of Wight Mental Health Alliance.

Isle of Wight Mental Health and Suicide Prevention Partnership

Isle of Wight Council

Isorropia Foundation

NHS Trust

The Youth Trust

Age UK Isle of Wight

Hampsire and Isle of Wight Constabulary

Hampshire and Isle of Wight

The Probation Service

Healthwatch Isle of Wight

The Samaritans

HM Prison Service

Op Courage

Isle of Wight Mental Health Alliance

Age UK IOW – ageuk.org.uk/isleofwight

Aspire – aspireryde.org.uk

Autism Inclusion Matters – autism.org.uk/directory/a/aim-autism-inclusion-matters

Barnardos – barnardos.org.uk/what-we-do/services/isle-wight-family-centres-early-help-support-services

Men in sheds
- Brading – bradingshed.uk
- Cowes – www.storeroom.org.uk/cowes-mens-shed

Breakout Youth – breakoutyouth.org.uk

Carers IW – carersiw.org.uk

Citizens Advice – citizensadviceiw.org.uk

Community Action IW – communityactionisleofwight.org.uk

Community Spirited – www.communityspirited.com

Equals IW – equalsiw.org.uk

Healthwatch – healthwatchisleofwight.co.uk

Independent Arts – independentarts.org.uk

Isle of Wight Council
- Adult social care and community wellbeing – iow.gov.uk/adults
- Children's services (early help) – iow.gov.uk/Residents/care-and-Support/Childrens-Services/Support-and-Advice-for-Families/About-Early-Help
- Communications and engagement – iow.gov.uk/mediarelations
- Housing – iow.gov.uk/housing
- Learning and development – iow.gov.uk/Residents/schools-and-learning/Education-Learning-and-Development

Isorropia – isorropia.uk

Maritime and Coastguard Agency – gov.uk/government/organisations/maritime-and-coastguard-agency

Men Only Isle of Wight – menonlyiow.co.uk

Natural Enterprise – naturalenterprise.co.uk

Nature Therapy – naturetherapyonline.com

NHS / ICB – hantsiowhealthandcare.org.uk

OSEL IOW – oseliow.org.uk

Our Place – westwight.org.uk/community/our-place

People Matter – www.peoplematteriw.org

Pigsty farm

Hampshire and Isle of Wight Constabulary – www.hampshire.police.uk

Prostate support group – iwpcsg.org

Safe Places – safeplacesiow.com

Samaritans – samaritans.org/branches/isle-of-wight

Sensory Space – facebook.com/sensoryspacecic

Solent NHS – solent.nhs.uk

St Marys NHS – iow.nhs.uk

Stonecrabs – stonecrabs.co.uk/out-on-an-island-lgbtq-heritage-on-the-isle-of-wight

The Island Collection – islandcollection.org.uk

Tidal Family Support – tidalfamilysupport.org.uk

Two Saints – twosaints.org.uk

Ventnor Town Council – ventnortowncouncil.gov.uk

Veterans Hub – veteranshubiow.co.uk

Veterans Outreach Support – vosuk.org/drop-in/iow

Wight Dash – wightdash.co.uk

You Trust – theyoutrust.org.uk

Youth Trust – iowyouthtrust.co.uk

Endnotes

Page 6

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3 phw.nhs.wales/files/aces/infographic-aces-and-their-impact-on-health-harming-behaviours-in-the-welsh-adult-population/

Page 9

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Page 13

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Isle of Wight Council, homelessness services, 2021/22, unpublished

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If you have difficulty in understanding this document, please contact us on 01983 821000 and we will do our best to help you.

Isle of Wight mental wellbeing plan

2023 to 2028

5186PH 5/23 SC

Equality Impact Assessment Template

Before carrying out an Equalities Impact Assessment (EIA), you should familiarise yourself with the guidance. This document should be in **plain English**, include **Stakeholder** involvement and be able to stand up to **scrutiny** (local and/or court) if/when challenged to ensure we have met the councils public sector equality duty.

An Equality Impact Assessment (EIA) should be completed when you are considering:

- developing, reviewing or removing policies
- developing, reviewing or removing strategies
- developing, reviewing or removing services
- developing, reviewing or removing a council function/system
- commencing any project/programme

Assessor(s) Name and job title:

Sharon Kingsman, Public Health Principal

Directorate and Team/School Name:

Public Health

Name, aim, objective and expected outcome of the programme/ activity:

Name: Isle of Wight Mental Wellbeing Plan 2023 to 2028

Vision

The Isle of Wight Mental Health and Suicide Prevention Partnership (MHSPP) have come together to formulate a shared vision for the Island over the next five years. The partnership will work together to put people and prevention at the heart of this plan, promoting mental wellbeing and supporting everyone on the Isle of Wight to have the best mental wellbeing they can.

The MHSPP will:

- Work together to improve the mental wellbeing of all Isle of Wight residents and ensure prevention of mental ill health is at the heart of what they do.
- Enable all Islanders to seek support when needed, without judgement; to feel enough resilience to cope and to experience joy and contentment.
- Acknowledge the major influence that outside factors (such as jobs, housing, life etc.) have on mental health and wellbeing and endeavour to make these aspects part of the solution.

Aim of the Plan

Delivery of the plan will be carried out in partnership; through many layers of activity and a range of organisations being involved, coordinating action to improve mental wellbeing on the Island.

The drive to achieve a shared understanding of our Island's mental wellbeing, enhance our ability to self-care and improve mental health interventions at the right time, in the right place, focusing on those with the greatest need is central to many of the Island's strategies and work programmes. The plan will sit alongside these strategies and aim to pull this work together, enabling the required focus to achieve the vision set out above. The plan does not focus on mental health services, however links closely with many other key policies and programmes of work across the Island which are being used to create resilient services, including aspects of transformation that are currently happening to improve mental health support for local people.
The plan will adopt a two-pronged approach:

- **Universal approach** to encourage good mental wellbeing, emotional resilience and self-care across the whole Island population
- **Targeted approach** to tackle mental wellbeing inequalities to reach, engage and improve the mental wellbeing of those at an increased risk of trauma and those at risk of poor mental health and wellbeing outcomes.

Objectives of the Plan

- Recognise the wide range of social and economic factors that affect an individual's mental wellbeing and resilience such as connectedness, housing, income, education and employment.
- Recognise inequalities in mental health and wellbeing, experienced by different groups and that different groups require different approaches.
- Value mental wellbeing equally to physical health and recognise they are interlinked
- Engage with the whole person by listening and responding in a way that respects their experiences and state of wellbeing
- Focus on partnership and cross-organisational working to ensure the right support at the right time, recognising the value and expertise of the voluntary and community sector alongside statutory services as integral partners
- Prevent and reduce the impact of trauma and break the cycle of adversity on people's mental health and wellbeing, building on existing trauma informed and restorative practice
- Proactively address issues of inclusion and diversity
- Use the latest evidence, data, professional good practice, living experience and Islanders views to drive decisions and shape local approaches.
- Build protective factors for mental wellbeing, alongside reducing risk factors
- Challenge stigma and prejudice at all levels by creating an Island where positive and open conversations about mental health and wellbeing are normalised
- Ensure the plan does not stand alone, but is firmly embedded across the Hampshire and Isle of Wight (HIOW) Integrated Care System and links to the Hampshire, Portsmouth and Southampton's mental wellbeing workstreams

Priority outcomes

The MHSPP is committed to working together and focusing efforts to improve mental wellbeing, prevent mental ill health and reduce death by suicide for all residents. The is shows the commitment needed to ensure we are always working collectively towards our end goal of improving the mental wellbeing of the Island population.
There are 5 priority outcomes.

1) **Focus on partnership working-** Islanders will live, work and thrive on a unique island where partners are committed to working together and differently to ensure positive improvements to mental wellbeing are made.

2) **Focus on and building resilience -** Islanders will benefit from the positive aspects of being part of their community and know where to access information and support to build both individual and community resilience.

3) **Focus on reducing stigma and discrimination -** Islanders will be comfortable talking about their mental health and wellbeing and be able to challenge prejudice around poor mental health.
4) **Focus on suicide prevention -** Islanders will feel assured that all partners are working together on suicide prevention and supporting those lives that are impacted by suicide.
5) **Focus on reducing inequalities and wider determinants-** Islanders will experience positive mental wellbeing, irrespective of their background, where they live or their life circumstances and value their mental wellbeing alongside their physical health.

	Reason for Equality Impact Asessment (tick as appropriate)	
This is a **new** policy/strategy/service/system function proposal		X
This is a proposal for a **change** to a policy/strategy/service/system function proposal function (*check whether the original decision was equality impact assessed)*		
Removal *of a* policy/strategy/service/system function proposal		
Commencing any project/programme		

Equality and Diversity considerations

Describe the ways in which the groups below may be impacted by your activity (**prior to mitigation**). The impact may be negative, positive or no impact.

Protected Characteristic	**Negative, positive or no impact (before mitigation/intervention) and why?**	**Does the proposal have the potential to cause unlawful discrimination (is it possible that the proposal may exclude/restrict this group from obtaining services or limit their participation in any aspect of public life?)**	**How will you advance the equality of opportunity and to foster good relations between people who share a protected characteristic and people who do not.**	**What concerns have been raised to date during consultation (or early discussions) and what action taken to date?**	**What evidence, analysis or data has been used to substantiate your answer?**	**Are there any gaps in evidence to properly assess the impact? How will this be addressed?**	**How will you make communication accessible for this group?**	**What adjustments have been put in place to reduce/advance the inequality? (*Where it cannot be diminished, can this be legally justified*?)**
Age (restrictions/difficulties	Positive Impact: Mental Wellbeing Plan (MWB plan) is focused on adults	The plan complies with the Equality Act 2010. The plan supports equitable	The plan supports equitable and targetted help to meet the needs of a diverse range of people aged 18 and over.	Ensuring the voice of people with lived/living experience is heard. Throughout the development of the plan	The Public Health Team undertook a needs	None	Communication about the plan and more generally about mental wellbeing is approached in both a targetted and universal way.	The plan complies with the Equality Act 2010. The plan is aimed at

s both younger/older)	only (18 years and over). The MWB plan will contribute to improvement in mental wellbeing for adults through the two-pronged approach mentioned above (universal and targetted). The plan is compliant with the Equality Act 2010.	and targetted help to meet the needs of a diverse range of people aged 18 and over. Plans are developed to support mental wellbeing of those under the of 18 by other agencies e.g. Integrated Care Board, NHS Trust, Childrens Services, Youth Trust, educational settings.	The partnership approach also supports fostering good relations between groups of people as the various partners represent groups often with protected characteristics e.g. Age UK IOW, Veterans, Carers	Healthwatch IOW was engaged and the data they gathered from a listening tour (carried out with the IWC Mental Health Lead Councillor) informed this process. We acknowledge there is more work to be done and plan to engage existing groups (e.g. patients experience, veterans and carers groups) as well as considering how we can listen and understand peoples' experience better.	assessment in Autumn 2022 which consisted of a desktop review of local and national data. Ongoing analysis of data is carried out and published in the Joint Strategic Needs Assessment. An analysis of the impact of covid carried out in 2022 also featured mental health and wellbeing		Assets are developed with the audience in mind and expertise of comms colleagues. Any materials are assessed for accessibility of format, use every-day, jargon-free language and will explain any technical terms. All comms will be considered for the person's age (or other protected characteristic), and any specific communication needs (for example because of learning disabilities, physical disabilities, cognitive impairments due to neurological conditions, race).	reducing inequalities as detailed in priority 5 above.
Disability **a) Physical** **b) Mental health** (must respond to both a & b)	Positive Impact: Although the focus for the plan is on mental health people with physical impairment and long-term conditions will also be better supported as mental and physical wellbeing are inextricably linked.	The plan complies with the Equality Act 2010. The plan supports equitable and targetted help to meet the needs of a diverse range of people aged 18 and over regardless of disability.	The plan supports equitable and targetted help to meet the needs of a diverse range of adults. The partnership approach also supports fostering good relations between groups of people as the various partners represent groups often with protected characteristics e.g. Age UK IOW, Veterans, Carers, sensory impairment, neurodiversity	As above	As above	None	As above	As above
Race (including ethnicity and nationality)	Positive Impact: The plan will contribute to improvement in mental wellbeing for adults through the two-pronged approach mentioned above (universal and targetted).	The plan complies with the Equality Act 2010. The plan supports equitable and targetted help to meet the needs of a diverse range of people aged 18 and over regardless of race.	The plan supports equitable and targetted help to meet the needs of a diverse range of adults regardless of race. The partnership approach also supports fostering good relations between groups of people as the various partners represent groups often with protected characteristics e.g. Age UK IOW, Veterans, Carers,	As above	As above	None	As above	As above

			sensory impairment, neurodiversity					
Religion or belief (different faith groups/those without a faith)	Positive Impact: The plan will contribute to improvement in mental wellbeing for adults through the two-pronged approach mentioned above (universal and targetted).	The plan complies with the Equality Act 2010. The plan supports equitable and targetted help to meet the needs of a diverse range of people aged 18 and over regardless of religion or belief.	The plan supports equitable and targetted help to meet the needs of a diverse range of adults regardless of religion or belief. The partnership approach also supports fostering good relations between groups of people as the various partners represent groups often with protected characteristics e.g. Age UK IOW, Veterans, Carers, sensory impairment, neurodiversity	As above plus we plan to engage more with faith groups/places of worship to ensure a wide variety of lived/living experiences shape future actions.	As above	None	As above	As above
Sex (Including Trans and non-binary – is your language inclusive of trans and non-binary people?)	Positive Impact: The plan will contribute to improvement in mental wellbeing for adults through the two-pronged approach mentioned above (universal and targetted).	The plan complies with the Equality Act 2010. The plan supports equitable and targetted help to meet the needs of a diverse range of people aged 18 and over regardless of sex.	The plan supports equitable and targetted help to meet the needs of a diverse range of adults regardless of sex. The partnership approach also supports fostering good relations between groups of people as the various partners represent groups often with protected characteristics e.g. Age UK IOW, Veterans, Carers.	Ensuring the voice of people with lived/living experience is heard. Throughout the development of the plan Healthwatch IOW was engaged and the data they gathered from a listening tour (carried out with the IWC Mental Health Lead Councillor) informed this process. We acknowledge there is more work to be done and plan to engage existing groups (e.g. patients experience, veterans and carers groups) as well as considering how we can listen and understand peoples' experience better.	As above	None	As above	As above
Sexual orientation (is your language inclusive of LGB groups?)	Positive Impact: The plan will contribute to improvement in mental wellbeing for adults through the two-pronged approach mentioned above (universal and targetted).	The plan complies with the Equality Act 2010. The plan supports equitable and targetted help to meet the needs of a diverse range of people aged 18 and over regardless of sexual orientation.	The plan supports equitable and targetted help to meet the needs of a diverse range of adults regardless of sexual orientation. The partnership approach also supports fostering good relations between groups of people as the various partners represent groups often with protected	As above plus there is work to be carried out to understand better, the lived experience of people regarding sexual orientation and mental wellbeing.	As above	None	As above	As above

			characteristics e.g. Age UK IOW, Veterans, Carers.					
Pregnancy and maternity	Positive Impact: The plan will contribute to improvement in mental wellbeing for adults through the two-pronged approach mentioned above (universal and targetted).	The plan complies with the Equality Act 2010. The plan supports equitable and targetted help to meet the needs of a diverse range of people aged 18 and over regardless of pregnancy or maternity.	The plan supports equitable and targetted help to meet the needs of a diverse range of adults regardless of pregnancy or maternity. The partnership approach also supports fostering good relations between groups of people as the various partners represent groups often with protected characteristics e.g. Age UK IOW, Veterans, Carers, sensory impairment, neurodiversity	Ensuring the voice of people with lived/living experience is heard. Throughout the development of the plan Healthwatch IOW was engaged and the data they gathered from a listening tour (carried out with the IWC Mental Health Lead Councillor) informed this process. We acknowledge there is more work to be done and plan to engage existing groups (e.g. patients experience, veterans and carers groups) as well as considering how we can listen and understand peoples' experience better.	As above	None	As above	As above
Marriage and Civil Partnership	Positive Impact: The plan will contribute to improvement in mental wellbeing for adults through the two-pronged approach mentioned above (universal and targetted).	The plan complies with the Equality Act 2010. The plan supports equitable and targetted help to meet the needs of a diverse range of people aged 18 and over regardless of a person's marriage or civil partnership status.	The plan supports equitable and targetted help to meet the needs of a diverse range of adults regardless of a person's marriage or civil partnership status. The partnership approach also supports fostering good relations between groups of people as the various partners represent groups often with protected characteristics e.g. Age UK IOW, Veterans, Carers, sensory impairment, neurodiversity	As above	As above	None	As above	As above
Gender reassignment	Positive Impact: The plan will contribute to improvement in mental wellbeing for adults through the two-pronged approach mentioned above	The plan complies with the Equality Act 2010. The plan supports equitable and targetted help to meet the needs of a diverse range of people aged 18 and over regardless	The plan supports equitable and targetted help to meet the needs of a diverse range of adults regardless of gender reassignment. The partnership approach also supports fostering good relations between groups of people as the various	As above plus there is work to be carried out to understand better, the lived experience of people regarding gender reassignment and mental wellbeing.	As above	None	As above	As above

	(universal and targetted).	of a person's status regarding gender reassignment.	partners represent groups often with protected characteristics e.g. Age UK IOW, Veterans, Carers, sensory impairment, neurodiversity					

In order to identify the needs of the groups, you will need to review data, statistics, user feedback, population data, complaints data, staffing data (SAPHRreports@iow.gov.uk), community/client data, feedback from focus groups etc. When assessing the impact, the assessment should come from an evidence base and not through opinion or self-knowledge.

H. Review

How are you engaging people with a wide range of protected characteristics in the development, review and/or monitoring of the programme/ activity?

The detailed activity to be carried out under the Mental Wellbeing plan is still in development but as evidenced above, the vision, aims and outcomes all focus on improving the mental wellbeing of the whole Island population. There is some targetted work aimed at higher risk cohorts and more work to be carried out regarding involving people with lived/living experience. When developing this work, we intend to ensure we seek involvement with people from a wide variety of backgrounds and communities to ensure protected characteristics are represented. This will enable our plan to be fully inclusive and make a positive difference to the lives of all Island residents.

The progress of the plan will be monitored by the Mental Health and Suicide Prevention Partnership and reported to the Isle of Wight Health and Wellbeing Board.

Date of next review: April 2028

H. Sign-off

Head of Service/Director/Headteacher sign off & date: 	Name: Eleanor Reed, Service Manager Date: 13/04/2023
Legal sign off & date: Judy Mason (by email)	Name: Judy Mason, Strategic Manager of Human Resources and Employment Lawyer Date: 12/04/2023

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Isle of Wight Suicide Prevention Plan

2023-2028

Ambition: *Islanders will feel assured that all partners are working together on suicide prevention and supporting those lives that are impacted by suicide*

Mental Health Alliance Isle of Wight

Contents

Introduction

The impact of suicide on family, friends, workplaces, schools and communities can be devastating; suicide is a major issue for society and a leading cause of years of life lost.

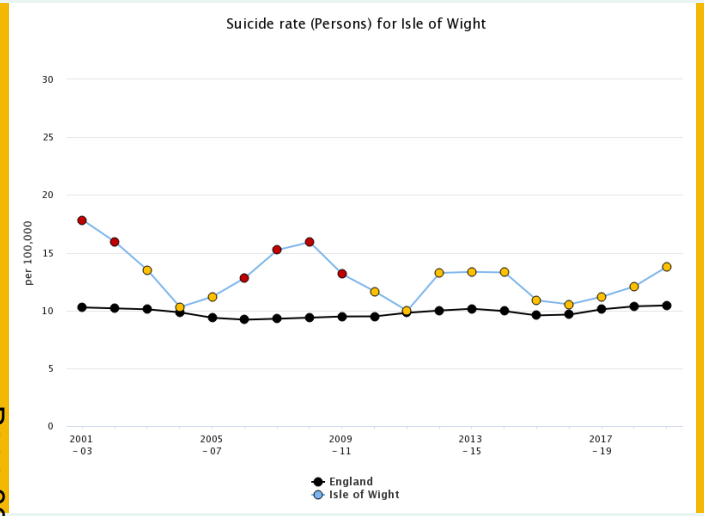
Suicide is often the end point of a complex history of risk factors and distressing events, but there are many ways in which services, communities, individuals and society as a whole can prevent suicides.

It is recognised that suicide prevention and mental wellbeing are intertwined and supporting both is essential; therefore this refreshed Isle of Wight Suicide Prevention plan is underpinned by our Mental Wellbeing Plan which was developed collaboratively with a wide range of partners.

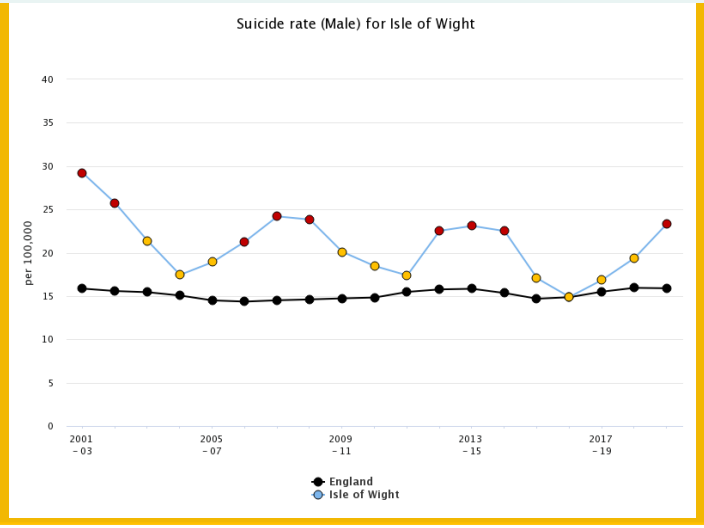
The Mental Health and Suicide Prevention Partnership is committed to our joint aim that **Islanders will feel assured that all partners are working together on suicide prevention and support for those lives that are impacted by suicide.**

Data

Suicide Rate (Persons) Isle of Wight



Suicide Rate (Males) Isle of Wight



Suicide Rate:

The suicide rate for the Island (2019 – 2021) is 13.8 per 100,000 (48 people) statistically similar to national average 10.4 per 100,000. The trend has been quite constant for the last few periods.

When looking at the male and female split we can see that the rate for males is now statistically significantly higher than the national average 23.3 per 100,000 (39 men) national average 15.9 per 100,000 (2019 – 2021).

Locally, 81% of those lives lost by suicide in this period (2019 – 2021) were male.

Emergency hospital admissions for intentional self-harm:

The Island's rate for intentional self harm is 279.3 per 100,000 (2021/22) statistically significantly higher than national average 163.9 per 100,000. This requires further understanding with regards to admissions policy and out of hours cover.

[Suicide Prevention Profile - OHID (phe.or.uk)]

Background

The Isle of Wight Mental Wellbeing Plan 2023 to 2028 sets out our vision for how we can improve our own and others' mental wellbeing across the Island. The strategy identifies suicide prevention as an area for focused attention, setting out our ambition to work in partnership to prevent suicide and support those lives impacted by suicide. Actions from the Mental Wellbeing Plan which support this priority are as follows:

1. **Partnership Working:** Islanders will live, work and thrive on a unique island where partners are committed to working together and differently to ensure positive improvements to mental wellbeing are made.
2. **Building Resilience:** Islanders will benefit from the positive aspects of being part of their community and know where to access information and support to build both individual and community resilience.
3. **Reducing stigma and discrimination:** Islanders will be comfortable talking about their mental health and wellbeing and be able to challenge prejudice around poor mental health.
4. **Suicide prevention:** Islanders will feel assured that all partners are working together on suicide prevention and supporting those lives that are impacted by suicide.
5. **Reducing inequalities and wider determinants:** Islanders will experience positive mental wellbeing, irrespective of their background, where they live or their life circumstances and value their mental wellbeing alongside their physical health

The main mechanism for coordinating and implementing these actions is through the development and implementation of a Suicide Prevention Action Plan for the Island

Background

In addition to our local strategy, the national Preventing Suicide in England Outcomes Strategy has the overall aim of reducing the suicide rate in the general population in England. It identifies six key areas of work that local suicide prevention plans should address:

Six Areas for Action Nationally and Locally:

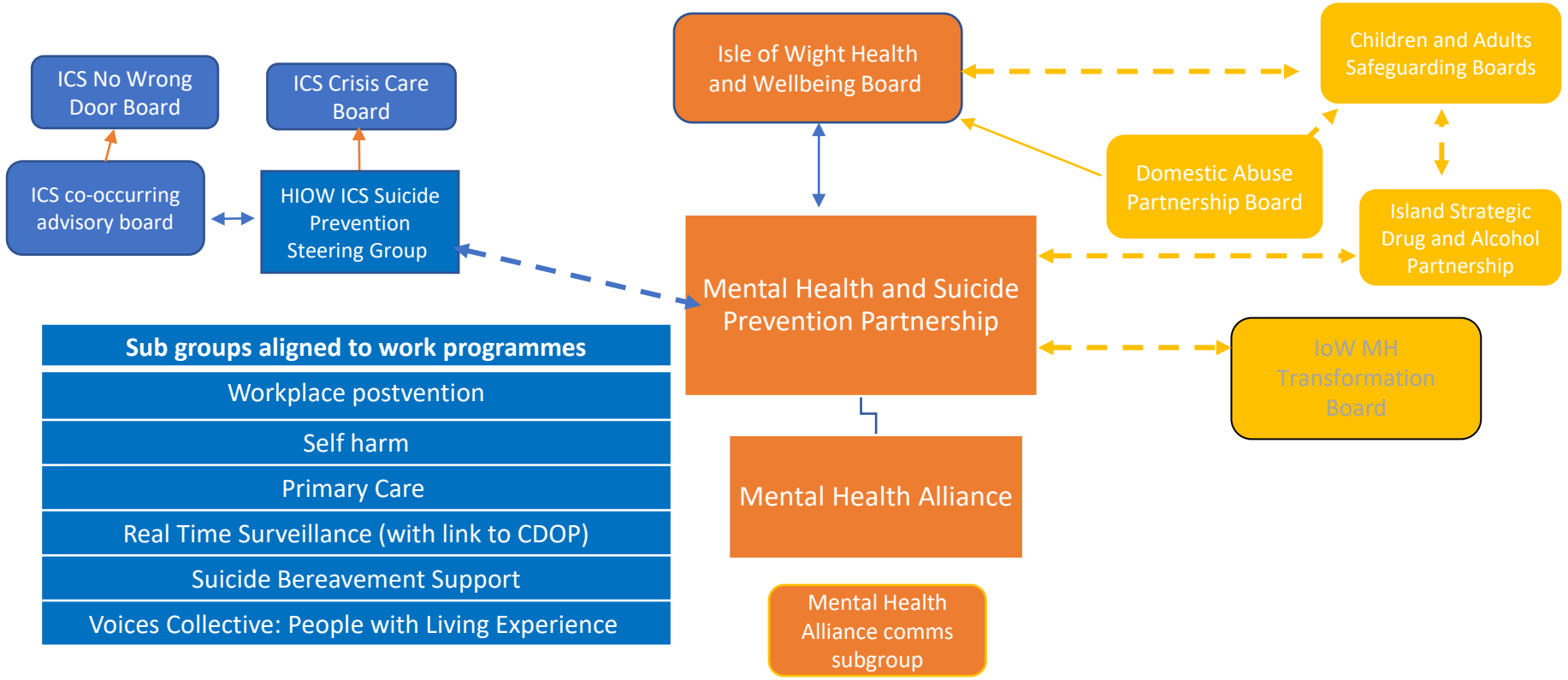
1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring

This strategy also outlines the responsibilities of local public health teams for developing local all-age suicide prevention action plans and for hosting multi-agency suicide prevention partnerships.

A revised National Strategy is due in summer 2023. The approach for the Island outlined in this document will be reviewed and amended accordingly.

Governance

The Isle of Wight Mental Health and Suicide Prevention Partnership is integral to the monitoring of suicide prevention actions across the Island.



Our progress so far…

Since the publication of the Isle of Wight Suicide Prevention Strategy 2018-2021, mental health, wellbeing and suicide prevention have been a focus of the Mental Health and Suicide Prevention Partnership with represented organisations working together to coordinate the Island's approach to suicide prevention and early intervention. Below outlines some of the achievements over the last four years, in partnership with the ICS.

Work in partnership to roll out a Local Real Time Surveillance System to strengthen our ability to respond to suspected suicides in a timely manner.

Jointly commissioned Amparo Suicide Bereavement Support Service. Amparo provide practical & emotional support for anyone (all ages) recently or historically affected by suicide.

AMPARO support following suicide

Mental wellbeing communications plan developed and rolled out, promoting self help, raising awareness of support available and reducing stigma

Strengthened networks and partnership working through the Mental Health and Suicide Prevention Partnership and Mental Health Alliance to promote mental wellbeing, share best practice, provide networking opportunities and link up of services

Work with schools though the PEACH programme (Partnership for education, attainment and childrens health) to raise awareness of mental and physical wellbeing for children, young people and staff; emphasising a whole school ethos of support, including development of a postvention protocol

Workforce Development: the commissioning of free training on mental health first aid, suicide prevention first aid and mental wellbeing for all partners

Guiding Principles

To achieve our vision that *Islanders will feel assured that all partners are working together on suicide prevention and supporting those lives that are impacted by suicide*, we have identified 5 guiding principles that will underpin all actions. These principles compliment those outlined within the Isle of Wight Mental Wellbeing Strategy and national actions .

1. **Living experiences:** Actions will be co-designed and developed alongside people with living experience.

2. **Adopt a lifecourse approach:** Consider how all ages and key transitions are managed and supported by actions.

3. **Partnership Working:** Partners recognise their roles and responsibilities in implementing actions identified within this plan; working closely across the suicide prevention and mental wellbeing arena.

4. **Data-led decision making:** Actions must make best use of available insight, intelligence and evidence to maximise effectiveness.

5. **Language:** All partners and actions promote appropriate and de-stigmatising language when discussing suicide and suicidality.

6. **Positive mental and physical wellbeing is part of suicide prevention:** work in a trauma informed way, recognising the whole person.

Areas for Action

The following actions are proposed as key actions for the Suicide Prevention Action Plan on the Island:

1. Increase awareness and understanding of the wider determinants that influence suicidality.
2. Tailor approaches to suicide prevention for particular groups and be informed through insights
3. Early intervention and prevention approach through training offer and promotion of mental wellbeing and support available
4. Reduce access of means to suicide by promoting suicide safer communities.
5. Ensure appropriate and sensitive communications of suicide and suicidality across all sectors on the Isle of Wight.
6. Work in partnership to provide the ‘right support’ at the ‘right time’ for those individuals and communities affected by a suspected suicide death.
7. Improve research, data sharing and monitoring.

Timescales, Monitoring & Reviewing

TIMESCALES

The following slides provide high-level summary of our proposed actions over the lifetime of this plan. Mirroring the Isle of Wight Mental Wellbeing Plan, actions are grouped into two groups **Now** and **Next**.

- **Now** actions are those that the Mental Health and Suicide Prevention Partnership is committed to delivering by June 2024.
- **Next** actions are those that will be completed within the lifetime of this action plan, but will not commence until 2024 and/or beyond.

MONITORING

The Mental Health and Suicide Prevention Partnership will monitor progress and risks on a bi-annual basis. An annual update will also be taken to the Isle of Wight Health and Wellbeing board.

An approach to evaluation of actions will be agreed with the Mental Health and Suicide Prevention Partnership in July 2023.

REVIEWING

National and local suicide prevention priorities are rapidly changing. Therefore, an iterative approached to action implementation and development is needed.

We expect that a review of key actions will be required following the publication of the revised national strategy (expected Summer 2023).

In the medium/long-term, actions will be reviewed on an annual basis to determine key actions for the upcoming year.

1. Increase awareness and understanding of the wider determinants that influence suicidality

Suicidal behaviours are shaped by the social, economic, and physical environments in which we live. In recent years, the impact of financial stress, poor housing, and social isolation on mental ill health and suicidality has been well documented. Effective suicide prevention strategies have a role to play in increasing awareness and advocating for policy and practice changes which allow for earlier intervention and prevention of suicide.

Area	Action	Outputs	Timescales
Training	Roll out of suicide prevention training and mental wellbeing training to wider workforce to ensure the 'Making Every Contact Count' ethos is embedded	Numbers trained and organisations represented	Now
	Workforce training to link up social and economic factors and mental health and suicidality	Money and mental health training commissioned and numbers trained	Next
Trauma informed	Support the roll out of trauma informed practice and psychologically informed environments (PIE) across the Isle of Wight Council, working with housing and the homelessness service	PIE self assessment tool completion and learning	Now
Co-occurring conditions and working with most vulnerable	Whole person approach to delivering support that includes joined up service provision	Increase in those with MH need in treatment accessing MH services Effective quality transition of care from prison / probation	Next

2. Tailor approaches to suicide prevention for particular groups and be informed through insights

While everyone is at risk of suicide, that risk is not distributed equally amongst the population. The 2023 NCISH Annual Report (2010-2020) highlights some of the population cohorts at greatest risk of suicide and suicide intent in England. Locally, data is used to identify trends amongst particular groups. We will use a combination of local and national insight and intelligence to target interventions at those with the greatest need.

Area	Action	Outputs	Timescales
Data led	Use available data and intelligence to identify which particular groups to focus interventions and support	Potential for projects with representatives to support in mental wellbeing and promotion of support available	**Now**
Partnership working to protect the most vulnerable	Work with Probation, substance misuse recovery services, domestic abuse services, adults and childrens services, ICB and the voluntary and community sector to ensure mental wellbeing and suicide prevention are incorporated in plans Work in partnership with schools and other key partners to support young people who are self-harming, or at high risk such as children in care and care leavers, those who have low mental wellbeing or suicide ideation to learn positive coping skills and know where to go for support.	Cooccurring conditions pathway Domestic abuse support pathway Increase in percentage people in probation known to support services PEACH Increase in reported wellbeing Increase in reported knowledge of services	**Next**
Insights and intelligence	Undertake projects to understand local vulnerable groups through the Mental Health Alliance and from people with lived experience	Tailored communications messaging and promotion of support informed by insights	**Next**

3. Early intervention and prevention approach through training offer and promotion of mental wellbeing and support available

We know the link between physical and mental wellbeing is strong and that positive physical and mental health supports in preventing suicide. However, Insights tell us that people are still unaware of where to go for support, stigma is still a barrier in accessing support and knowledge on self help and positive coping mechanisms is limited.

Area	Action	Outputs	Timescales
Comms	Improved communications and messaging promoting physical and mental health and wellbeing, including promotion of 5 ways to wellbeing and positive coping mechanisms for self care.	Clicks through on islefindit website Clicks through on iwmentalhealth hub website Organisations using 5 ways to wellbeing branding	**Now**
Training	Roll out of suicide prevention training and mental wellbeing training to wider workforce	Numbers trained in suicide prevention training and mental wellbeing training. Outcome: IWC staff and partner agencies will have knowledge on promotion of positive coping mechanisms, how to have conversations about mental wellbeing and suicide prevention and where to signpost people for support.	**Now**
Insights Project	Work with the third sector, vulnerable groups and those with lived/living experience to better understand barriers to accessing support and how to overcome them. Based on insights - roll out of 5 Ways to wellbeing branding and information to link physical and mental health	Delivery of targeted comms and increased awareness of support available Increased recognition of 5 ways to wellbeing and use of services promoting this	**Next** **Next**

4. Reduce access of means to suicide by promoting suicide safer communities

Reducing access to suicide means is an important component of suicide prevention. The effectiveness of restricting the availability of pharmaceuticals and chemicals, and restricting access to heights and train stations on suicide rates, has been well documented. The National Institute of Health and Care Excellence published an evidence review (2018) on soft and hard measures aimed at reducing access of means. It highlights key actions that can be taken both nationally and locally. Local insight into lethal suicide methods will also be used to inform priority actions.

Area	Action	Outputs	Timescales
Data led	Use updated analysis of available data and intelligence to inform reduction of access to means	To be identified at a later stage.	**Next**
Partnership working to reduce access to means	Work with the Coastguard, custodians of the cliffs, licensing, substance misuse services and third sector partners to reduce access and increase awareness of risks	Reduction in underage sale of alcohol	**Now**
Online Harms	As a proposed theme within the revised national strategy, specific actions will be identified/taken once further guidance is provided	Promotion of R:pple	**Next**

5. Ensure appropriate and sensitive communications of suicide and suicidality across all sectors on the Isle of Wight

The topic of suicide should be approached with care and compassion. Irrespective of context (engaging in dialogue, talking to someone with living experience, or writing about the issue in a professional setting) it's important we remain mindful of our language to avoid reinforcing the stigma that prevents people from seeking help. It's also important that frontline staff, volunteers, and members of the public feel confident and equipped to intervene and signpost people to the right support, if they are concerned that someone may be at risk of suicide.

Area	Action	Outputs	Timescales
Communications plan	Have a partnership co-ordinated mental health communications plan which regularly focuses on suicide prevention e.g. marking suicide awareness days, promoting support, reducing stigma and working with partners to gain insight	Increased awareness of support available Reduced stigma and increased reporting of confidence talking about mental ill-health and suicide prevention	**Now**
Workforce Development	Commissioning of mental wellbeing training and suicide prevention training and promotion to wider workforce	Numbers attending training Number of organisations represented Competent workforce equipped with skills to talk about suicide and suicidality and refer appropriately to services.	**Now**
Local Media	Work with media through awareness raising and training to ensure the importance of language is recognised with ethical and safe reporting of matters around suicide	Responsible and sensitive reporting on suspected suicide or suicide incident locally which consistently signposts to support.	**Next**

6. Work in partnership to provide the ‘right support’ at the ‘right time’ for those individuals and communities affected by a suspected suicide death

When someone dies by suspected suicide there is an immediate and often devastating effect on the people around them. Suicide has a ripple effect on the community and those affected are 65% more likely to attempt suicide themselves. As a result, providing guidance and support for those navigating this complex grieving process is an important aspect of local suicide prevention plans.

Area	Action	Outputs	Timescales
Education Postvention Protocol	Work with partners to refresh existing postvention protocol & promote new postvention protocol	Increased confidence amongst professionals of the postvention process; process followed where required. Suicide prevention & postvention policy to be included within annual school safeguarding audit	**Now**
Amparo Bereavement Support Service	Continue to promote and signpost to Amparo support service	Improved pathways of support for people bereaved by suicide: increased awareness and uptake of Amparo service for those that need it.	**Now**
Workplace Postvention & Suicide Prevention Safety Plans	Work with partners to provide postvention framework for workplaces where identified as need	Number of organisations with suicide prevention and postvention protocol	**Next**
Data led	Use of data, including through the Real Time Surveillance System (RTSS) to improve prevention and postvention response	Data led plans and actions	**Now**

7. Improve Research, Data Collection, and Monitoring

A local suicide audit provides us with valuable insight into local needs. Since 2019, the Real Time Surveillance System has allowed us to identify potential suicide contagions and clusters in a timely manner; improving our ability to provide an appropriate, joined-up postvention response. Ongoing work is needed to enhance our understanding of the patterns of suicide, self-harm, and serious suicide attempts.

Area	Action	Outputs	Timescales
Data sharing	Partners on the Mental Health and Suicide Prevention Partnership agree to share data to inform prevention such as ambulance and A&E attendances where appropriate	Identify emerging patterns and priorities for future suicide prevention action across the system.	**Next**
Real Time Surveillance System (RTSS)	Embed and expand the multi-agency HIOW Real Time Surveillance (RTS) of suspected suicides to ensure timely prevention, postvention and ongoing surveillance takes place	Increase in active partners in Real Time Surveillance Working Group (RTS WG) Identification of Suicide Cluster Response Plan, individual by each partner All partners are aware of children and young people postvention response for an individual suspected suicide	**Now**
Insights	Develop projects to listen to vulnerable groups and those with living experience to inform prevention and effective comms	Better informed delivery and more effective comms	**Next**

Mental Health Alliance
Isle of Wight

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Committee: **HEALTH AND WELLBEING BOARD**

Date: **20 JULY 2023**

Title: **BETTER CARE FUND UPDATE Q1 2023/24**

Report of: **IAN LLOYD, STRATEGIC MANAGER PARTNERSHIPS AND SUPPORT SERVICES**

CHERYL HARDING-TRESTRAIL, ASSOCIATE DIRECTOR OF COMMISSIONING – URGENT AND EMERGENCY CARE AND COMMUNITY SERVICES, HAMPSHIRE AND ISLE OF WIGHT INTEGRATED CARE BOARD – ISLE OF WIGHT

Sponsors: **LAURA GAUDION, DIRECTOR ADULT SOCIAL CARE AND HOUSING NEEDS**

MICHAELA DYER, HAMPSHIRE AND ISLE OF WIGHT INTEGRATED CARE BOARD – ISLE OF WIGHT

Summary

1. The Better Care Fund (BCF) programme supports the Isle of Wight Council (IWC) and Integrated Care Board (ICB) to successfully deliver integrated working that best supports Island residents. The requirements of the BCF are set by NHS England (NHSE), including details on financial and contractual arrangements.
2. For 2022/23 we can confirm that all requirements have been complied with to date.
3. The final national requirement for 2022/23 was the submission of an End of Year template reviewing the delivery performance against plan for both the BCF and the Adult Social Care Discharge Fund.
4. On 4 April 2023 the Department of Health and Social Care (DHSC) issued the *2023 to 2025 Better Care Fund policy framework* and accompanying *Better Care Fund planning requirements 2023-25* guidance document.
5. This paper provides an update for the Health and Wellbeing Board about the
   a) 2022/2023 Better Care Fund (BCF) End of Year template submission to the National Better Care Fund team (Appendix 1), and
   b) proposal for the 2023-25 BCF (Appendices 2 and 3).
6. The Health and Wellbeing Board is asked to receive the update on the 2022 / 2023 year-end position and the BCF plan for 2023-25.
7. The Board is asked to approve the work undertaken to date and to delegate to the Director for Adult Social Care and Housing Needs for the Isle of Wight (IWC) and the ICB (Isle of Wight place) Place Director authority to further develop and submit the BCF 2023 – 2025 templates in line with the national deadlines.
8. It is proposed that the documents, submitted in line with the national requirement, are provided to the Board for final approval at the July 2023 meeting. The national assurance process will only be able to be completed once confirmation of the final

HWB approval has been submitted to NHSE.

Background

9. The Isle of Wight BCF has been in place since April 2017. Since 2018/2019 the BCF has been stable in terms of the workstreams it contains, and the funding provided by both the council and the ICB.

10. The only significant changes in year (2022/23) have been the:

    a) inclusion of the short-term funding arrangement of the Adult Social Care Discharge Fund. This fund temporarily introduced the following projects for the period of 16 November 2022 to 31 March 2023 (Breakdown included in Appendix 1):

Home care capacity	Home Bridging Service
Reablement capacity	Telehealth and proactive support to care homes
Residential capacity	Community Day Hub Pilot
Additional medical workforce (Geriatrician)	Community Unit
Discharge team capacity extension	Discharge to assess beds

    b) cessation of the Falls Co-Ordinator Role, Life After Stroke Service and Independent Living Centre as of 31 March 2023. Funds from these workstreams have been retained within the BCF and will be reallocated to support adult social care as part of the 2023-2025 plan.

    c) Community Equipment Service specification has been consulted upon and redesigned. This is due to be implemented during Q1 of 2023/24.

2022 / 2023 End of Year Template

11. The End of Year template has been issued by the national BCF team to provide a closing position on the performance of both the BCF and the ASC DF. Both elements were submitted to NHSE on the 2 May 2023 to comply with national requirements.

2023 – 2025 National Better Care Fund Planning Requirements

12. The DHSC and NHSE have determined that there will be a shift in the planning arrangement to cover a two-year period instead of the more recent annually developed plans.

13. For 2023 - 2025, the BCF four national conditions that are mandated to be complied with are:

    a) Plans are to be jointly agreed between the ICB and IWC with approval by the HWB.

    b) Enable people to stay well, safe and independent at home for longer

    c) Provide the right care in the right place at the right time

    d) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services

14. Plans will consist of two parts: a narrative plan, and a BCF planning template. New for this year:

a) Inclusion of the demand and capacity plan. A year's overview is included within the main Planning Template. However, there is a further requirement to provide monthly capacity updates via separately issued templates.

b) Inclusion of Adult Social Care Discharge Fund (Revenue) Grant. This will be included within the BCF s75 arrangements. The IWC has received a direct allocation of £866,442 for 2023/24. The Hampshire and Isle of Wight ICB also receive an allocation to direct within the wider footprint. The ICB allocation to the Isle of Wight place for 2023/24 has been confirmed as £1,085,966. National allocations to the IWC and ICB for 2024/25 are to be confirmed by central government. However, initial guidance from the NHSE is that this is anticipated to increase by 66%

c) There is an increased focus on addressing housing and health inequalities – these elements are covered within the narrative template.

d) The metrics being monitored centrally have been updated to now include emergency hospital admissions due to falls in people over 65. It has also been advised that a further discharge metric will be released ahead of winter 2023. Further national changes are planned for 2024/25.

e) Quarterly reporting will recommence from Quarter 2 in 2023/24 and will cover progress in implementing BCF plans, progress against metrics and ongoing compliance with the requirements and conditions of the fund. This is in addition to fortnightly reporting on the Discharge Fund (place), monthly reporting on Demand and Capacity Planning (place) and quarterly reporting on the Discharge Fund (ICB).

15. The Island's 2023-2025 BCF plan will be approved by NHSE following joint NHS and Local Government regional assurance process against a set of national key Lines of Enquiry (KLOEs).

16. The deadline for submission of the main narrative and planning templates was the 28 June 2023.

17. Failure to comply with this requirement, or any of the stipulated conditions, would trigger additional assurance and oversight processes with NHSE and Local Government Association (LGA). Should the system not agree and fail to submit its plan by the indicated deadline, the system would not receive additional funding earmarked for local systems to support ASC. In particular, the Improved Better Care Fund (iBCF), Disabled Facilities Grant (DFG) and ASC DF continue to be paid to local authorities on the condition that they are pooled locally into the BCF and spent on specific purposes set out in the grant determinations and conditions.

18. Where the local governance schedule does not coincide with the submission deadline, submission is still required with an explanatory note that final approval from the Health and Wellbeing Board is pending. The plan may then proceed through the early stages of the national assurance process but, where otherwise all other conditions are fulfilled, final approval will be held in abeyance until the local Board has granted approval. Only once both approval processes have been completed will the Plan be deemed officially signed off and that the s75 agreement may be put into place. Until that point, all expenditure in line with the BCF intentions will be considered as undertaken 'at risk'.

19. Once the Health and Wellbeing approval has been confirmed, and where all KLOEs have been satisfied, NHSE will issue approval letters on the 8th September 2023 with a requirement to execute the s75 agreement by the 31st October 2023.

20. Due to the two-year nature of the pan, the national team has recognised that councils and ICB's may wish to amend plans in-year, following sign off and assurance, to:

a) modify or decommission schemes

b) increase investment or include new schemes. For example, final details regarding the 2024-25 additional funding for discharge are pending confirmation and plans may need to be amended or updated to reflect any changes to conditions once these are in place.

21. In such instances, any changes to assured and approved BCF plans arising in-year must be jointly agreed between the local council and ICBs and continue to meet the conditions and requirements of the BCF.

22. Consequently, a mechanism has been built into the assurance process should the Health and Wellbeing Board subsequently raise a request for an amendment to the BCF Plan after it has been submitted.

Outline of 2023 – 2025 Proposals

23. The BCF planning template and associated Section 75 agreement is developed and updated by the ICB and Council; processes are in place to ensure that the current submission is reflective of input from both organisations.

24. An engagement process with wider stakeholders was undertaken as part of the 2022 / 23 in year development work. As wider stakeholders have been strongly involved in the development of the refreshed Health and Care Plan and previous BCF planning, feedback will also be drawn from these sources to inform the development of the 2023 - 2025 submission.

25. Review of the BCF has led all parties to conclude, that, as with every health system nationally – and in light of the very challenging financial position across both the HIOW ICB and the council, we must be absolutely committed to ensuring that best value, best outcomes, and best experience is delivered for every pound invested in the BCF. Specifically, we are committed to ensuring that we minimise any duplication in service, which could be better invested in other service models – for the benefit of our local population.

26. There is likely to be a need to jointly agree and vary the BCF in year, as part of a line-by-line review of all investment

27. A submission narrative and planning document have been prepared and are attached as Appendices 2 and 3. These have been submitted on behalf of the Isle of Wight Health and Wellbeing Board, although clearly marked as ‘subject to approval’ in order to meet nationally mandated timelines.

28. To complete the assurance process, approval of the documents is required to be granted by the Health and Wellbeing Board. This may be applied retrospectively, as in this submission, but must be in place in advance of the 8th September 2023.

Decisions, recommendations and any options

29. **To**:

a) **NOTE** the attached End of Year template for submission to NHSE as a closing position for the Isle of Wight BCF 2022 / 23.

b) **NOTE** the new conditions provided by the DHSC and NHSE regarding the development of the BCF 2023 – 2025.

c) **NOTE** the work undertaken to date in relation to the BCF 2023-2025 and to delegate to the Director for Adult Social Care and Housing Needs for the Isle of Wight (IWC) and the ICB (Isle of Wight place) Interim Managaing Director and Place Director authority to further develop and submit the BCF 2023 – 2025 templates in line with the national deadlines.

d) **NOTE** initial submission of BCF Planning documents by the Interim Managing Director – Hampshire and Isle of Wight ICB (IW) and the Director for Adult Social Care and Housing Needs on the 28 June 2023 on behalf the Isle of Wight Health and Wellbeing Board.

e) **APPROVE** the BCF 2023 – 2025 Plan and accompanying template at the July 2023 HWB meeting.

Appendices

1. BCF End of Year Template 2022 / 23
2. BCF 2023-2025 Narrative document
3. BCF 2023-2025 Planning template

NATASHA TAPLIN

Interim Managing Director, Hampshire and Isle of Wight ICB - IW

LAURA GAUDION

Director for Adult Social Care and Housing Needs for the Isle of Wight, IW Council

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Better Care Fund 2022-23 End of Year Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2022-23, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) To confirm actual income and expenditure in BCF plans at the end of the financial year
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of
4) To enable the use of this information for national partners to inform future direction and for local areas to inform

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICB's, local authorities and service providers) for the purposes noted above.

BCF reports submitted by local areas are required to be signed off by HWBs as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website in due course.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance
The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require
Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste Values only.

The details of each sheet within the template are outlined below.

ASC Discharge Fund-due 2nd May

This is the last tab in the workbook and must be submitted by 2nd May 2023 as this will flow to DHSC. It can be submitted with the rest of workbook empty as long as all the details are complete within this tab, as well as the cover sheet although we are not expecting this to be signed off by HWB at this point. The rest of the template can then be later resubmitted with

After selecting a HWB from the dropdown please check that the planned expenditure for each scheme type submitted in your ASC Discharge Fund plan are populated.
Please then enter the actual packages of care that matches the unit of measure pre-specified where applicable.
header. At the very bottom there is a totals summary for expenditure which we'd like you to add a breakdown by LA and ICB.

Please also include summary narrative on:
1. Scheme impact
2. Narrative describing any changes to planned spending – e.g. did plans get changed in response to pressures or demand? Please also detail any underspend.
3. Assessment of the impact the funding delivered and any learning. Where relevant to this assessment, please include details such as: number of packages purchased, number of hours of care, number of weeks (duration of support), number of individuals supported, unit costs, staff hours purchased and increase in pay etc
4. Any shared learning

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Ter
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign o
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to: england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2022-23 (link below) continue to be met through the delivery of your plan. Please
https://www.england.nhs.uk/publication/better-care-fund-planning-requirements-2022-23/

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: NHS contribution to adult social care is maintained in line with the uplift to NHS Minimum
National condition 3: Agreement to invest in NHS commissioned out-of-hospital services
National condition 4: Plan for improving outcomes for people being discharged from hospital

4. Metrics

The BCF plan includes the following metrics: Unplanned hospitalisation for chronic ambulatory care sensitive conditions, Proportion of discharges to a person's usual place of residence, Residential Admissions and Reablement. Plans for these metrics were agreed as part of the BCF planning process.
This section captures a confidence assessment on achieving the plans for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes that have been achieved.

The BCF Team publish data from the Secondary Uses Service (SUS) dataset for Dischaege to usual place of residence and avoidable admissions at a local authority level to assist systems in understanding performance at local authority level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric plans and the related narrative information and it is advised that:
- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy
- In providing the narrative on Challenges and Support needs, and Achievements, most areas have a sufficiently good perspective on these themes and the unavailability of published metric data for one/two of the three months of the quarter is not expected to hinder the ability to provide this useful information. Please also reflect on the metric performance trend when compared to the quarter from the previous year - emphasising any improvement or deterioration

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national

5. Income and Expenditure

The Better Care Fund 2022-23 pool constitutes mandatory funding sources and any voluntary additional pooling from LAs (Local Authorities) and NHS. The mandatory funding sources are the DFG (Disabled Facilities Grant), the improved Better Care Fund (iBCF) grant, minimum NHS contribution and additional contributions from LA and NHS. This year we include

Income section:

- Please confirm the total HWB level actual BCF pooled income for 2022-23 by reporting any changes to the planned additional contributions by LAs and NHS as was reported on the BCF planning template.
- In addition to BCF funding, please also confirm the total amount received from the ASC discharge fund via LA and ICB if this has changed.
- The template will automatically pre populate the planned expenditure in 2022-23 from BCF plans, including additional contributions.
- If the amount of additional pooled funding placed intothe area's section 75 agreement is different to the amount in the
- Please provide any comments that may be useful for local context for the reported actual income in 2022-23.

Expenditure section:

- Please select from the drop down box to indicate whether the actual expenditure in your BCF section 75 is different to the planned amount.
- If you select 'Yes', the boxes to record actual spend, and explanatory comments will unlock.
- You can then enter the total, HWB level, actual BCF expenditure for 2022-23 in the yellow box provided and also enter a short commentary on the reasons for the change.
- Please provide any comments that may be useful for local context for the reported actual expenditure in 2022-23.

6. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2022-23 through a set of survey questions

The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 5 questions. These are set out below.

Part 1 - Delivery of the Better Care Fund

There are a total of 3 questions in this section. Each is set out as a statement, for which you are asked to select one of the
- Strongly Agree
- Agree
- Neither Agree Nor Disagree
- Disagree
- Strongly Disagree

The questions are:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2022-23
3. The delivery of our BCF plan in 2022-23 had a positive impact on the integration of health and social care in our locality

Part 2 - Successes and Challenges
This part of the survey utilises the SCIE (Social Care Institue for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration' expressed in the Logic Model.

Please highlight:
4. Two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2022-23.
5. Two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2022-23?

For each success and challenge, please select the most relevant enabler from the SCIE logic model and provide a narrative describing the issues, and how you have made progress locally.
SCIE - Integrated care Logic Model

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rurual factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

Better Care Fund 2022-23 End of Year Template

2. Cover

Version 1.0

Please Note:

- The BCF end of year reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

			Checklist: Complete:
Health and Wellbeing Board:	Isle of Wight		Yes
Completed by:	Matt Leek, Cheryl Harding-Trestrail		Yes
E-mail:	cheryl.harding@nhs.net		Yes
Contact number:	01983 552064 (preference via MS Teams)		Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No		Yes
If no, please indicate when the report is expected to be signed off:	Thu 20/07/2023	<< Please enter using the format, DD/MM/YYYY	Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the ASC

Please see the Checklist on each sheet for further details on incomplete fields

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Income and Expenditure actual	Yes
6. Year-End Feedback	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 End of Year Template

3. National Conditions

Selected Health and Wellbeing Board: Isle of Wight

Confirmation of Nation Conditions			Checklist
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in 2022-23:**	Complete:
1) A Plan has been agreed for the Health and Wellbeing Board area that includes all mandatory funding and this is included in a pooled fund governed under section 75 of the NHS Act 2006? (This should include engagement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes		Yes
2) Planned contribution to social care from the NHS minimum contribution is agreed in line with the BCF policy?	Yes		Yes
3) Agreement to invest in NHS commissioned out of hospital services?	Yes		Yes
4) Plan for improving outcomes for people being discharged from hospital	Yes		Yes

Better Care Fund 2022-23 End of Year Template

4. Metrics

Selected Health and Wellbeing Board: Isle of Wight

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2022-23 planning	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements	Checklist Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	650.0	On track to meet target	A challenging workforce position remains a consistent theme across the health and care system.	However, despite this, the continuation of schemes during 2022/23 have been successful contributed on a reduction in unplanned hospitalisations for ACS conditions. BCF SUS data Grand Total for	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	84.0%	Not on track to meet target	As a system one of the greatest challenges has been, and continues to be, that of sourcing home care packages. Urgency to enable discharge from hospital and sparsity of domiciliary care provision on the Isle of	In spite of the workforce / package of care shortfall the target has only been missed by 1.01% (82.99%) and this is still an improvement on the 21/22 position. Confirmation has been received that	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	644	Not on track to meet target	We are still seeing an increasing trend of c.17% compared to 2018/19, this correlates with the reported increase in acuity and complexity being seen by all teams. End position 753.	ASC DF interventions have helped to increase domiciliary care Nov 22-Mar 23 offering additional flexibility and capacity in the system, along with TEC solutions. This, along with Virtual Wards, is seeking to help	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	77.8%	Not on track to meet target	Please note due to the nature of this measure figures for 91 days will always be 3 months in arrears. Current quarterly average 80% - likely to be slightly over planned position. Subject to final data provision 91	Relatively stable levels of activity with slight positive trend; given the heightened pressures experienced by the system during and since the pandemic this is viewed as an achievement to maintain performance	Yes

Better Care Fund 2022-23 End of Year Template

5. Income and Expenditure actual

Selected Health and Wellbeing Board: Isle of Wight

Income

	2022-23	
Disabled Facilities Grant	£2,272,039	
Improved Better Care Fund	£6,180,112	
NHS Minimum Fund	£13,223,950	
Minimum Sub Total		£21,676,101

	Planned	Actual			
NHS Additional Funding	£26,325,379	Do you wish to change your additional actual NHS funding?	Yes	£27,129,039	
LA Additional Funding	£2,889,617	Do you wish to change your additional actual LA funding?	Yes	£3,035,472	
Additional Sub Total	£29,214,996				£30,164,511

	Planned 22-23	Actual 22-23
Total BCF Pooled Fund	£50,891,097	£51,840,612

ASC Discharge Fund

	Planned	Actual			
LA Plan Spend	£0	Do you wish to change your additional actual LA funding?	Yes	£638,679	
ICB Plan Spend	£0	Do you wish to change your additional actual ICB funding?	Yes	£1,281,632	
ASC Discharge Fund Total	£0				£1,920,311

	Planned 22-23	Actual 22-23
BCF + Discharge Fund	£50,891,097	£53,760,923

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2022-23	Note template error not displaying Planned ASC Discharge Fund. Central team notified with advice to enter values under actual. Variation in ICB funding of £17,500 (Planned £1,299,132) due to being unable to recruit a Geriatrician.

Checklist Complete:
Yes
Yes
Yes
Yes
Yes

Expenditure

	2022-23
Plan	£50,891,097

Do you wish to change your actual BCF expenditure?	Yes	Yes

Actual	£51,840,612	Yes

	ASC Discharge Fund
Plan	£0

Do you wish to change your actual BCF expenditure?	Yes	Yes

Actual	£1,920,311	Yes

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2022-23	The BCF has seen a much higher CHC/FNC outturn compared to budget, resulting in an increased spend of £674k. Many ICB service lines have also seen an increase compared to the original plan due to pay inflation adjustments in year.	Yes

Better Care Fund 2022-23 End of Year Template

6. Year-End Feedback

The purpose of this survey is to provide an opportunity for local areas to consider and give feedback on the impact of the BCF.
There is a total of 5 questions. These are set out below.

Selected Health and Wellbeing Board: Isle of Wight

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate to what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response	Checklist Complete:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	The establishment of a refreshed governance structure, including the Joint Strategic Partnership Board with representation across the ICB, IWC and Public Health, is raising the profile of the Better Care Fund. This is helping to increase system-wise integrated working and create a clear route for partners to implement pathway changes. The cultural shift for	Yes
2. Our BCF schemes were implemented as planned in 2022-23	Strongly Agree	All workstreams were implemented as planned. Additional workstreams added in year including those funded through the ASC Discharge Fund.	Yes
3. The delivery of our BCF plan in 2022-23 had a positive impact on the integration of health and social care in our locality	Agree	The workstreams implemented helped to continue collaborative working practices along the patient pathway. The additional governance work undertaken, including initial service reviews, have identified opportunities for future development going into the 2023 - 2025 planning cycle.	Yes

Part 2: Successes and Challenges

Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and two Enablers which you have experienced a relatively greater degree of challenge in progressing.
Please provide a brief description alongside.

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2022-23	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes	
Success 1	9. Joint commissioning of health and social care	The Living Well and Early Help Service, delivered by Aspire Ryde and their community partners, was awarded 'Gold' in the transformation in health and social care category in this year's iESE Transformation Awards. The service was jointly commissioned by the Isle of Wight Council and the Hampshire and Isle of Wight Integrated Care Board (ICB) in April 2022. Since then, this community-led partnership has made a real difference to the lives of more than 2,390 Islanders, helping them to stay well, independent and connected with their local community. And with the launch in December of its innovative	Yes
Success 2	5. Integrated workforce: joint approach to training and upskilling of workforce	Approval was granted in-year to commence an integrated workforce development pilot. The IWC has linked in with the HTP College and the IOW College to enable learners who will be completing Level 2 and 3 H & SC programmes to access practice experiences within their first year of employment. This is helping to support a local 'grow our own' approach to the workforce challenges being faced. Locally, we are more geographically isolated due to the Solent. By implementing this scheme we are encouraging local residents to remain on the Island with access to long-term careers development opportunities.	Yes

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2022-23	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges

Challenge 1	5. Integrated workforce: joint approach to training and upskilling of workforce	Workforce remains a recurrent theme both within the context of the BCF and wider service delivery. The Isle of Wight, like other more isolated areas, faces a degree of geographical isolation which impacts on recruitment and retention of staff. Services often then are unable to reach optimum delivery of their potential either due to carrying internal vacancies or becoming holders of caseloads where bottlenecks prevent onwards flow. At present, whilst services and pathways may be integrating, workforce is still often viewed at a service rather than system level - often resulting in high turnovers with	Yes
Challenge 2	6. Good quality and sustainable provider market that can meet demand	There is a significant challenge being faced in respect of workforce within the Isle of Wight community services. In additional to local capacity issues experienced prior to the pandemic, the impact of Covid-19 has further reduced capacity across both care homes and home care – a position which is disproportionately felt by those with complex needs and people with dementia who require more specialist support. One of the most significant consequences arising is that we are seeing a higher number of individuals, 'Not Meeting the Criteria to Reside' (NMCtR), remaining in hospital longer than we, and they,	Yes

Footnotes:

Question 4 and 5 are should be assigned to one of the following categories:

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

Other

Better Care Fund 2022-23 End of Year Template

ASC Discharge Fund

Selected Health and Wellbeing Board: Isle of Wight

Please complete and submit this section (along with Cover sheet contained within this workbook) by 2nd May

For each scheme type please confirm the impact of the scheme in relation to the relevant units asked for and actual expenditure. Please then provide narrative around how the fund was utilised, the duration of care it provided and and any changes to planned spend. At the very bottom of this sheet there is a totals summary, please also include aggregate spend by LA and ICB which should match actual total prepopulation.

The actual impact column is used to understand the benefit from the fund. This is different for each sheme and sub type and the unit for this metric has been pre-populated. This will align with metrics reported in fortnightly returns for scheme types.

1) For 'residential placements' and 'bed based intermediary care services', please state the number of beds purchased through the fund. (i.e. if 10 beds are made available for 12 weeks, please put 10 in column H and please add in your column K explanation that this achieve 120 weeks of bed based care).
2) For 'home care or domiciliary care', please state the number of care hours purchased through the fund.
3) For 'reablement in a person's own home', please state the number of care hours purchased through the fund.
4) For 'improvement retention of existing workforce', please state the number of staff this relates to.
5) For 'Additional or redeployed capacity from current care workers', please state the number of additional hours worked purchased through the fund purchased.
6) For 'Assistive Techonologies and Equipment' , please state the number of unique beneficiaries through the fund.
7) For 'Local Recruitment Initiatives', please state the additional number of staff this has helped recruit through the fund.

If there are any additional scheme types invested in since the submitted plan, please enter these into the bottom section found by scrolling further down.

Scheme Name	Scheme Type	Sub Types	Planned Expenditure	Actual Expenditure	Actual Number of Packages	Unit of Measure	Did you make any changes to planned spending?	If yes, please explain why	Did the scheme have the intended impact?	If yes, please explain how, if not, why was this not possible	Do you have any learning from this scheme?
community unit	bed based intermediate care services	step down (discharge to assess pathway 2)	£451,333	£451,333	14	Number of beds	No		Yes	Intensive rehabilitation bedded unit located at Isle of Wight NHS Trust main site to provide a nurse led unit for patients no longer meeting criteria to reside but awaiting onward care. Beds	Weekly reporting templates varied method of counting which made it harder to
home bridging service	home care or domiciliary care	domiciliary care packages	£300,000	£350,000	2,323	Hours of care	Yes	We have encountered some delays in being able to rapidly mobilise additional services and this is predominately around recruitment and delays to services starting over the Christmas	Yes	Planned up to 80 care visits per day by 8 carers. Patient numbers will vary depending on the frequency of visits needed per patient. Service provided immediate care for patients who	Workforce challenges still in place. The care sector in general is difficult to recruit
discharge to assess beds	bed based intermediate care services	step down (discharge to assess pathway 2)	£268,299	£268,299	101	Number of beds	No		Yes	Successsful implementation that exceeded original planning. The average LOS reduced, demonstrating the benefit of increase flexibility of capacity in the community. Contributed to additional	Flexible approach to needs rather than just beds allowed for patients needs
residential capacity	residential placements	care home	£266,193	£266,193	119	Number of beds	No		Yes	28 intermediate care beds across Hartford Care, (Springfield and Elms) and Solent Grange and extra residential capacity. The Elms x 5 beds 21 Jan – 31 Mar	Discrepancy of method of counting across different reporting sources as well as
home care capacity	home care or domiciliary care	domiciliary care to support hospital discharge	£222,486	£222,486	3,456	Hours of care	No		Yes	Successfully increased number of hours available to facilitate discharge with immediate support available via Elder Care to supplement existing team, augmenting Outreach improved flow.	Demand and capacity planning needs to reflect seasonal variances in acuity
reablement capacity	bed based intermediate care services	step down (discharge to assess pathway 2)	£150,000	£150,000	13	Number of beds	No		No	Bluebell House plan 70 beneficiaries to be aided. Actual: 13 beds 267 referrals	
community day hub pilot	home care or domiciliary care	domiciliary care to support hospital discharge	£98,000	£98,000	593	Hours of care	No		Yes	Number of packages from fortnightly reporting route of ASC Business Intelligence; not secondarily validated by service lead.	Where only short-term funding in place more successful to recruit to
telehealth and proactive support to care homes	assistive technologies and equipment	telecare	£73,000	£73,000	20	Number of beneficiaries	No		No	Plan 48 per month. Time taken to secure equipment and set up process - limited by number of handset for pilot. Costs include whole package - equipment, Wightcare link and response.	TEC model complements shift towards alternative pathways e.g. virtual wards.
additional medical workforce (geriatrician)	additional or redeployed capacity from current care workers	costs of agency staff	£67,500	£0	0	hours worked	Yes	Unable to recruit. Funding reallocated to support Home Bridging Service.	No	Unable to recruit.	The island despite its age demographic does not have a comprehensive frailty
discharge team capacity extension	additional or redeployed capacity from current care workers	costs of agency staff	£41,000	£41,000	248	hours worked	Yes		Yes	Immediate support available to supplement the existing team. Contributed to 4297 hours of home or domiciliary care packages and 2323.25 hours of reablement in a person's own home.	Where only short-term funding in place more successful to recruit to

HM Government

NHS England

1. Cover

1.1. Health and Wellbeing Board(s).

This submission has been made on behalf of the Isle of Wight Health and Wellbeing Board (HWB) in line with its direction to commence the national assurance process. Final approval will be considered retrospectively due to the scheduling arrangements of the 2023 / 2024 HWB meeting dates.

1.2. Bodies involved strategically and operationally in preparing the plan

This document, along with the supplementary planning template, have been prepared by officers of Hampshire and Isle of Wight Integrated Care Board (ICB) Isle of Wight place team and Isle of Wight Council (IWC) with support from the Voluntary Care Sector (VCS), on behalf of the HWB. Service reviews provided by operational leads, including those across the Isle of Wight NHS Trust (IWT), VCS organisations and social care providers have been incorporated in the development of this plan and will continue to shape transformation of delivery across 2023 – 2025.

A golden thread of alignment between the previous BCF and wider system strategies has been the Isle of Wight Health and Care Plan (HCP; 2019) and its refreshed document for 2022-25, which included public consultation, whole system participation in its development with engagement from the ICB-Isle of Wight place, IWT, IWC, GPs, primary care, VCS, Independent Care Providers, Public Health (PH) and Healthwatch.

In addition, the following documents have also aided the development of the Isle of Wight's BCF Plan for 2023-2025: the NHS Long Term Plan (2019), NHS Trust Strategy (2020), Local Government Association Managing transfers of care – A High Impact Change Model, Quality Outcomes Framework, RightCare, Isle of Wight Council Corporate Plan, the IWC Care Close to Home Strategy, the Isle of Wight Joint Strategic Needs Assessment (JSNA), ONS Health Index and Public Health Insight.

The inclusive approach which has been adopted to date will be carried forward into the implementation phase of this plan and beyond to ensure the BCF Plan represents the views of the widest possible range of stakeholders, people with lived experience and those who access care and support, together their families and carers.

1.3. How have you gone about involving these stakeholders?

This plan has been developed through a mixture of local place-based discussions and feedback from all sectors across the Isle of Wight health and care system, as well as strategically considered at an 'at scale' level within the ICB after its establishment on 1 July 2022. Examples of such forums include:

- System Resilience Group which includes the ICB, LA, Trust and Independent Care Home Sector leads
- Tactical Discharge Group which includes Hospital Discharge Team, LA Social Workers and VCS
- Community Transformation Board which includes ICB, Primary Care, IW Trust divisional leads including Mental Health and Ambulance staff
- Project Fusion leads which include clinical and managerial leads from the three current community services who are set to merge into one new organisation by April 2024
- Hampshire and Isle of Wight Transformation Board
- ICS Primary and Local Care Programme Board which oversees the transformation and modernisation of community and out of hospital services
- Executive Delivery Group (place) which is tripartite and includes the ICB Place Director, Trust CEO and DAS for the Local Authority.
- Executive Management Group (ICB)

- Joint Strategic Partners including the VCS, Earl Mountbatten Hospice and Public Health

Within the BCF governance structure outlined below, at a place level our BCF Plan is co-produced through local partnership meetings with commissioning representation from the ICB, IWC and PH. Within these forums, priorities for the local organisations are presented and reviewed together to form the basis of shared decisions to invest or transform pathways. Additional pathway engagement throughout the year has included:

- BCF workstreams reviewed with commissioners and provider leads in 2022 / 23 via a workshop and accompanying desktop review comparing current delivery models with original (pre-pandemic) specifications.
- Feedback from independent consultations e.g., 4OC review of the Community Equipment Service (CES).
- Stakeholder pathway workshops when developing new specifications e.g., Prescriber Engagement Event for CES.
- Feedback from Emergency Care Improvement Support Team (ECIST) review and multi-agency discharge events (MADE)
- ICB community public engagement event with place executive representation hosted by People Matter Isle of Wight and supported by the new ICB Community Involvement Officer.
- Learning Disability Consultation (ages 16+) co-produced with the Learning Disability Partnership Group.
- Autism Consultation (ages 16+) co-produced with the Autism Partnership Board

Work underpinning the refresh of the Island Health and Care Plan 2022–25 has also been incorporated with feedback from a range of stakeholders on the plan, its strategy and approach.

2. Governance

The Isle of Wight Health & Wellbeing Board provides strategic leadership and direction for decision-making and joint commissioning across the Isle of Wight. The Isle of Wight Health and Wellbeing Board has a statutory role (set out in law by the Health & Social Care Act 2012). It works to:

- improve the health and wellbeing of local people,
- to reduce health inequalities amongst the Island population, to promote the integration of services so they work more closely together.

Budget	Value for 23/24
DFG	£2,272,039
Minimum NHS Contribution	£13,972,426
iBCF	£6,180,112
Additional LA Contribution	£3,943,489
Additional NHS Contribution	£2,739,223
Local Authority Discharge Funding	£866,442
ICB Discharge Funding	£1,085,966
Total	**£31,059,697**

Table 1: Funding Streams

Hosted by the Isle of Wight Council, the Board brings together the NHS, public health, adult social care and children's services, including elected representatives and Local Healthwatch, to plan how best to meet the needs of the local population and tackle local inequalities in health. Within the scope of duties, the Board has ultimate responsibility for the development and delivery of the local Better Care Fund. In execution of this duty, the HWB is consulted and asked to approve the Isle of Wight Better Care Fund Plan, and to endorse the execution of the Section 75 Framework Partnership Agreement between the IWC and ICB which governs the BCF and enables an aligned budget inclusive of the grant and funding streams detailed in Table 1.

Sitting beneath the Health and Wellbeing Board, the Joint Strategic Partnership (JSP) acts as the lead partnership forum for the development, and management of, the Isle of Wight Better Care Fund plan. This group includes tripartite statutory commissioning representation overseen by the:

- Director for Adult Social Care and Housing Needs for the Isle of Wight (IWC)
- ICB Isle of Wight Place Director
- Associate Director of Public Health

The JSP acts as a single health and wellbeing commissioning voice for the Isle of Wight, ensuring oversight, delivery and efficiency assurance. It convenes monthly and exercises its functions following consensus / consultation with each other on those functions in scope – including the Better Care Fund. Where consensus is not reached, it has the power to allocate tasks to the joint BCF Working Group to enable furth clarification or proposal development to reach a decision.

The JSP was established to ensure effective collaboration, assurance, strategic oversight, and good governance across integrated, joint and aligned commissioning arrangements between the Isle of Wight Council and NHS Hampshire and Isle of Wight Integrated Care Board (Isle of Wight Place/Local Delivery System). The JSP agrees priority areas of work to be taken forward against a vision for integrated/joint commissioning; developing and overseeing the programme of work to be

delivered. It provides direction on priorities and the agreed work programme with deliverable milestones. Evidence based commissioning acts as a key to achieving an integrated/joint commissioning vision with decisions to invest or transform pathways being informed and driven by local needs assessment, market analysis, the experiences of local people and the communities they live in, through collaboration, co-production, consultation, and engagement.

Tactical oversight is provided by a monthly joint BCF Working Group, which is drawn from key partners within the system. Transformational plans and programmes are formally discussed and approved by existing local authority governance processes and within each ICB's governing bodies.

The operational delivery of the BCF plan is undertaken on an integrated end-to-end basis; from point of commissioning to service provision, including the aligned budget arrangements. Oversight of the latter is supported by quarterly meetings of a BCF / S75 finance sub-group drawn from the council and ICB Isle of Wight local delivery team.

Leadership for service delivery is agreed and comes from across the system for the individual schemes and interventions, including specialist interest groups to address local inequalities, such as Mental and Children's Health teams. Where development of new models and services requires contractual changes, formal contractual processes with providers are put in place to ensure effective assurance and consistent and robust monitoring.

3. Executive Summary

The Isle of Wight boasts a unique combination of rural, coastal, and urban communities with its population of c. 145,750 registered residents (May 2023) which increases up to 150% during peak tourism weeks. It is the home of one of the oldest populations in England: as of May 2023, the CSU reported 42,172 were aged 65 and older – 28.9% of the population with the ONS projecting that this percentage will continue to grow. 18% of demographic profile live in a single person household (2021 Census) and almost one in four people (23.1%) have two or more long-term conditions and the acuity and complexity witnessed in patients accessing services has also, in general, continues to be exacerbated since the pandemic with non-elective admissions still showing an increasing trajectory with c.55% of patients requiring some type of onward support (Pathway 1-3). Some of this may be directly attributable to Covid-19, and some indirectly as a consequence of restricted access to care during the peak of the pandemic response, with subsequently compounded delays during the restoration and recovery period as waiting lists are addressed. The combination of single-person households with increasing prevalence and acuity of health conditions increases the likelihood that people will turn to statutory services for care needs.

The BCF programme helps support the Isle of Wight health and care system to address these challenges and successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for local people and carers. In particular, the entire intermediate care model of services sits within in the BCF as a lynchpin of supporting the flow of entire health and care system. The allocations are set by NHS England and are pooled into a section 75 agreement alongside the Disabled Facilities Grant (DFG), Improved Better Care Fund (iBCF) and Additional Discharge Fundings (ADF). The total value of the 2023/24 Isle of Wight BCF pooled budget is £31,059,697. This final figure reflects an increase in line with average NHS revenue growth (5.66%) and the Additional Discharge Fund, introduced for 2023/24.

3.1. Priorities for 2023-25

The Health and Wellbeing Board has developed the *Healthy Places for Healthy People to lead Healthy Lives: The Isle of Wight Health and Wellbeing Strategy (2022 to 2027)* which, together with the Health and Care Plan, have a joint aim to ensure that people on the Island live healthy and independent lives.

The HWB strategy outlines a shared vision using an approach for improving health and wellbeing on the Island for all ages (the life course) under which the Better Care Fund sits as a facilitator for integrated design and delivery of services. The strategy is based on the principle that a family-centred, all age approach that promotes a holistic view of an individual's total health and wellbeing is an effective means of improving the health in our communities. It also emphasises the social perspective, looking back across an individual's or group's life experiences for clues to current patterns of health and disease, while recognising that both past and present experiences are shaped by the wider social, economic, and cultural context.

As a system, our ambition is to create healthy places for healthy people to live healthy lives across the Island, through a focus on three priorities:

- Healthy Places focus - healthy homes including addressing the four housing themes of affordability, quality, security, and homelessness
- Healthy People focus - mental health and emotional wellbeing
- Healthy Lives focus - health inequalities including delivery of healthcare provision in line with the NHS programme of CORE 20 plus 5 and addressing the growing prevalence of long-term conditions.

The Health and Care Plan identifies four pillars of opportunity through which this may be achieved: prevention, partnerships, productivity, and pathways. Better Care Funded schemes and services are key to delivering the priorities of the Health and Wellbeing Strategy and the Health and Care Plan.

The ambitious Health and Wellbeing strategy is set against a need to work in collaboration to address workforce challenges and drive towards long-term financial sustainability as a system. More recently, on 22 May 2023, the Discharge Support and Oversight Group (part of the Department of Health and Social Care) met to discuss demand and capacity planning within the wider context of work being undertaken to create a structured and comprehensive scoping process and cross-system focus on hospital flow - particularly regarding hospital discharge and system-wide demand and capacity. In advance of this meeting, preparatory work was undertaken to collate data sources and present in a single-system approach. A follow up meeting was undertaken on 12 June 2023.

Review and support of the Discharge Support and Oversight Group led all parties to conclude that, as with every health system nationally – and considering the very challenging financial position across both the HIOW ICB and the IWC, we demonstrated absolute commitment to ensuring that best value, best outcomes, and best experience is delivered for every pound invested in the BCF. Specifically, we are committed to ensuring that we minimise any duplication in service, which could be better invested in other service models – for the benefit of our population.

During 2023 – 2025, the joint fund will:

1. Continue to support the four BCF schemes developed in 2022/23 of:

    - Integrated Early Help and Prevention
    - Integrated Discharge and Admissions Avoidance
    - Integrated Community Support
    - Integrated Mental Health and Learning Disability Support

2. Continue to use local data to review and refresh specifications for services enabled via the BCF, implementing agreed service changes during the lifetime of this strategy to ensure that patient experience, workforce resilience, efficiency and financial sustainability opportunities are optimised.

3. Act as a key enabler for ‘Project Fusion’ – the work being undertaken to bring together all community, mental health and learning disability services across Hampshire and the Isle of Wight into one, new NHS Trust. Our ambition is to have formed the new organisation by April 2024.

4. Work in partnership towards a single system financial control, finding efficiency opportunities that can only be delivered the combined efforts of commissioning and provider organisations.

3.2. Key Changes since previous BCF plan

This year has seen the introduction of Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs), helping to broaden our opportunities to work at scale across other HWB footprints to deliver our ambitions for integration and shared priorities, and our duties set out in the Care Act. We have also seen:

- Agreement between HIOW partners to undertake Project Fusion
- The expansion of the Living Well and Early Help Service
- The redesign and re-specification of the Community Equipment Service.
- The end of the Falls Co-Ordinator role, Life After Stroke and Independent Living Service workstreams following evaluation.
- The reallocation and reinvestment of funds into supporting Care Home Providers (via the Maintenance of Adult Social Care Provision and Community Equipment Service) and Community Equipment Service,

supporting the *2023/24 priorities and operational planning* objective to Deliver a balanced net system financial position for 2023/24.

- The introduction and application of the Adult Social Care Discharge Fund during Q3/4 of 22/23, securing additional capacity to improve discharge flow during Winter.

4. National Condition 1: Overall BCF plan and approach to integration

Local health and care partners have a long history of working together and with our population and are united in our vision to support people in our communities to live healthier, longer lives. We are committed to further building on our partnerships with local authorities, emergency services, voluntary organisations, independent sector providers and local communities for the benefit of our populations.

We have a shared ambition to be one of the best health and care systems, with local partners continuing to work closely together with the wider community to tackle the challenges we face. Working in partnership, we can provide more consistency of care, break down barriers between services and reduce inequalities. With rising demand on the health and care system and increasing complexity of presentations set against a backdrop of workforce and financial challenges, there is an increasing impetus for the Island's partners to work as one. Collaboration and integration of services is an essential factor in developing the local health and care model for sustainable delivery now and into the future.

As partners we have committed to acting together for the population of the Isle of Wight by:

- aligning and allocating our collective resources to achieve priority outcomes that make real differences.
- orientating our work to the whole population, or to groups of the population where significant improved outcomes can be secured
- supporting people to become more independent and do things for themselves by changing the relationship between local people and local offers of care and support
- promoting choice and control for local people
- being innovative and have an appetite for risk to make the change
- making the most of new opportunities and powers
- building on our existing good work and relationships
- ensuring that the system is financially sustainable and flexible enough to meet current and future challenges
- being clear, open, and honest with ourselves about priority work areas that we are going to jointly take forward and commit to resourcing and delivering the expected change outcomes

At a place-level, the model of care for the Isle of Wight was developed in partnership with the Island's citizens and its health, wellbeing and care related statutory, voluntary, and independent sector organisations. In 2018, the Isle of Wight began development of a joint Island Health and Care Plan which was refreshed in 2022. Key to the Health and Care Plan is the shared vision, which is echoed in the BCF Plan, that Islanders will spend fewer years of their lives in ill health as health and care services focus on promoting, improving and maintaining independence as well as preventing ill health, addressing health inequalities and better management of long-term conditions. To enable this, the plan outlines a commitment for partner organisation to work together to address wider issues that impact the health of local people, from the earliest age and support those in the most vulnerable families at risk of the poorest health.

One element has included alignment with the *Healthy Places for Healthy People to lead Healthy Lives: The Isle of Wight Health and Wellbeing Strategy (2022 to 2027)* and Island Health and Care Plan's 2022-25 vision of a 'life course' approach which is being implemented via four system priority pillars: prevention, partnerships, productivity, and pathways. 'Pathways' includes reviewing models of care including community supported care, mental health, and supporting return to home.

The productivity work stream focuses predominately on the internal systems and process of all health and social care partners, making sure we work together in a more integrated way, communicate better with each other and the public, and use our collective resources as efficiently and effectively as possible, to aid admission flow and

discharge. Our collective approach to delivering improvement to admission flow and discharge is framed around the High Impact Change Model, applying a Home First model, which is underpinned by the BCF Plan.

The alignment of the Health and Care Plan and the BCF Plan is aimed at improving the health, wellbeing, and care of our Island population, improving care and quality outcomes, delivering appropriate care at home and in the community, whilst delivering financial sustainability for the longer term.

Further joint working has emerged and been aligned with the development of the Community Transformation Programme (CTP) which enables collaboration across the whole system including commissioners and providers from across statutory, VCS and independent organisations. Alongside this transformative undertaking, Project Fusion will now facilitate a closer working relationship with 'off-Island' teams.

Over the past year we have seen this approach slowly progress the groundwork laid during the 22/23 BCF strategy to review existing schedules of work and governance structure. We have seen the following changes arise as a result:

- The expansion of the Living Well and Early Help Service: The development of the Living Well and Early Help service was indeed ground-breaking as following the review over 2020 - 2021 it recognised that the service would better support the community by being within the heart of the community and run by those organisations within it. Pulling together Voluntary Community and Social Enterprise organisations and Town, Parish, and Community Councils to work together providing that wrap around support that our islands residents need, enabled cohesive and seamless support for people, who may have in the past been passed from pillar to post. Working as a collective support network to maximise peoples' abilities and building the community resilience that our Island needs, is something which both the health and social care statutory partners endorse though the commissioning of the Living Well and Early Help service. The importance of having a holistic service to support people not eligible for statutory services, enables us as a Health and Social Care System to ensure that people live a good, healthy, and happy life, that they are supported to 'thrive' and not simply 'survive', and that we minimize the need for intrusive or unwanted statutory service interventions.

  The service was jointly commissioned by the IWC and the ICB in April 2022. Since then, this community-led partnership has made a real difference to the lives of more than 2,390 Islanders, helping them to stay well, independent and connected with their local community. And with the launch in December of its innovative mobile hub, the service can reach people living in more rural areas of the Island. The mobile support vehicle provides targeted provision in the community including emergency support, advice, and education to enable people to live safe and affordable lives. It is also helping the most vulnerable Island residents during the cost-of-living crisis with the provision of food, drink, and a warm space to spend some time.

  The service between April and December 2022 is has:
    - Actively supported in the community 2,389 individuals
    - Supported 1,046 new individuals (not known to the service previously)
    - Only 23 people have been referred to further statutory service support

  The Living Well and Early Help Service, delivered by Aspire Ryde and their community partners, won the Gold Award in the transformation in health and social care category at this year's iESE Transformation Awards.

- The redesign and re-specification of the Community Equipment Service: System pressures and external reviews (MADE/ECIST/4OC) made recommendations around planning and preparing for discharge under a 'Home first' approach. A working group was established to review the service considering these recommendations, seeking to align with the wider HIOW ICS and become financially sustainable after the removal of the temporary Contain Outbreak Management Fund (COMF) uplift. Engaging with stakeholder and prescribers, a new specification has been written and is due to commence from the end of Q1 2023/24.

- The end of the Falls Co-Ordinator (see Planning Template Tab 7, 8.2 Falls), Life After Stroke and Independent Living Service workstreams: following review, it was identified that the efficiency and value for money could be improved via the reallocation and reinvestment of funds into supporting Care Home Providers (via the Maintenance of Adult Social Care provision) the Living Well and Early Help offer and the Community Equipment Service to help address the current shared shortfalls across health and social care in facilitating discharge flow from acute admissions in order to enable people to return, and remain, at their usual place of residence.

- The introduction and application of the Adult Social Care Discharge Fund during Q3/4 of 22/23: This additional funding was distributed to both the IWC and ICB to pool into the local BCF. Our aims were identified as being to:
    - enable more people to be discharged to an appropriate setting with adequate and timely social care support as required
    - prioritise those approaches that are most effective in freeing up the maximum number of hospital beds and reducing bed days lost
    - boost general adult social care workforce capacity through recruitment and retention, where that will help to reduce delayed discharges.

  The following schemes were developed and implemented to help achieve the identified aims:

Scheme Name	Scheme Nature	Impact	Investment
Community Unit	Bed based intermediate care services	14 beds	£451,333
Discharge to Assess Beds		101 placements	£268,299
Reablement Capacity		13 beds	£150,000
Residential Capacity	Residential placements	119 placements	£266,193
Home Bridging Service	Home care or domiciliary care	2,323 hours of care	£350,000
Home Care Capacity		3,456 hours of care	£222,486
Community Day Hub Pilot		593 hours of care	£98,000
Telehealth and Proactive Support to Care Homes	Assistive technologies and equipment	20 packages (reusable)	£73,000
Discharge Team Capacity Extension	Additional or redeployed capacity from current care workers	248 hours	£41,000

The role of the BCF during 2023-2025 remains as a key enabler for the design and implementation of shared system priorities where integrated and aligned working will generate improvement for individual outcomes as well as system resource management. It enables a shared ambition to transform the delivery of health and care across the Isle of Wight so that it is better integrated, delivered as locally as possible, person centred and has an emphasis on prevention and early intervention to prevent escalation. Key priorities for this period will include:

1. Continue to support the four schemes developed in 2022/23 which sustain admission avoidance, enhanced personalisation, facilitate timely hospital discharge to return people back to their normal place of residence and improve equality and reduce health inequalities. The four schemes are:

1. Integrated Early Help and Prevention	Our place-based partnerships between statutory organisations and the VCS enables us to engage with and shape our communities, build / enhance our community assets, and help to tackle the challenges of increasing demand for health and care services. Through prevention and earlier intervention, we seek to address local health inequalities at a grass roots level so that people can live healthier, longer, and happier lives. Services will be commissioned to underpin and promote independence and self-management.
2. Integrated Discharge and Admissions Avoidance	The BCF, iBCF and ADF are utilised to fund a complete intermediate care model spanning reablement services, bridging and short-term care and rehabilitation to support system flow and help people return more quickly to their usual place of residence when they have needed an acute stay. Key to this will be the continued application of Discharge to Assess (D2A) and the Home First policy.

3. Integrated Community Support	As a system we have seen that the health and social care needs of people are often intrinsically linked. As a result, we are continuing to work as a single system to identify opportunities for collaboration on community-based pathways to bring together health and social care resources. Through this we seek to co-ordinate the management of people with complex needs, improving the health and well-being for our residents, as well as increase efficiency of service delivery.
4. Integrated Mental Health and Learning Disability Support	As a system we have recognised that there is no health without mental health and continue to support a 'No Wrong Door' approach to accessing mental health support. The BCF continues to support this ethos. It also recognised that, whilst all services are required to make reasonable adjustments to ensure equity of access, additional bespoke support for people with learning disabilities helps to address the needs of our local population who often experience more complex co-existing health needs

2. Continue to review and refresh specifications for services enabled via the BCF, implementing agreed service changes during the lifetime of this strategy to ensure that experience of local people is positive, we support and promote workforce resilience, and financial sustainability opportunities are optimised.

3. Act as a key enabler for Project Fusion: across Hampshire and the Isle of Wight, community, mental health and learning disability services are currently provided by several NHS organisations plus local authority, voluntary and independent sector organisations. This complex arrangement can mean that some people and communities, depending on where they live, do not have the same access to care services, receive the same services or have the same health outcomes. Following an independent review of these services in January 2022 a compelling case was made to bring together all community, mental health and learning disability services across Hampshire and the Isle of Wight into one, new NHS Trust. Our ambition is to have formed the new organisation by April 2024.

4. Work in partnership towards a single system control, finding efficiency opportunities that can only be delivered the combined efforts of commissioning and provider organisations including improvements in productivity, clinical effectiveness, commissioning at-scale and designing more effective models of care. Partners will focus on the cost-effectiveness of the whole system, not cost shifting between organisations, applying a 'One Island Pound' approach.

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

Many things influence our health and wellbeing – the lifestyles we lead, our social contacts, the environment around us, our jobs, and homes, as well as the health and care services which support us. Everyone on the Island should have the right to enjoy good health and wellbeing and the majority do, however we know that some groups and communities experience poorer health than others. Together, with the Health and Wellbeing Strategy and the Health and Care Plan, the BCF shares a joint aim to ensure that the people of the Island live healthy and independent lives. This is aligned with the need to achieve clinical and financial sustainability for the health and care system.

Whilst all the workstreams implemented through the BCF have the intention to enable people to stay well, safe and independent for longer, key to their implementation have – and will continue to be:

- Collaborative commissioning – The CES specification development is an example of the increased collaboration between organisations for responding to system needs and designing solutions together with contributions across commissioning organisations and provider partners. This approach will be applied throughout the duration of the 2023-25 strategy to enable ongoing service development and reviews. A further example of increased collaboration is that of the new role of the Joint Commissioner for Learning Disabilities, Autism and Mental Health which is a shared role across the ICB and IWC to enable smoother cross-organisational commissioning of services for people with Learning Disabilities and /or Autism, enabling our population's voices to be heard to enable co-production in service

development and helping to break down traditional barriers faced when accessing services across both health and social care.

- End-to-end pathway working across primary, intermediate and secondary services – with the formation of the ICB there was a change in commissioning scope to include Optometry, Pharmacy and Dentistry. Work on Project Fusion (community services) and the Acute Partnership (elective care) has been further aligning these pathways for improved efficiency and reduction in unwarranted variation. The Rehabilitation, Reablement and Recovery scheme within the BCF is an example of a tiered collaborative approach with GP, step-up and step-down community and acute based health and social care partners working together to deliver the discharge support services.
- Population health management - We are building on our existing collaborative commission processes and increasingly adopting a Population Health Management approach, using data to improve person-centred care, reduce health inequalities and plan improvements to services. Trends, themes and outcomes from data enables us to make evidence-based decisions about the way we can collectively improve health and wellbeing - from setting health and care priorities, through to designing new models of care and interventions to improve health and care outcomes.
- Implementation of the Fuller Stocktake – the Primary Care Commissioning team in partnership with the ICB Quality Team have been working on the findings of the Fuller Stocktake to
    - widen the traditional GP-based primary care model to include broader ARRS roles and provide more proactive, personalised care with support from a multidisciplinary team
    - streamline access to care and advice so that patients contacting their practice are directed to the most appropriate person able to help them
    - align with community and acute teams to deliver an MDT-approach to care, building on the establishment of the Primary Care Networks
    - develop a primary care estates plan
    - improve digital infrastructure and communication including the expansion of SystmOne, currently used by primary care and the local hospice, into the Isle of Wight NHS Trust.
- Recognition of unpaid carers – Caring is a selfless role, where families and friends look after their loved ones or others that they feel a sense of responsibility for, but it should not be carried out at the expense of the carer's own health and wellbeing. We know that many carers do not access the support that they may need as they do not think of themselves as 'carers' or have not been identified by statutory organisations as such (known as 'hidden carers'). Through the Carers' Prospectus and Carers Lounge, the BCF seeks to specifically address the needs of this cohort of our local population – recognising that it will not only help them to support their loved one in retaining their independence for longer in the community of their choice, but also supports the carer themselves to maintain their own ability to stay well and safe. This is expanded upon in the section below *Supporting unpaid carers.*
- Housing adaptations – The Isle of Wight Council has led on the development of the Adult Social Care and Housing Needs Care Close to Home Strategy (CCTH) 2022 – 2025. This strategy reflects both the social care and housing needs of our local communities and seeks to address them through a series of '6 Keys to Success' which are focused on supporting people with appropriate housing solutions to promote and enhance independent living. This is expanded upon in the section below *Disabled Facilities Grant (DFG) and wider services.*

Work against these areas will continue in 2023-2025. There is also a significant challenge being faced in respect of workforce within the Isle of Wight community services requiring a shared focus on addressing workforce recruitment, retention and resilience now and into the future. The local capacity issues experienced prior to the pandemic and the impact of Covid-19 has further reduced workforce capacity across health and social care.

Looking back at the demand for 2022/23, there was very little seasonal variation in non-elective admission activity to the Isle of Wight NHS Trust with the greatest variance being a difference of 362 admissions between the lowest rate of 1,160 during October 2022 and the highest of 1,522 in March 2023. However, one of the most significant challenges that we are seeing a higher number of individuals, 'Not Meeting the Criteria to Reside' (NMCtR), remaining in hospital longer than we, and they, would like. This is currently the highest level in the Southeast region, at 27% of acute capacity. This creates clinical risk, cost, and capacity pressure to the system, and also poses risks to both those requiring admission to hospital and those unable or unwilling to leave who may subsequently decompensate.

The previous demand and capacity plan covered the period of October 2022 – March 2023. Demand was predicted to be relatively static throughout the period with increases for January and March. On review of the daily Situational Reports, the actual activity has reflected this. What did change over the period was the amount of capacity. The Adult Social Care Discharge Fund Determination (2022-2023) provided additional spend on supporting discharges and social care workforce capacity that was not originally planned for the 22/23 BCF submission. The impact of the increased care and support capacity had an impact on discharges with a decrease in the metric '*Of the total number of people who have a length of stay of 7 days or over who had been assessed as not meeting the criteria to reside: the number of additional days in total they remained in hospital despite not meeting the criteria.*'

Key learning from this identified the following:

- Workforce capacity on the Isle of Wight remains a challenge due to high levels of vacancies and current demand and complexity outstripping current available capacity. Recruiting to cover vacancies / provide additional workforce proved difficult due to the short-term nature of the funding as this results in job insecurity for applicants seeking stability during the current national cost of living crisis. Workforce recruitment was more successful via bank / additional hours for existing partners and staff.
- The full impact of new pilots funded by the short-term grant was not able to be optimised due to the need to mobilise and decommission within the funded period resulting in 'lost' days to ensure that the appropriate care was in place for individuals in their onward pathway.
- Economies of scale can be capitalised on by bolstering existing teams (which have existing infrastructure in place) rather than creating new teams.
- Reliance on agency can meet some of the current short-term need but is not financially sustainable to continue indefinitely – a wider workforce strategy is needed including a 'grow our own approach'. As part of the BCF, approval was granted in-year to commence an integrated workforce development pilot: the Care Graduate Scheme. This offers a two-year employment opportunity with support, mentoring and coaching. Locally, we are more geographically isolated due to the Solent. By implementing this scheme, we are encouraging local residents to remain on the Island with access to long-term careers development opportunities.
- There is a need to address capacity supporting people being discharged on both Pathway 1 and Pathway 2 after an acute stay; implementing a mixture of schemes enabled the system to manage flow more flexibly.

Going into 2023/24 the substantively commissioned service capacity is currently unchanged. This is due to a mixture of some services having already been reviewed and refreshed during 22/23, along with ongoing discussions and reviews currently under way across all members of the Isle of Wight health and care system. A summary of these schemes is outlined below:

SCHEME:		BUDGET:	NC1 Integration	NC2 Independence	M1 Avoidable Admissions	M2 Falls	M3 Discharge to usual residence	M4 Residential Admissions	M5 Reablement	Carers Support	Housing / DFG	Addressing Inequalities
1) INTEGRATED EARLY HELP & PREVENTION												
1.1	Living Well & Early Help	£732,627		■	■					■		■
1.2	Voluntary Sector Infrastructure Support Grant	£50,000		■								
1.3	Support for Providers	£80,000			■							
1.4	Assistive Technology	£48,350		■	■		■					
Sub Total		**£910,977**										
2) INTEGRATED DISCHARGE & ADMISSION AVOIDANCE												
2.1	Crisis Response Service	£391,992	■		■		■					
2.2	Social Work Hospital Team	£684,178	■		■		■	■	■			
2.3	CCG Reablement - LA Reablement Support	£95,000					■	■	■			
2.4	Carers Support (ASC Community Care)	£296,008		■	■					■		■
2.5	Disabled Facilities Grants (Capital)	£2,272,039		■			■				■	■
2.6	Community Occupational Therapy	£490,547		■	■	■						
2.7	Community Reablement (IWC)	£2,206,405					■	■	■			
2.8	Community Unit	£1,085,966					■	■	■			
2.9	Adelaide Resource Centre (IWC)	£1,632,222					■	■	■			
2.10	Gouldings Resource Centre (IWC)	£1,812,495					■	■	■			
2.11	Trust Rehab Team (Including CQUIN)	£4,186,252					■	■	■			
2.12	24 Rehab Beds	£1,605,921					■	■	■			
2.16	Additional External Care Home Beds	£162,978					■	■	■			
Sub Total		**£16,922,003**										
3) INTEGRATED COMMUNITY SUPPORT												
3.5	Community Outreach (IWC)	£1,234,365		■	■							
3.6	Carers Prospectus (Inc Carers Lounge)	£287,158		■						■		■
3.7	Community Equipment Store	£1,044,166	■	■	■		■				■	■
3.11	Care Act implementations & Infrastructure	£544,027		■						■		■
3.12	User Led Organisation (People Matter)	£50,000		■								■
3.13	Care Graduate Programme	£531,515										
3.14	Maintenance of Adult Social Care provision	£5,466,334						■				
Sub Total		**£9,157,565**										
4) INTEGRATED MENTAL HEALTH & LEARNING DISABILITY SUPPORT												
4.1	Woodlands NHS Staff	£1,639,281	■	■	■		■					■
4.2	Social Care Contribution to Woodlands	£147,000	■	■	■		■					■
4.3	MH Grant Agreements	£1,011,231		■								■
4.4	Westminster House - Respite Support	£616,489		■	■				■			■
4.5	Reeve Court Supported Living	£655,151	■	■	■						■	■
Sub Total		**£4,069,152**										
Total		**£31,059,697**										

It is anticipated that in-year changes will be undertaken with subsequent updates to the BCF Plan. Review of the demand and capacity planning has highlighted a need to prioritise a refresh of the Integrated Discharge and Admissions Avoidance scheme with a particular focus on discharge Pathways 1 and 2 where additional complex support is needed to facilitate a return home.

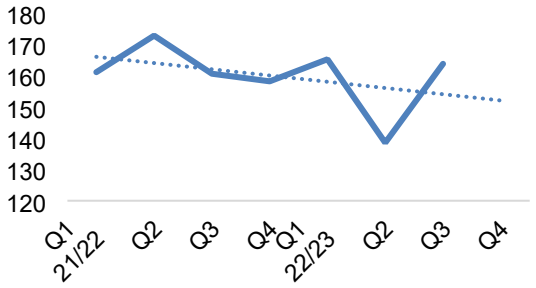
However, during the period of redesign, the capacity of the system will be supported by the Adult Social Care Discharge Fund (Revenue) Grant Determination (2023-24): No 31/6645. Learning from the demand and capacity review outlined above have helped to inform the application of this additional income to address the identified gaps in capacity.

This will predominantly support reablement in a person's own home with some of the additional funding being utilised to secure bedded care.

Scheme Name	Scheme Nature	Impact	Investment
Social Work Hospital Team	Additional or redeployed capacity from current care workers	3 posts	£153,071
Care Graduate Programme		20 placements	£295,000
Community Reablement	Home care or domiciliary care	11,500 hours	£255,393
Additional External Care Home Beds	Bed based intermediate care services	4 beds for 12 months	£162,978
Intensive Rehab Beds		10 beds for 12 months	£1,085,966

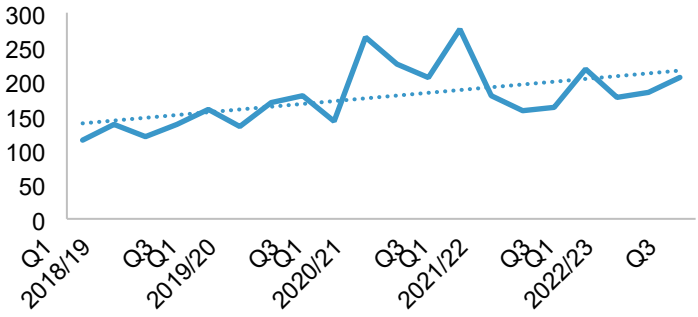
It is intended that these schemes will continue to support the positive trajectory against the BCF metrics. Whilst the overarching number of non-elective admissions has been increasing, those relating to unplanned hospitalisation for chronic ambulatory care sensitive conditions have been decreasing. Key to this has been the embedding of the Crisis Rapid Response team [BCF 2.1, supporting *2023/24 priorities and operational planning* objective to improve A&E waiting times, reduce bed occupancy and meet the UCR standard], roll-out of virtual wards and increasing primary care access through the recruitment of ARRS roles and utilisation of digital / telephonic techniques. These have been able to maximise early access before escalation to the acute setting occurs, enabling people to stay well, safe and independent at home for longer.

Unplanned hospitalisation for chronic ambulatory care sensitive conditions Indirectly standardised rate (ISR) of admissions per 100,000 population

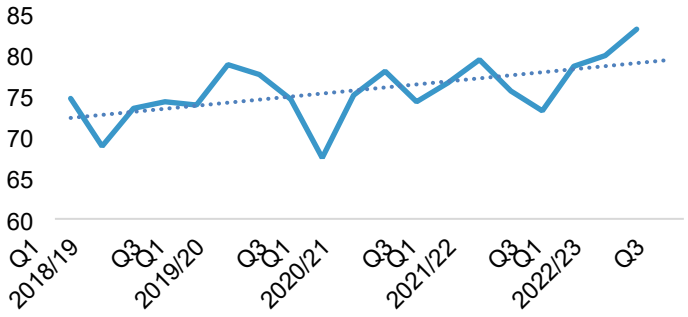


The success of these changes can be seen through the increasing proportion of people (65 and over) who are still at home 91 days after discharge.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population



Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

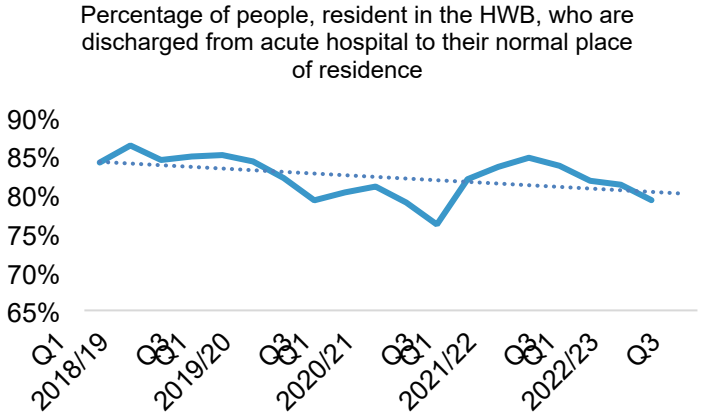


However, there is still a need to address acuity, complexity and inequalities arising through individuals living longer in poor health as can be seen from an increasing number of people needing a long-term residential admission to have their needs met. This need is also echoed in bedded capacity tracking in the community: the majority of intermediate care services are fully utilised with demand exceeding capacity. Key to this will be providing the right care, in the right place, at the right time. (NC3 below)

6. National Condition 3: Provide the right care, in the right place at the right time

The NHS, GPs, IWC and the community and voluntary sector are working together to improve health and social care. We share a single vision, that people will lead healthy, independent lives. In support of this vision, the BCF Plan seeks, through implementation of its schemes, to provide personalised and coordinated services to help local people get the right support, in the right place, at the right time. To achieve this ambition, the BCF has been used to deliver services and support offers across the whole health and care pathway; from neighbourhood-level prevention via the LWEH service, to supporting people at home after discharge from hospital. The integrated, collaborative approach to commissioning and implementation of services seeks to break down traditional barriers that can occur across organisations and even within them.

6.1. Home first



When an individual's health has required an acute admission, the system takes a 'Home First' approach, providing people with support at home or intermediate care, to help facilitate a timely discharge once their acute needs have been met. Reviewing demand and capacity during Q3/4 of 22/23 – typically the period with increased activity due to Winter pressures – 45% of local people were discharged home with no active support required. The remaining cohort required a relatively equal split between support at home and a short-term admission to receive rehabilitation. Going forward into 2023 – 2025 we will utilise the Additional Discharge Fund as part of the wider BCF plan to enhance Pathway 1 and Pathway 2 capacity through the schemes outlined above (p.11) whilst we review the substantively commissioned services with a view to turning the curve on the current decreasing trend for the percentage of people discharged to their usual place of residence.

6.2. HICM – transfers of care

The High Impact Change Model (HICM) has been applied to the Isle of Wight Health and Care system planning since it was first introduced by the Local Governments Association (LGA) in 2015. The HICM objectives, and subsequent refreshes, have been incorporated into the development of the Health and Care Plan as the framework that underpins key phases of delivery and transformation.

One of the key litmus tests for successful implementation of the HICM remains monitoring of the management of transfers with a view to reducing the number of people who are in an acute setting but who don't meet the criteria to reside in a hospital bed (medically optimised for discharge). This receives weekly oversight at System Leadership Level, and monthly at Exec level where there is a detailed review of flow through the acute hospital and community bedded and non-bedded care settings. This process ensures focus is maintained on achieving the system targets and seeking to identify solutions at an individual level, where needs and care solutions are complex.

The maturity matrix table below summarises key changes which have been implemented and exampled of ongoing work to improve flow. For the HICM self-assessment, the matrix levels from the Local Government Association (LGA) have been applied as:

Established	Standard processes in place, repeatedly used, subject to improvement over time
Mature	Processes tested over a period of time, evidence of impact beginning to show

Theme	Ambition	Status
1. Early discharge planning	• Identify people needing complex discharge support early • Ensure multidisciplinary engagement in early discharge plan • Set expected date of discharge (EDD), and discharge within 48 hours of admission	Established

Whilst the BCF workstreams in place are primarily focussed on the preventative and community support elements of people's pathways, the review of services has identified how various departments and organisations work together to support safe and timely discharge. A key enabler of this are the workstreams within the Integrated Discharge and Admission Avoidance scheme. These services are engaged to help provide ongoing arrangements to embed a Home First approach and ensure that more people are discharged to their usual place of residence with appropriate support, supporting the *2023/24 priorities and operational planning* objective to reduce bed occupancy. The co-location of health and care services within the Integrated Discharge Team has seen an improved degree of oversight and clarity regarding system availability of onward support. This has been particularly important considering the ongoing workforce challenges within community support.

During 22/23 reviews of the Rehabilitation, Reablement and Recovery services was undertaken by an external consultant agency with additional ECIST and MADE events. The Pathway 1 and 2 review identified a need to reset the service configuration and criteria applied within pathways for Regaining Independence (RI) services. The Covid pandemic has significantly impacted business-as-usual activities. The emphasis on acute flow continues, which is essential to keep beds available. At the same time, there is a requirement to reduce the number of delayed transfers of care and escalation beds that are open due to these delays. It was acknowledged that some people are experiencing delays in receiving the care they need in the most appropriate setting and are experiencing long stays in short-term placements.

Next steps: The current intermediate care pathway within the BCF has evolved over several years – a review of the pathway to draw together the multi-stranded pathway, incorporating the feedback from the 22/23 reviews will help to clarify pathways and the MDT approach to discharges. Alongside this, at the end of Q1 we will be implementing the new Community Equipment Service approach which will require an increased focus on early discharge planning so that orders may be placed and fulfilled in a timelier manner.

2. Monitoring and responding to system demand and capacity	• Develop demand/capacity modelling for local and community systems • Manage workforce capacity in community and social care settings to better match predicted patterns in demand for care and any surges	Established

Our Demand and Capacity Plan assumptions were based on the previous work undertaken in the development of the BCF including:

- Previous performance levels for IWT, broken down by pathway (assumption made that (a) only a small number of people will attend an acute hospital off-Island (b) Of those that travel off Island, those who will require onward reablement / rehabilitation will be low numbers as will be predominantly for elective surgical intervention and (c) those who have undergone surgical intervention who require additional support will be on an outpatient basis e.g. through the independent community physiotherapy provider / virtual wards).
- Applied recent SitRep activity levels seen during Oct-22 to Mar-23 and adjusted monthly performance to reflect previous trends seen during Winter
- UCR assumptions: The 2 hr standard is currently being achieved which would suggest that demand and capacity are currently in balance. Numbers taken from average referrals per month. However approx. 10% increase of referrals observed.
- Pathway 0 calculations from actual discharges onto P0 Oct-Mar 22/23 at 80% allowing for adjustment that a cohort will have attended hospital and require no support / signposting on discharge e.g. admission as a result of accident but otherwise no other health / social need. Data on P0 limited. Community figures Age UK Intermediate Care comprising of average number of people supported each month - 40 by Activity Co-ordinator in community unit, 5.5 by Crisis response, 9.6 by Day Hub
- P1 Reablement calculations (Reablement / domiciliary care / rehab at home amalgamated): Activity seen at 10.5 hours POC each week for 52 weeks divided by 1; this is for 9 months of the year. The winter 3 months are uplifted. For bedded care, an average of 2 people each week, multiplied by 52 weeks and divided by 12. An increase at the end of the year is the Gouldings coming back on stream.
- Community demand based upon monthly average inpatient non-elective admissions percentage performance during 2022/23 YTD compared for same time periods in previous year taken to identify an average variance of +12%. NICE recommended occupancy rate of 85% applied which would suggest an overall difference of +27% of activity increased capacity needed in the system to meet NICE occupancy rate.
- An element of double-counting noted as some people mapped under community demand if all workforce at capacity. However, due to waiting times for interventions / workforce shortfalls people who may have been supported at one tier in the community are exacerbating and attending hospital; additional counts operate as a secondary prevention until system stabilises. This may then see a reduction in hospital demand.
- Bed Based Intermediate Care: Rehab bed admissions each month - assumption of change of bed model and increased flow resulting in increased new admissions. System pressures resulting in maximal utilisation of bed

base for step down restricts step up usage; alternative measures implemented to support people in their usual place of residence such as VCS, UCR and Virtual Wards.

- Residential care (likely long term): The assumption numbers are low as we do not make arrangements for people to access long-term residential care direct from the hospital setting.
- Note historical dips in activity during Feb/ Mar from historical performance included into demand. Increase in activity during April 23 (Easter) not replicated in reablement March (Easter 24) as increase in bedded reablement from completion of refurbishment.

This means our gaps are particularly in respect of Pathway 0 VCS support (limited data available), Pathway 1 (Reablement at home) and Pathway 1 and 2 bedded reablement / rehabilitation care. Due to rising demand in both volume and complexity (see Capacity and Demand Plan), the system partners have accelerated and extended the virtual health provision which has seen initial success during its implementation during December 2021 to support covid patients on a step up/step down basis from the acute wards. The IOW virtual health scheme is now able to support people with respiratory and/or frailty-related conditions with 26 'beds' now available.

The second piece of work being undertake is designed to improving internal trust flow, same day emergency care (SDEC) throughput and % of people treated by increasing SDEC operational hours and additional Trust grade staff to increase flow, SDEC throughput and percentage of people treated. A third strand has been the expansion of the Community Rapid Response team. The three elements are interfaced enabling people to be seen quickly by the most appropriate person and reduce the need to be admitted to the acute setting.

Ongoing monitoring of demand and capacity facilitated through the Systems Resilience Group and Tactical Discharge Group. Via the BCF, there is now an increased awareness being driven by the monthly capacity planning template along with key stakeholders receiving weekly SitRep reports on the admission and discharges within the system.

The Additional Discharge Fund has also been allocated to mitigate workforce capacity issues with focus on Pathway 1 and 2.

Next steps: Expansion of Virtual Ward support to people with heart failure once senior clinical oversight has been secured. Refresh the BCF Integrated Discharge and Admissions Avoidance model.

3. Multi-disciplinary working	• Ensure multidisciplinary engagement in early discharge plan • Ensuring consistency of process, personnel and documentation in ward rounds • Streamline operation of transfer of care hubs	Mature

Multi-disciplinary working is probably one of the Isle of Wight's greatest strengths: in June 2021 92% of Island services were CQC rated good or outstanding which exceeds the national average. There is also a strong cross-organisational approach to delivering care pathways and projects. An example of a BCF supported piece of this approach is the multi-agency Integrated Discharge Team (IDT). Established in May 2019, the IDT now includes the site team, patient pathway navigators, single point of access, single point of onward care commissioning, social work team, Trust Rehabilitation, Trusted Assessors, voluntary sector hospital discharge team, Red Cross, Housing Liaison, ASC Reablement leaders and others.

Co-commissioning of services is regularly undertaken on a collaborative approach with increasing system maturity regarding risk sharing and a 'One Island' approach. The benefits of this are being seen at both a place and neighbourhood level. An example of this is the work currently being undertaken to collaboratively commission and implement a refreshed Community Equipment Service model. It is also acknowledged that the Island has a particularly vibrant and diverse voluntary sector which has been further highlighted through the embedding of the 'Living Well and Early Help' Service.

Next steps: Ongoing work will be needed to capitalise on the multi-disciplinary model within the community to improve efficiency and clarity of assets available. Improved communication will be facilitated between primary care and the community division, including the Integrated Locality Services, via the roll-out of SystmOne within the Trust.

4. Home First discharge to assess	• Streamline operation of transfer of care hubs • Revise intermediate care strategies to optimise recovery and rehabilitation	Established

Whilst a discharge to assess (D2A) and Home First approach is included within workstreams – particularly those such as the Onward Care and Independence Team (OCIT) and Hospital Social Work Team, this area has been identified as an opportunity for additional improvement.

The *Community Transformation Programme (CTP), Hospital Discharge and Community Capacity* workstream includes a dedicated sub-stream to improve the D2A model to match national standards. The outline scope is to determine current delivery and performance and key areas for future opportunity through gap analysis, developing perfect week, modelling, with the ambition of increasing stakeholder engagement with D2A.

BCF steering group members are involved with the development of the Community Transformation Programme to help ensure alignment of the future developments with the principles of the BCF.

Next steps: Revise intermediate care specifications in light of recommendations made in 2022/23.

5. Flexible working patterns	• Apply seven day working to enable discharge of patients during weekends • Streamline operation of transfer of care hubs	Established
As part of the CTP, there is an objective to improve the 7 day a week (7/7) discharge approach and accelerate discharge for people with complex behaviour or needs. The Integrated Discharge Team (IDT) has a blend of nursing and social care staff who work closely with therapists, community rapid response services and continuing health care. The team apply the principles of Home First and D2A across a 7-day working basis. During January 2023 an NHSE / ECIST review highlighted that the team demonstrated a good example of integrated working across health and social care. ***Next steps:*** Revise intermediate care specifications in light of recommendations made in 2022/23.		
6. Trusted assessment	• Ensuring consistency of process, personnel and documentation in ward rounds • Revise intermediate care strategies to optimise recovery and rehabilitation • Apply seven-day working to enable discharge of people during weekends	Established
The further development of the Trusted Assessment approach is incorporated within the work being undertaken as part of HIC 4. D2A is the default route for all people who at the time of discharge from the acute setting require assessment of their care needs along with a "Home First" approach. Under the current model, Trusted Assessors carry out assessments on the wards and the Acute Assessment Unit (AAU) within the hospital, with the exception of people who have already been identified to the Social Work team via either of the following pathways: • in A&E to the Adult Social Workers who cover A&E and AAU • on other wards for complex safeguarding. ***Next steps:*** Revise intermediate care specifications in light of recommendations made in 2022/23.		
7. Engagement and choice	• Identify people needing complex discharge support early	Established
The Integrated Discharge Team is now an embedded service that actively supports early discharge planning including those with complex needs. Included within the team is the role of the Discharge Co-Ordinator which facilitates and ensures there is a discharge plan for all people in hospital, liaises with outreach/SPOC for updates on onward care provisions and attends weekly MDTs to facilitate discussions around discharge planning when appropriate. Oversight of flow is maintained on a daily basis with an NMCTR Huddle and weekly MDT. A weekly Tactical Discharge Group provides oversight and feeds into the System Resilience Board. ***Next steps:*** Revise intermediate care specifications in light of recommendations made in 2022/23.		
8. Improved discharge to care homes	• Ensure multidisciplinary engagement in early discharge plan • Set expected date of discharge (EDD), and discharge within 48 hours of admission • Manage workforce capacity in community and social care settings to better match predicted patterns in demand for care and any surges	Mature
The BCF model on the Island allocates around 1/3 of the budget on intermediate care. In addition to the discharge pathway support outlined in the above, the BCF also provides support for independent residential and care home providers so that they are able to access additional learning and development opportunities, increasing competencies to support more complex patients and improving confidence and capability for supporting more complex discharges. This in turn boosts confidence in the Trusted Assessor, D2A and Home First principles. Continued progress is also being made with widening the scope and capacity of the Telehealth (three care homes now live) and Proactive Support offer as part of the Care Home Support workstream under the Community Transformation Programme. Additional care home support projects include a Hydration Pilot and provision of falls equipment (Raisers and Elk cushions) with training. A wider system roll-out of SystmOne is underway. Used within Primary Care and the local hospice, the patient record system is being expanded into the Community Division of the IWT and care homes. ***Next steps:*** Continue to build our support to maximise the skills and confidence in the social care workforce to facilitate additional discharges / prevent unnecessary admissions to hospital. Expansion of SystmOne into care homes to improve shared communication.		
9. Housing and related services	• Identify patients needing complex discharge support early	Mature
The Island's BCF DFG provision sits within the Adult Social Care and Housing Needs directorate of the Council, enabling a multi-disciplinary approach to enable people to stay well, safe and independent at home for longer on an asset-based care approach. Further information regarding DFG implementation has been outlined below.		

6.3. Care Act

The IWC and other statutory bodies have a legal duty to meet the needs for unpaid carers and the people that they care for, below is the list of those duties and commitments to unpaid carers:

- Care Act 2014 places a requirement on local authorities to promote the wellbeing of individuals when carrying out their social care functions. Carers have a right to an assessment to establish whether they have eligible needs, together with the provision of information and advice to help make the best choices about accessing support.
- Children and Families Act 2014 makes it easier for young carers to have an assessment of their needs and introduced 'whole family' approaches to assessment and support.
- In addition, the NHS Commitment to Carers sets out eight priorities for the NHS:
    - Raising the profile of carers
    - Education, training and information
    - Service development
    - Person-centred, well-coordinated care
    - Primary care
    - Commissioning support
    - Partnership links
    - NHSE / NICE guidelines on supporting adult carers

We also have a duty to safeguard carers from any kind of abuse or neglect, in relation to their own needs or those of the person they care for. This includes making it straightforward to raise any kind of safeguarding concern, safe in the knowledge that we will be supportive and non-judgemental throughout.

To ensure the sustained delivery of the Care Act duties, Better Care funding continues to be used to support the delivery of the Care Act Implementation and Infrastructure (£544,027 for 23/24) in order to enable the following principles:

- People know best about the outcomes that they want to achieve
- People views, wishes, feelings and beliefs should always be considered
- The main aim of professionals should be on people's well-being, on reducing the need for care and support, and on reducing the likelihood that people will need care and support in the future
- Any decisions made should take into account all relevant circumstances
- Any decisions should be made with person or their representative's involvement
- People's well-being should be balanced with that of any involved family and friends
- Professionals should always work to protect the person and other people from abuse and neglect
- Professionals should ensure that any actions taken to support protect a person affect their rights and freedom as little as possible

A range of services are included within the infrastructure funding including assessment, care and support planning, advocacy and financial assessment through to information and advice, carers support services and reablement.

7. Supporting unpaid carers

The Isle of Wight has over 19,000 unpaid carers over the age of 18 within our island's community, providing essential support to those they care for. (Census data 2021) – 59% are female carers, 51% male and c.300 are young carers. Of these, during a 2021 survey over half the respondents reported that they provide care for more than 100 hours a week. 35% of respondents advised that their duties had resulted in financial difficulties and 42% said that they struggled to look after themselves.

Launched in June 2023, a new unpaid carers strategy, *Isle of Wight Carers' Strategy 2023 to 2028*, was developed by the IWC, ICB and the IWT which recognises the important and vital role of our island's unpaid carers. The views of people with lived experience were sought by holding focused discussions with carers in a range of locations to gather real life examples of their everyday challenges and what might help. In addition to this, further engagement was undertaken via an island-wide survey during 2021, regular meetings with Healthwatch IW, Carers IW, AGE UK IW and People Matter IW, and a workshop with carers to review the draft

strategy and give their feedback. This new strategy aims to make a real difference to the lives of our island's unpaid cares. It has three key priorities:

- Priority one: To ensure that our Islands unpaid carers are recognised.
- Priority two: Our islands unpaid carers can communicate and have access to health and social care services when needed.
- Priority three: Unpaid carers on the Island are supported, so that their health and wellbeing are improved

As collective system we will be working on the strategy action plan which work towards achieving the strategy objectives. As an enabler, the BCF will also continue to support these objectives. In addition to the funding allocated for the Care Act Implementation and Infrastructure noted above, the BCF also funds the Carers Prospectus and Carers Lounge delivered in partnership with Carers IW. These services help raise awareness of carers across both health and adult social care along with providing signposting and support to enable carers to access appropriate services and activities that will support them to remain or become connected within their community. The dedicated teams offer a range of support including:

- Clear information and accessible services to support informal carers
- Carers needs assessments on behalf of the Isle of Wight Council
- Opportunities for carers to take a break from their caring role through various methods including clubs and regular drop in support sessions
- Helping carers to have a sense of value and connection within their local community by working with local services and companies where possible to provide benefits or discounts to those undertaking this role and to the person they care for
- Reaching out to carers that are currently identified and to those carers, who do not identify themselves as a carer yet
- Ensuring that all carers are recognised, respected and given the opportunity to have their support needs met
- A carers support service within the acute hospital setting, to assist and signpost carers when in crisis and to help support patient discharge from hospital
- Provision of a link worker with Adult Social Care to enable strong links with statutory services to be established and sustained
- Supporting carers so that they are not facing financial hardship whilst providing their caring role and maximise potential income they are entitled to
- Providing carers with the opportunity to develop contingency plans to avoid and address crisis situations
- Developing ways to support carers through partnership working with the three primary care networks and the Northeast, South Isle of Wight and Central and West.
- Developing ways to support carers through local pharmacies.
- Improving carers groups and activities aimed at supporting younger working age carers aged over 18
- Supporting those carers in transition from children to young adult carers.

The number of individual unpaid carers being directly supported with interventions each month by the team at Carers IW is on average around 690. At the beginning of this contract the number of people supported each month was on average 468. There is a growing number of carers reaching crisis point and the complexity of the support needed is also increasing. These factors are leading to more intensive intervention and support needed to keep people away from statutory service provision and failing into crisis.

In addition to the broader support in place for carers, BCF funding also supports delivery of the Westminster House offer. This is a residential care home registered to provide accommodation and personal care for up to 10 people with a learning disability or autism. Westminster House provides all single bedrooms, suitable communal areas and access to a rear patio and garden which provides respite care for individuals, offering carers a break and potentially prevents a deterioration in their wellbeing and general health which could lead to hospital admissions or breakdown in relationships. The service is rated 'GOOD' by CQC since its last inspection on 07 February 2022.

8. Disabled Facilities Grant (DFG) and wider services

The Island's Housing team, including DFG provision, sits within the Adult Social Care and Housing Needs directorate of the Council. The Isle of Wight Council has led on the development of the *Adult Social Care and Housing Needs Care Close to Home Strategy (CCTH) 2022 – 2025*. This strategy reflects both the social care and housing needs of our local communities and seeks to address them through a series of '6 Keys to Success' which are focused on supporting people with appropriate housing solutions to promote and enhance independent living. Alongside this, sits the *Isle of Wight Extra Care Housing Strategy 2017–2032*, 'Independent Island Living' which promotes a partnership approach to build new extra-care schemes and bespoke supported accommodation as required. Since its initial drafting, Ryde Village was developed to support over 55s with a mix of apartments for rent and bungalows for shared ownership, supported by on site community facilities and a 24/7 Wellbeing Team. Another site, Green Meadows, was developed in Freshwater with 75 apartments. This strategy is currently being reviewed which will shape future provision of Extra Care Housing on the Island. A further action plan is detailed to support individuals experiencing homeless via the *Isle of Wight homeless and rough sleeping strategy 2019 to 2024* which targets prevention, intervention and recovery supporting people to find a new home quickly and rebuild their lives.

The CCTH strategy 'Keys' are in alignment with the underpinning BCF Plan which acts as a golden thread between the HWB strategy, HCP and CCTH. Of note is the commitment to the 'Home First' agenda, developing greater capacity within the domiciliary care team, along with enhancement of the Regaining Independence Service and Living Well and Early Help offer. However, it goes much further than the current BCF workstreams including commitments to develop a 'one-Island' approach to commissioning and supporting the delivery of the right types of housing and alternative accommodation, as well as ensuring offers are in place vulnerable cohorts such as local people who are homeless.

Alongside the wider strategy work, the Council's Housing Renewals Team, who administer the DFG, sit outside of the Adult Social Care and Housing Need (ASCHN) department. However, the two departments are aligned aspects in terms of how the DFG is used for the schemes and requirements set out in the aforementioned strategies. This alignment is greatly enhanced by the addition of Housing Commissioners in the ASCHN commissioning department. It should be noted that the IWC are currently undertaking an organisational structural review which could see the Housing Renewals team being incorporated within the Adult Social Care and Housing Needs directorate. This will provide an opportunity to review the way in which the DFG is utilised to ensure maximum impact for Island residents.

During delivery, the Housing Renewals teams work particularly closely with the ASC community Occupational Therapy Service and the Community Equipment Service to support independent living to help achieve these goals. In collaboration, the teams work closely with the individual and, where applicable, their nominated carer to ensure that they are fully involved in identification of their needs followed by the development and delivery of their own care plan. The approach is "asset based"; ensuring that the focus is on what a person can do, identify the person's strengths and use a community network of friends, neighbours and family to achieve the best possible outcomes.

In practicality, the Disabled Facilities Grant is primarily utilised to facilitate adaptations and the deployment of equipment to support Island residents to maintain their independence and to remain in their own home. The types of works that are being undertaken include (but are not limited to):

- Making it easier to get in and out of the dwelling by, for example, widening doors and installing ramps
- Providing better access to living spaces
- Providing or improving access to the bedroom, and kitchen, toilet, washbasin and bathing facilities, for example by installing a stair lift or adapting a room to provide an easy access shower facility

The support provided through DFG is tailored to meet the individual's needs with the allocation of funding being aligned to both the individual's current needs and their future prognosis; it is about delivering outcomes and not just finding the solution. All equality needs of the household are considered in any plan, including age; disability;

gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; and sexual orientation to ensure that no health or wellbeing inequalities arise.

Use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services has not been locally applied.

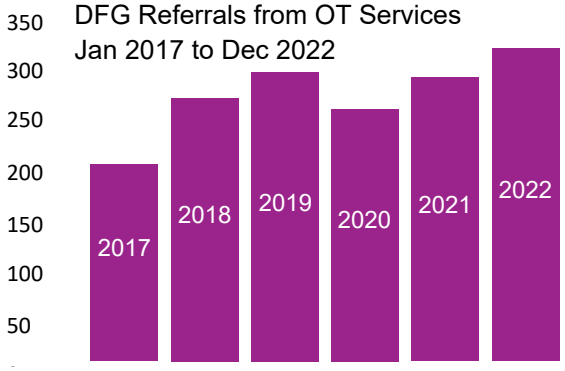
To implement the changes highlighted above, the services operate in five key ways to implement change:

8.1. Change 1: Providing a wide range of housing types and choices.

The Disabled Facilities Grant program (DFG) assists by adapting the homes of people with disabilities and has been a successful mandatory program since 1996. This provides a bespoke adaptation service that directly applies to the individual's assessed needs (with an eye for medium term future needs as well), and enables them to stay safe, independent and secure at home. In doing so it not only indirectly increases the number of adapted properties on the Island, but it also reduces the need for provision of new build/converted general needs disabled adapted premises (at much higher cost). The team works with social services to advise and assist with supported housing solutions, particularly where private operators create Houses in Multiple Occupation (HMO). Their role is to ensure the premises and dwelling units are fit and safe and administer licences where they are required to operate licensed HMOs. The team also administer the PAN Meadows completion certificates, which is a form of housing enabling to provide more properties into the market. They have in the past facilitated bespoke adaptations and housing solutions where a household in particular need has been allocated a property pre-build, although that hasn't lately. They provide services to assist and advise property owners and developers in regard to prospective housing purchases/projects to enable wider choice and types in the market. Typically, these services relate to HMOs, but have included reviews of changing existing residential care homes into supported living facilities, and existing providers wishing to cater for niche clients (e.g., bariatric). This work is not currently funded by BCF budget.

8.2. Change 2: Influencing and improving local housing markets

Whilst a relatively minor part of the portfolio of services, the team collaborates with various departments and organisations in regard to strategy and planning.



8.3. Change 3: Improving and adapting existing homes

The service administers the DFGs (see above summary). Research completed by the local team in 2017, indicates that for roughly every £1 capital spent on an adaptation it saves/avoids £5 of social services and NHS revenue budget spend. The demand for DFGs locally is at the highest level see (see graph), and it has been challenging to keep up with demand due to the Covid impact and staffing resources. The team also operates an in-house grant assistant that acts as an agent for vulnerable customers, or where the work or process is complex. The DFG scheme also allows for external agents and experts to help enable complex projects (such as architects, structural engineers, independent agents, etc). The team has a dedicated Occupational Therapy staff member who works within the Housing Renewal team.

The DFG process allows for urgent criteria and fast tracking of cases where necessary. This is especially helpful in cases of delayed discharge of care. The team are able to accept referrals from hospital OT services where appropriate and can also accept referrals from Social Services teams. Where the DFG is considered too bureaucratic for the situation, they are able to utilise a discretionary process called the Repair and Wellbeing Grant, which can be more flexible and speedier in some situations- in order to achieve the goals of the high impact change model and BCF planning. Application of the process allows for individual flexibility for solutions based on the individual's desires as long as the plans achieve the essential outcomes of the eligible work. Often this can be achieved at the same cost, but where it differs the individual will be required to pay any difference in cost of the grant and the desired solution. Care is always taken by housing renewal staff to ensure the medium to longer term needs are met and the work is fit for purpose. This work is undertaken using BCF funding.

8.4. Change 4: Tackling housing and associated health inequalities

The Housing Renewal team at the IWC have the responsibility for regulating housing standards on the Island, particularly in the private and social rented sectors. It is the same officers who administer DFGs who undertake housing standards surveying and this lends itself well to providing a comprehensive service for the purposes of this model. The team has well established policies and procedures to encourage and ultimately enforce appropriate conditions in residential housing.

This team also manages the Repair and Wellbeing Grant. A discretionary grant that assists vulnerable homeowners with essential repairs, as well as providing disabled adaptations that either do not quite fit within the scope of a DFG, or it is deemed a more appropriate route to use this scheme. Lately it has been used to help top up DFGs due to rising construction costs and allow challenging financial situations to be resolved with local people where otherwise they would not be able to get the essential adaptations they need.

An additional offer of the service is the management of work streams in relation to energy efficiency and fuel poverty such as the latest ECO Flex scheme which will assist many people with free energy efficiency measures helping to keep the warm and well and keep fuel costs down. Recently, the team were successful in a bid for Fuel Poverty grant assistance which is in the process of being designed for best use with the circumstances on the Island at present.

8.5. Change 5: Use of technology to support people to live independently at home

The DFG allows for using technology for adaptation solutions. This currently includes for remote controls to equipment, but also for bespoke solutions to situations that cannot be fully resolved using physical environmental solutions (i.e., bricks and mortar) for example installation of CCTV. This is always a developing area in the construction and adaptations industry and the team are open to such solutions where they provide a satisfactory solution at a reasonable cost.

9. Equality and health inequalities

Tackling inequalities is an integral part of the Public Health Prevention and Early Intervention Strategy, Health and Care Plan and the Adult Social Care (ASC) Care Close to Home Strategy with a focus on locality-based care linked with the three Primary Care Networks. Two of the leading variables affecting our local residents' ability to live healthy are an aging demographic profile and deprivation.

There is a significant variation in deprivation across the Island which appears to be worsening. In 2010, the Island was ranked 106 out of 317 Local Authority areas (Indices of Multiple Deprivation 2019; 1 being the most deprived). As of 2019 it was placed at 80; a change of 26 points with 19,652 residents living in the 20% most deprived areas nationally. The presence of additional protected characteristics can exacerbate this for example, 13% of residents aged 60 or over experience income deprivation.

There is a direct impact of deprivation on people's health. A boy born today in the most deprived areas will live on average 6.1 years less compared to a boy born in a least deprived area. Not only are people in the most deprived areas having a shorter life expectancy, but they are also living a smaller proportion of their lives in good health. Males and females living in the most deprived areas of the Island live in poor health for 10.3 years and 7.5 years longer respectively, compared to those living in the least deprived areas. 21.3% of people responding to the 2021 Census identified as being Disabled under the Equality Act.

Key to addressing these inequalities is prevention which is being led on by Public Health across 5 domains within the *Isle of Wight Council Public Health Strategy 2020-2025*, these are:

Workstreams [BCF Support]		
1. Good start in life	**2. Physical Wellbeing**	**3. Mental Wellbeing**
1.1. The first 1000 days • Smoking in pregnancy • Infant feeding • Supporting parenthood • Accident prevention **1.2. Education**	**2.1. Healthy lifestyles** • Being a healthy weight • Increasing physical activity levels [BCF 1.1] • Stopping smoking • Reducing alcohol consumption	**3.1. Good mental health and emotional wellbeing for all** • Childhood • Adulthood [BCF 4.2-4] • Old age

• Ready to learn • Healthy educational settings • Higher educational opportunities [BCF 3.13]	**2.2. Healthy ageing** • Continuing to prevent ill-health [BCF 1.1] • Continuing to be physically active [BCF 3.7] • Preventing falls [BCF 1.4, 2.5, 3.7]	**3.2. Reducing the impact of mental health disorders** • Substance misuse • Self-harm • Suicide
4. Healthy places **4.1. Healthy communities** • Planning • Healthy homes [BCF 2.5] • Green and blue spaces • Food environment • Healthy settings • Violence	**5. Protect from harm** **5.1. Prevent** • Immunisation • Screening • Sexual health and relationships **5.2. Prepare and respond to emergencies** • Outbreaks • COVID 19 • Emergency planning	

Whilst often the primary focus has been, and continues to be, on addressing these cohorts, evidence shows that people who are socially excluded underuse some services, such as primary and preventative care, and often rely on emergency services such as A&E when their health needs become acute. This results in missed opportunities for preventive interventions, serious illness, and inefficiencies, and further exacerbates existing health inequalities. Together, the Island's health and social care partners share a vision that people will be supported to live fulfilling lives regardless of age, sex, disability, ethnicity, or social background, helping them to access the care they need to live as independently as possible.

A key cohort currently in focus is that of people with Learning Disabilities and / or Autism. During 2022/23, the Joint Commissioner for Learning Disabilities, Autism and Mental Health led on a Learning Disability Consultation, co-produced with the Learning Disability Partnership Group and an Autism Consultation, co-produced with the Autism Partnership Board. This has enabled a collaborative approach between health and social care to address the needs of our local population. The findings of the collaboration will be collated and analysed to inform decisions that will help shape pathway developments into 2023 and beyond with a view to not only improving services, but also breaking drown traditional organisational barriers and working towards the achievement of the *2023/24 priorities and operational planning* objectives of delivering annual health checks and reducing reliance on inpatient care. Key themes for improvement were identified to be taken forward into 2023-2025 were:

- Increased variety of services – this included respite, carers support and social activities
- Health care improvements – this includes options for face to face as well as online health appointments, better access and support from mental health services, and better support from physical health service both in primary and secondary care such as Occupational Therapists.
- Reasonable adjustments and equality – this included access to services, support for people without a diagnosis, adaptations, and support to live fulfilling lives

Each of the existing BCF specifications continue to address this as all services contained within the BCF have been commissioned to ensure that they are accessible to all residents regardless of any protected characteristic they may have. To provide further, targeted support, dedicated services such as the following BCF workstreams help to address areas of need:

- Living Well & Early Help Partnership [BCF 1.1] is made up of four Island VCSE organisations whose focus is on building their communities to be resilient and support each other. Its service helps to reduce barriers to accessing health and care services.
- Mental Health Recovery Pathway [BCF 4.1-2] offers access to employment, education and training and supports delivery of the *2023/24 priorities and operational planning* objective to increase community mental health support.
- People Matter IW User Led Organisation [BCF 3.12] facilitates engagement across multiple interest group to enable peer support and people's voices to be heard when designing services.

As part of the ASC *Care Close to Home strategy*, we will ensure that we consider anti-poverty strategies in all our work and ensure that our assessments and support consider the 'whole' person and not just their presenting needs. This will include providing advice, information, guidance, and support in relation to fuel poverty, access to benefits and support through foodbanks. The BCF Plan is helping to support the additional demands arising from the cost-of-living crisis through the Living Well and Early Help workstream [BCF 1.1]. Through this, the team have

established ‘Warm spaces’ in public buildings for people to go. Approval was also received for a one-year pilot project which enabled a mobile community vehicle to be commissioned; over the past 6 months this has been enabling the LWEH to reach areas of concern and provide both advice and support towards some of the cost-of-living needs, empowering people to live safe and affordable lives.

The local BCF governance structure continues to review service specifications within the BCF. As part of our integrated commissioning agenda, we will ensure that overarching goals to address health inequalities are embedded; for example, preventing people from dying prematurely, enhancing quality of life for people with long-term conditions and helping people recover from episodes of acute ill health or following injury. When making a decision to change, recommission or introduce new schemes or ways of working through the BCF, an assessment is undertaken with stakeholders, to document the impact on inequalities, health inequalities and disparities. We are able to use the Commissioning Support Unit and Business Intelligence teams from across organisations to drive an evidence-based approach, identifying the needs of our local population. Information gathered via public stakeholder consultation events, and directly from the people who draw on services or who have lived experience, is able to enhance insight into where our local population feels the most need. As part of this process, we are supported by a dedicated Quality Team who supporting the Isle of Wight as a pilot within the wider ICB in respect of a new, more robust approach to completion of Equality and Quality Impact Assessments. All specifications for service will include, as is standard, a date for review in light of the changing demands of our population in line with the Health Equity Assessment cyclical approach to service development.

Our commitment to tackling inequalities extends beyond the scope of the BCF and we are also working with ICS partners on the use of funding for health inequalities that the ICS received, linking plans to the *Core 20 Plus 5* model. Key to this is the development of an ICS Local Care Forward Plan which goes wider than the Isle of Wight Health and Wellbeing geographical footprint. This aims to deliver Local Care in a person-centred and joined up way by resilient teams across primary care, community services and partners with the ambition that:

- People receive care in the right place at the right time, in their homes and communities where possible, focusing on proactive care, avoiding unnecessary hospital admissions, and enabling timely discharge.
- Services support people to stay well and take greater responsibility for their own health, decreasing and delaying the need for longer term health and social care support
- Inequity in service access and outcomes is reduced

Area	Action Plan [BCF Support]
CORE20	• Practices are also looking to relaunch patient participation groups (PPGs) and widen groups to become more inclusive and representative of diversity across the Island to help shape the future direction of travel. [BCF 3.12] • Other areas in focus include development of an estate strategy, reducing variation in access to ARRS roles and completion of a boundary mapping exercise to ensure demographic profiling is up to date and needs are identified to improve resource distribution.
PLUS	• There is a Triple Aim to Reduce Primary Care Demand, Reduce Non-Elective Hospital Demand [BCF 1.1, 1.3-4, 2.1,3.7, 4.1-2] and Optimise Community Capacity [BCF 2.3, 2.7-10, 2.16, 3.5, 3.14]. • The BCF Fund is integral to the delivery of this, linking Schemes and services to deliver Proactive Case Management [BCF 2.1]. The Community Transformation Programme Localities workstream will co-ordinate the delivery on Island and take forward the longer-term refinement and implementation of the approach. • Diabetes: Diabetes prevalence on the Isle of Wight has been on an increasing trend since 2009/10 with prevalence higher than the England average. The ICS Local Care Plan includes a dedicated focus on addressing the needs of people experiencing diabetes including prevention.
5	• Chronic Respiratory Disease: A Virtual Ward has been developed which is under the wider Community Transformation Programme for further development. The initial cohort supported has been respiratory patients. [BCF 1.4] • Severe Mental Illness: A working group has been implemented to focus on improving the uptake of LD and SMI health checks. [BCF 4.1-5] • The ICS Local Care Plan includes a dedicated focus on addressing the needs of people experiencing CVD and cancer.

A key enabler for enabling informed design and decision making is quality data. The Isle of Wight is supported by individual organisation business intelligence teams. A local system-wide Population Health Management steering group was established in 2022/23 to:

- Share knowledge and expertise regarding PHM tools available, their different functions and role in building up the whole Island picture
- Agree governance to best use PHM data to articulate potential priorities for the Health & Care System
- Provide oversight to projects and identify opportunities for partners to work together as we evolve our PHM approach e.g., onward development of Proactive Case Management and clinical projects
- Support system-wide awareness of impact of PHM, best practice, platform, and analytics including local PHM case studies, examples and good news stories
- Progress the development and implementation of HealtheIntent population health platform with the ambition for accessibility to be in place during 2023/24. Layered over any existing information systems, it standardises and normalises data into a single source of truth record for individuals and provides the new tools that are required to manage the health and wellbeing of the population.

9.1. Overarching BCF Equality Impact Assessment

A cumulative impact report provides additional insight, focusing on those groups of people (with protected characteristics) that may be affected multiple times, by different policies and service changes. Learning from undertaking this process in respect of the BCF has highlighted the need to diversify our engagement processes to ensure all cohorts are consulted and represented. Previous consultation approaches have typically focussed on the primary cohort intended to benefit rather than taking into account people may be fall within more than one category and have different engagement needs.

Protected characteristic groups: Summary explanation of the main potential positive or adverse impact of your proposal	**Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact**
Age:	2023-2025 intentions to refresh service specification. To work with stakeholders and business intelligence to identify any current barriers in access and make adjustments to improve accessibility in new service models. The first workstream to undergo this process is the Community Equipment Service which was reviewed in 22/23 and the new model will be implemented in Q1 23/24. The next area for refreshing will be the Rehabilitation, Reablement and Recovery / Regaining Independence services which support the Island's intermediate care pathway. Alongside this, the results from the Learning Disability and Autism consultations will be analysed to help inform service models going forwards utilising the feedback from people with lived experience. Individual QIAs will be completed to accompany service change proposals. These will be reviewed by the Joint Strategic Partnership with support from the Quality Team in the ICB.
Positive Impact: Delivery of the *Integrated Discharge and Admissions Avoidance* and the *Integrated Community Support* schemes are designed to be flexible around the needs of the adult population but are particularly focused on the aging demographic profile to enable people to live longer in the residence of their choosing. The schemes within the BCF are designed to support adult services. However, the Carers Prospectus workstream, LWEH and ULO workstreams support young people and those in transition.	
Disability:	
Positive Impact: The BCF enables delivery of the CES and DFG which improves the ability of people to maintain independence at home for longer. The new Mental Health Recovery pathway was implemented in 2021/22 with the current biopsychosocial model contributing to the reduction in admissions within acute mental health settings, as well as a reduction in length of stay in acute mental health settings. The Mental Health grants also support: • Issoropia - a Wellbeing Organisation that has been designed to self-empower individuals to become the best version of themselves. We provide face-to-face workshops, on-line engagement, and on-going focused development to move members towards their goals and dreams. • Two Saints – Community Safe Haven for people experiencing a mental health crisis. • Osel Enterprises – employment advisor service for people with mental health and / or learning disabilities.	
Gender Reassignment and/or people who identify as Transgender; Marriage & Civil Partnership; Pregnancy and Maternity; Race and ethnicity; Religion and belief; Sex; Sexual orientation:	
Neutral to Minor Positive Impact: No dedicated BCF workstream. All services include requirement for providers to execute their duties in compliance with the Equalities Act 2010 and National Health Service Act 2006 as amended by the Health and Social Care Act 2012.	

Groups who face health inequalities: Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
Looked after children and young people **Neutral to Minor Positive Impact:** No dedicated BCF workstream. All services include requirement for providers to execute their duties in compliance with the Equalities Act 2010 and National Health Service Act 2006 as amended by the Health and Social Care Act 2012.	There are currently no plans to widen the BCF to include dedicated children's services.
Carers of patients: **Positive Impact:** In addition to inclusion of the consideration of carers within specifications, there are dedicated workstreams investing in the enabling of the Care Act Infrastructure, Carers' Prospectus, and a Carers' Lounge at the Trust.	The carers offer within the BCF has been identified as an area for review and refreshing of the existing specification. Feedback from the LD and Autism consultations will be included.
Homeless people. **Neutral Impact:** No dedicated BCF workstream. However, the housing team is integrated within ASC and the *Isle of Wight homeless and rough sleeping strategy 2019 to 2024* targets prevention, intervention and recovery supporting people to find a new home quickly and rebuild their lives. Additional support is also available via the Two Saints outreach service which has been commissioned by the IWC to support those individuals who are rough sleeping, in emergency accommodation or facing homelessness.	There are currently no plans to widen the BCF to include dedicated workstreams in these areas.
People involved in the criminal justice system: **Neutral to Minor Positive Impact:** No dedicated BCF workstream. Some support offered via the Mental Health Recovery pathway.	
People with addictions and/or substance misuse issues: **Neutral to Minor Positive Impact:** No dedicated BCF workstream. Some support offered via the Mental Health Recovery pathway	
People or families on a low income; People with poor literacy or health Literacy; People living in deprived areas; People living in remote, rural and island locations: **Positive Impact:** These cohorts have benefitted from the refresh of the Early Help offer into the newly commissioned LWEH service. Some services are designed to enable PCN-level delivery such as the Community Nursing team.	These cohorts continue to be in focus for the re-designing of services into 2023-2025, recognising the benefits of building resilient communities, and delivering care closer to home. The application of population health management approaches is also helping to support PCNs and practices with cohort specific projects, such as the Proactive Case Management Project.
Refugees, asylum seekers or those experiencing modern slavery; Other groups experiencing health inequalities (please describe): **Neutral to Minor Positive Impact:** No dedicated BCF workstream. All services include requirement for providers to execute their duties in compliance with the Equalities Act 2010 and National Health Service Act 2006 as amended by the Health and Social Care Act 2012.	There are currently no plans to widen the BCF to include dedicated refugee / asylum seekers specific services. Outside of the BCF, support is commissioned by the IWC from Community Action IW. The Primary Care Commissioning team has collaborated to ensure arriving individuals are enabled to access health services.

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BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.
4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
7. Please ensure that all boxes on the checklist are green before submission.
8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where ‘Social Care’ is selected and the source of funding is “NHS minimum” then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select ‘Joint’. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

9. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

			Complete:
Health and Wellbeing Board:	Isle of Wight		Yes
Completed by:	Matt Leek, Cheryl Harding-Trestrail		Yes
E-mail:	cheryl.harding@nhs.net		Yes
Contact number:	01983 552064 (preference via MS Teams)		Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No		Yes
If no please indicate when the HWB is expected to sign off the plan:	Thu 20/07/2023	<< Please enter using the format, DD/MM/YYYY	Yes

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Lora	Peacey-Wilcox	Lora.Peacey-Wilcox@IOW.gov.uk	Yes
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Natasha	Taplin	natasha.taplin@nhs.net	Yes
	Additional ICB(s) contacts if relevant		Simon	Gerfen	Simon.Gerfen@IOW.gov.uk	Yes
	Local Authority Chief Executive		Wendy	Perera	Wendy.Perera@IOW.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)		Laura	Gaudion	laura.gaudion@iow.gov.uk	Yes
	Better Care Fund Lead Official		Pete	Smith	Peter.Smith@iow.gov.uk	Yes

LA Section 151 Officer		Chris	Ward	Chris.Ward@portsmouthcc.gov.uk	Yes

Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Isle of Wight

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£2,272,039	£2,272,039	£2,272,039	£2,272,039	£0
Minimum NHS Contribution	£13,972,426	£14,763,265	£13,972,426	£14,763,265	£0
iBCF	£6,180,112	£6,180,112	£6,180,112	£6,180,112	£0
Additional LA Contribution	£3,943,489	£3,943,489	£3,943,489	£3,943,489	£0
Additional ICB Contribution	£2,739,223	£1,948,384	£2,739,223	£1,948,384	£0
Local Authority Discharge Funding	£866,442	£1,438,294	£866,442	£1,438,294	£0
ICB Discharge Funding	£1,085,966	£1,513,972	£1,085,966	£1,513,972	£0
Total	**£31,059,697**	**£32,059,555**	**£31,059,697**	**£32,059,555**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£3,970,567	£4,195,301
Planned spend	£6,379,515	£7,170,354

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£7,226,903	£7,635,945
Planned spend	£7,739,911	£7,739,911

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	162.0	136.0	153.0	146.0

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,323.2	1,255.7
	Count	552	524
	Population	41300	41300

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	83.1%	83.1%	81.8%	83.3%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	773	760

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	81.6%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	No
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Isle of Wight

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:

- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	Previous 22/23 Demand and Capacity calculations used as starting point (see narrative document for additional background). Pathway 0: Calculations from actual discharges onto P0 Oct-Mar 22/23 @ 80% allowing for adjustment that a cohort will have attended hospital and require no support / signposting on discharge e.g. admission as a result of accident but otherwise no other health / social need. Data on P0 limited.

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!
(Select as many as you need)

Trust Referral Source	Demand - Hospital Discharge Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
ISLE OF WIGHT NHS TRUST	Social support (including VCS) (pathway 0)	157	215	157	157	215	157	215	129	157	163	142	215
ISLE OF WIGHT NHS TRUST	Reablement at home (pathway 1)	527	539	527	527	539	527	539	567	567	579	439	451
ISLE OF WIGHT NHS TRUST	Rehabilitation at home (pathway 1)												
ISLE OF WIGHT NHS TRUST	Short term domiciliary care (pathway 1)												
ISLE OF WIGHT NHS TRUST	Reablement in a bedded setting (pathway 2)	74	74	74	74	74	112	147	147	147	147	147	147
ISLE OF WIGHT NHS TRUST	Rehabilitation in a bedded setting (pathway 2)	110	117	110	110	117	110	117	110	110	117	110	117
ISLE OF WIGHT NHS TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement	5	6	5	5	6	5	6	5	5	6	5	6

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	115	120	115	115	120	115	120	115	115	120	115	120
Urgent Community Response	315	315	315	315	320	320	320	320	325	325	325	325
Reablement at home	435	435	435	435	440	440	440	460	465	465	445	445
Rehabilitation at home												
Reablement in a bedded setting	9	9	9	9	9	18	18	18	18	18	18	18
Rehabilitation in a bedded setting	27	28	27	27	28	27	28	27	27	28	27	28
Other short-term social care												

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	85	85	85	85	85	85	85	85	85	85	85	85		100%	
Reablement at Home	Monthly capacity. Number of new clients.	273	273	273	273	273	273	273	273	273	273	273	273		100%	
Rehabilitation at home	Monthly capacity. Number of new clients.															
Short term domiciliary care	Monthly capacity. Number of new clients.															
Reablement in a bedded setting	Monthly capacity. Number of new clients.	4	4	4	4	4	4	4	4	4	4	4	4		100%	
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	35	35	35	35	35	35	35	35	35	35	35	35	100%		
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	6	6	6	6	6	6	6	6	6	6	6	6		100%	

3.4 Capacity - Community

Capacity - Community Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	55	55	55	55	55	55	55	55	55	55	55	55		100%	
Urgent Community Response	Monthly capacity. Number of new clients.	315	315	315	315	320	320	320	320	325	325	325	325	100%		
Reablement at Home	Monthly capacity. Number of new clients.	273	273	273	273	273	273	273	273	273	273	273	273		100%	
Rehabilitation at home	Monthly capacity. Number of new clients.															
Reablement in a bedded setting	Monthly capacity. Number of new clients.	4	4	4	4	4	4	4	4	4	4	4	4		100%	
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	36	36	36	36	36	36	36	36	36	36	36	36	100%		
Other short-term social care	Monthly capacity. Number of new clients.															

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Isle of Wight

Local Authority Contribution			
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2	**Complete:**
Isle of Wight	£2,272,039	£2,272,039	Yes
DFG breakdown for two-tier areas only (where applicable)			
Total Minimum LA Contribution (exc iBCF)	**£2,272,039**	**£2,272,039**	

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2	
Isle of Wight	£866,442	£1,438,294	Yes

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2	
NHS Hampshire and Isle Of Wight ICB	£1,085,966	£1,513,972	Yes
Total ICB Discharge Fund Contribution	£1,085,966	£1,513,972	

iBCF Contribution	Contribution Yr 1	Contribution Yr 2	
Isle of Wight	£6,180,112	£6,180,112	Yes

Total iBCF Contribution	**£6,180,112**	**£6,180,112**

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	Yes

Yes

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
Isle of Wight	£3,943,489	£3,943,489	Contribution Yr2 TBC and will be subject to in year reviews of services / demand & capacity needs analysis. Investments in early help, reablement and LD services. Used to implement the following workstreams: Voluntary Sector Infrastructure Support Grant Community Occupational Therapy Social Work Hospital Team (partial) Adelaide Resource Centre (partial) Gouldings Resource Centre (partial) Reeve Court Supported Living (partial) Westminster House - Respite Support Community Equipment Store (partial)
Total Additional Local Authority Contribution	**£3,943,489**	**£3,943,489**	

Yes

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Hampshire and Isle Of Wight ICB	£13,972,426	£14,763,265
Total NHS Minimum Contribution	**£13,972,426**	**£14,763,265**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	Yes

Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
NHS Hampshire and Isle of Wight ICB	£2,739,223	£1,948,384	Includes Community based MH services
Total Additional NHS Contribution	**£2,739,223**	**£1,948,384**	
Total NHS Contribution	**£16,711,649**	**£16,711,649**	

Yes

	2023-24	2024-25
Total BCF Pooled Budget	**£31,059,697**	**£32,059,555**

Funding Contributions Comments Optional for any useful detail e.g. Carry over
DFG, iBCF and Additional Discharge Fund grant determinations to be confirmed by central government for 2024/25. Indicative value entered for year 2 only based upon 2023/24 allocation. The distribution of the discharge money for 2024-25 is still subject to ministerial decision and allocations have therefore not yet been published. For the purposes of BCF plans, funding based on local allocations increasing in line with the national grant amount; assuming that the funding will be distributed in the same

proportions as in 2023-24 and plan on an increase to the 2023-24 allocation of 66% (i.e. multiplied by 1.66). The ICB DF allocations to place have been initially calculated and adjusted to the listed proportion.

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Isle of Wight

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£2,272,039	£2,272,039	£0	£2,272,039	£2,272,039	£0
Minimum NHS Contribution	£13,972,426	£13,972,426	£0	£14,763,265	£14,763,265	£0
iBCF	£6,180,112	£6,180,112	£0	£6,180,112	£6,180,112	£0
Additional LA Contribution	£3,943,489	£3,943,489	£0	£3,943,489	£3,943,489	£0
Additional NHS Contribution	£2,739,223	£2,739,223	£0	£1,948,384	£1,948,384	£0
Local Authority Discharge Funding	£866,442	£866,442	£0	£1,438,294	£1,438,294	£0
ICB Discharge Funding	£1,085,966	£1,085,966		£1,513,972	£1,513,972	£0
Total	**£31,059,697**	**£31,059,697**	**£0**	**£32,059,555**	**£32,059,555**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£3,970,567	£6,379,515	£0	£4,195,301	£7,170,354	£0
Adult Social Care services spend from the minimum ICB allocations	£7,226,903	£7,739,911	£0	£7,635,945	£7,739,911	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

>> Incomplete fields on row number(s):

58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102

									Planned Expenditure									
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Expected outputs 2023-24	Expected outputs 2024-25	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
1	INTEGRATED EARLY HELP & PREVENTION	Living Well & Early Help	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£359,616	£359,616	100%
1	INTEGRATED EARLY HELP & PREVENTION	Living Well & Early Help	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Charity / Voluntary Sector	iBCF	Existing	£373,011	£373,011	100%
1	INTEGRATED EARLY HELP & PREVENTION	Voluntary Sector Infrastructure Support Grant	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess					Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£50,000	£50,000	100%
1	INTEGRATED EARLY HELP & PREVENTION	Support for Providers	Care Act Implementation Related Duties	Other	Market Management & Quality				Social Care		LA			Charity / Voluntary Sector	iBCF	Existing	£80,000	£80,000	100%
1	INTEGRATED EARLY HELP & PREVENTION	Assistive Technology	Assistive Technologies and Equipment	Assistive technologies including telecare		1102	1467	Number of beneficiaries	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£48,350	£48,350	100%

2	INTEGRATED DISCHARGE & ADMISSION	Crisis Response Service	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£391,992	£391,992	100%
2	INTEGRATED DISCHARGE & ADMISSION	Social Work Hospital Team	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£326,388	£326,388	100%
2	INTEGRATED DISCHARGE & ADMISSION	Social Work Hospital Team	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Local Authority Discharge	Existing	£153,071	£153,071	100%
2	INTEGRATED DISCHARGE & ADMISSION	Social Work Hospital Team	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Additional LA Contribution	Existing	£204,719	£204,719	100%
2	INTEGRATED DISCHARGE & ADMISSION	Carers Support (ASC Community Care)	Carers Services	Other	Advice Information & guidance	1088	1088	Beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£296,008	£296,008	100%
2	INTEGRATED DISCHARGE & ADMISSION	Disabled Facilities Grants (Capital)	DFG Related Schemes	Adaptations, including statutory DFG grants		320	320	Number of adaptations funded/people	Social Care		LA			Private Sector	DFG	Existing	£2,272,039	£2,272,039	100%
2	INTEGRATED DISCHARGE & ADMISSION	Community Occupational Therapy	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Social Care		LA			Private Sector	Additional LA Contribution	Existing	£490,547	£490,547	100%
2	INTEGRATED DISCHARGE & ADMISSION	Community Reablement (IWC)	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		3908	3908	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,678,335	£1,678,335	100%
2	INTEGRATED DISCHARGE & ADMISSION	Community Reablement (IWC)	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		635	635	Packages	Social Care		LA			Local Authority	iBCF	Existing	£272,677	£272,677	100%
2	INTEGRATED DISCHARGE & ADMISSION	Community Reablement (IWC)	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		595	595	Packages	Social Care		LA			Local Authority	Local Authority Discharge	Existing	£255,393	£255,393	100%
2	INTEGRATED DISCHARGE & ADMISSION	Adelaide Resource Centre (IWC)	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		11	11	Number of Placements	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£962,489	£962,489	100%
2	INTEGRATED DISCHARGE & ADMISSION	Adelaide Resource Centre (IWC)	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		7	7	Number of Placements	Social Care		LA			Local Authority	Additional LA Contribution	Existing	£669,733	£669,733	100%
2	INTEGRATED DISCHARGE & ADMISSION	Gouldings Resource Centre (IWC)	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		14	14	Number of Placements	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,176,375	£1,176,375	100%
2	INTEGRATED DISCHARGE & ADMISSION	Gouldings Resource Centre (IWC)	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		8	8	Number of Placements	Social Care		LA			Local Authority	Additional LA Contribution	Existing	£636,120	£636,120	100%
2	INTEGRATED DISCHARGE & ADMISSION	Trust Rehab Team (Including CQUIN)	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£4,186,252	£4,186,252	100%
2	INTEGRATED DISCHARGE & ADMISSION	24 Rehab Beds	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		48	48	Number of Placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£1,605,921	£1,605,921	100%
2	INTEGRATED DISCHARGE & ADMISSION	LA Reablement Support	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		221	221	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£95,000	£95,000	100%
2	INTEGRATED DISCHARGE & ADMISSION	Additional External Care Home Beds	Residential Placements	Care home		4	4	Number of beds/Placements	Social Care		LA			Private Sector	Local Authority Discharge	New	£162,978	£162,978	100%
2	INTEGRATED DISCHARGE & ADMISSION	Intensive Bedded Care	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		10	10	Number of Placements	Acute		NHS			NHS Community Provider	ICB Discharge Funding	New	£1,085,966	£1,513,972	80%
3	INTEGRATED COMMUNITY SUPPORT	Community Outreach (IWC)	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		1716	1716	Hours of care	Social Care		LA			Local Authority	iBCF	New	£737,188	£737,188	100%
3	INTEGRATED COMMUNITY SUPPORT	Community Outreach (IWC)	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		1158	1158	Hours of care	Social Care		LA			Local Authority	Additional LA Contribution	New	£497,177	£497,177	100%
3	INTEGRATED COMMUNITY SUPPORT	Carers Prospectus (Inc Living Well - Carers Lounge)	Carers Services	Other	Advice Information & guidance	662	662	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£180,070	£180,070	100%
3	INTEGRATED COMMUNITY SUPPORT	Carers Prospectus (Inc Living Well - Carers Lounge)	Carers Services	Other	Advice Information & guidance	393	393	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	iBCF	Existing	£107,088	£107,088	100%
3	INTEGRATED COMMUNITY SUPPORT	Community Equipment Store	Assistive Technologies and Equipment	Community based equipment		7840	8035	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£548,702	£548,702	100%
3	INTEGRATED COMMUNITY SUPPORT	Community Equipment Store	Assistive Technologies and Equipment	Community based equipment		7094	16916	Number of beneficiaries	Social Care		LA			Local Authority	Additional LA Contribution	Existing	£495,464	£495,464	100%

3	INTEGRATED COMMUNITY SUPPORT	Care Act implementations & Infrastructure	Care Act Implementation Related Duties	Other	Infrastructure Support				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£544,027	£544,027	100%
3	INTEGRATED COMMUNITY SUPPORT	User Led Organisation (People Matter)	Personalised Budgeting and Commissioning						Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£50,000	£50,000	100%
3	INTEGRATED COMMUNITY SUPPORT	Care Graduate Programme	Workforce recruitment and retention						Social Care		LA			Local Authority	iBCF	New	£236,515	£236,515	100%
3	INTEGRATED COMMUNITY SUPPORT	Care Graduate Programme	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge	New	£295,000	£295,000	100%
3	INTEGRATED COMMUNITY SUPPORT	Maintenance of Adult Social Care provision	Care Act Implementation Related Duties	Other	Infrastructure Support				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,092,701	£1,092,701	100%
3	INTEGRATED COMMUNITY SUPPORT	Maintenance of Adult Social Care provision	Community Based Schemes	Other	Support for care packages				Social Care		LA			Private Sector	iBCF	Existing	£4,373,633	£4,373,633	100%
4	INTEGRATED MENTAL HEALTH & LEARNING	Woodlands NHS Staff	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Mental Health		NHS			NHS Mental Health Provider	Additional NHS Contribution	Existing	£1,639,281	£1,639,281	100%
4	INTEGRATED MENTAL HEALTH & LEARNING	Social Care Contribution to Woodlands	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Social Care		NHS			NHS Mental Health Provider	Minimum NHS Contribution	Existing	£147,000	£147,000	100%
4	INTEGRATED MENTAL HEALTH & LEARNING	MH Grant Agreements	Prevention / Early Intervention	Choice Policy					Mental Health		NHS			Charity / Voluntary Sector	Additional NHS Contribution	Existing	£1,011,231	£220,392	100%
4	INTEGRATED MENTAL HEALTH & LEARNING	MH Grant Agreements	Prevention / Early Intervention	Choice Policy					Mental Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£0	£790,839	100%
4	INTEGRATED MENTAL HEALTH & LEARNING	Westminster House - Respite Support (IWC)	Carers Services	Respite services		10	10	Beneficiaries	Social Care		LA			Local Authority	Additional LA Contribution	Existing	£616,489	£616,489	100%
4	INTEGRATED MENTAL HEALTH & LEARNING	Reeve Court Supported Living	Personalised Care at Home	Physical health/wellbeing					Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£283,200	£283,200	100%
4	INTEGRATED MENTAL HEALTH & LEARNING	Reeve Court Supported Living	Personalised Care at Home	Physical health/wellbeing					Social Care		LA			Private Sector	Additional NHS Contribution	Existing	£88,711	£88,711	100%
4	INTEGRATED MENTAL HEALTH & LEARNING	Reeve Court Supported Living	Personalised Care at Home	Physical health/wellbeing					Social Care		LA			Private Sector	Additional LA Contribution	Existing	£283,240	£283,240	100%
5	TO BE CONFIRMED	Additional Discharge Fund 24/25 workstreams pending review of 23/24 progress	Other						Other	To be confirmed on review of 23/24	LA			Local Authority	Local Authority Discharge	New	£0	£571,852	100%

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.

15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Isle of Wight

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	165.1	138.0	155.4	148.0	We have reviewed our previous performance against planned activity for 22/23. Whilst we noted an improvement of 31.1 from 2021-22 to 2022-23, we anticipate that part of this effect will have been generated from work undertaken on the restoration and recovery of preventative and community services post-	General activity: Several of the BCF workstreams have undergone changes in delivery model to accommodate an increase in demand and complexity. Whilst they are still experiencing an increase in demand and complexity, coupled with system-wide workforce capacity issues, post-pandemic restoration is well	Yes
	Number of Admissions	341	285	321	-			
	Population	142,296	142,296	142,296	142,296			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Indicator value	162	136	153	146			Yes

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition	
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,486.9	1,323.2	1,255.7	Falls direct standardisation data shows a reduction in falls. Ambition is to maintain that position over the next year whilst changes to falls investment embeds (ending of BCF falls co-ordinator role from Apr 23; pilot investments in care home support / falls urgent response equipment and training outside of BCF.)	Investment via BCF into LWEH, Community Equipment Service (inclusive of minor adaptations) and DFG (inclusive of major adaptations) to help improve personal safety and ability to mobilise with reduced risk. Occupational Therapy able to assist with improving confidence to self-manage, with its previous move to the LA enabling it to better support a strengths based	Yes
	Count	620	552	524			Yes
	Population	41,300	41300	41300			Yes

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	84.0%	83.6%	81.9%	84.0%	Whilst longer term changes are still under development to facilitate more significant variations to the number of discharges (denominator), the in year application of the Additional Discharge Fund should facilitate additional flow through the system. However, not all of the schemes will support improvement in this indicator as they include bedded care settings to support rehabilitation / onward admission	BCF investments into care at home services and carers support within the BCF have been prioritised this year after being identified as critical activity to prevent carer crisis and avoid hospital admissions which are resulting in long term residential admissions. Support for care homes has been increased this year from reallocation and re-investment of BCF funds. Carers are being prioritised as a key cohort via the	Yes
	Numerator	3,244	3,196	3,021	3,258			
	Denominator	3,863	3,825	3,690	3,878			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Quarter (%)	83.1%	83.1%	81.8%	83.3%			
	Numerator	3,240	3,200	3,025	3,250			Yes
	Denominator	3,900	3,850	3,700	3,900			Yes

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	773.4	643.9	790.9	760.5	2022/23 estimated figure provided is taken from our annual ASC SALT return and is the number of NEW admission to residential and nursing care homes in the period (65+) as per ASCOF 2A part a definition. 2023/24 plan is based on an average over the past 3 financial years where we have seen an increase in residential / nursing placements since the start of the Covid pandemic.	Domiciliary care workforce continues to be extremely challenged on the Isle of Wight and as a result IOW has been unable to source the required levels of home support which has had a direct impact in the high levels of placements. A number of workforce initiatives and close working with local providers is starting to see increases in successful recruitment activity which should support improved performance. BCF investments into care at home services and carers support within	Yes
	Numerator	316	276	339	333			Yes
	Denominator	40,858	42,862	42,862	43,788			

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	75.5%	77.8%	82.3%	81.6%	2022/23 estimated figure is taken from our annual ASC SALT return and is based on activity during Qtr 3 of the financial year as per ASCOF measure 2B part 1. 2023/24 forecast of 82% (93/114) is based on activity over the past 24 months for ASC to maintain a similar outturn to 2022/23 and remain in line with national avg. (82%) .	As our services embed their alignment with the Regaining Independence cluster, we will see greater economies of scale with the Trusted Assessor Team support us to take more appropriate referrals. Investment in year into intermediate care (including care at home) via Additional Discharge Funding with further work identified to refresh the specification(s) for rehabilitation, reablement and recovery services. Community Equipment Store model has been redesigned during 22/23	Yes
	Numerator	114	112	79	93			Yes
	Denominator	151	144	96	114			Yes

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

Better Care Fund 2023-25 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Isle of Wight

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it	Complete:
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan	No	Plan covers only one HWB footprint and has been developed in partnership between stakeholders (narrative p. [XX]) with the JSP providing oversight via the BCF governance structure (narrative p. [XX]). The HWB Chair and Cllr have been notified of the BCF national deadlines with a briefing paper	The HWB is not meet until July. Arrangments are in place to provide a briefing paper in advance with final approval to be granted at the July-23 meeting.	HWB scheduled for 20 July 2023.	Yes
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan	Yes	Narrative document provided. Integrated approach outlined on p. [XX], housing p.[XX], DFG p.[XX] and joint commissioning on p. [XX]. Discussion on health inequalities p. [XX], protected charactersitics p.[XX] and EIA overview provided on p.[XX]. Equality Act and Core20Plus5 discussed on p. [XX].			Yes
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan	Yes	Please see narrative document for DFG p. [XX] and housing p. [XX]. Two-tier arrangments are not applicable. Funding has been passed directly to IWC see Tab 5 and 6a.			Yes
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	PR4	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan	Yes	See narrative p. [XX] and Tab 6a for approach and discussion on investments. Demand and capacity plan completed Tab 4 and narrative p. [XX]			Yes

Additional discharge funding	**PR5**	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans	Yes	Discussions held via BCF Working Group and Joint Strategic Partnership. Final approval of investment made at JSP 23-June. Schemes outlined on Tab 6a and narrative p. [XX]. The IW has not been identified as an area of concern in respect of UEC services. In respect of the ADF, the funds have been pooled into the BCF to build additional adult social care and community-based reablement capacity to reduce hospital discharge delays through delivering sustainable improvements to services for individuals. This is in line with the conditions of the Adult Social Care Discharge Fund (Revenue) Grant Determination (2023-24): No 31/6645.			Yes
NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan	Yes	Yes see narrative p.[XX] and Tab 6a. Metrics discussed on p. [XX] and demand & capacity p.[XX]. HICM summaraised p. [XX].			Yes
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan	Yes	See Tab 3			Yes

Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan	Yes	See Tabs 4, 5 and 6a and narrative p. [XX] Discussion on carers narrative p. [XX], Care Act duties p.[XX].			Yes
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Have stretching ambitions been agreed locally for all BCF metrics based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan	Yes	See Tab 7.			Yes

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Purpose: For Noting

Committee report

Committee	**HEALTH AND WELLBEING BOARD**
Date	**20 JULY 2023**
Title	**PLACE-BASED REGENERATION AND ITS IMPACT ON HEALTH OUTCOMES**
Report of	**DIRECTOR OF REGENERATION**

EXECUTIVE SUMMARY

1. This report provides insight into the subject of place-based regeneration and its links to health outcomes. Following previous discussion at HWB board and the continuing pandemic recovery and cost of living challenges, this report aims to delve deeper into the interconnection between place, deprivation, regeneration, and their effects on health.

2. The report sets out the current “response” landscape to the issues of place, deprivation and health highlighting the need for sustained structured collaboration at an island and local community level.

3. The continuing need for a sustained, structured and actively monitored, integrated responses to the issues by all agencies represented at the Health and Wellbeing Board is advocated, through development of whole system “place” based wellbeing action plans reporting twice yearly to the board. A pilot in one area of the island to explore the benefits and challenges of implementing this approach is proposed.

RECOMMENDATION

4. Health and Wellbeing board note the issues highlighted in the report regarding place, deprivation and health and consider instructing development of a pilot of whole system responses to priority places reporting bi-annually on integrated place - based wellbeing action plans

BACKGROUND

5. Understanding Place-Based Regeneration:

a) Integrated Approach:
Place-based regeneration takes a holistic approach to address the multifaceted challenges faced by specific areas or neighbourhoods. It involves a comprehensive

analysis of the local context, including social, economic, and environmental factors. This approach recognizes that health outcomes are influenced by various interrelated aspects of a place and requires coordinated efforts to bring about positive change.

b) Community Engagement:
Central to place-based regeneration is the active involvement and participation of local communities. Engaging residents, community organizations, and stakeholders in the decision-making process ensures that regeneration efforts are responsive to the specific needs, aspirations, and priorities of the community. Community ownership fosters a sense of empowerment and strengthens the sustainability of the regeneration initiatives.

6. The Impact of Place on Health Outcomes:

a) Social Determinants of Health:
Place significantly shapes health outcomes through various social determinants of health. These determinants include factors such as access to quality healthcare services, educational opportunities, employment prospects, safe housing, clean environments, and supportive social networks. Deprived areas often lack these essential resources, leading to higher rates of chronic diseases, mental health issues, and reduced life expectancy.

b) Health Inequalities:
Health inequalities refer to disparities in health outcomes between different population groups. Place plays a crucial role in perpetuating or mitigating these inequalities. Deprived areas, characterized by limited access to resources and opportunities, tend to experience higher levels of health inequalities. Regeneration efforts that focus on addressing the underlying social determinants of health can help reduce these inequalities and create a fairer society.

7. Understanding Deprivation:

a) Dimensions of Deprivation:
Deprivation encompasses various dimensions, including material deprivation (e.g., income, employment), social deprivation (e.g., educational attainment, access to services), and geographical deprivation (e.g., lack of infrastructure, isolation). These dimensions interact and reinforce each other, leading to complex challenges that affect the health and well-being of communities.

b) Health Impacts of Deprivation:
Deprivation is closely linked to poor health outcomes. Individuals and communities experiencing deprivation are more likely to suffer from higher rates of chronic diseases, mental health problems, and lower life expectancy. Socioeconomic inequalities, limited access to healthcare, unhealthy living conditions, and social exclusion contribute to these health disparities.

8. The Role of Regeneration in Improving Health Outcomes:

a) Health-Centred Regeneration:
Regeneration initiatives that prioritize health outcomes can have a transformative impact on communities. By integrating health considerations into urban planning,

regeneration can create environments that promote physical activity, healthy eating, and mental well-being. It involves designing walkable neighbourhoods, ensuring access to green spaces, improving air quality, and promoting active transportation options.

b) Social Infrastructure and Community Development:
Regeneration projects need to focus on strengthening social infrastructure, fostering community cohesion, and nurturing social capital. This includes investing in community centres, libraries, schools, and public spaces that facilitate social interactions, promote social inclusion, and address social isolation. Building strong social networks enhances mental health and provides a support system for individuals and families.

c) Economic Opportunities and Employment:
Regeneration initiatives prioritise creating sustainable economic opportunities within the community. This involves attracting businesses, promoting entrepreneurship, and supporting local industries. By providing accessible job opportunities, training programs, and skills development, regeneration can address unemployment and poverty, which are key determinants of health.

d) Housing and Environmental Improvements:
Improving housing conditions is crucial for health outcomes. Regeneration efforts should focus on providing affordable, safe, and decent housing that meets the needs of the community. Additionally, investing in environmental improvements such as clean air initiatives, efficient waste management systems, and sustainable infrastructure can have significant positive impacts on the health and well-being of residents.

e) Collaboration and Partnerships:
Successful regeneration requires collaboration and partnerships among various stakeholders. Local government, community organizations, healthcare providers, educational institutions, businesses, and residents must work together to develop a shared vision, coordinate resources, and implement strategies effectively. Collaboration ensures that regeneration initiatives are comprehensive, sustainable, and aligned with the health needs of the community.

THE CURRENT LANDSCAPE

9. Some communities on the island continue to experience worse physical and mental outcomes than island and national and island averages as outlined in the JSNA, Joint Strategic Needs Assessment.

10. These inequalities have been impacted further by the legacy of the pandemic and the current cost of living crisis with advice and guidance services and practical and financial support agencies finding it increasingly difficult to service significant increases in demand.

11. The community response to these issues at a local level, during the pandemic and in the current crisis demonstrates the value of supporting place based responses to local need. Public sector agencies, operating at an island level, in a challenging public sector finance climate struggle to resource differentiated responses to meet distinct needs in specific communities on the island.

12. As a result, while strategic whole island responses to health and wellbeing challenges (HWB strategy), social and economic issues (IWC Corporate Plan), covid recovery (recovery plan), emerging IWC anti-poverty strategy provide settings for inter-agency collaborative working in meeting islander well being the ability to translate strategic intent into co-ordinated localised response still needs improvement

13. Community led responses by “anchor” organisations are crucial to effective place based regeneration and resulting physical and mental wellbeing. Organisations such as Pan Together, Ryde Aspie and West Wight Community centre provide a key platform around which agency responses can mobilise.

14. The success of the Living Well programme delivered by these partners , supported by Community Action IOW, demonstrates the potential of targeted local interventions in meeting community health and wellbeing.

15. Local regeneration “Place planning” including area regeneration managers, the Community Action Community resilience team, working at an area level, provide the base resource for establishing differentiated evidence baselines, developing differentiated responses and implementing measured local initiatives to improve identified deficits.

THE PROPOSED RESPONSE

16. The council will shortly be introducing a reorganisation of its services to better integrate its place based response in a pressured financial environment

17. An island wide anti-poverty strategy is also being developed to embed responsiveness to:
    - Ensuring mental and physical wellbeing of those on low incomes
    - Maximising income for those in need
    - Food security for all through minimising waste
    - Embedding sustainable local support initiatives

18. Ensuring all agencies, committed to the success of the Health and Well Being strategy can effectively support place based responses is the next key step. Development of whole system place based working, through creation of place based well being action plans is recommended , with piloting of the approach in one area initially to identify the benefits of challenges of taking the approach.

19. Public health and regeneration staff based within the council will collaborate with other HWB board partner agencies to bring the pilot forward over the next 6 months

20. The Draft Island Planning strategy has been formulated with spatial in equalities in mind and contains policies to help improve health outcomes eg. Increased sustainable transport and more affordable housing.

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