WARWICKSHIRE cares Better Together

Item 6 Appendix

Better Care Fund

2017/19 Planning Submission

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NHS

Warwickshire County Council

Description: This document is a first draft of the narrative plan for the BCF for 2017/19 that will be submitted to NHS England for assurance.

Responsibilities:

Accountable: Christine Lewington

Responsible: Rachel Briden

Consulted: Warwickshire Cares Better Together Programme Board

Informed: Health and Wellbeing Board

Document History:

Version	Summary of changes	Author	Date
V0.11	Updated version following feedback received from WCBT programme board members following programme board on the 17th August.	Rachel Briden	24/08/17

Outstanding

Decisions	• GLT and HWBB sign off
Changes	•
Additions	•

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Contents

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Introduction / Foreword

The NHS Five Year Forward View (published in 2014) sets out how the NHS needs to change, recognising the benefits of engaging with patients, their carers' and wider communities to promote self-resilience and wellbeing and to prevent ill health. It also recognises the need to have a different narrative with patients, carer and the wider public to empower them and the communities within which they live to take greater ownership of their own health and wellbeing. It argues for a greater focus on prevention and public health citing; increasing rates of obesity, especially in the young; smoking, especially during pregnancy and increasing rates of alcoholism. It calls for better engagement with communities to involve them directly in decisions about the future of health and care services. Importantly the NHS recognises the need for change. It calls for greater integration across the health and care system as a whole to deliver personalised and co-ordinated care rather than …'single, unconnected episodes of care'.

The Better Care Fund has been one of the key contributors towards building stronger partnerships between the commissioners and providers of health and care services in Warwickshire. It is in fact the only mandatory policy to drive integration. Despite significant pressures across the system including a continual reduction in social care resources and increasing acuity of need, partners have strived to make a sustained difference to the way services are organised and delivered. By working together the expertise and strengths within the system have been acknowledged and resulted in opportunities to be more innovative and reshape how services are commissioned and delivered. These developments have actively included wider partners such as; housing, the voluntary and community sector, and market providers; as well as feedback from the residents of Warwickshire from the Home Truths Diagnostic project and Out of Hospital contract critical success factors and outcomes.

We know, however, that there are significant challenges to the health and care system which require a stronger focus and pace in how services are commissioned and delivered in the future if the ambitions of the Five Year Forward View are to be fully realised. We also know that if we are to meet these challenges then integration of key services needs to be firmly established. Integration will be the driver for the Better Together Programme over the next two years.

Warwickshire has much to build upon, for example; there has been wide interest in the outcome based model for Domiciliary care, there is also national recognition for the locally grown Discharge to Assess model as well as the opportunity to bring community health teams and reablement teams together using the Home First model.

Importantly the views of those who use services and their carers/families have been key contributors to the progress made.

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This plan has been approved by board members of the Better Together programme representing: Coventry and Rugby Clinical Commissioning Group (C&R CCG), South Warwickshire Clinical Commissioning Group (SWCCG), Warwickshire North Clinical Commissioning Group (WN CCG), George Eliot Hospital (GEH), South Warwickshire Foundation Trust (SWFT), Coventry and Warwickshire Partnership Trust (CWPT), University Hospital Coventry (UCH) and Warwickshire; Stratford Upon Avon District Council, and Public Health, Community Capacity and Social Care Commissioners and Operational Leads at Warwickshire County Council. And includes the views of additional key partners including: Warwickshire District Council, Nuneaton and Bedworth Borough Council, Rugby Borough Council and North Warwickshire Borough Council, the Voluntary and Third sector, and Care providers.

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Background and context to the plan

The latest Joint Strategic Needs Assessment (JSNA) identifies key local needs and pressures upon the health and social care economy including:

Population change and increasing dependency
In Warwickshire, our population is ageing and more people are living for longer with long term medical conditions. The county currently has approximately 16,100 people aged over 85, and by 2035 this group is expected to grow by 117%. The demographic profile of Warwickshire identifies older people as a key priority for the health and social care economy and as is already demonstrated the impact of this is being felt significantly across the three acute services.

Lifestyle factors affecting health and wellbeing
Locally there is concern around obesity, a lack of physical activity and smoking and actions to address this are detailed in the Public Health business plan for 2017/18.

Long Term Conditions (LTCs)
Around 1 in 3 adults live with at least one LTC and with a growing and ageing population; Warwickshire is predicted to see significant increases in these numbers.

Mental Wellbeing
For people aged between 16 and 65 living in Warwickshire, an estimated 55,600 people have a common mental health problem. By 2035 this is expected to increase by 3.7% to 57,700.

Disability
There are estimated to be 34,667 people aged 18-64 with a moderate or serious physical disability in Warwickshire and this is predicted to decrease to 34,943 by 2035.

Ageing & Frailty
Warwickshire's population is forecast to grow by 1.9% over the next 5 years, with 7.2% growth in the over-65 population and 11.8% in the over-85 population, altering the age profile of the county and increasing the median age. Although many people remain well, active and independent during later life, for others, increasing age brings an increasing chance of frailty, long-term medical conditions, dementia, terminal illness, dependency and disability.

Dementia
In 2017, there were 4,463 patients on Warwickshire GP's disease register for dementia and an estimated diagnosis rate of 60.9%, leaving an estimated 2,864 people without a diagnosis.

These needs are often exacerbated by increased isolation and loneliness, as 32.5% of the population live in rural areas.

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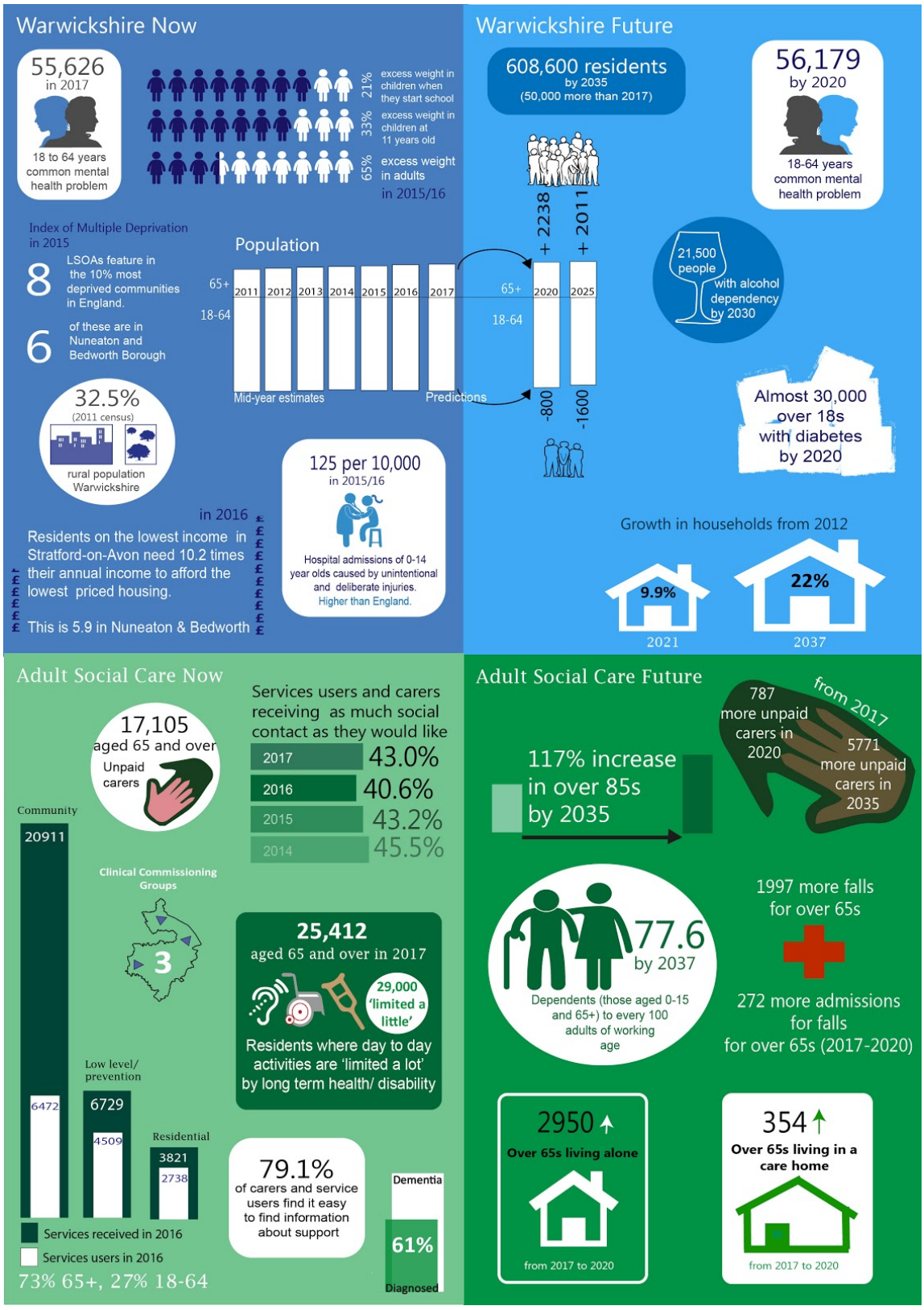
The JSNA co-produced between Public Health and Adult Social Care continues to provide the evidence and context to the challenges faced by the health and social care system in Warwickshire. A one page summary of the Warwickshire JSNA is detailed below:



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The table below provides a summary of key health and social care indicators from the CCGs for Warwickshire. These indicators show that there is significant variance in life expectancy and healthy life expectancy dependant on where people live in Warwickshire.

	Average Registered Population	Male Life Expectancy (Years)	Female Life Expectancy (Years)	65+ (%)	Long Term Condition Prevalence (%)	Long Term Mental Health Condition	Depression Prevalence	Dementia Prevalence	Caring Responsibility (%)	Unemployment (%)
England CCG Average	7,324	79.5	83.4	17.1%	54%	5.1%	7.3%	1.0%	18.2%	5.4%
Coventry and Rugby CCG (Rugby only)	8,005	79.68	84.02	19%	55%	4.5%	6.9%	0.9%	18%	2%
South Warwickshire CCG	7647	80.2	84.6	20%	50.2%	3.86%	7.24%	0.9%	17.6%	2.5%
Warwickshire North CCG	6,724	78.12	82.65	19%	58%	5%	5.6%	0.9%	20%	5%

Combined this indicates that a different focus and delivery model is required for each component part of the health and care system in Warwickshire to ensure we reflect the needs of the local population.

In this 2017/19 plan the work of the Better Together programme is addressing the key issues and challenges that relate to an ageing population, particularly people over the age of 85 who have increasingly complex needs and increase the demand on carers and statutory services.

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Progress so far

In the 2016 plan Warwickshire partners had big ambitions to improve the health and social care system by improving the level and quality of integration and joint working. Detailed below is a summary of:

- some of our key achievements in 2016/17 that enabled more people to be supported closer to home, and
- our 2016/17 performance against prescribed national metrics

System wide achievements:

- A Section 75 agreement was signed by all three CCGs and Warwickshire County Council in November 2016 outlining our joint commitment to a partnership framework for commissioning health and social care services.
- A joint approach to Information Sharing with a protocol in place across the STP footprint.
- Both Coventry and Warwickshire's Health and Wellbeing Boards have agreed a Concordat agreeing the principles of how organisations within the STP footprint will work together. Appendix D details Case Studies of some of Warwickshire HWBB's 101 achievements, delivered through the Better Together programme in 2016/17.

2016/17 Plan	Theme: Community Capacity Resilience / Primary Prevention	
2016/17 Activity		
	What we aimed to achieve	What we achieved
Healthy Lifestyles and Self-Care	A continuation and expansion of public health initiatives ensuring prevention is the job of everyone where all key stakeholders are actively promoting and embedding prevention approaches, at all stages of the publics contact with every part of the health and care system. Establishing self-care and management support where the third sector and Districts and Boroughs play a lead role in the shaping the service offers.	**Fitter Futures Warwickshire** Between 01 July 2015 and 31st March 2017, over 7,000 referrals have been made with just under 2,000 people completing a weight management and/or physical activity service have shown sustained health improvements. Support for people with mental health and wellbeing has been implemented through the development and delivery of both the Suicide Prevention Strategy and the Mental Health and Wellbeing Strategy.
Community led redesign of access to information and support	Staff, 3rd sector partners and people with lived experience will be brought together to shape how health and social care services can work best at a local level. The principle aim will be to deliver models that keep bureaucracy to a minimum whilst ensuring that the system and its processes work swiftly and responsively to people's needs and	Localities Officers have developed a live mapping webpage which is searchable by postcode and is populated with information pulled through from the Warwickshire Directory and local intelligence about community assets. Wider access to this tool will be made available in 2017/18. Warwickshire County Council was

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	circumstances.	successful in securing Community Catalysts to establish community businesses as part of a community assets development model. This will build on the already extensive micro enterprise initiatives within the county.
Social Prescribing	The development of an agreed county wide model via a lead commissioner that where social prescribing projects are viewed on two delivery method continuums; either virtual or physical and formal and informal and where the delivery method determines the level / intensity of the support required.	Various social prescribing pilots were undertaken across the county in 2016/17. Evaluation is now in progress to enable a robust business case to be produced to implement a best practice model across the county. A position statement for Warwickshire will be reviewed by the WCBT programme board in September 2017.

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2016/17 Plan	Theme: Integrated Care	
2016/17 Activity		
	What we aimed to achieve	What we achieved
Care Coordination for the Over 75's	Evaluation of existing pilots across the south of the county and identify the features of most value with costed options for ongoing but improved integrated delivery – with a focus on the development of integrated teams and priority prevention and early intervention programmes.	Key stakeholders and the 3rd Sector social prescribers and a technology provider have shaped a series of pilots for the over 75s with a prime purpose of accelerating the uptake of assistive technology enabled care. In addition, the pilots have upskilled a range of front line staff (voluntary, community nursing) from a range of settings through the delivery of learning and development sessions of enhanced MECC, falls prevention, nutrition and hydration and delivered within the Social Prescribing and South Warwickshire CCG's 'Fit For Frailty' projects. The results of the Fit for Frailty projects have also been shared and the scheme continues to receive substantial investment from South Warwickshire CCG.
Integrated teams in and around primary care	Evaluate existing initiatives in both the north and south of the county, currently operating in different ways, and identify the features of most value and options for ongoing delivery.	An evaluation of integrated teams and ways of working was published by South Warwickshire Foundation Trust (SWFT) in 2016 and the findings have been used to inform ongoing service improvement and integration activity. In addition, KPMG support was secured to support the system in identifying an approach to further improve performance during 2016/17. A multi-agency DTOC task and finish group was established and initiated the mapping of end to end discharge processes and practice across our three hospital sites beginning with discharge teams. This work was completed in June 2016 and will now be used to support the system wide review.
Children's and Adolescent Mental Health Services (CAMHS)	CAMHS (tiers 1 to 4) is being redesigned across Coventry and Warwickshire in partnership with Warwickshire County Council, Coventry City Council and the three local CCG's.	An outcomes framework has been co-produced and is the foundations on which the newly awarded contract has been established. A lead commissioner for the 5 commissioning organisation has been secured with a governance structure that brings all key elements of a robust CAMHS programme together. The new 0-5 years Children and Young Person Emotional Wellbeing and Mental Health Service went live on the 1st August 2017.

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2016/17 Plan	Theme: Integrated Care	
HomeFirst	Integration of intermediate health teams including the Integrated Community Team, Community Emergency Response Team and Reablement services and community based beds for step up/down purposes. Developing more effective pathways for recovery and rehabilitation; reducing the current overlaps between these services to ensure that people get the right service at the right time in the right place.	A co-located HomeFirst service delivery model (integrating South Warwickshire Foundation Trust's Community Emergency Response Team (CERT) and Intermediate Care Services with Warwickshire County Council's Reablement service) went live in two operational hubs in the North & South of the county in January 2017.
Rugby Place Based Commission-ing	To develop a place based commissioning model for Rugby linking in with the emerging integrated neighbourhood team model and social prescribing.	A place based pilot in Rugby is now in place delivering improved access, increased self-management, early intervention and crisis avoidance opportunities for the public.
D2A	Develop Discharge to Assess services and improved services for the over 75s.	D2A – Discharge to Assess is now business as usual across the county with the same level of pathway 3 beds extended for an additional12 months. Joint Multi-Disciplinary Teams are now in place across the county for over 75s.

2016/17 Plan	Theme: Care at Home	
2016/17 Activity		
	What we aimed to achieve	What we achieved
Housing Board	Scoping and establishing housing focussed element of the programme.	The Housing Partnership was established in 2016, following the successful launch of the county wide Home Environment Assessment Response Team (HEART) which we reported on in last year's plan. This partnership is now the delivery vehicle for county wide housing plans.
Residential and nursing care homes	• Contract awards for jointly commissioned residential and nursing care homes • Introduction of the quality assurance framework • Implementation of a single quality management and assurance team • Enhanced GP support to residential and nursing care homes	A single specification across health and care has been produced and forms the contractual relationship between the health and care system and providers. A robust joint approach to fee rates ensured that the health and care system worked together to secure a sustainable market at a fair price.
Falls strategy	First phase development and implementation of a falls strategy. First phase to include detailed as-is picture, including analysis of target population.	A detailed as-is picture and understanding of prevention activity aimed at the over 50s has been completed. The first of a series of pilots aimed at accelerating the uptake of public health prevention and assistive technology enabled care are now planned for delivery in 2017/18. The first pilot commenced on 10/7/17 and have upskilled a range of front line staff (Voluntary, Community Nursing) from a range of settings through the delivery of learning and development sessions on enhanced MECC, falls prevention, nutrition and hydration and delivered within the Social Prescribing and South Warwickshire CCGs 'Fit for Frailty' projects. Customers are currently being assessed and prescribed Assistive Technology products, supplied via ICESS. These pilots are supporting the development of a Falls strategy with an agreed integrated pathway and an Assistive Technology commissioning strategy.
Extra Care Housing (ECH)	Development of schemes as per planning permission approvals. Cost benefits analysis of ECH compared to other housing options including sheltered housing. Further development of ECH model as a potential step down facility	The first ECH scheme suitable for Older People in Warwickshire opened in June 2010. There are now 9 schemes suitable for those aged 55+ in operation across Warwickshire. The Extra Care Homes dementia locksmith model/proof of concept pilot commenced in

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2016/17 Plan	Theme: Care at Home	
	from acute settings.	March 2017.
Carer Support Services	Agree a co-ordinated and countywide approach to carer support	Warwickshire's Joint Carers Strategy has been developed and agreed by all health and social care partners. The Joint Carers Wellbeing Service was awarded in April 17 and the contract went live on the 1st June 2017. This forms the basis of our continued focus and support for Carers over the next two years. This is outlined in more detail in our Care at Home activity plan.
The Integrated Community Equipment Support Service (ICESS)	Implement a county wide service.	In 2016, the Integrated Community Equipment Service now delivers a robust 7 day service. With significant growth in the number of requests from the Acute sector supporting people to be discharged earlier and/or avoiding admissions to residential care.
Domiciliary Care (Care at Home) contract	Phase 2 - Redesign the Care at Home contract framework moving towards outcome based commissioning and understand the impact the new contract is having in terms of demand and service requirement.	Phase 1 and 2 of the redesign of domiciliary care is completed and a new Care at Home contract agreed.

These achievements mean that the foundations are now in place for further integration and joint working over the next two years.

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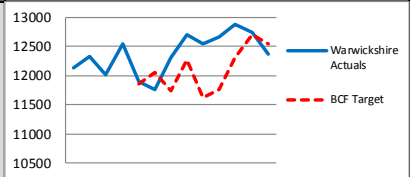
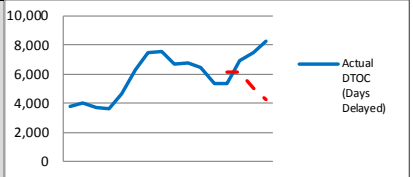
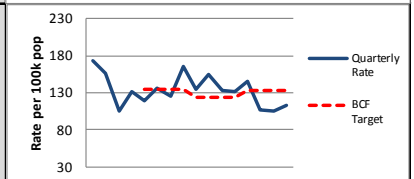
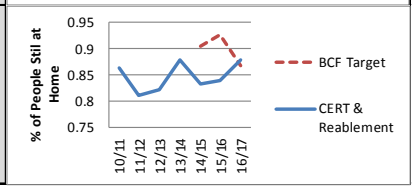
Summary of 2016/17 performance

A summary of last year's performance compared to previous years and the 2016/17 BCF targets is set out below:

			Growth vs 2015/16			
Metric	**RAG**	**Weekly Volumes**	**% Growth**	**Weekly Growth**	**Trend**	**Graphs**
Non-elective Admissions	R	974	2.7%	26	↑	
DTOC (days delayed)	R	539	11%	53	↑	
Res & Nursing Admissions (year to date)	G	10	-13%	-2	↓	
Reablement / CERT (% still at home 2016/17)	G	53	4 % pts vs 2015/16		↑	

Performance against two of the national metric remains a significant challenge.

1. Non-elective admissions (NEAs) – Two issues that contributed to the growth in NEAs in 2016/17 were i) a data recording issue at University Hospitals Coventry and Warwickshire (UHCW) starting in Sep-15 and ii) a pathway change at South Warwickshire Foundation Trust (SWFT) in Jan-16.
    - i) In Sep-15, the coding of patients in the UHCW GP assessment ward was changed from outpatients to non-elective admissions and this had a significant impact on the numbers of NEAs of Rugby residents. In Q1 2016/17 (the only quarter affected by a comparison with a quarter prior to this change in coding) there was 19% growth in NEAs for Rugby residents. Whereas, there was minimal or negative growth in the remaining quarters of 2016/17.
    - ii) ii) In Jan-16 a pathway change at SWFT resulted in a higher number of people being admitted for shorter periods of time. This will have been a contributory factor in the significant growth seen in the first 3 quarters of this financial year. As mentioned, NEAs at SWCCG reduced in Q4 2016/17 (the first quarter where a like for like comparison could be made with the previous year).

Despite these issues, it is though encouraging that performance in the latter quarters of 2016/17 improved and we are confident of this trend continuing into 2017/18 through the planned developments of care co-ordination for the over 75s, falls prevention, nutrition and hydration work and carers support activity that is now in place.

2. Delayed Transfers of Care –The last three quarters of 2016/17 saw a reversal of the downward trend seen in April 2015 to March 2016. Warwickshire days delayed have increased by 11% in 2016/17 compared with 2015/16, missing the target of a 14% reduction over this period. Warwickshire days delayed in Q4 2016/17 reached their highest levels ever at 8,257. There was an increase in this metric at all providers for this quarter (compared to last year), in particular at George Eliot Hospital (131%) and University Hospitals Coventry and Warwickshire (80%). Both Social Care and NHS delays increased by approximately 55% in quarter four compared with 2015/16. The top reasons for Social Care delays were included Care Package in the Home, Residential Home and Assessment Completion. The top reasons for NHS delays include Nursing Home, Care Package in the Home and Assessment Completion. However, since the peak in Jan 2017, delays have been on a downward trend and in the latest month's data (May-17) delays were 14% lower than this peak.

   Effectively managing transfers of care and reducing delays remains a top priority for all partners across the Better Together programme. Performance against this metric and the associated activity plans / high impact change model improvement plans are now subject to increased visibility and scrutiny. This is a system wide challenge for Warwickshire.

3. At the end of quarter four of 2016/17 performance relating to long term admissions to residential and nursing homes had continued to improve and we are confident that similar admission rates can be sustained because we are offering other sustainable independence models. For example the success of Extra Care Housing as a suitable alternative to residential care and the impact of the new Home Care contract are two contributing success factors.

4. Similarly, by the end of 2016/17 the effectiveness of reablement in supporting people to still be at home after 91 days against target was extremely positive and we are confident similar levels can be maintained. Countywide services including the go live of the co-located HomeFirst service, HEART and ICESS are all significant contributing success factors. Both social care and CERT performance was though included in both the provided target and reported actual performance for 2016/17 and previous years. Following clarification of the SALT return and BCF guidance, CERT has now been removed for 2017/18 onwards. This change now provides a more realistic baseline for the assessment of system wide achievements and progress.

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The local vision and approach for health and social care integration

Although our Vision for the Residents of Warwickshire has not changed:

Vision for Residents: "I can plan my care with people who work together to understand me and my carers, allow me control, and bring together services to achieve the outcomes important to me."

Our Vision for the health and care system has. We have agreed that we want to create:

One System, One Budget so that people get the right service at the right time and in the right place

We are committed to working together to challenge the status quo, champion innovation and break down barriers, transforming services to deliver improved outcomes for the residents of Warwickshire. Our aspiration is that these arrangements will result in increasingly positive outcomes that make a real and tangible difference to how people live their lives. We are redefining our roles as we become part of a multi-faceted system of health and care services that works with and supports individuals and communities.

Because of the growing demands on the health and care system and the continued funding pressures that we are all experiencing we need to collectively redesign how services are provided and how the public access and receive services in the future.

We need to reduce the demands on the health and care system if financial balance is to be achieved. It is therefore imperative that when considering this we look across the whole customer journey and view it holistically across the health and care system.

As people age and by supporting people to remain independent and well at home for longer we can sustain and improve individuals health outcomes. The increasing prevalence of care home and hospital admissions reduce the levels of independence people can enjoy. Prevention and early intervention approaches delivered by skilled front line practitioners can guide and support people to avoid crisis interventions.

In our original submission we talked about wanting people to take more control over their lives. Over the next two years we are developing our self-management approaches for the public so that:

- People and communities take accountability and responsibility for their own health and wellbeing and live in good health for longer. We will support individuals, families and communities to build and utilise better their local community assets;

- We also want to make sure that people with short term needs regain/sustain their independence and wellbeing where their self-sufficiency is optimised;

- And finally for those with long terms needs, their quality of life is optimised and maintained for as long as possible without total dependence on services.

Our objectives are therefore based upon adding maximum value by working directly with individuals, communities and key partners. We will achieve this by:

Helping people to help themselves by:

- Ensuring people have access to timely, quality information and advice and information;
- Building services around people's own strengths and those of the families and the communities in which they live;
- Empowering citizens to continue to build a support network of trusted people, places and services tailored to their needs and minimising their dependence on formal services;
- Working with communities to ensure people can develop or retain a choice of social links and networks to maintain health and prevent social isolation ;
- Equipping and educating people to maintain their own physical and mental health and wellbeing;
- Exploiting advances in innovation and technology to enable people to live independently for as long as possible.

Continuing to provide quality services by:

- Upskilling all NHS and care staff on prevention and early intervention approaches (primary, secondary and tertiary) as a routine part of their service offer, in support of the maintenance of physical and mental health and wellbeing;
- More effective partnership working, particularly the co-production of commissioned services;
- Agreeing clear and consistent practice standards across the system and the county, but recognising distinctive local solutions for delivery;
- Encouraging a positive and responsive culture that enables the health and care workforce to innovate with confidence and continue to deliver a quality service.

Using Place Based Planning to:

- Redesign the way services are organised around populations and communities, with teams working together from across; health, housing, social care and the voluntary and community sector.
- Ensure that services respond rapidly and effectively to meet needs.
- Providing the right assessment at the right time to support people to achieve or regain their ability to manage their lives including the use of trusted assessors.
- Provide support that is proportionate to people's needs and those of their families.
- Make every penny count in achieving customer outcomes and value for money services.

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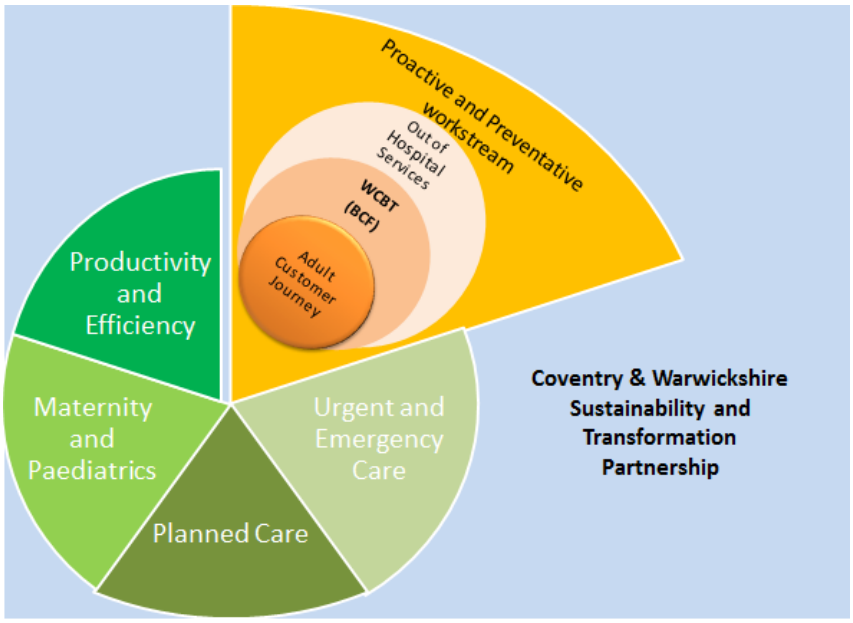
So what does all this mean?

The Coventry & Warwickshire Sustainability and Transformation Partnership (STP), known locally as Better Health, Better Care, Better Value is the local response to the Delivering the Forward View: NHS Planning Guidance 2016/17 - 2020/21 and includes:

- New Models of Care;
- An uplift in prevention – *being delivered through co-production with Public Health;*
- Greater personal control of care;
- Integration of care;
- More out of hospital/place-based care;
- Redesign of Acute care;
- Networks of care around GP – *being underpinned by the GP Five Year Forward View*

The Coventry & Warwickshire STP plan outlines five strategic programmes of which one is the Proactive & Preventative work stream. Existing pieces of work, such as the Out of Hospital redesign and the Better Together Programme form part of the work stream and is the cornerstone of the redesign of the whole system and its ability to achieve quality outcomes within a sustainable financial framework.



Since last year and following the Annual NHS Planning Guidance, together with the Better Together Integration Guidance 2017-19, we are sharpening our focus and taking positive steps to bring commissioning and the delivery of services closer together. For health this will be the redesign of Out of Hospital services. For Social Care it is the reshape of how Adult Social Care operates. Over the next two years we will bring these pieces of work together and in partnership build consensus on how to secure an integrated model for the health and care system beginning with services delivered outside a hospital environment.

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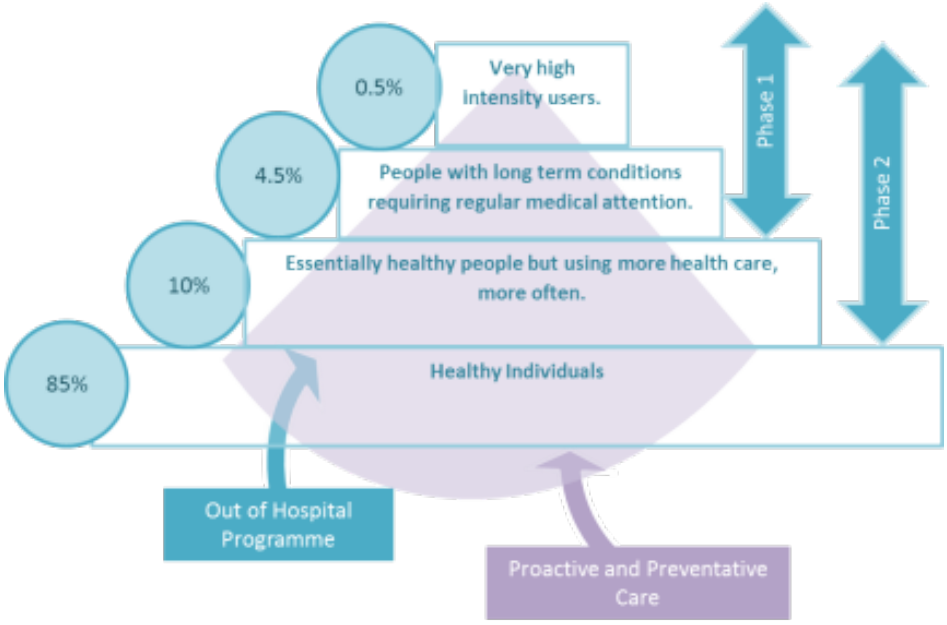
Out of Hospital Programme

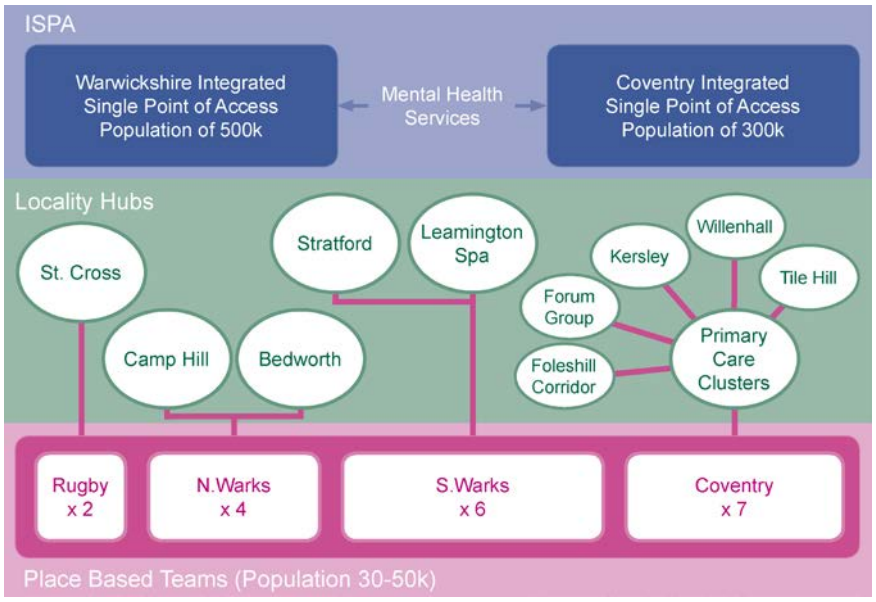
Following substantial consultation and engagement with the public and other key stakeholders, the Clinical Commissioners and GPs across Coventry and Warwickshire established the Out of Hospital Programme that seeks to address the structural, cultural and professional barriers to the delivery of person centred care. On the basis of the consultation and engagement undertaken, clear objectives were defined:

- To deliver more care outside of hospital;
- To ensure providers have a sustainable workforce that can work across professional boundaries;
- To address complex needs of an ageing population;
- To facilitate the creation of person centre care delivered through integrated provision;
- To support people to maximise independence;
- To enable a financially sustainable care system.



Warwickshire Out of Hospital Model
Source: Business Case: Provision for Out of Hospital Services, Executive Summary, page 7

Following extensive commissioning activity the contract has been recommended be awarded to South Warwickshire Foundation Trust and Coventry and Warwickshire Partnership Trust. Over the next two years SWFT and CWPT will be planning for the two year transitional plan and alignment of health and social care activity to deliver this new Clinical Delivery Model. The key deliverables in the next 2 years, demonstrated on the diagram below are: Integrated Single Points of Access; Place Based Teams; Locality Hubs and Integrated care records.

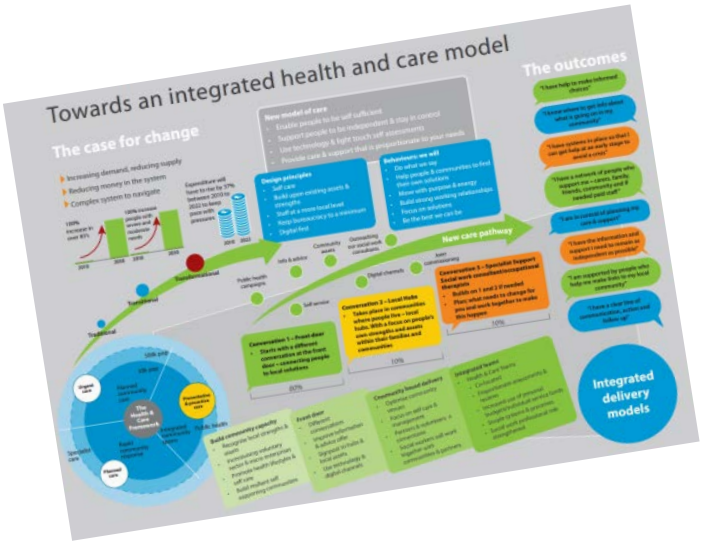


Operational Out of Hospital Model
Source: Business Case: Provision for Out of Hospital Services, Executive Summary, page 8

Adult Social Care Transformation Programme

Evidence shows that people who can take control of their own care at home or with support from community-based services have better outcomes than the alternative of hospital stays and care homes. This, combined with the voice of those who use services, together with the need to do things differently because of financial and other resource constraints is the catalyst for change. Standing still is no longer an option and any radical change will require a shift in behaviour, attitude and mind-set. To achieve the desired cultural, behavioural and wellbeing changes we need to develop a series of new conversations with the public; our own staff, and staff across the wider partnerships including health, housing and voluntary and community sector so that:

- People and communities are able to take responsibility and accountability for their own health and wellbeing and live in good health for longer;
- The independence and self-sufficiency of people with short term needs is optimised and maintained with short term help when it is needed;
- The quality of life and independence of people with long term and/or complex needs is optimised and maintained for as long as possible without total dependence on services.



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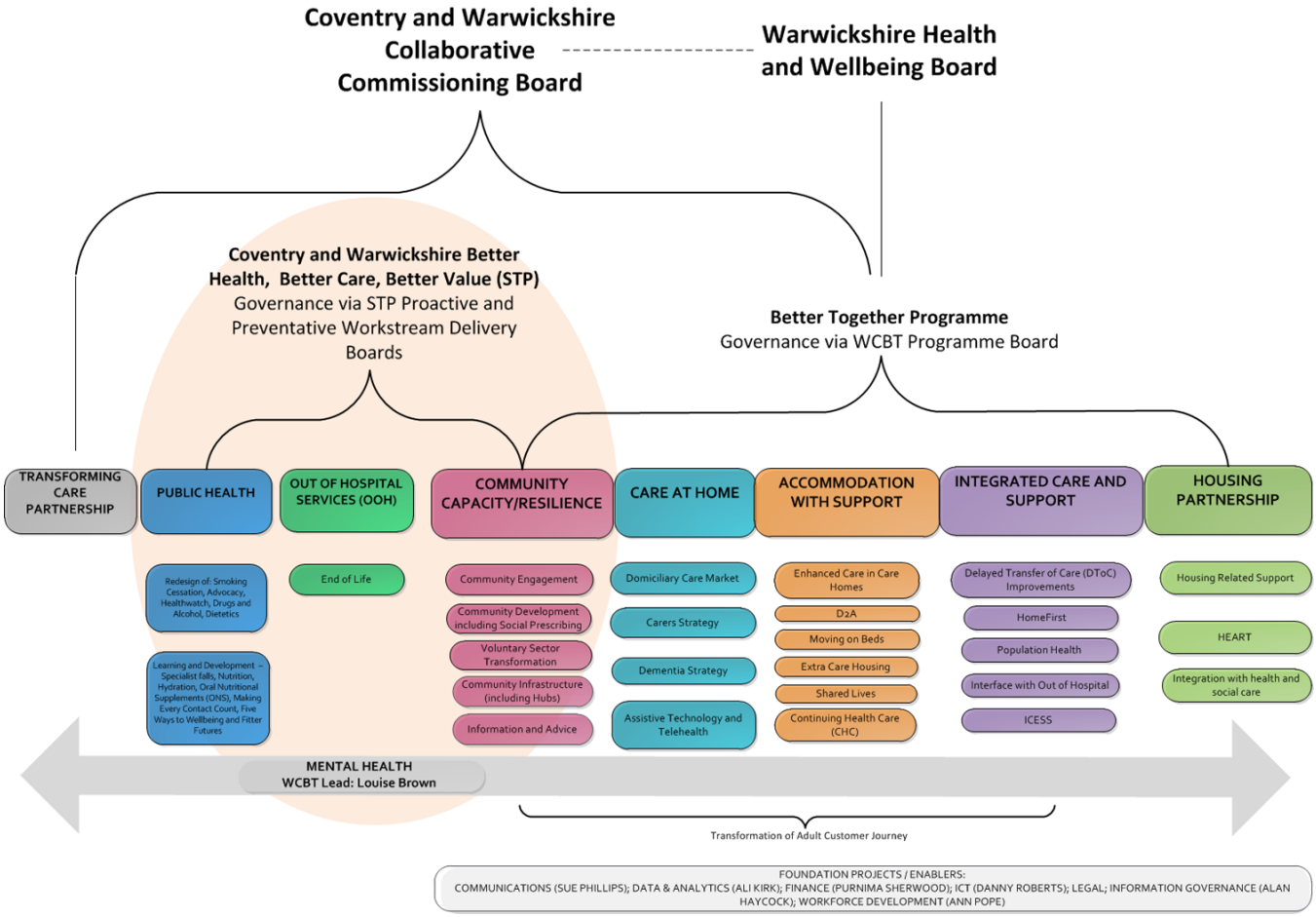
The Better Together Programme

But we are not starting at the beginning. The Better Together Programme has established strong foundations on which to take its next steps towards integration, for example; health and care commissioners have worked together to create a single outcome based specification for residential and nursing homes, including a joint approach to fee setting. For Domiciliary Care there has been a significant redesign with the new geographical zones and the introduction of a broker model to support Delayed Transfers of Care. And for mental health we have retendered the CAMHS services using a lead commissioner model and outcomes framework.

The governance framework below outlines the portfolios of work that form the current Better Together Programme:



More detail on our existing programme governance framework and approach is provided in Appendix A.

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Building a Future – establishing an Integrated Model for Warwickshire

Between now and 2020, as a health and care system, we want to build the infrastructure that will facilitate more formal arrangements for the integrated commissioning and delivery of health and care services in Warwickshire. This is not an easy task and will require; trust, patience, honesty and determination to succeed. It will mean different and sometimes difficult conversations between us all but also those who use services and their carers/families and will need strong leadership and the willingness to invest in change to improve outcomes for the citizens of Warwickshire.

An appropriate governance framework will be essential to underpin a complex and changing organisational landscape. However we will continue to work within the auspices of the STP and specifically the Proactive & Preventative work stream and respond to the principles of the Joint Health and Wellbeing Concordat to agree and commit us all to working together.

An early output will be agreement on our collective commissioning. Critical success factors to achieving this transformation include:

- Alignment of strategies across partners;
- Ownership from communities to look after their own health and wellbeing;
- Sustaining our focus on outcomes not activities;
- Working thematically and not in organisational or service silos;
- Taking a system-wide focus on prevention and early intervention;
- Daring to let go of things that we currently do ourselves and
- Delivering the right service to the right people at the right time based on customer segmentation.

The changes will require a long-term commitment to education, developing and upskilling our workforce with a broader and more inclusive view of individuals mental and physical health and wellbeing needs to support self-management and early intervention and advice at every contact with the public. These prevention at scale and by place approaches will be embedded into the new Out of Hospital service and the redesign of Adult Social Care at the heart of this plan.

Establishing an Integrated Commissioning Governance Framework

Over the next two year we want to secure an integrated governance framework to support joint decision making and stronger accountability. In order to deliver against this commitment and to work collaboratively we need a mechanism for commissioners to have oversight of all contracts relating to OOH and all projects governed through the Better Together Programme so that joint decisions can be made. To do this and to work within a formal collaborative commissioning framework we will produce a ‘Handbook’. This will include the production of a formal and legal Section 75 handbook that sets out; roles and responsibilities, risk sharing protocols, decision making and an accountability framework. It will be a legal document which will also include an agreed set of principles between the commissioning organisations (the “Collaborative Commissioning Principles”) and outline a

process that delivers a more formal collaborative commissioning arrangement to be in place by 2020.

In the first instance and recognising that this will take some time we will establish a Memorandum of Understanding to govern and progress the agreed programme of work. Part of the MOU will set out that the formal handbook is a working document and will commit each organisation:

- To develop a system wide commissioning approach that supports providers to work together in the interests of patients/customers rather than organisations;
- To adopt the collaborative commissioning arrangement with a common language to ensure communication between commissioners, stakeholders and the public has clarity and transparency;
- To move through the continuum for collaborative commissioning in a systematic way.

There is strength in commissioners coming together. One of our abiding principles therefore will be – Equity of outcome not Equity of delivery!

Bringing the delivery of services together – an integrated model of provision

Bringing commissioning together will enable providers to consider how the delivery of services are organised to meet the demands and outcomes for people who use the health and care system.

With the advent of the Out of Hospital contract award and the emerging transformation programme for Adult Social Care there is an opportunity to establish an integrated health and care model for all out of hospital care and support.

Over the next two years we will ensure that opportunities for greater integration at an operational level are secured. Existing progress includes, for example; the co-location of the reablement teams with the community hospital teams; some joint multi-disciplinary teams now in place across the County, and the County wide Home Environment Assessment Response Team (HEART).

The establishment of Design Boards at a local CCG level and the production of the lower level area area/locality based JSNA geographical profiles (refer to Appendix C) form part of the intelligence that support a joint health and care delivery mechanism. The creation of community health and care hubs will also provide the opportunity for local communities to access local services and resources in support of the objectives of the Better Together programme and the Out of Hospital contract.

As a partnership we want to bring greater transparency and visibility to how funding and budgets support the delivery of care and support outside a hospital environment and to create opportunities for shared dialogue in why and how funding is utilised. For example, in

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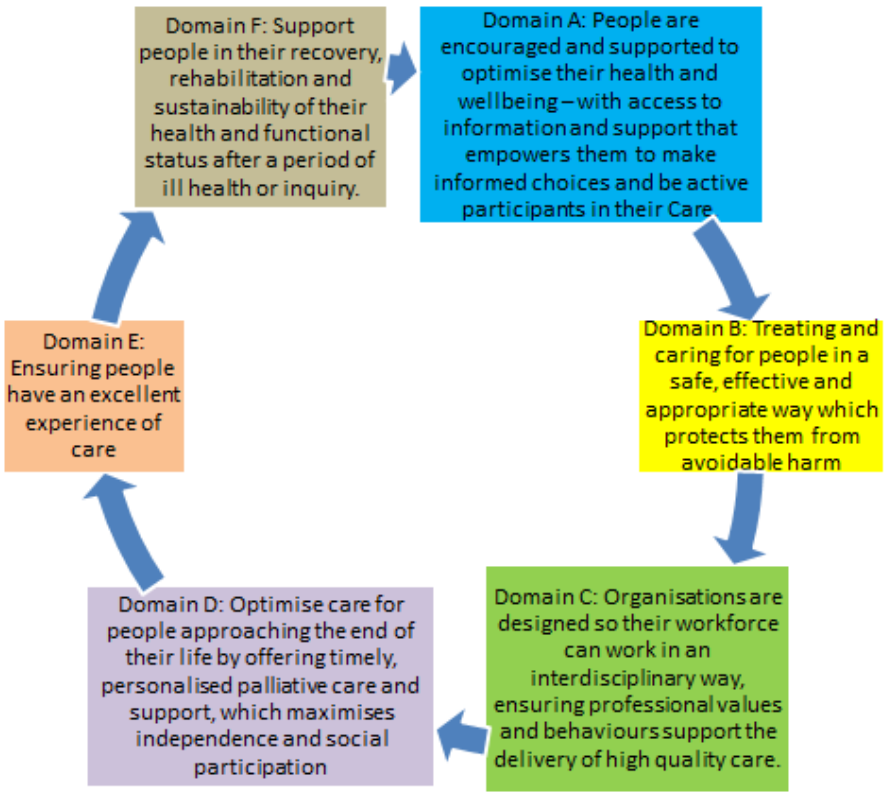
the use of funds across the system we will provide the opportunity to constructively challenge existing funding decisions and make informed decisions on investment, potentially removing duplication and supporting the delivery of improved, targeted services based on the JSNA profiles.

The model for Out of Hospital and Adult Transformation are inextricably linked. We share the same outcomes (see below) and are now creating a shared delivery platform at a local level so that staff, communities and individuals can achieve the outcomes important to them.



Out of Hospital Outcomes Framework.

Source 'Coventry and Warwickshire Out of Hospital Programme Governance Structure, Appendix 1' paper to The North Warwickshire Design Board for Out of Hospital dated 2nd March 2017

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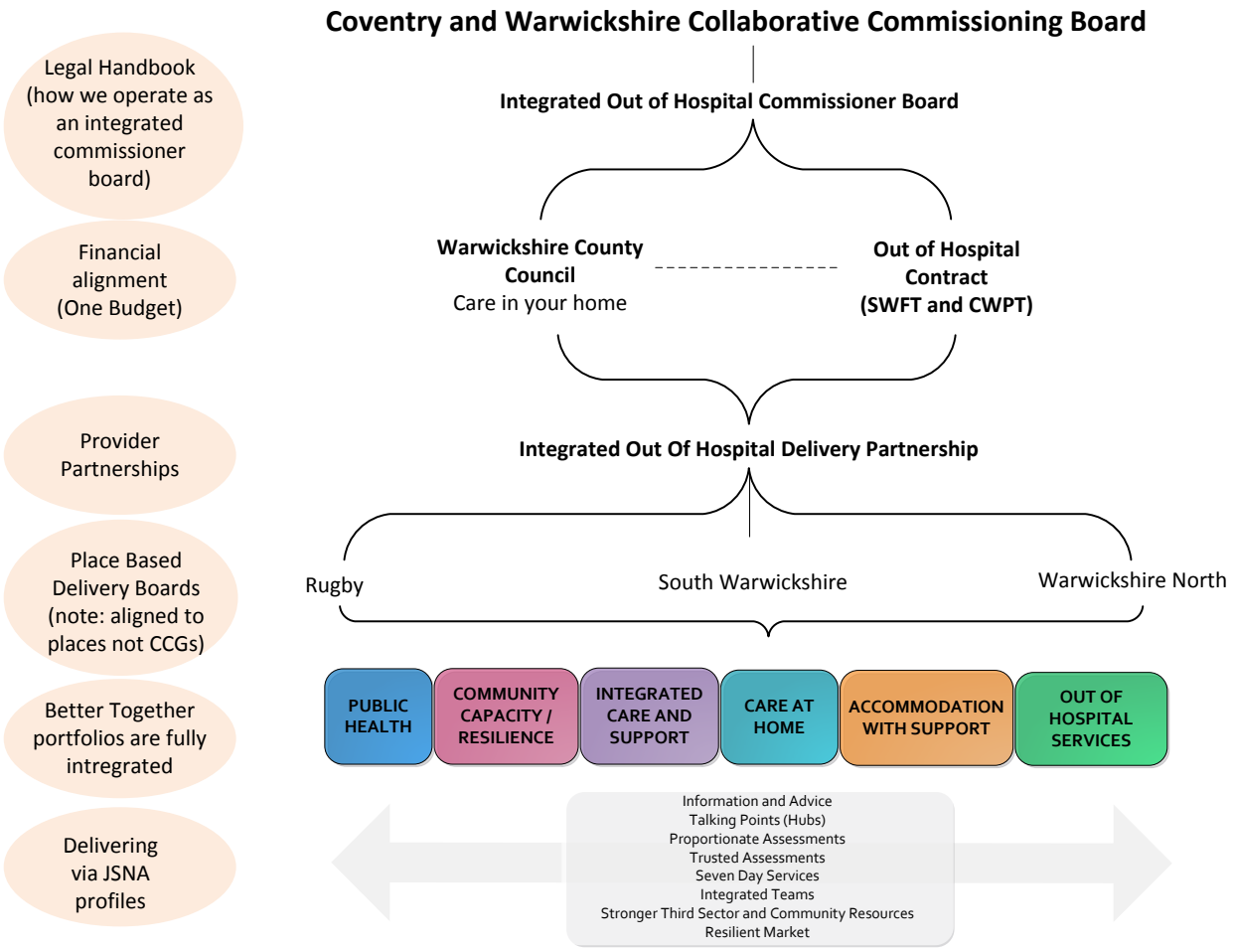
What will the Health and Care system look like by 2020?

As we keep moving towards an integrated and transformed health and care system, our governance framework and delivery model will continue to evolve.

By 2020 our Integrated Governance Framework will be



Work is already progressing to put the building blocks in place towards integration. We have:

- begun the development of a Memorandum of Understanding as the pre-requisite to a more formal handbook of how we will work together as commissioners;
- agreed that we will align each organisation's respective funding envelope to create greater transparency and visibility for services delivered outside of a hospital environment (primarily for older people in the first instance);
- begun work through the Delivery Design Boards that will explore actions required to bring services together such as reablement and community nurses via the Home First model;
- jointly agreed the geographical profiles for placed based planning and delivery.

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The **key design features** of a transformed health and care system will include:

Community based self help	Early intervention	Specialist service
• A shift towards self-management (wherever possible) • People equipped to maintain their own health and wellbeing • Provide educational opportunities including health coaching as a prevention tool • Build services on people's own strengths and those of the families and communities in which they live • People with access to good information and advice at the right time • Active use of public health information and expertise to guide the approaches to place based prevention • Innovation and technology used as a key tool to enable people to access support and information independently of formal services • Build signposting tools for patients, carers and clinicians for out of hospital resources • Establish local community hubs that are place based and integrated	• Build co-ordinated placed based teams that are connected and responsive to local community needs. • Secure a greater focus on reablement and support that maximises independence • Enable a whole systems approach to the personalisation of health and care services e.g. Trusted Assessor Model • Deliver assessments and support that is proportionate to people's needs and those of their families • Co-ordinate health and care responses at a system level to deliver multi-agency care packages tailored to individuals on a case by case basis • All staff to be trained to identify and support individuals at every contact to improve their own mental health and wellbeing	• Practice will be outcome based • People will have greater access to personal budgets/personal health budgets so they have greater control • Greater focus on efficient working – doing the right things well • Stronger shared data and intelligence at a local level • Greater focus on performance management and improvement and managing the required cultural changes in support of transformation • Provide educational and continued professional development opportunities to health and social care staff and other public facing members of staff • Greater incentive for the wider provider market in recognition of their key role in the delivery of quality services • Greater focus on value for money

By 2020 we will have an integrated health and social care system that supports:

- Resilient self-supporting communities that engage in community activities and connected communities, which recognise, value and fully utilise local assets;
- Targeted activities, that reduce isolation and improve health and wellbeing through well developed and sustainable social networks;
- Supported community change agents, connecting with other local people through local community assets and activities ;
- Self care programmes running across the County in local village halls/libraries for all age groups, supporting the development of improved community resilience;
- A full network of community health and social care hubs in place and functional;
- Early Intervention and prevention initiatives (relevant to community/population need) established within selected hubs and thriving;
- Social prescribing as the norm because the benefits are evident within the health and care system ;

- Whole systems improvement across health and care with shorter term care arrangements that enable people to leave hospital and recover as quickly as possible;
- Services initiated/organised and facilitated by community volunteers/third sector forming an integral part of the health and social care system at a local level;
- Specialist Services such as Community Nurses and/or Social Workers visible and accessible via referral within the health and care hub(s);
- Wider partnership initiatives visible within the hub(s) eg; housing options clinics/debt management/how to start up your own small business.
- Training delivered in the local Hubs, ensuring that the local health and care teams and GPs understand the range of services available to them, and that they are appropriately using integrated pathways that will be developed;
- A place based integrated team liaising closely with patients, relatives and carers to provide more autonomy over their care co-ordination;
- Within the placed based integrated teams there will be a deep and evolving knowledge of local services, including those outside of traditional healthcare settings. This will be formalised in the Directory of Services, which is kept up to date with any changes.

Cross Cutting Themes

Strengths based approach - Competent and confident staff who understand their roles and have the skills and commitment (hearts and minds) putting their customers outcomes and needs at the heart of all that they do.

Frontline staff are highly motivated and focussed on delivering support and services that promote independence, choice and control. Core values will support people and their families live full, active, self-determined lives (but when necessary expert support is given).

Access to and use of data and intelligence across the health and care system is responsive and comprehensive. Digitised approaches become the norm as a first point of reference for the public and supports and informs practice and commissioning decisions.

In Summary

Bringing the Out of Hospital services and the Adult Transformation Programme together will ensure the outcomes of each respective local health and social care organisation is delivered. It accords with the strategic direction that has already been established through the Better Together Programme, i.e. that care should be delivered closer to home.

To do this we need to take bolder steps towards integration beginning with greater transparency and visibility of how services can be reorganised and financially sustainable through improved joint commissioning and delivery. For commissioning a Memorandum of Understanding will provide the framework in which to operate and move towards greater

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collaborative commissioning. For providers there is an appetite to work closer together to deliver services at a local level using the JSNA geographical profiles and the local design boards.

The Better Together programme will provide the framework for bringing, in the first instance greater transparency and visibility of the systems financial envelope for services delivered outside a hospital environment and will be the vehicle which drives the integration of both commissioning and delivery of services closer together.

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National Conditions

National Condition 1: jointly agreed plan

Through workshops (April, July and August 17), board meetings (May, July and August 17) and on-going activity all partners involved in the Better Together programme have been engaged in developing the joint targets, activities, plans and spending schemes outlined on page 32 in this document and Planning Template.

We are therefore pleased to confirm commitment to, and agreement by, all signatories of the plan. This includes the funding and spending proposals summarised in this plan (Local Authority – DFG, CCG minimum contributions and iBCF) and set out in more detail in the Planning Template.

We can also confirm the Disabled Facilities Grant has been pass-ported in full to the five borough and district councils in Warwickshire, including the £784k underspend from 2016/17.

This funding will be used to support:

- Housing Related Support (Non-Statutory Service for adults aged 16+)
- HEART - Housing Adaptations, the Disabled Facilities Grant and Information and Advice
- Development of an integrated approach to Housing, Social Care and Health

The planned activities over the next two years are outlined in the Housing Partnership action plan which has been co-produced by representatives from the district and borough councils housing team, CCGs, Public Health and Strategic Commissioning.

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National condition 2: social care maintenance

The planned spend on social care from the BCF CCG minimum contribution is set out in line with inflation. This equates to 1.79% in 2017/18 and 1.9% in 2018/19.

The contributions from all CCGs for 2017/18 and 2018/19 are detailed in the Planning Template for Warwickshire. In setting the contribution to social care from the CCGs minimum contribution, partners have provided assurance that the local health and system will not be destabilised.

National condition 3: NHS commissioned Out of Hospital services

Our activity and scheme spending plans demonstrate that we have committed an amount equal to the minimum contribution for NHS commissioned out-of-hospital services.

A summary is provided below:

NHS Commissioned Out of Hospital Services Spend from MINIMUM BCF Pool	**2017/18 Expenditure**	**2018/19 Expenditure**
Mental Health	£0	£0
Community Health	£19,589,362	£19,964,213
Continuing Care	£2,208,253	£2,247,556
Primary Care	£0	£0
Social Care	£0	£0
Other	£0	£0
Total	**£21,797,615**	**£22,211,769**
NHS Commissioned OOH Ringfence	£9,747,735	£9,932,942

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National Condition 4: Managing Transfers of Care

Building on the KPMG independent review in 2016 on DToC and the completion of end to end process mapping, the Better Together programme has commissioned a system wide end to end review of managing transfers of care to support the reduction of DToC to the agreed targets set out in this plan.

This project, led by South Warwickshire Foundation Trust on behalf of the Better Together programme is supported by colleagues from acute providers; social care in Warwickshire has commissioned external support and expertise to assist.

The key areas of focus, identified from assessment against the High Impact Change model are:

- Proactive discharge planning
- Patient and family expectation management
- Resilient discharge pathways and DTOC escalation process
- Improve logistics at point of discharge
- Proportionate and trusted assessment between agencies.
- Improved IT support systems with cross functional access and automated reporting

Stage 1 of the project which is already underway involves:

1. A Review of the current DTOC data extract and reporting processes for Warwickshire patients at: - Warwick; George Eliot and UHCW Hospitals.
   This work is being conducted during July and August 2017 and is designed to identify the current constraints and secondly develop recommendations for improved and consistent DTOC reporting.

2. The development of a new DTOC dashboard for Warwickshire.
   This new dashboard will be more detailed. It will still include the overall Warwickshire DTOC performance but it will have the addition of individual site DTOC reports, which will show each site's DTOC performance and contribution to the overall Warwickshire performance. The dashboard and its supporting Governance reporting structure will identify areas of concern and help drive improvement focus and resource to the sites that need to improve their DTOC performance levels.

   Success will be evidenced visually in the dashboard's Weekly Plan Versus Actual Performance graphs and corrective actions will be recorded in the dashboards inbuilt action plan section. In addition the results from the patient and staff satisfaction surveys can be used to inform progress.

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Our Plan for 2017-19 - Scheme

This section outlines our plans for 2017-19 which are separated into key themes (portfolios). Alignment with the Health and Well Being Board and STP priorities are previously indicated on page 22.

In all portfolios, Public Health guidance and expertise on the implementation of prevention and early intervention approaches will underpin all developments, including learning and development offers for front line staff.

The focus of activities for the Better Together programme over the next two years has been streamlined to align with the Out of Hospital services. This is split into the five key portfolios of:

- Community Capacity / Resilience
- Care at Home
- Accommodation with Support
- Integrated Care and Support
- Housing

207/19 Plan	Theme: Community Capacity / Resilience
Purpose	
I will be able to get information to maintain my health and well-being, take control of my care and access support in my local community that meets my needs	
How we will achieve this	
Community Resilience is a key STP Proactive and Preventive workstream. The Better Together programme is a catalyst for change building support of self-sufficient communities where places and people can access help, advice and universal services self-managing their own behaviour change to achieve sustainable health improvement outcomes. In addition we want to support the public to build and maintain their own personal resilience. We will agree a countywide social prescribing model that can be applied and tailored to local needs and delivery requirements and is place based in delivery with an enhanced focus with hospital facing teams and include specialist mental health support. Social Care on-call support to A & E will be expanded into the late evening to support those who can go home to avoid admissions.	
2017/19 Activity	
Community Engagement In order to facilitate a new relationship with our communities, it is imperative that we	• In 2017/18 we will agree our approach to Community Engagement, setting out: How we communicate, including how we will ensure greater alignment between partner organisations' approaches to community engagement, recognise the value of coproduction and share responsibility for engagement with the Third Sector.

establish clear and consistent methods of engaging with residents and our formal and informal partners.	• In 2018/19 we will implement our new approach, including: Effective communication of our new 'deal' with Warwickshire's residents.
Community Alternatives Supporting residents and community groups to utilise community assets to help themselves and others, including Social Prescribing	During 2017-19 we will continue to build relationships with identified communities to identify assets, community resources, strengths as per the principles of 'Asset Based Community Development' (ABCD). In 2017/18 we will: • Finalise and publish our Community Development Strategy/Policy. • Use Community Catalysts to establish community businesses as part of a community assets development model. This will build on the already extensive micro enterprise initiatives within the County. • Review and extend the reach of Safer Places within local communities. • Complete a universal approach for mapping community provision/ assets and produce community asset maps/ registers. • Design and roll out a universal e-learning programme to educate staff and partners about asset based ways of working. • Review the social prescribing model across the County with the view to establish a Countywide strategic approach with place based interpretation. In 2018/19 we will: • Review neighbourhood patches both within WCC and taking into account the wider landscape of other-agency community development work with a view to refreshing the allocation of neighbourhood patches. • Create local connecting people campaigns throughout the year - to build up an awareness of how people can engage in local activities. • Establish a robust mechanism for joint evaluation of Community Development activity. • Extend the social prescribing model to include an enhanced hospital facing model.
Third Sector Transformation Developing a thriving Third Sector and volunteer economy which enables new models of service delivery and reduced demand on social care services.'	In 2017/18 we will: • Mobilise and organise the voluntary, community and faith sector to support the Vision for Warwickshire. • Develop a mature understanding of funding to the Third Sector, to remove duplication and ensure the best use of future resources. • Develop a co-production approach - on a placed based footing to establish a range of forums for the voluntary sector to help the Local Authority and partners better understand communities.

	• Develop an initial Third Sector Strategy (based on data from co-production activity) that includes delivering placed based services and support. • Review Third Sector Support contracted service and refine the support offer. In 2018/19 we will support the ongoing development of: • Opportunities for people to volunteer formally and informally are easily accessed and well promoted. • Increased Third Sector resilience which plays an increasing role in the delivery of local services and is embedded in referral processes across health and social care. • WCC's approach to volunteering is established and widely understood. Staff across all partners are encouraged to participate in their own communities to spread skills and capacity into the community sector.
Community Infa-structure (inc: Hubs) allowing residents to better access and be signposted to services (delivered by WCC and others), with a focus on prevention	In 2017/18 we will: • Using the JSNA profiles identify potential locations and physical assets where services will be offered/located within the community. • Co-produce the design for hubs with communities, recognising the roles of partner agencies and Third Sector Providers. • Work with communities to understand their needs and assets to shape the concept of hubs and the offer. • Implement and evaluate proof of concept Community Hubs. • In 2018/19 we will: • Develop and implement a plan for full roll out of Community Hubs (depending on evaluation) • Confirm the management model for community hubs eg; community asset model. • Increase the wider offer within the hub model to include a range of health and care services and make visible services such as; housing, debt management, carer support.
Information & Advice	In 17/18 we will: • Review and update existing Directory to include a wider range of service offers to support people's health and care at a local level. • Upgrade the Warwickshire Directory and fully embed the wider information & Advice e.g.; all health services, housing, community and local activities. • Establish opportunities for individuals and communities to interact via the portal. • Secure key information portals in all community hubs and local GP practices. In 18/19 we will: • Continue to build a single information & advice resource for the health and care system • Rebuild a customer information and advice portal that is

	easy to access/navigate and is intuitive and directs people to the right resources. Include tools that empower people to manage their health, wellbeing and care needs and understand the triggers for support. • Procure an emarket solution to allow people to purchase their own care and support. • Link all current portals e.g.; dementia/health and wellbeing to a fully functioning health, care and wellbeing hub. This needs to include the functionality to produce early self assessments to help people manage their own health and well being. Links to training/elearning tools.
Measures	
• Non-elective admissions (general and acute) • Admissions to residential and care homes • Effectiveness of reablement • Delayed transfers of care • Proportion of people self-reporting their health is fair, good or very good • Proportion of people actively involved with at least one local community or voluntary organisation • Average scores on self-reported mental health well-being scale	

2017/19 Plan	Theme: Care at Home
Purpose	
I can stay in my own home and my independence is maintained for as long as possible.. My home is equipped so that I can live independently.	
How we will achieve this	
This Portfolio will support people to remain independent in their own homes for as long as possible, maintain their independence and reduce/delay the need for care in Acute settings (hospital, residential and nursing homes). At its core is the delivery of services that supports people to remain in control and to make decisions that reflect the outcomes important to them. This links directly to the co-ordination of community resources and services commissioned by the health and care system and/or is available through local community businesses. This will include a well co-ordinated place based local support offer for carers so that they feel equipped/supported to continue in their role and to enjoy life in their own right.	
2017/19 Activity	
Care at Home contract	• Fully embed the new Domiciliary Care service delivery model within the Care At Home contract to reflect support delivered based on outcomes • Undertake a full commissioning service review of the new contract that went live in August 2016. • Increase the reach of the broker model to include community and CHC. • Working with domiciliary care providers, reach into local community assets to reduce the need for POCs and increase people's social inclusion and activities.
Carers Strategy	• Embed the Carers Strategy and the commissioned carers support service using the JSNA place based profiles to determine the right services for the right levels of need within each geographical profile eg; dementia prevalence/high levels of older frailer people. • Ensure carer support models are firmly embedded into the local community hub models. • Introduce a Countywide expert by experience programme that is local delivered via the hubs. • Fully review breaks for carers with the intention of developing an inclusive model that responds directly to the needs of carers and those they care for including when an emergency break is required.
Rapid Response	• Commission: a) a rapid response support team to assist with avoiding preventable hospital admissions for a cared for individual that is living in their own home. This service will be for a period of up to 4 weeks and will result in the person staying at home with no ongoing intervention or ongoing domiciliary care or other support as required. The support team may also escort a person home following a stay in hospital where this is required. b) Two Service Improvement Managers to work closely with the Care Home Provider market to offer targeted support and guidance

2017/19 Plan	Theme: Care at Home
	when a home is entering into a challenging phase that has had a negative impact on their quality and safety. • c) Enable late discharge from A & E by providing on call support to get people home out of hours and support them until mainstream support can take over.
Assistive Technology	• Invest in multiple elements of Assistive Technology within packages of care as a cost effective and viable alternative eg; Dom care technology/ECH ICT infrastructure/care applications. • Evaluate the falls programme and explore the potential to use AT within the home as a falls prevention model. • Through innovation and joined up activity carry out a series of pilots to reduce falls. Eg. Assistive technology pilots in conjunction with social care, CCGs and Public Health to test a range of appliances to prevent a first fall and improve nutrition and hydration.
Occupational Therapy	• Recruit OT resource and assign to hospital discharge reviews . • In addition recruit staff and pilot the early community OT reviews of new customers who in the past would not have had an early OT assessment to avoid admissions either to hospital or residential care.
Joint working	• Explore opportunities for joint Health and Social Care Direct Payments, Personal Health Budgets and Integrated Care Packages.
High Impact Change Model (DToC)	• Identify how Care at Home activity can support and deliver the eight high impact changes, with particular focus on Change 7: Focus on Choice and Change 5: Seven Day Service.
Measures	
• A reduction in non-elective admissions (general and acute) • A reduction in long term admissions to residential and care homes • Increased effectiveness of reablement • A reduction in delayed transfers of care • An increase in customer outcomes being met • A reduction in injuries due to falls in people aged 65 and over • An increase in the average age of people entering residential care	

2017/19 Plan	Theme: Accommodation with Support
Purpose	
I will be able to choose where I live that is most appropriate to meet my needs. My care will be personalised to me and support my independence. It will maintain my dignity at all times and provide me with safe care and support.	
How we will achieve this	
This portfolio will focus on the delivery of high quality residential and nursing care that is responsive to the needs of each individual and the outcomes defined by them. It will build capacity and capabilities within the market place ensuring that the right type of accommodation with support is provided at the right time and in the right place. This will mean the continued development of a mixed tenure of supported accommodation such as; residential and/or nursing homes, extra care housing with support, discharge to assessment and moving on beds for those leaving and/or rehabilitating from hospital and more innovative solutions such as shared lives.	
2017/19 Activity	
Enhanced Care in Care Homes	• Continue to build a single co-ordinated model for residential and nursing care within the market. Secure a fair price for care within the market that ensures sustainability to meet the changing demands and needs of the population. • Support the outputs of the enhanced care in care homes model as part of the High Impact changes. • Co-produce a model of short breaks with users and carers, redesigning residential respite.
Discharge to Assess (D2A)	• Produce a further evaluation and improvement plan for the D2A model.
Moving on Beds	• Evaluate and redesign the provision of Moving on Beds to support the transfer of individuals from an acute hospital to an alternative community setting to prevent delayed transfers of care and enable the customer to make longer term care decisions. • Pilot the use of wrap around services within an Extra Care Housing environment.
Extra Care Housing	• Produce a detailed updated analysis of the need for extra care housing to meet the future needs of the population using the placed based planning profiles. • Evaluate the Memory Support model of care for people with dementia. • Build into the delivery programme and changes to the points above taking into account the need to provide further units to support those with dementia. • Ensure there is sufficient supply in the remaining areas of the county that currently does not have extra care housing as an option.
Shared Lives	• Develop and embed a Coventry & Warwickshire Shared Lives Scheme to provide sufficient family based care as a viable alternative to residential/institutional care in a family setting. • Expand the Scheme to deliver 19 Shared Lives carers and 25 placements by 2020.

2017/19 Plan	Theme: Accommodation with Support
Delivering high quality care through high quality staff	• Produce an integrated model for assuring quality that is co-produced with health partners, providers and customers/carers, that is visible to all key stakeholders including the wider public making quality 'Everyone's Business'. • Establish a peer review model for monitoring quality. • Establish a joint health and care dashboard that monitors performance • Establish a workforce development programme that reduces admissions from residential/nursing care homes. This will include a learning & development programme to improve quality eg; dementia care/medicines administration/hydration/Leadership/End of Life care.
NHS Continuing Healthcare (CHC)	Produce a system wide review and model to improve the flow of patients, productivity and cost effectiveness by: • Addressing current issues • All agencies working to a common (national) framework • Clarifying thresholds for funded nursing care when individuals are not CHC eligible.
High Impact Change Model (DToC)	Identify how Accommodation with Support activity can support and deliver the eight high impact changes, with particular focus on Change 8: Enhancing Health in Care Homes and supporting Change 5: Seven Day Service and Change 7: Focus on Choice.
Measures	
• A reduction in non-elective admissions (general and acute) • A reduction in long term admissions to residential and care homes • An increase in the average age of admissions to residential and nursing care • Improved effectiveness of reablement • A reduction in delayed transfers of care • The number of older people entering long term residential care direct from hospital as a percentage of all admissions to residential care • Overall satisfaction of people (who use services and live in a residential or nursing home) with their care and support	

2017/19 Plan	Theme: Integrated Care
Purpose	
I tell my story once and know that my needs will be met by high quality competent staff within the health and care system who work together to achieve outcomes important to me.	
How we will achieve this	
This portfolio will develop proactive and jointly delivered care to the most vulnerable people and their carers through the establishment of integrated teams and joint processes that support admission avoidance and timely discharge from hospital	
2017/19 Activity	
Delayed Transfers of Care	• Produce a system wide end to end review and analysis of transfers of care across Warwickshire to understand the multi-factoral blockages and critical improvements to improve DTOC. • Develop and implement a jointly agreed action plan which includes key elements of the High Impact Change Model. Produce a jointly agreed end to end performance dashboard that is accessible by all key agencies. • Secure resources to ensure that access to shared data and intelligence forms the basis of decision making across all agencies in support of improved DTOC.
Home First	• Establish a governance structure and MOU to take forward an integrated Home First model for Warwickshire. • Produce a jointly agreed operating model for the integration of the community health teams with the reablement service. • Establish an agreed outcomes framework and measures of success • Review each business process to produce a single integrated pathway. • Bring together and relevant policies and procedures to optimise an integrated approach to service delivery • Develop an optimised service redesign to deliver improved operational effectiveness and efficiency, improved customer/patient experience and a roadmap over the next 2 years to a seamless and integrated service.
Population Health	Population health has been defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group". It is an approach to health that aims to improve the health of an entire human population. It has been described as consisting of three components. These are "health outcomes, patterns of health determinants, and policies and interventions". A priority considered important in achieving the aim of Population Health is to reduce health inequities or disparities among different population groups due to, among other factors, the social determinants of health, SDOH. The SDOH include all the factors that the different populations are born into, grow up and function with throughout their lifetimes which

2017/19 Plan	Theme: Integrated Care
	potentially have a measurable impact on the health of human populations. The Population Health concept represents a change in the focus from the individual-level, characteristic of most mainstream medicine. It also seeks to complement the classic efforts of public health agencies by addressing a broader range of factors shown to impact the health of different populations. The World Health Organization's Commission on Social Determinants of Health, reported in 2008, that the SDOH factors were responsible for the bulk of diseases and injuries and these were the major causes of health inequities in all countries. In the US, SDOH were estimated to account for 70% of avoidable mortality. The STP will support the delivery of population health at the most appropriate level whereby some services will be based at a population level of 1.5million and others at a much more 'needs based' local level . The Out of Hospital Model of Care will be looking to address the health of the local populations in areas of 30,00 to 50,000.
Integrated Place Based Teams	• Configure fully integrated place based mental health and social care teams around clusters of GP practices. • Embed new mindsets that place prevention and pro-active care at the heart of how integrated teams work. • Explore how teams can have access to shared records.
ICESS	Further integrate the ICESS model and potential for pooled budgets by developing the service to increase take up of Community Equipment and Assistive Technology to reduce the demand for more expensive services. ICESS - Integrated Community Equipment Support Service (commissioned by Warwickshire County Council on behalf of itself and health partners)
Dementia	Implementation of the dementia strategy across multiple partners to increase the reach of support to people newly diagnosed and those living with dementia.
Measures	
• A reduction in non-elective admissions (general and acute) • A reduction in long term admissions to residential and care homes • Increased effectiveness of reablement (Proportion of people given a reablement service by WCC after discharge from hospital, who are free of all services 91 days after starting reablement) • A reduction in delayed transfers of care • Proportion of people who use services, and carers, who find it easy to find information about support • Improved patient satisfaction as recorded by the national GP survey • Proportion of people feeling supported to manage their own long term conditions	

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2017/19 Plan	Theme: Housing Partnership
Purpose	
I have a home of my own with my own front door and have significant or full control of my life. Where appropriate my home is adapted and equipped so that I can live independently and if I need support to enable this independence it is available.	
How we will achieve this	
The Housing Partnership is the key delivery vehicle for the housing related elements of the Warwickshire Cares Better Together Programme. The partnership is committed to delivering a joined up approach to improving outcomes across health, social care and housing. System wide benefits of housing include helping the frail, elderly and vulnerable from being admitted to hospital, be discharged from hospital; and be supported to remain independent in their community. The key improvement activities are outlined in a Housing Partnership Action Plan.	
2017/19 Activity	
Housing Related Support (Non-Statutory Service for adults aged 16+)	• Prevention and early intervention activities to enable people to remain happy, healthy and safe within their own homes and make more suitable housing choices before the point of crisis • Re-model and restructure Housing Related Support to deliver a needs led HRS service where the greatest systemic benefits and improved outcomes can be demonstrated
Development of an integrated approach to Housing, Social Care and Health	• Understanding of the housing estate across the county and the changes necessary to meet the needs of the frail and vulnerable population • Data and intelligence production and validation to identify and target care and support to joint populations of interest • HEART – developing the county wide service to support a reduction in delayed transfers of care, with particular focus on Change 5: Seven Day Service and Change 7: Focus on Choice.
Housing Adaptations and the Disabled Facilities Grant delivered via the HEART service	• Strategic thinking about the use of home adaptations and assistive technology offer to support people to maintain their independence at home and strengthen their resilience • Delivery of statutory and discretionary housing functions designed to improve the quality of people's home environment • Monitor and manage the expenditure against the Disabled Facilities Grant • Develop and enhance the services delivered through HEART including the Information and Advice service, Handyperson service etc

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2017/19 Plan	Theme: Integrated Care
Measures	
• Evidence how housing is contributing to system wide health and care solutions and WCBT Programme Board's 4 priority measurable benefits eg. o Reduction in delayed transfers of care due to housing issues/needs o Reduction in admissions to residential care due to inappropriate / unsuitable housing o Robust quantification of housing related DTOC	

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Our Plan for maintaining progress on the 2016/17 national conditions

A summary of how we continue to maintain progress against these critical integration enablers is summarised as follows:

Condition	Progress update and activity planned for 2017/19
Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admission to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	To be finalised
Better data sharing between health and social care, based on the NHS number	Digital maturity is being developed by all health and social care organisations across Coventry and Warwickshire under the guidance of the established 'Digital Transformation Board' (DTB). The DTB is accountable to the STP for the delivery of the Local Digital Roadmap (LDR). Each organisation is committed to achieving a shared Citizen Electronic Record based initially around record sharing between existing systems by 2020. The NHS number provides a universal identifier across the local area with plans currently being developed to increase interoperability between systems in coming years. It should be noted that each partner is at a different level of maturity in terms of internal electronic record keeping and programmes are underway to increase the breadth and quality of data that can be captured before it can then be shared.
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional.	To be finalised
Agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans.	To be finalised

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Our Plan for 2017/19 – Spending

A summary of planned spend and activity has been allocated to the following schemes and is set out below:

1. Local Authority Contribution – Disabled Facilities Grant

	2017/18 £000's (includes underspend from 2016/17)	2018/19 £'000s
BCF DFG allocations transferred to District / Borough Councils for Housing	**4,632**	**4,185**
North Warwickshire Borough Council	801	649
Nuneaton and Bedworth Borough Council	1,738	1,349
Rugby Borough Council	539	586
Stratford-on-Avon District Council	724	785
Warwick District Council	830	816

The full Disabled Facilities Capital Grant allocation has been pass-ported to the five borough and district councils. In addition, there is a £784k underspend from quarter 4 of 2016/17. The agreed use of the DFG is set out as follows:

Condition	How condition will be achieved
Housing representative to be involved in developing and agreeing the BCF Plan	Nick Cadd, Housing and Communities Manager for Stratford on Avon District Council chairs he Housing Partnership and a member of the Better Together Programme and has been actively engaged in development of the plan.
Each area must continue to meet their statutory duty to provide adaptations to the homes of disabled people including in relation to young people aged 17 and under	All five district and borough councils in Warwickshire, represented on the Housing Partnership have committed to on-going delivery of their statutory duties and this has recently been re-affirmed.
Establish and maintain an information and advice service, and the contribution made by the housing authority and local Home Improvement Agency to the provision of information and advice, particularly around housing issues	Housing Information and Advice is provided in a number of different ways across the county to ensure most reach. For advice and information in a crisis or emergency situation, the Local Housing Options Teams in each of the five borough or district councils provides support. More recently in July 2017, this advice and information service has been enhanced through the contribution of the Trailblazer pilot, providing advice and information to support prevention of homelessness. In addition an Out of Hours housing advice and support service is available county wide 24/7.

	HEART is the local and countywide HIA in Warwickshire, providing advice around housing adaptations, equipment and suitability. More information on how we plan to enhance this service over the next 2 years, is outlined in the Housing Partnership Action Plan.

Our plans for how the countywide HEART service will allocate the Disabled Facility Grant are detailed below:

	2017/18		
	Total £000's	**DFG £000's**	**Non DFG / Other £000's**
North Warwickshire	**596**	328	268
Nuneaton and Bedworth	**1,239**	681	558
Rugby	**539**	539	0
Stratford-on-Avon	**724**	398	326
Warwick	**750**	413	338

Other (non adaptation) works include:

2017/18

- Works to the home to prevent accidents increasing safety and warmth in the home
- Fast track works to assist with hospital discharge
- Adaptations and preventative works to reduce the impact of ill health
- Increased assistance to top up DFG
- Development and enhancement of the service offer including: Information and Advice and a new Handyperson service

	2018/19		
	Total £000's	**DFG £000's**	**Non DFG / Other £000's**
North Warwickshire	**649**	357	292
Nuneaton and Bedworth	**1,349**	742	607
Rugby	**586**	322	264
Stratford-on-Avon	**785**	432	353
Warwick	**816**	449	367

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Other (non adaptation) works include:

2018/19

- Works to the home to prevent accidents increasing safety and warmth in the home
- Fast track works to the home assist with hospital discharge
- Preventative works to reduce the impact of ill health
- Increased assistance to top up DFG
- Development and enchancement of the service offer including: Information and Advice and a new Handyperson service

2. CCG minimum contributions

All three CCGs in Warwickshire have committed more than their minimum contributions as follows:

CCG Minimum Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
NHS Coventry and Rugby CCG	£6,641,659	£6,767,851
NHS Warwickshire North CCG	£11,565,190	£11,784,928
NHS South Warwickshire CCG	£16,095,430	£16,401,243
Total Minimum CCG Contribution	**£34,302,279**	**£34,954,022**

In addition all CCG out of hospital provision has also been included in the fund.

Additional CCG Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
NHS Coventry and Rugby CCG	£2,899,341	£2,853,149
NHS Warwickshire North CCG	£5,326,810	£5,263,072
NHS South Warwickshire CCG	£14,176,220	£14,222,536
Total Additional CCG Contribution	**£22,402,371**	**£22,338,757**

Summary scheme level spending plans are detailed below:

Accommodation with Support	Total Funding	Total Funding
	£'000	£'000
Joint funded CHC packages	2,208	2,248
Residential and Nursing Care	36,479	36,479
Total	**38,687**	**38,727**

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Care at Home	Total Funding	Total Funding
	£'000	£'000
Intermediate care/community teams	8,526	8,755
Carers breaks	842	860
ICES (Health)	3,324	3,381
Domiciliary Care	17,143	17,253
Reablement	4,638	4,726
ICES (Social Care)	1,570	1,600
District and Borough DFGs	4,632	4,185
Total	**40,675**	**40,760**

Integrated Care and Support	Total Funding	Total Funding
	£'000	£'000
Discharge to Assess beds (D2A)	800	801
Discharge to Assess - Pathway 3	349	356
Out of Hospital	28,151	28,151
Moving on beds	489	498
Sub Total - Warwickshire County Council Spending	**489**	**498**
Total	**29,789**	**29,805**

Cross Cutting	Total Funding	Total Funding
	£'000	£'000
Falls Prevention	150	150
Reduction of savings plans	908	1,949
Investment in market stability	2,765	3,170
Reducing pressure on the NHS	1,500	1,565
Meeting adult social care service needs	3,127	3,976
Sub Total - Warwickshire County Council Spending	**8,450**	**10,810**
Total	**8,450**	**10,810**

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3. Additional CCG minimum contributions

Due to fluctuations and revisions in performance data last year, there is no intention to set a local Non Elective Admissions target over and above the CCG plans for 2017/19. Therefore no additional funds have been allocated specifically for this area.

4. iBCF (Additional Social Care Fund)

The additional social care fund has been allocated in the four following ways to meet immediate and growing local pressures:

		2017/18 £000's	2018/19 £'000s
Total iBCF	**Objectives**	**8,300**	**10,660**
Reduction of savings plans	The mitigation activity will enable the Council to: provide additional top up on home care fees to mitigate pressure and sustainability of the market and increase/improve access to home cares thus improving the flow out of hospital; enable increased funding to reduce the risks inherent within the residential and nursing care to improve market sustainability, stop the decommissioning of key services to people living with dementia in the Community and to also reduce the risks to adult social care management budgets because of sustained pressures from elsewhere. In addition the additional money will mean budget cuts will not be as severe in some areas as originally planned eg. care management capacity and support; and building community resilience.	908	1,949
Investment in market stability	1. Market sustainability 2. Provider failure risks reduced 3. Quality of provision increased 4. Increase in end to end flow across health and care through improved market provision. 5. Care provision secured for vulnerable groups.	2,765	3,170
Reducing pressure on the NHS	More timely responses/ intervention (improved flow) achieved through increased capacity (brokerage and OT/Physiotherapists and a reduction in carer breakdown). This includes the recruitment of service improvement managers (with further potential to become trusted assessors).	1,500	1,565
Meeting adult social care service needs	Improved social worker, carer and community capacity to meet and manage demand and deliver transformed services in a new way ensuring sustainability for the future.	3,127	3,976

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Overview of Funding Contributions

The funding contributions for the BCF have been agreed and confirmed by all partners. In the Planning Template we have set out in more detail how we plan to fund our activities over the next two years. The total aligned budget covering the two years of this plan is as follows:

	2017/18 Gross Contribution	2018/19 Gross Contribution
Total Local Authority Contribution exc iBCF	£52,596,000	£52,149,688
Total iBCF Contribution	£8,300,584	£10,659,261
Total Minimum CCG Contribution	£34,302,279	£34,954,022
Total Additional CCG Contribution	£22,402,371	£22,338,757
Total BCF pooled budget	**£117,601,234**	**£120,101,728**

The following funds have also been identified and agreed from the CCG minimum contribution:

	2017/18 £000's	2018/19 £000's
Specified funding	**TBC**	**TBC**
1. Care Act 2014 implementation		
2. Reablement		
3. Carer's breaks		

For more detail please refer to the Planning Template.

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Assessment of Risk and Risk Management

This section summarises the approach to programme and financial risk management and details the risks to this two year plan.

Programme Risk Management

Risks and issues are managed at three levels:

- Project
- Portfolio
- Programme

In the majority of cases risks and issues relating to individual projects are managed by their respective board or lead. A risk and issue register is a critical element of project management and it is necessary for all projects to have one using a recognised risk and issue management methodology, e.g. Prince2. Guidance and support is available to Project Leads and Project Managers from the Better Together programme office.

Portfolio and Project leads have to assure themselves that this is happening consistently within their area. Similarly if project level risks or issues remain immune to mitigating actions the Project Lead can escalate these risks and issues to their respective Portfolio Lead or the Programme Manager.

Portfolio and Project Leads review current risks for their area on a regular basis with the intention of identifying risks that are impacting on one or projects simultaneously. These risks or issues may be considered minor within each individual project but may cumulatively have a big impact on the overall programme. Portfolio Leads will be responsible for:

- Identifying Portfolio level risks and issues
- Ensuring a risk and issue register for their area is maintained and regularly reviewed
- Ensuring risks and issues are reported in the Portfolio Summary for the programme board every 6 weeks. The Programme Manager then identifies potential programme level risks and mitigation.

Regular reporting to our programme board of risks, issues, performance and finances has proven critical in maintaining a focus on this priority and galvanising partners across the system to take action.

Risk management arrangements for the programme will continue as agreed at the beginning of the programme and as reflected in our section 75 agreement:

- Under overspends will be the responsibility of the contracting partner, Local Authority or relevant CCG.
- Scheme leads are responsible for leading and coordinating the development of new activities and developments which may change patterns of spending.

- Budgetary control responsibility for the day-to-day management of the services within budget, remains with the relevant budget holders within the partner organisation pending the money.

Risks will continue to be reported on by exception to programme board so that all partners are fully informed. Risks will be actively managed by the partner who has most control over the area within which the risk is identified.

Any risks that impact more than one partner in equal measure will be subject to decision making at the programme board with the option of escalation to the HWB Executive team.

Financial Risk Management

During 2016/17 pooled budgets and financial risk sharing arrangements were tested in two areas; career support and all commissioning arrangements with Age UK. These risk share arrangements and developments have built confidence in a methodology, which will enable financial risk sharing to become increasingly possible. Using this methodology, options for a more mature approach to risk sharing across partners and in particular financial risk sharing is underway. These options will be discussed by partners (strategic commissioning and finance leads from the three CCGs and Warwickshire County Council) at a workshop in September 2017 where we intend to agree a new approach. This new approach will be developed during quarter three 2017/18 to support the 2018/19 spending plans.

Identified risks to delivery of our 2017/19 plan

The top five system wide risks have been identified which may impact successful delivery of our plan and associated realisation of benefits.

1. Poor and inconsistent data quality. This has and continues to undermine confidence in a number of areas including the DToC project, where inconsistency and poor recording means it has been difficult to agree county wide actions.
2. Due to risks associated with provider failure in the domiciliary care market and the associated impact on non-elective admissions, iBCF money has been allocated to set up a Rapid Response Team to provide cover.
3. Due to risks associated with late discharges from A&E and the associated impact on delayed transfers, iBCF money has been allocated for A&E on call support to get people home out of hours and support them until mainstream support can take over.
4. Data Sharing/Information Governance remains a real challenge for the system in terms of both direct health and care delivery and in terms of strategic partnership working. Legislation still lags behind the work we are expected to do and the approach we are expected to take. Clarity and support at a national level are urgently required.

For more detail please refer to the risk log – Appendix B.

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National Metrics

Non-Elective Admissions

Warwickshire have made no changes to the target set out by the BCF Team in the Planning Template which is consistent with submitted CCG plans. The reason for this is that NEA per 100k in 2016/17 saw growth of 6% in South Warwickshire CCG, -1.7% in Warwickshire North CCG and 2.6% in Coventry & Rugby CCG. In addition, the overall Warwickshire activity plan shows a 2.3% growth in 2017/18 and a -0.7% growth in 2018/19. This is against underlying population growth of 2.5% in 2017/18 and 2.4% in 2018/19.

Residential Admissions

In 2016/17, the rate of new permanent admissions to residential and nursing care was 470 admissions per 100k population. This is a 15% reduction on performance for 2015/16. Investigations suggest that a significant contributor for this reduction, which began in Q2 2016/17, was the work undertaken by the Older People's teams to place people aged 75+ into community alternatives (home care packages) at the first point of contact, rather than into a permanent placement. We have set a stretching yet realistic target for 2017/18 and 2018/19 which is to maintain 2016/17 performance. The reason for this is because we will be placing significant focus on DToC in Warwickshire, which may have an impact on other metrics, including this one. If however, despite this, we maintain current performance levels, the current forecast for 2017/18 is 425 admissions per 100k population.

Reablement

In 2016/17 87.9% of older people (65+) were still at home 91 days after discharge from hospital into reablement / rehabilitation services. This performance did not meet the target of 90.4% but did meet the adjusted target of 86.8% which was agreed upon once 2015/16 performance was available (84%). This new target represented a statistically significant improvement on 2015/16 performance. Given that the 2017/19 targets for delayed transfers of care are so stretching and that the HomeFirst service is not yet fully integrated, we have agreed to set a stretching yet realistic target for this metric. Therefore the target for 2017/18 and 2018/19 is 89%. This has been calculated by applying the population growth for those aged 65+ to the number of people offered this service in 2016/17.

Note: It should be noted that the targets for 2017/19 only include the performance for reablement. In previous years both the figures for the target and performance (including 2016/17) included the performance of both reablement and CERT. However, in the process of completing the SALT submission for 2016/17, it has been identified that CERT patients should not be included in the performance for this particular measure.

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Managing Delayed Transfers of Care (DToC)

Warwickshire have made no changes to the target set by the BCF Team in the DTOC Metric template. The plan for the months of Jul-17 to Oct-17 (Q2 & Q3 17/18) represents a straight line trajectory from the average performance in Jan-May 2017 (Q4 16/17 - Q1 17/18) to the target set for Nov-17 (halfway through Q3 17/18). It is assumed that this target will then be maintained for the remainder of 2017/18 and throughout 2018/19. This target requires a 54% reduction on the 2017 performance by Nov-17 for all Warwickshire days delayed. In other words, on an average day in 2017 to date, there were 87 delayed Warwickshire residents occupying a hospital bed. By Nov-17 the target is to reduce this to 40 delayed Warwickshire residents occupying a hospital bed on average day (a reduction of 9 every month for 5 months). The target for Social Care is even more stretching and requires a 63% reduction (from 50 to 19 delayed Warwickshire residents occupying a hospital bed on an average day).

For this to be achieved by November 2017 is clearly unrealistic, but we are putting plans and activities in place to achieve this ambition during 2017/19.

Note: In 2016/17 22% of Warwickshire's days delayed were due to patients in non-acute settings. It is much harder to achieve the 3.5% target in community settings and in the past this has been recognised. South Warwickshire also has the added complication of hosting he Central England Rehabilitation Unit (CERU). This accounts for 25% of our days delayed and previously has this has been recognised and the target adjusted accordingly. Clarity is currently awaited from NHSE regarding the overall south Warwickshire and Warwickside wide target for DTOC.

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Approval and sign off

The activities, funding and performance targets summarised in this plan and detailed in the Planning Template have been agreed by:

- all partners of the Better Together Programme Board at its meeting on the 17th August 2017
- South Warwickshire CCG on the 20th August 2017
- Coventry and Rugby CCG on the 21st August 2017
- Warwickshire North CCG on the 24th August 2017

And approved by the Warwickshire Health and Wellbeing Board at its' meeting on the 6th September 2017.

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Appendices

A Warwickshire Cares Better Together programme management and governance framework

B RAID Log

C JSNA Geographical Profiles

D 2016/17 – WCBT Case Studies