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

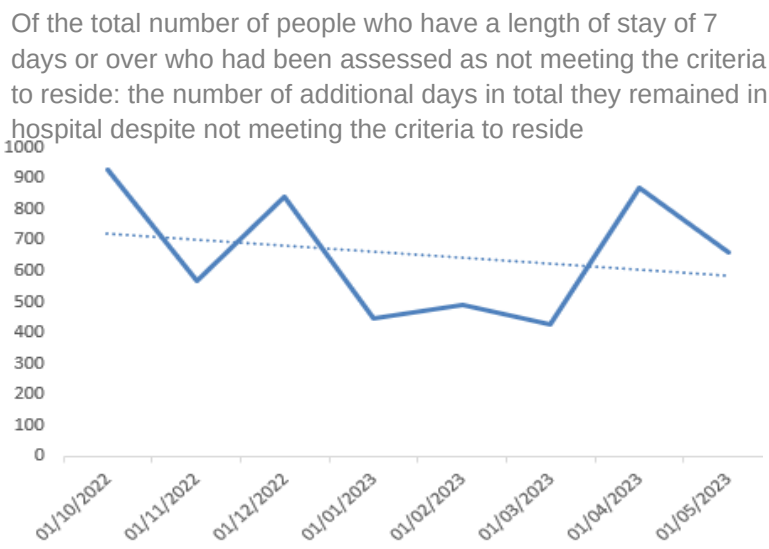
development and helping to break down traditional barriers faced when accessing services across both health and social care.

- 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.

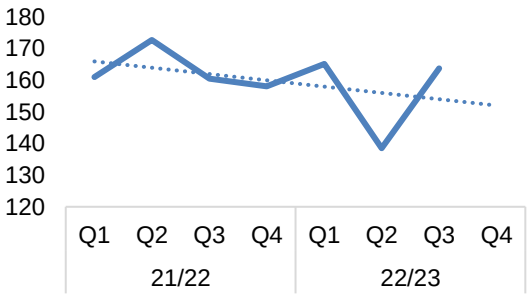
However, during the period of redesign, the capacity of the system will be supported by the Adult Social Care Discharge Fund (Revenue) Grant Determination (2023-24): No 31/6645. Learning from the demand and capacity review outlined above have helped to inform the application of this additional income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

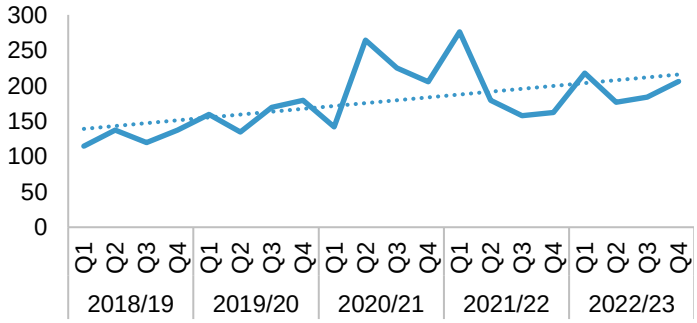
It is intended that these schemes will continue to support the positive trajectory against the BCF metrics. Whilst the overarching number of non-elective admissions has been increasing, those relating to unplanned hospitalisation for chronic ambulatory care sensitive conditions have been decreasing. 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

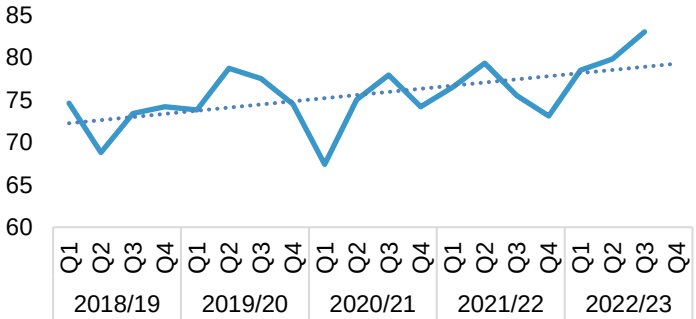


The success of these changes can be seen through the increasing proportion of people (65 and over) who are still at home 91 days after discharge.

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

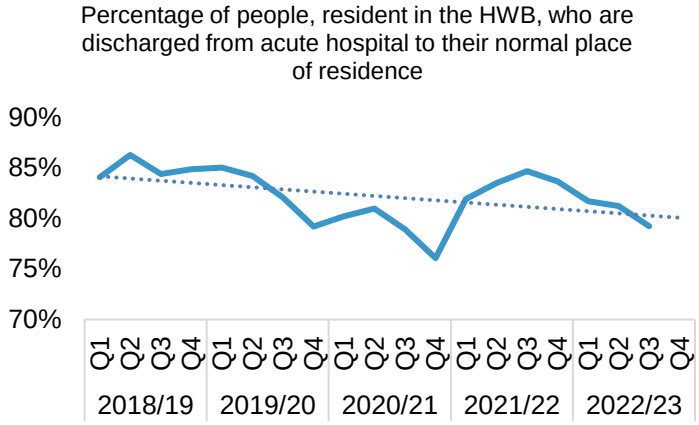


However, there is still a need to address acuity, complexity and inequalities arising through individuals living longer in poor health as can be seen from an increasing number of people needing a long-term residential admission to have their needs met. This need is also echoed in bedded capacity tracking 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.

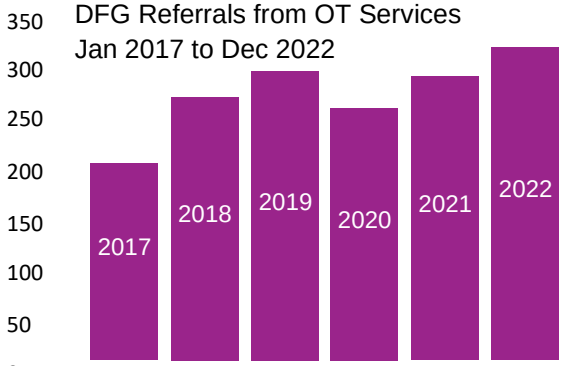
To implement the changes highlighted above, the services operate in five key ways to implement change:

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.