Health and Wellbeing Board

Date: Wednesday 17 November 2021
Time: 9.00 am
Venue: Committee Room 2, Shire Hall

Membership
Councillor Margaret Bell (Chair)
Councillor Jeff Morgan
Councillor Jerry Roodhouse
Councillor Isobel Seccombe OBE
Councillor Marian Humphreys
Councillor Julian Gutteridge
Councillor Howard Roberts
Councillor Jo Barker
Councillor Jan Matecki

Warwickshire County Council Officers: Shade Agboola and Nigel Minns

Coventry and Warwickshire Clinical Commissioning Group: Sarah Raistrick

Provider Representatives: Russell Hardy (South Warwickshire NHS Foundation Trust and George Eliot Hospital NHS Trust), Dame Stella Manzie (University Hospitals Coventry & Warwickshire), Dianne Whitfield (Coventry and Warwickshire Partnership Trust)

Healthwatch Warwickshire: Elizabeth Hancock

NHS England: Julie Grant

Police and Crime Commissioner: Polly Reed (Office of the PCC)

Items on the agenda: -

1. General

(1) Apologies

(2) Members' Disclosures of Pecuniary and Non-Pecuniary Interests

(3) Chair's Announcements

Discussion items

2. **Better Care Fund Submission** 5 - 58

The Board is asked to support the submission of the Better Care Fund Plan to NHS England.

Monica Fogarty
Chief Executive
Warwickshire County Council
Shire Hall, Warwick

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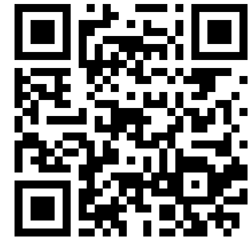

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- Not participate in any discussion or vote
- Leave the meeting room until the matter has been dealt with
- Give written notice of any unregistered interest to the Monitoring Officer within 28 days of the meeting

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The public reports referred to are available on the Warwickshire Web https://democracy.warwickshire.gov.uk/uuCoverPage.aspx?bcr=1

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Agenda Item 2

Health and Wellbeing Board

Better Care Fund 2021/22 Plan Submission

17 November 2021

Recommendation(s)

The Board is recommended to support the submission of the Better Care Fund Plan to NHS England.

1. Executive Summary

1.1 The Better Care Fund (BCF) is a programme spanning both the local government and the NHS which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.

Better Care Fund Policy Framework 2021/22

1.2 Earlier in the year, Health and Wellbeing Boards (HWBs) were advised that BCF policy and planning requirements would be published and that similar to previous years prior to the Covid-19 pandemic, HWBs would be required to submit their BCF Plans to NHS England for approval.

1.3 The Better Care Fund 2021/22 Planning Requirements published on the 30th September 2021, set out the template for Health and Wellbeing Boards (HWBs) to submit their annual plans for approval.

For 2021-22, BCF plans will consist of:

- A narrative plan
- A completed BCF planning template, including:
  - Planned expenditure from BCF sources.
  - Confirmation that national conditions of the fund are met, as well as specific conditions attached to individual funding streams.
  - Ambitions and plans for performance against BCF national metrics.
  - Any additional contributions to BCF section 75 agreements.

1.4 The deadline for submission of the BCF plan to NHS England is the 16th November 2021.

National Conditions

1.5 The Better Care Fund Policy Statement for 2021-22 provides continuity to previous years of the programme. The policy framework outlines the four national conditions:

1. **A jointly agreed plan between local health and social care commissioners and signed off by the Health and Wellbeing Board** - That a BCF Plan, covering all mandatory funding contributions have been agreed by Health and Wellbeing Board (HWB) areas and minimum contributions (specified in the BCF allocations and grant determinations) are pooled in a section 75 agreement (an agreement made under section 75 of the NHS Act 2006) by the constituent local authorities (LAs) and CCG.

2. **NHS contribution to adult social care to be maintained in line with the uplift to Clinical Commissioning Group (CCG) minimum contribution** - The contribution to social care from the CCG via the BCF is agreed and meets or exceeds the minimum expectation. In 2021/22 for Warwickshire the minimum contribution is £14.455m.

3. **Agreement to invest in NHS commissioned out-of-hospital services** - That a specific proportion of the area's allocation is invested in NHS commissioned out-of-hospital services, while supporting integration plans. In 2021/22 for Warwickshire the minimum contribution is £11.552m.

4. **Plan for improving outcomes for people being discharged from hospital** – (national condition 4 – managing transfers of care) Ensure there is an agreed approach to support safe and timely discharge, including ongoing arrangements to embed a home first approach. BCF plans already include expenditure to support discharge and plans for 2021-22 should set out how BCF funding aligns in support of discharge. This should include:
   - How collaborative commissioning of discharge services is supporting this.
   - Providing details in the BCF planning template of planned spend on discharge related activity.
   - How joint health and social care activity will contribute to the improvements agreed against BCF national metrics for discharge (reducing the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days).

1.6 The Clinical Commissioning Group and local authority are required to confirm compliance with the above conditions to the Health and Wellbeing Board. Compliance with the national conditions will be confirmed through the planning template and narrative plans. Spend applicable to these national conditions will be calculated in the planning template based on scheme-level expenditure data.

1.7 The CCG and local authority are also required to ensure that local providers of NHS and social care services have been involved in planning the use

of BCF funding for 2020 to 2021. In particular, activity to support discharge funded by the BCF should be agreed as part of the whole system approach to implementing the Hospital Discharge Service Policy and should support an agreed approach for managing demand and capacity in health and social care. This continues to be achieved through the Better Together Programme and Joint Commissioning Board.

2. Financial Implications

Grant Funding to Local Government

2.1 **Improved Better Care Fund (iBCF)** – The County Council's Corporate Board and the Clinical Commissioning Group approved the proposed schemes to be funded from the iBCF in 2021/22 at their respective meetings on the 13th January 2021. Since then, in May 2021 the grant determination for the Improved Better Care Fund was issued and confirmed that since 2020-21 funding that was previously paid as a separate grant for managing winter pressures would continue to be included as part of the iBCF grant but is not ringfenced for use in winter. Overall allocations for BCF revenue and capital grants to local government for each local authority remain the same in cash terms as in 2020-21.

2.2 The grant conditions remain broadly the same as 2020-21. The funding may only be used for the purposes of:

- Meeting adult social care needs.
- Reducing pressures on the NHS, including seasonal winter pressures.
- Supporting more people to be discharged from hospital when they are ready.
- Ensuring that the social care provider market is supported.

2.3 In addition, all iBCF schemes also support the local health and care system respond to priorities set out in:

a) Local Place Based and Acute Winter Delivery Agreements and Winter Pressures Plans required by NHS England and NHS Improvement; and
b) The national Hospital Discharge and Community Support Policy and Operating Model published on 05th July 2021.

2.4 **Disabled Facilities Grant** - Ringfenced DFG funding continues to be allocated through the BCF and will continue to be paid to upper-tier local authorities. The statutory duty to provide DFGs to those who qualify for them is placed on local housing authorities.

2.5 Similar to previous years, the Disabled Facilities Grant continues to be allocated through the Better Care Fund through top tier authorities due to its importance to the health and care system and is pooled into the BCF to promote joined-up approaches to meeting people's needs to help support more people of all ages to live in suitable housing so they can stay independent for longer. Creating a home environment that supports people to live safely and independently can make a significant contribution to health and

wellbeing, and is an integral part of our integration plans, and strategic use of the DFG can support this. The amounts allocated to the District and Borough Councils are pass-ported straight to them and monitoring of expenditure takes place at the Heart Board, with assurance through the Housing Partnership Board, a sub-group of the Better Together programme, as decisions around the use of the DFG funding need to be made with the direct involvement of both tiers working jointly to support integration.

Financial contributions

2.6 Funding sources and expenditure plans:

		2021/22		
		Pooled Contribution	**Aligned Allocation**	**Total Budget**
		£'000	**£'000**	**£'000**
Minimum NHS ring-fenced from CCG allocation	C&W CCG (SW Place)	19,074	44,345	**63,419**
	C&W CCG (WN Place)	13,576	22,568	**36,143**
	C&W CCG (Rugby Place)	7,842	13,725	**21,566**
Disabled Facilities Grant (DFG)		5,124	-	**5,124**
Warwickshire County Council Improved Better Care Fund (iBCF)		14,688	-	**14,688**
Warwickshire County Council		-	68,590	**68,590**
Total Pooled Contribution		**60,304**		
Total Additional Aligned Allocation			**149,227**	
Total Budget				**209,530**

* Notes:

1) The above table is rounded to £000's for summary purposes.
2) Areas can agree to pool additional funds into their BCF plan and associated section 75 agreement(s). These additional contributions are not subject to the conditions of the BCF but should be recorded in the planning template.
3) Please refer to the attached Appendix for more detail on funding contributions and spending plans.
4) All finances in the BCF Plan 2021/22 have been prepared by the Finance Sub-Group in which Finance Leads from both the Local Authority and CCG are represented.

2.7 Local Areas are also expected to keep records of spending against schemes funded through the BCF. This activity is led by Finance Leads at WCC and the CCG on the Finance Sub-Group which supports the Better Together Programme and assurance is through the Joint Commissioning Board.

iBCF funding can be allocated across any or all of the four purposes of the grant in a way that local authorities, working with CCG(s), determine best meets local needs and pressures. No fixed proportion needs to be allocated across each of the purposes. The grant conditions for the iBCF also require that the local authority pool the grant funding into the local BCF and report as required through BCF reporting.

Mandatory funding sources

2.8 The following minimum funding must be pooled into the Better Care Fund in 2021/22:

Funding Sources	**2021/22**
DFG	£5,124,786
Minimum CCG Contribution	£40,490,953
iBCF	£14,688,367
Total	**£60,304,106**

Financial Implications

2.9 The programme and initiatives for its success are in part funded through national grants: Better Care Fund, Improved Better Care Fund and Disabled Facilities Grant (2021/22: £60.3m). The former comes from the Department of Health and Social Care through the Clinical Commissioning Group, while the latter is received by the local authority from Department for Levelling Up, Housing and Communities. All three are dependent on meeting conditions that contribute towards the programme and the targets, and that plans to this effect are jointly agreed between the Clinical Commissioning Group and the Local Authority under a pooled budget arrangement.

2.10 Similar to previous years the County Council continues as the pooled budget holder for the fund.

2.11 The County Council also continues to align Out of Hospital service provision and funding with Coventry and Warwickshire Clinical Commissioning Group to support closer integration as part of plans for moving to an Integrated Care System.

2.12 The iBCF is temporary and is awaiting a national Social Care funding review. In order to counter the risk inherent in temporary funding, all new initiatives are temporary or commissioned with exit clauses. There are, however, a number of areas where the funding is being used to maintain statutory social care spending and this would require replacement funding if the Better Care Fund was removed without replacement. This risk is noted in Warwickshire County Council's annual and medium-term financial planning.

2.11 As in previous years, a Section 75 Legal Agreement will underpin the financial pooling arrangements. This cannot be signed until our Plan is nationally approved. In order to avoid under delivery and underspends, schemes and initiatives have to be entered into prior to the legal agreement being signed, but this is no different to previous years. The intention is that the Section 75 agreement will be drafted so that it can be signed by the partner organisations as soon as approval is granted.

3. Environmental Implications

3.1 None

4. Supporting Information

Metrics

4.1 The BCF Policy Framework sets national metrics that must be included in BCF plans in 2021-22. Ambitions should be agreed between the local authority and CCG and signed off by the HWB.

4.2 The framework retains two existing metrics which impact the local authority from previous years:
- effectiveness of reablement (proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation
- older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population.

4.3 The previous measure on non-elective admissions has been replaced by a measure of avoidable admissions (unplanned hospitalisation for chronic ambulatory care sensitive conditions). Areas need to agree expected levels of avoidable admissions and how services commissioned through the BCF will minimise these.

4.4 With regard to Discharge Metrics – areas are also required to agree ambitions and a plan to improve outcomes across the HWB area for the following measures:
- Reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days.
- Improving the proportion of people discharged home using data on discharge to their usual place of residence.

4.5 The proposed ambitions and rationale are set out in the Planning Template and Narrative Plan.

4.6 Locally we will continue to monitor progress quarterly against the BCF metrics set out above through the Joint Commissioning Board and Coventry and Warwickshire A&E Delivery Board.

5. Timescales associated with the decision and next steps

5.1 Prior to approval by the Health and Wellbeing Board, the BCF Plan for 2021/22 has been reviewed and approved by:

Organisation	Board	Date
WCC	People Directorate Leadership Team	27/10/21
Partnership	Joint Commissioning Board - virtual	01/11/21
WCC	Corporate Board	02/11/21
CCG	Finance and Performance Committee Approved on behalf of the Governing Body who will ratify decision on	03/11/21 17/11/21
WCC	Cabinet via an Urgent Decision by the Leader of the Council	11/11/21
Submission date		**16/11/21**
Partnership	Health and Wellbeing Board	17/11/21

Regional and National Assurance

5.2 NHS England will approve BCF plans in consultation with the Department for Health and Social Care and the Department for Levelling Up, Housing and Communities. Assurance processes will therefore resume in 2021/22 to confirm that national conditions are met, ambitions are agreed for all national metrics and that all funding is pooled, with relevant spend agreed. Assurance of plans will be led by Better Care Managers (BCMs) with input from NHS England and local government representatives and will be a single stage exercise based on a set of key lines of enquiry. Once approved - NHS England, as the accountable body for the CCG minimum contribution to the fund, will write to areas to confirm that the CCG minimum funding can be released.

Assurance activity	Date
BCF planning requirements received	1 October 2021
Optional draft BCF planning submission submitted to BCM	By 29 October 2021
Review and feedback to areas from BCMs	By 2 November 2021
BCF planning submission from local HWB areas (agreed by CCG and WCC) sent to national BCF Team at NHS England	16 November 2021
Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation	16 November to 7 December 2021
Regionally moderated assurance outcomes sent to national BCF team	7 December 2021
Cross-regional calibration	9 December 2021
Approval letters issued giving formal permission to spend (CCG minimum)	From 11 January 2022
All section 75 agreements to be signed and in	31 January 2022

place	

Appendices
1. Appendix 1 – Better Care Fund 2021/22 Narrative Plan
2. Appendix 2 – Better Care Fund 2021/22 Planning Template

Background Papers
None.

	Name	Contact Information
Report Author	Rachel Briden	rachelbriden@warwickshire.gov.uk
Assistant Director	Becky Hale Assistant Director People Strategy and Commissioning	beckyhale@warwickshire.gov.uk
Strategic Director	Nigel Minns Strategic Director for People	nigelminns@warwickshire.gov.uk
Portfolio Holder	Councillor Bell	margaretbell@warwickshire.gov.uk

The report was circulated to the following members prior to publication:

Local Member(s): n/a
Other members: Councillors Golby, Holland and Drew

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Integration and Better Care Fund (BCF) Plan

Better Care Fund Plan 2021/22 Submission – version 0.6

Health and Wellbeing Board (HWBB):

Warwickshire

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National Condition 1: A jointly agreed plan

Planning Requirement 1 - A jointly developed and agreed plan that all parties sign up to

Partnership Working and Engagement

The following organisations have been involved in developing the schemes and joint integration activities as set out in this Better Care Fund (BCF) Plan for 2021/22 (and supporting BCF Planning Template), that will be submitted to NHS England for assurance:

- Representatives on the Joint Commissioning Board:
  - Commissioning, delivery and finance leads from children/young people and families (including Education), public health and adult social care from Warwickshire County Council (WCC);
  - Clinical, commissioning and finance leads from Coventry and Warwickshire Clinical Commissioning Group (CWCCG);
  - Operational and contracting leads from South Warwickshire NHS Foundation Trust Out of Hospital Collaborative (SWFT) and Coventry and Warwickshire Partnership Trust (CWPT);
  - Office of the Police and Crime Commissioner for Warwickshire, and Warwickshire Police Safeguarding Team;
  - Head Teacher representatives
- Acute Trusts (South Warwickshire NHS Foundation Trust, George Eliot Hospital NHS Trust and University Hospital Coventry and Warwickshire NHS Trust) and Coventry City Council through the Coventry and Warwickshire A&E Delivery Board.
- The five District and Borough Councils (Stratford Upon Avon District Council, Warwick District Council, Nuneaton and Bedworth Borough Council, Rugby Borough Council and North Warwickshire Borough Council) through the Better Care Fund Housing Partnership Board.
- Social care providers through Quarterly Provider Forums.
- VCS organisations through Place Based Partnerships, local Working Together Boards (Out of Hospital Collaborative) and neighbourhood Place Based Teams.

Preparatory Activity

In advance of receipt of the Better Care Fund Policy Framework and Planning Requirements, draft schemes, activities and priorities to be delivered through the Better Care Fund local delivery programme (the Better Together Programme) were discussed and agreed in meetings and through wider engagement between October 2020 and February 2021 with the partners listed above, ready for the start of the 2021/22 year. In September 2021 Warwickshire County Council also shared details of how the BCF funded schemes are contributing to place based winter plans.

Preparing the BCF Plan

Following receipt of the BCF Planning Requirements on the 1st October 2021 – the stakeholders represented on the Joint Commissioning Board and Coventry & Warwickshire A&E Delivery Board (listed above) have been re-engaged during October 2021 to reaffirm and update, where required, the schemes, activities and new metrics.

Approval of the BCF Plan

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 contribution and iBCF) and set out in more detail in the Planning Template.

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Approval timetable

The following confirms the governance route for signing off the plan:

Organisation		Decision / Approval Date
WCC	People Directorate Leadership Team	27/10/21
Wider Partnership	Joint Commissioning Board	01/11/21
WCC	Corporate Board	02/11/21
CCG	Finance and Performance Committee approved the plan on behalf of the Governing Body who will ratify decision on	03/11/21 17/11/21
WCC	Cabinet via an urgent decision by the Leader of the Council	11/11/21
Submission date		**16/11/21**
Partnership	The Health and Wellbeing Board's approval is pending. The HWBB is meeting to approve the plan on:	17/11/21

Responsibilities for preparing this plan

Accountable: Becky Hale, Assistant Director People Strategy and Commissioning, Warwickshire Council (WCC) and Chair of the Warwickshire Joint Commissioning Board.

Responsible: Rachel Briden, Integrated Partnership Manager, WCC.

Consulted: All partners represented on the Warwickshire Joint Commissioning Board, Warwickshire County Council's Corporate Board and Cabinet, Coventry and Warwickshire CCG Executive Team and Governing Body and Coventry and Warwickshire's A&E Delivery Board.

Informed: Warwickshire Health and Wellbeing Board

Document History

Version	Summary of changes	Author	Date
V0.1	Draft version shared within WCC	Rachel Briden	14/10/21
V0.2	Draft version shared with People DLT with finances and health inequalities section added	Rachel Briden	26/10/21
V.03	Version for sign off by Corporate Board and the CCG following feedback on the sign-off process	Rachel Briden	27/10/21
V.04	Version shared with Joint Commissioning Board with updated links to the HICM	Rachel Briden	28/10/21
V0.5	Updated out of hospital programme illustration	Rachel Briden	02/11/21
V0.6	Updated template with CCG Joint Funding scheme splits and narrative plan with reference to HEART improvement plan	Rachel Briden	03/11/21

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Executive Summary

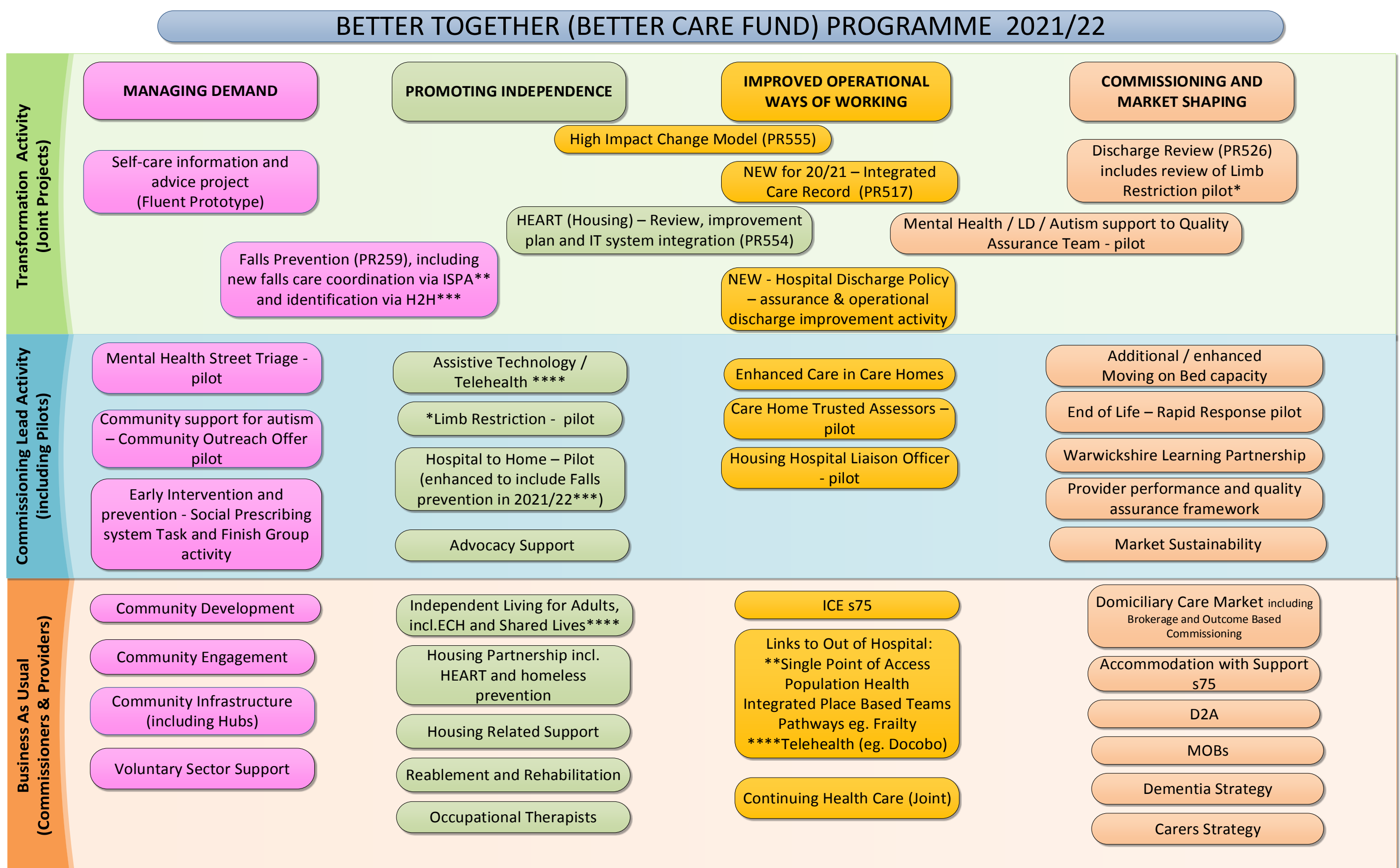
Background

The Better Care Fund has been one of the key contributors over the last six years towards building stronger partnerships and integration between the commissioners and providers of health and care services in Warwickshire. 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. The foundations are therefore in place for the services currently commissioned through the Better Care Fund to move into the geographical collaboratives of the new Coventry and Warwickshire Integrated Care System, in Phase 1 (2022/23).

Locally our BCF Plan for 2021/22 will continue to build on our long-term vision, as outlined in our original submission in 2015/16, our updated 2017-19 plan, and builds on the progress made from 2016-21.

The majority of schemes and activities in our BCF plan for 2021/22 continue on from previous years, under the following portfolio areas: community resilience; care at home; accommodation with support; integrated care and support; housing and cross-cutting schemes.

The illustration below summarises the schemes in our BCF Plan:



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Joint Priorities for 2021/22

At the beginning of the year, five additional areas of focus aimed at wrapping support around people closer to home or in their own home, rather than in an acute based or 24-hour setting were agreed as part of our BCF plan:

1. An increased focus on improved support for mental health through piloting a Mental Health / Learning Disabilities and Autism Practitioner in the Quality Assurance Team;
2. Strengthening support for P0 and P1 discharges by enhancing the Hospital to Home offer to include falls prevention screening and support;
3. Completion of the system wide review of the Discharge to Assess commissioning model (Pathways 1, 2 and 3) and subsequent re-design of D2A Pathway 2 bed-based therapy to more Pathway 1 home-based support; and
4. Transformation project activity delivered through the Better Together programme:
    a. Implementation of a new falls prevention and falls pathway for repeat falls,
    b. Implementation of a new shared care record across health and social care across Coventry and Warwickshire; and
5. Co-ordination of the operational discharge improvement activity to deliver the Ageing Well Hospital Discharge and Recovery programme across both Coventry and Warwickshire.

Midlands Ageing Well Priorities

Urgent Community Response – 2hr Crisis Response

- Use of long term plan (SDF) funding within each ICS/STP
- Achievement of 7 day 8 – 8 ambition of community provision country wide by April 2022
- Link with 111/999, enabling direct referrals
- Data quality and improvement – community services data set and national UCR dashboard

Enhanced Health in Care Homes (EHCH)

- Joined up Care programme
- Better Security Better Care programme
- NHS mail - provision of secure email to care providers
- Shared Care Records programme
- Proxy ordering of medicines
- Dementia care and Older Person's Mental Health
- Falls, Strength & Balance
- Wounds of the Lower Leg
- Palliative & End of Life Care (in Care Homes)

Anticipatory Care (AC)

- Embed a cycle of AC within systems – reduce variation in the delivery of AC at neighbourhood level
- Deliver a minimum set of recommended clinical and non-clinical interventions (Publication operating model, Q2)
- Development of a limited menu of advanced risk stratification tools
- Anticipatory Care system level posts in place to map local maturity, identify best practice/emerging evidence of impact (funding for posts, £100k pa, from Q3)

Hospital Discharge and Recovery Programme

- Continued focus on embedding of home first discharge to assess.
- Understanding system flow through pathways 0,1,2 and 3 – demand, capacity. LOS and improved use of data
- Integrated commissioning of pathways across health & social care
- Out of area flows
- Understanding and resolving constraints, barriers and reasons for delays
- Continue established links with acute and community LOS, 7, 12 and 21 day metrics

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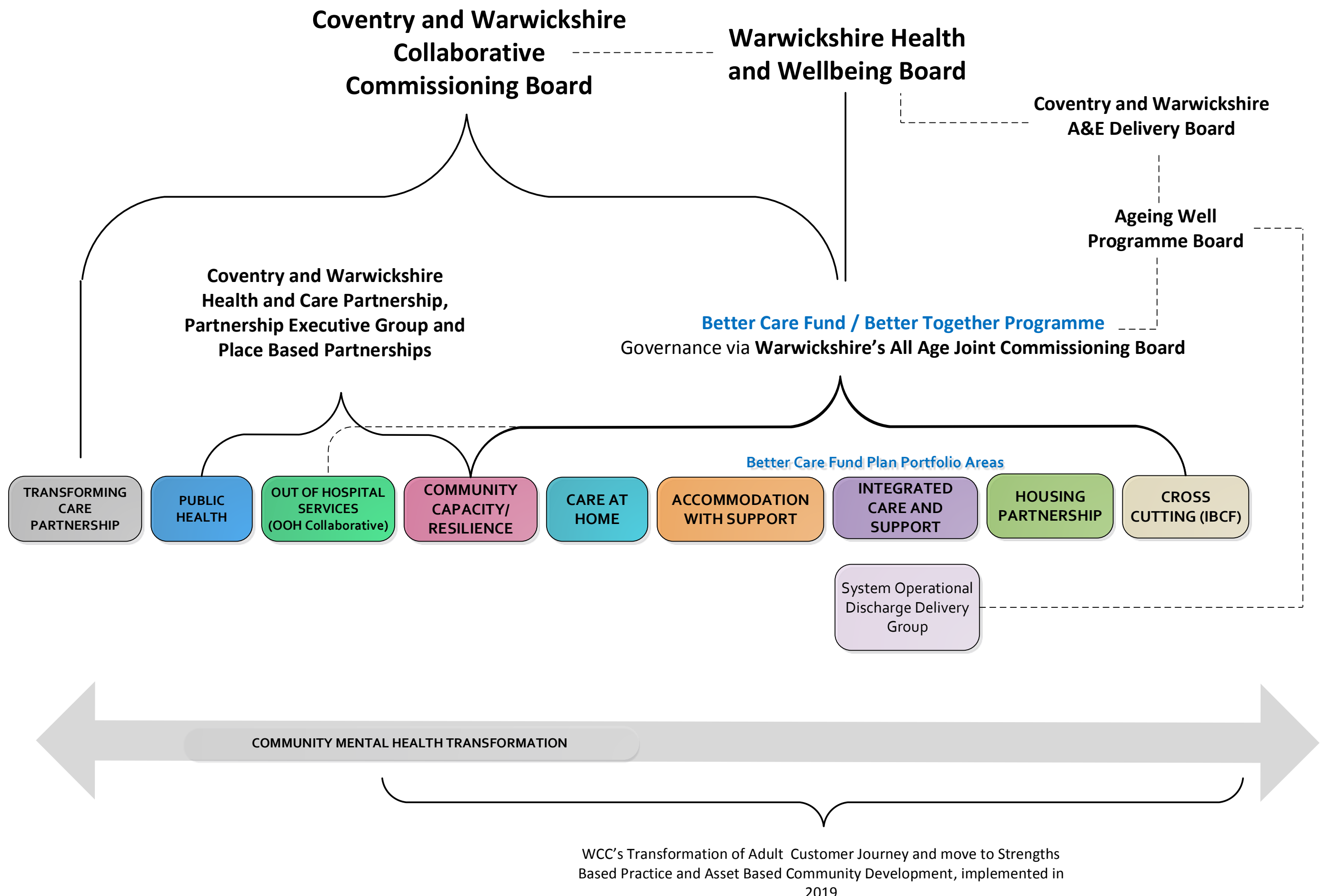
Governance

In Warwickshire the mechanism for joint health, housing and social care planning is through the Better Together Programme.

In April 2020 in response to the Covid-19 pandemic, the Better Together Programme Board was stood down and since then governance of implementation of the Better Care Fund, BCF Plan and Better Together Programme has been through the new all age Warwickshire Joint Commissioning Board. The schemes and services commissioned and delivered through the BCF have been central to our local Covid-19 response and recovery plans and it has been beneficial to consider this into wider joint commissioning activity and the Hospital Discharge Policy, Requirements and associated Hospital Discharge Grant.



Our BCF Plan comprising of the pooled/aligned budgets, list of schemes, metrics and priorities outlined in the Planning Template and this Narrative Plan have been developed by the Joint Commissioning Board, as part of these wider partnership and system governance arrangements.

The Board is supported by a Finance Sub-Group (comprising of Finance Leads from the local authority and CCG) which leads on scheme level spending plans for the pooled (base BCF) and aligned budgets, claims to the Hospital Discharge Grant, risk share and associated Section 75 arrangements.

The BCF Plan prepared and agreed by the Joint Commissioning Board and Finance Sub-Group has also been approved by the relevant governing bodies (WCC's Corporate Board, and Cabinet; and the CCG's Governing Body) before being submitted and will be signed off on the day after the submission deadline by the Health and Wellbeing Board.

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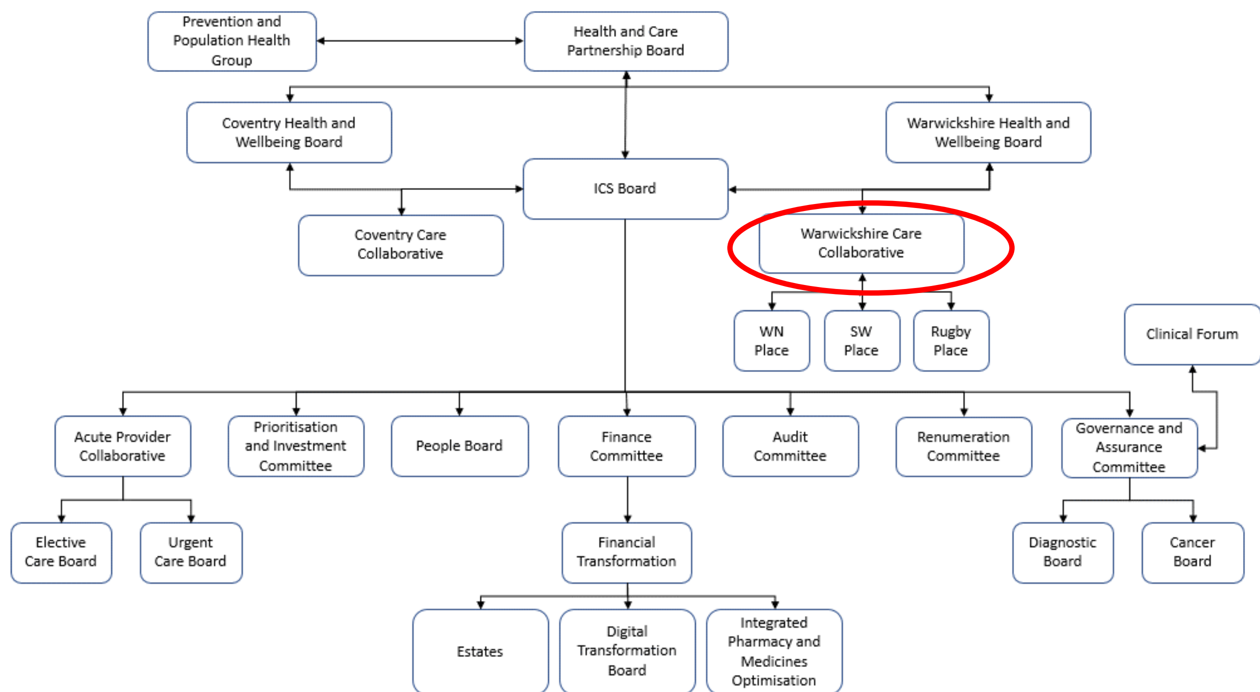
Future governance arrangements

The Coventry and Warwickshire Integrated Care System is currently being developed with a focus on clarifying where functions will be delivered in future and the required form to enable this. The illustration below summarises current thinking in relation to the Coventry and Warwickshire system architecture.

There is mutual agreement that the Better Care Fund will become a responsibility of the Warwickshire (and Coventry) Care Collaborative in future. The Warwickshire Care Collaborative will be supported by a host organisation to deliver its functions.



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Planning Requirement 2 - A clear narrative for the integration of health and social care

Overall approach to integration

Health, social care and wider partners within Warwickshire and Coventry have developed a variety of integrated and joint working arrangements to date. These are the foundation for further design and development of the Coventry and Warwickshire ICS.

Appendix 1 provides a summary of the current arrangements in place including joint commissioning, partnerships, funding and strategies, lead commissioning arrangements and integrated approaches to quality assurance, training and market management.

Led through the CCG, system partners are currently working together to co-design the Coventry and Warwickshire ICS. Aligned to the various guidance documents, work is underway to confirm the functions and configuration of the Coventry and Warwickshire Integrated Care Board (ICB) and Integrated Care Partnership (ICP).

Work is also underway to respond to the Thriving Places guidance specifically to agree:

- The configuration, size and boundaries of the ICS's places
- The system responsibilities and functions to be carried out at place level
- The planned governance model, including membership, decision making arrangements, leadership roles as well as agreed representation on, and reporting relationships with, the ICP and ICB

The Coventry and Warwickshire ICS will largely be operating through two geographic Collaboratives; a Coventry Care Collaborative and a Warwickshire Care Collaborative. These collaboratives will be a partnership of providers and commissioners of health and care, willing and capable to take on commissioning and delivery functions and resource delegated by the ICS. They will share accountability for delivering goals set by the ICS – a key goal being to transform the delivery of health and care services so that there is greater integration that deliver benefits for both our population and staff working in our system.

There will be a 'Host Organisations' for the respective Coventry and Warwickshire Collaboratives. The host will manage the resource delegated from the ICB and will be an enabler and facilitator for delivery. Within Warwickshire there is commitment to integrate commissioning resource between the NHS and local authority as part of this host function.

With support from the local authority, the CCG is currently undertaking work to co-design a functional operating model for the Warwickshire Care Collaborative.
Collaborations around specific areas are being considered and will be progressed where there is a clear scope and benefit, e.g., acute care, mental health, children and young people.
Within Warwickshire, the Care Collaborative will have a clear relationship with the lead providers operating within our three health and wellbeing partnerships in Warwickshire North, Rugby and South Warwickshire. The relationship between the Warwickshire Care Collaborative and the health and wellbeing partnerships will be critical to the delivery of the overall goals of the ICS and must be mutually enabling.

The initial scope for year one of the geographic collaboratives includes the Better Care Fund and the following:

- Acute NEL and A&E attendances;
- Out of Hospital;
- Any adult hospices that have not been incorporated into the Out of Hospital contracts;
- Community diagnostic services;

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Current integration arrangements

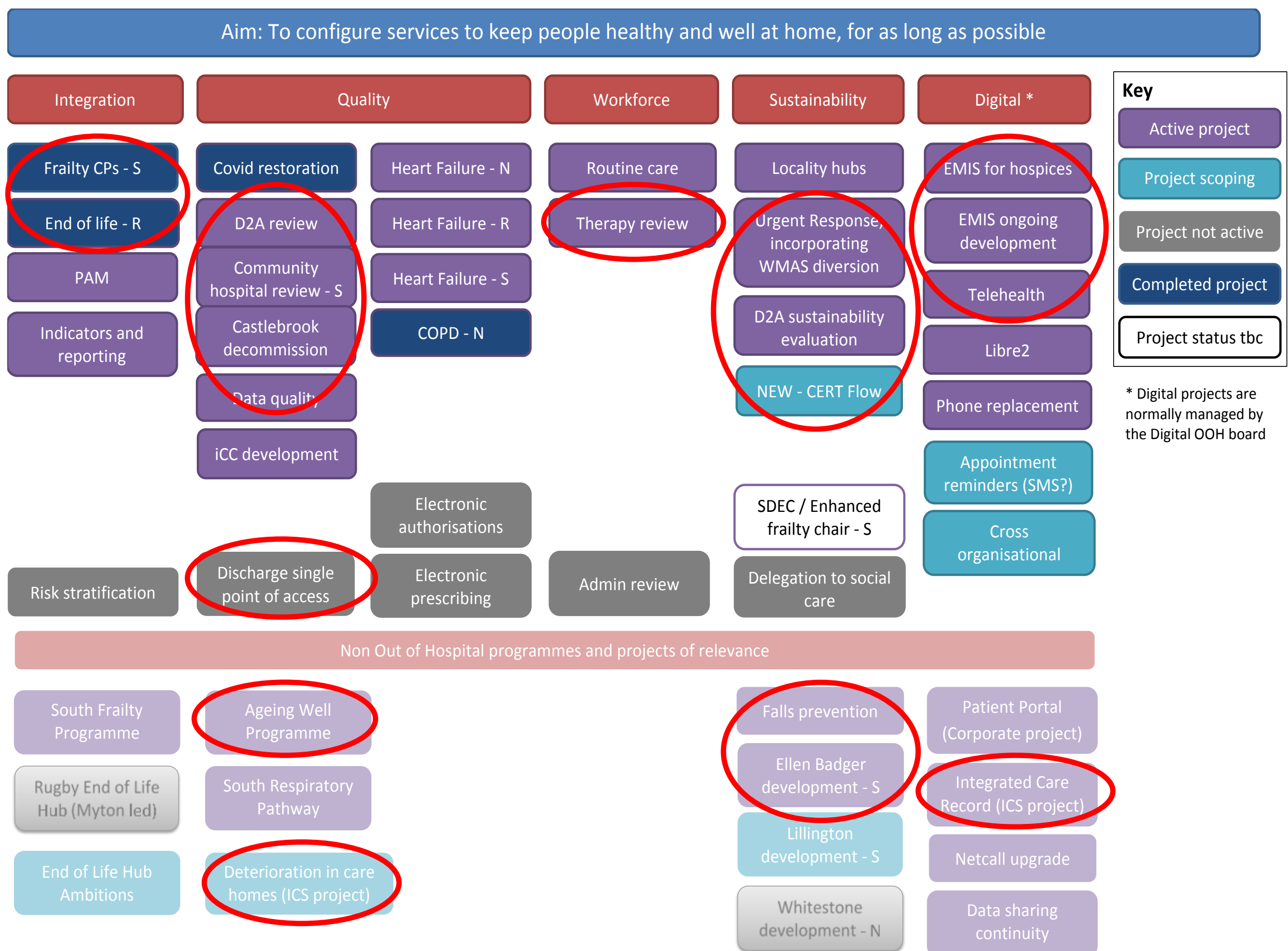
Joint Priorities for 2021/22

The five additional areas of focus for 2021/22 outlined on page 5 are being delivered through the Better Together Programme, in conjunction with South Warwickshire Foundation Trust's Out of Hospital Collaborative to meet the Better Care Fund, Warwickshire County Council's Covid-19 Recovery Plan and Coventry and Warwickshire's Ageing Well Programme's ambitions. All support a more collaborative and joined up approach to commissioning and delivery.

For example: implementation of a new falls prevention and falls pathway for repeat falls, is an enhancement to the Out of Hospital Collaborative's Frailty Pathway (low, moderate and high risk) as Warwickshire has a high number of patients who are admitted to hospital due to a trip or fall compared to regional and national averages. Fear of falls and repeat falls has been identified as a significant contributor to cause of injury, loss of confidence, independence and social isolation and is one of the top 4 causes of ambulance call outs in Warwickshire. The pathway links with the Integrated Single Point of Access and Place Based Teams which support populations of c30-50k, where personalised care and support including from the voluntary and community sector is discussed and agreed.

Schemes and services funded through the Improved Better Care Fund as well as transformation activity are also aligned to the Out of Hospital Collaborative so that operational, commissioning and Programme/Project resources and expertise across health and social care are used to best effect. This is clearly demonstrated by the illustration below.

South Warwickshire NHS Foundation Trust's Out of Hospital Programme Activity – November 2021.



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Overarching approach to supporting people to remain independent at home

As mentioned above and detailed in Appendix 1 – an integrated approach to commissioning and operational delivery to support people to be discharged to their usual place of residence (Pathway 0 & 1) or remain independent at home is well embedded within Warwickshire.

In 2019, transformation change projects implemented:

- Strengths Based Practice across Adult Social Care within Warwickshire County Council and Person-Centred Care in the NHS Out of Hospital Collaborative by South Warwickshire NHS Foundation Trust. Out of Hospital Place Based (Community) Teams are aligned to PCNs, ensuring that community assets from local areas (e.g. social prescribers, voluntary/community sector, housing) are involved when making decisions about health/care.
- A new and enhanced Assistive Technology self-care and early intervention offer for residents, social care and NHS Out of Hospital / community services.

These foundations are now embedded through our '*how we will work principles*'. Community resilience remains a portfolio area for the Better Together Programme – where we are using the Better Care Fund as a platform to continue to build relationships with identified communities to identify assets, community resources, strengths as per the principles of *'Asset Based Community Development'.*

What's important to us:

- Start with strengths whether with our customers, communities, colleagues or ourselves. We continuingly focus on what is important to people, what they would like to achieve, who is important in their life and focusing on ideas of how to achieve what matters to people.

- Doing what we say - we will have clear information presented in a user-friendly format and we will respond in a timely manner and maintain open communication channels.
- Helping people and communities to find their own solutions - we will work with and listen to customers and colleagues, to find solutions. We will give people timely helpful information and advice on support, services, equipment and assistive technology devices available. We will work with customers to take risks and support their decisions.

Three additional integrated commissioning posts were appointed in 2019:

- A jointly funded (WCC/SWFT) Lead Public Health Consultant for Long Term Conditions, aligned to the Out of Hospital Collaborative acting as public health lead for delivery of the Health and Wellbeing strategy. Working alongside 3 existing jointly funded consultants supporting a more integrated proactive, preventative approach,
- A jointly funded (WCC/SWFT), Integrated Lead Commissioner and commissioner for Integrated and Targeted Commissioning and Out of Hospital Services,
- An Integrated Commissioner for People with Disabilities, (WCC/CCGs/Coventry City Council), followed by a new Integrated Partnership Manager responsible for the Better Care Fund on behalf of WCC and the CCG in 2020.

Changes to our BCF Plan in response to the Covid-19 pandemic and Covid-19 recovery plan

The health and care system in Warwickshire has maintained and strengthened, its 'discharge to assess' model through the COVID19 pandemic by remaining aligned to its' core principle of maintaining a person centred 'home first' approach. Lessons learned from the pandemic have

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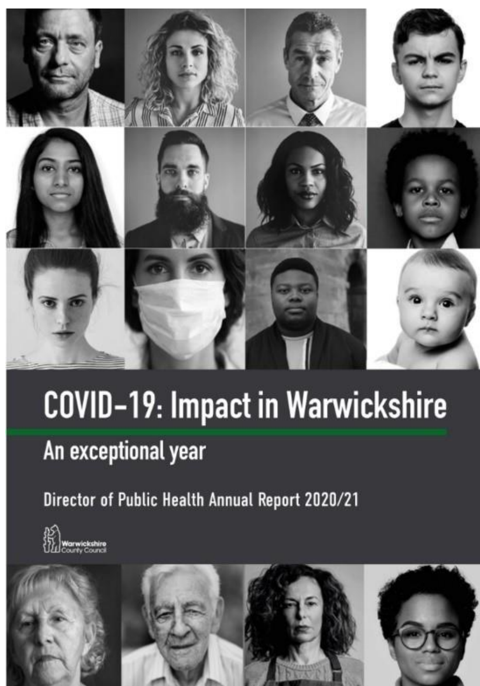
been included in the system wide review of discharge to assess in Warwickshire and helped inform the agreed changes and recommendations for the future commissioning and delivery model. More detail is provided under National Condition 4 on pages 17 and 18.

The local authority's relationship with our provider market was crucial too, understanding the market, its pressures and the opportunities was a key enabler to partnership preparedness and response. During this year our D2A pathway 1 has expanded with more people supported to return home than in previous years, with pathway 2 being commissioned at a system level by the local authority.

Equality and health inequalities

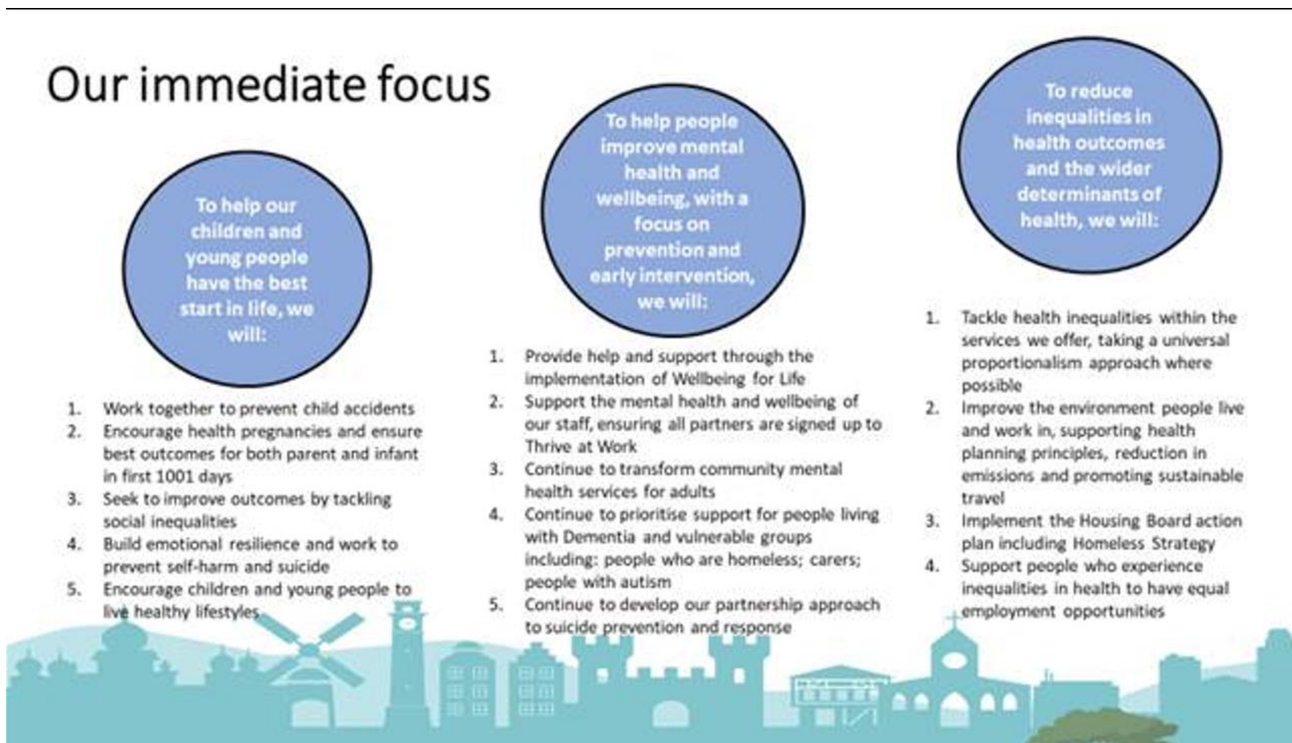
Warwickshire has a robust approach to health inequalities that capitalises on the strategic and operational expertise of our cross-sector partners. System partners benefit from our Joint Strategic Needs Assessment (JSNA) approach when researching and targeting population health inequality, and commissioning and joint commissioning activities and services. By placing health inequality at the heart of our long-term approach to population health and wellbeing, we drive the foundational principle of equity through every aspect of system working. Equality Impact Assessment (EQIA) is embedded in the commissioning cycle, giving assurance that spend and service targeting takes account of people and places at higher risk of falling outside traditional interventions. WCC's EQIA form has been redesigned recently to include questions from Public Health England's Health Equity Assessment Tool (HEAT) and therefore any EQIA form that is completed has a strong health inequalities section.



COVID-19 and the necessary lockdown restrictions to control its spread have had an impact on our health, the economy, and how we function as a society. COVID-19 has replicated existing health inequalities with the burden falling on the most vulnerable, the most deprived and the more marginalised, and, in some cases, has increased them. Understanding both the positive and negative impact of COVID-19 will help us to recover from the pandemic and protect and improve the health and wellbeing of Warwickshire residents. Following the Coventry and Warwickshire COVID-19 Health impact assessment, the Director of Public Health Annual Report 20/21 focused on the impact of COVID-19 on health inequalities and a series of recommendations were endorsed by the Warwickshire Health and Wellbeing Board (HWBB) in March 2021.

One of the key recommendations in the report was to adopt a 'health in all policies' approach which has been endorsed by the HWBB; an implementation plan for WCC was endorsed by senior council leaders in July 2021. A public facing 'Monitoring Health Inequalities in Warwickshire' has been developed to monitor inequalities over time. This is currently under review and being developed for the Warwickshire system.

The Warwickshire Health and Wellbeing Strategy for 2021-26 lists 3 short term priorities on which we are focused. Health inequalities run through the strategy as a golden thread, however as inequalities increased through pandemic period, it is listed explicitly as a top priority.



The Better Together Programme is one of our delivery programmes which support addressing the inequalities in the HWB Strategy. This is evidenced by for example the BCF funding for the Community Outreach Offer for Adults with Autism, Dementia services, Carers support, an increasing focus on social prescribing and Housing/Homelessness. Housing inequalities is a key focus within our delivery plan for reducing inequalities in health, and the BCF Housing Action Plan supports action against these inequalities and can found in Planning Requirement 3 on pages 15 and 16 of this report.

Our approach to developing and delivering work to address health inequalities happens at 3 levels: 1) system-level; 2) county level; 3) place level.

We share a Health and Care Partnership system with Coventry, and all strategy, prioritisation and implementation of work is endorsed through it.

Warwickshire consists of three geographical places; Warwickshire North; Rugby; and South Warwickshire. Each place has its own distinct partnership mechanism, and interrogates, commissions, and oversees the tailored activity delivered around health inequalities specific to place. Data and intelligence drawn from 'geographical place' partners enables work specifically targeting people with protected characteristics to be wholly standard to how we address health inequalities. Health inequalities is a key priority for all three of these places.

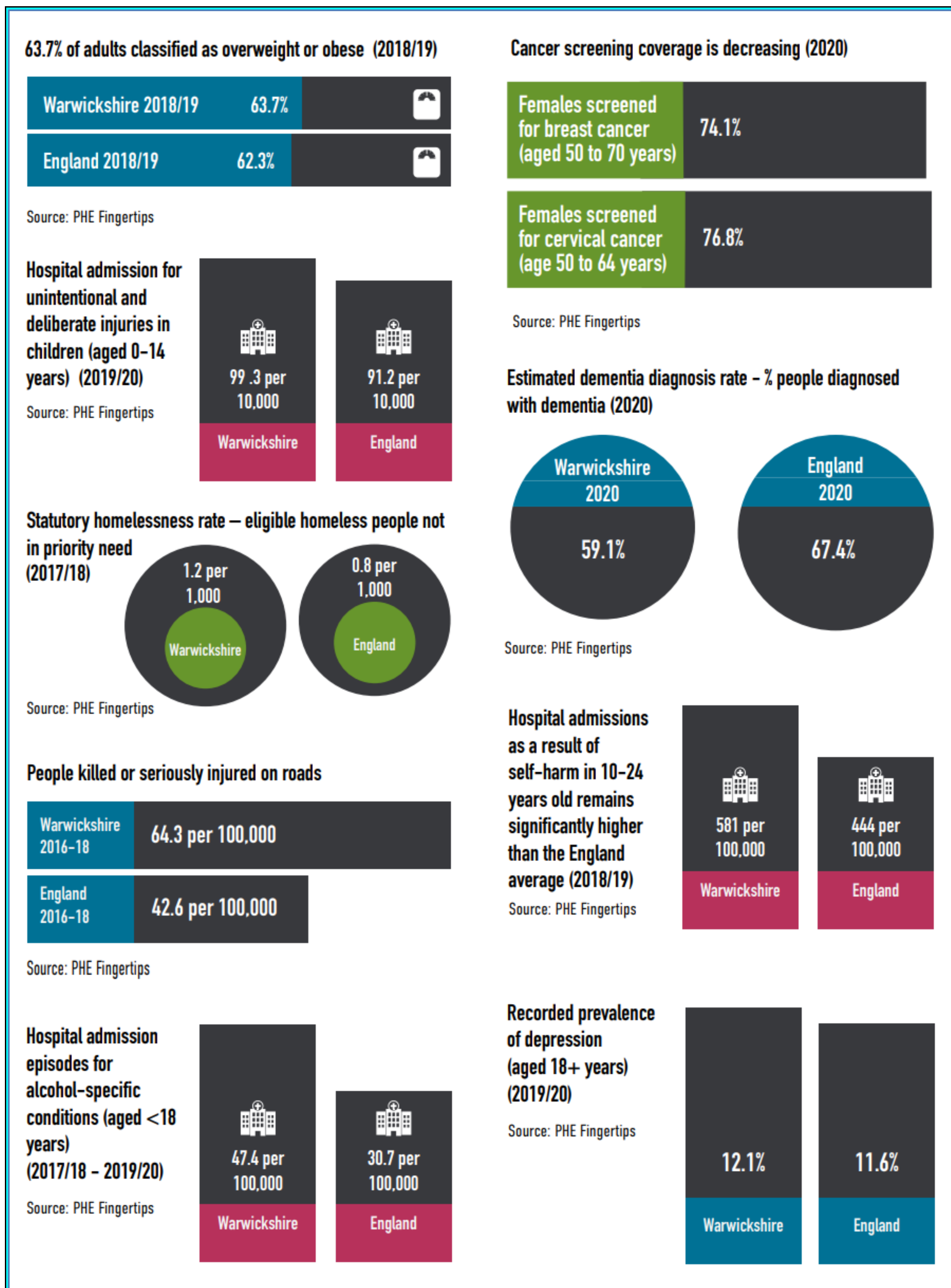
Additionally, the Better Together (BCF) programme links with and contributes to other programmes of work to tackle inequalities:
Coventry and Warwickshire COVID-19 Health Impact Assessment 2020
Warwickshire COVID-19 Recovery Plans e.g implementation of the Integrated Care Record Project
Warwickshire County Council Plan 2020-25 e.g. enhanced Discharge to Assess model and reducing delays to discharge
NHS Long Term Plan – 'Chapter 2: More NHS action on prevention and health inequalities'

In development: Coventry and Warwickshire Health Inequalities Strategic Plan, and accompanying Prevention Strategy. The plan will set out our 'five high impact actions' as well as national NHS health inequalities initiatives such as 'Core 20+5'. The intention is that the

BCF will support delivery of this Plan and Strategy, as a key element of our joint admissions avoidance activity as we move into an Integrated Care System.

What are the health inequalities and challenges in Warwickshire?

Overall health outcomes for Warwickshire are above the national average but they vary, with residents in more deprived parts living shorter lives and spending a greater proportion of their lives in poor health. In less deprived parts of the county males can expect to live over 9 years longer and females 5 years longer than those in more deprived areas. People are spending more of their later years in ill-health – over 18 years for men and nearly 20 years for women. There are avoidable differences in health outcomes, often linked to smoking, alcohol consumption, obesity and lack of physical activity.



(Taken from DPH Annual Report 20/21, p10. Data sources up to date at Feb 2021.)

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Around one in four adults experience mental health problems, but the county has seen an improvement in the suicide rate. Levels of suicide in Warwickshire have historically been higher than the England average. However, following a large programme of work aimed at suicide prevention, local rates are now in line with the England average.

Warwickshire also has a growing older population. There are more people over the age of 65 than the national average (20.8% in Warwickshire and 18.4% for England) and those over 85 are expected to almost double from 16,561 in 2020 to 30,132 in 2040. 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 (including falls). Importantly, COVID-19 has highlighted the importance of ethnic inequalities as well as socio-economic inequalities and the disproportionate impact that the virus, alongside control measures, have had upon people from Black and Minority Ethnic communities.

Of note, in our more deprived boroughs in the North of the County (Nuneaton and Bedworth and North Warwickshire), we can see a lower life expectancy, higher levels of adult obesity, a greater proportion of women smoking at the time of delivery, higher proportions of sickness absence, and higher rates of preventable mortality.

How is our plan contributing to reducing health inequalities in Warwickshire?

The BCF Plan is a vehicle for articulating how we will use system, county and place level mechanisms to cement health inequality work in strategic and operational planning. The Director of Public Health is a key member of the Joint Commissioning Board which oversees the Better Together Programme and BCF Plan, and this means that there is a robust connection between decision making bodies, allocation of BCF funds to address inequalities and frontline services. ‘Live’ learning about health inequality impacts on disproportionately disadvantaged groups features in discussions and decision making. This supports triangulation of the data held at system level, and, has a clear influence over BCF spend in recognition that pressures vary from place to place. We are continuing to make the connections with emerging tools and approaches across the system, as well as seeing the benefits of their use in the process of commissioning activity to meet needs.

An example of this is the use of the Health Equity Assessment Tool in the design of the new falls prevention pathway and enhancement of the End-of-Life Rapid Response service, to change the footprint over which the service is delivered.

Other examples of the use of BCF budget to target activity to disproportionately disadvantaged groups include pilots to test new approaches to understand their impact such as on expansion of Carers Support to younger adults with caring responsibilities for adults and on the BAME community through the Mental Health Street Triage Pilot.

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Planning Requirement 3 – A Strategic Joined-Up Plan for Disabled Facilities Grant (DFG) spending and wider services

We can confirm that the total Disabled Facilities Grant of £5,124,786 has been pass-ported in full to the five borough and district councils in Warwickshire.

Disabled Facilities Grant (DFG)	2021/22 allocation
North Warwickshire	£794,560
Nuneaton and Bedworth	£1,652,119
Rugby	£717,236
Stratford-on-Avon	£961,444
Warwick	£999,427
Disabled Facilities Grant (DFG)	**£5,124,786**

The strategic approach to using housing support and DFG funding

The HEART service was set up in 2016 to deliver improved health and social care outcomes and maximise people's independence in their own homes through:

- effective use of the Disabled Facilities Grant (DFG),
- prevention activity, including advice and information,
- provide equipment and major / minor adaptations,
- emergency support, and
- in 2020/21 expansion to include a countywide handy person service.

In Warwickshire, under the Regulatory Reform Order 2002 legislation, the DFG has also been used for wider purposes. Warwickshire Housing Authorities have agreed harmonised financial assistance policies under a RRO, with additional financial assistance for removing category 1 housing hazards (Warm and Safer Homes Grants), small home safety grants, hospital discharge grants and enhanced help for DFG's above the statutory maximum.

Governance of the HEART Service is through a multi-agency HEART Board, which commissioned an independent review by Foundations earlier in 2021 to ensure it is efficient, effective and the expected outcomes are being achieved. The HEART Board is currently considering next steps in relation to the review recommendations and a comprehensive action plan is being developed to address the areas for improvement raised.

Approach to bringing together health, care and housing services

The Housing Partnership Board, a sub-group of the Better Together Programme is the key delivery vehicle for the housing and homelessness related elements of the Warwickshire Health and Wellbeing Strategy 2021-2026 and Strategy Delivery Plan for 2021-23. The Housing Partnership is committed to delivering a joined-up approach across housing, social care and health to improve outcomes and reduce inequalities in health outcomes. System wide benefits of suitable and appropriate housing include helping the frail, elderly, those with more complex needs and specific vulnerable groups from being admitted to hospital, be discharged from hospital; and be supported to remain independent in their community.

To achieve this experience for every resident, the Housing Partnership Board maintains oversight of the following housing related activity which is delivered in partnership to support people to remain within their own homes for as long as possible or transitioning into more appropriate housing to maintain their independence by:

- Developing an integrated approach to Housing, Social Care and Health where housing solutions are embedded into health and social care pathways and efficiencies and effectiveness are maximised.

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- 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.
- Supporting people to smoothly transition into more appropriate housing.
- Improving choice and access to appropriate support, advice and information.
- Providing Housing Adaptations through effective use and monitoring of the Disabled Facilities Grant.
- Co-ordinating homelessness prevention activities and associated statutory duties.
- Implementing the housing related elements under Change 9 of the High Impact Change Model.

Aims of the Housing Partnership Board

The planned activities for 2021/22 are outlined in the Housing Partnership action plan which has been co-produced by representatives from the district and borough councils housing team, CCG, Public Health and Strategic Commissioning. Our plan includes the following core deliverables as well as additional specific areas of focus for this year:

a. Focus discussions, strategic thinking/overview and decision making in relation to:
   ii. understanding of the local authority housing estate and support offer across the county and the changes necessary to meet the needs of the frail and vulnerable population
   ii. data and intelligence production and validation to identify and target care and support to joint populations of interest
   iii. the use of home adaptations and assistive technology to support people to maintain their independence at home and strengthen their resilience
b. Contribute to the development and implementation of joint pilots, strategies and joint commissioning activity relating to housing and interfaces with the wider range of health and care services provided for vulnerable people, e.g. health, substance misuse services, etc.
c. Delivery of statutory and discretionary housing functions and housing solutions (including Housing Information and Advice and Housing Related Support) that:
   iv. allow people to live independently across all levels of need
   v. improve the quality of people's home environment
d. Assurance against housing policy and requirements as set out in the Better Care Fund (BCF) Policy Framework including:
   vi. monitoring progress and manage the expenditure against the Disabled Facilities Grant;
   vii. evidencing how housing is contributing to system wide health and care solutions and the BCF metrics (Acute – increasing admission avoidance, improving flow and reducing length of stay; Social Care - reducing long term admissions to residential and nursing care and increasing the effectiveness of reablement services).

Addressing health inequalities through housing

Our Housing Action plan focusses on the following key activities to reduce health inequalities due to poor or unsuitable housing:

- Reducing & Preventing Homelessness
- People will lead a healthy and independent life / People will experience effective and sustainable services
- Early Intervention and Prevention - tackling the causes of health-related problems and supporting people with long term conditions
- Reducing Health Inequalities and Mental Health

A copy of our plan is attached in **Appendix 2.**

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National Condition 4: Plan for improving outcomes for people being discharged from hospital

Planning Requirement 6: An agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach

Our operational delivery approach to improving outcomes for people being discharged from hospital

The recently established Coventry and Warwickshire (System) Operational Discharge Delivery Group is responsible for implementing the operational changes required to our local discharge processes and continuing to embed the High Impact Change Model. Discharge Leads for Pathways 1 to 3 and Acute Operational Leads for Pathway 0 discharges from the 3 acute trusts and community hospitals are represented on the group.

To achieve this as a health and care system we are completing a joint assurance exercise (Coventry and Warwickshire) against the discharge to assess model and Hospital Discharge and Community Support Policy and Operating Model published on the 5th July 2021, and our ambition is to meet or exceed the national expectations for Pathways 0, 1 and 2 (as detailed below).

Pathway	Ambition	Think	Definition
Pathway 0	50% of people	As Is	Discharge home to usual place of residence with: • no support from health or social care once at home or, • the same level of care as that provided prior to admission (even if with different provider)
Pathway 1	45% of people	Own Bed	Discharge home with new or an increased level of care compared to that provided prior to admission
Pathway 2	4% of people	Interim Bed	Discharge to an interim / temporary step-down bed
Pathway 3	1% of people	Permanent Bed	Discharge to a 24-hour care setting that is likely to be a permanent placement

As a foundation we have mapped the current offer across both Coventry and Warwickshire and set up a local system discharge dashboard to capture at a local authority level discharge performance so that we have the data and intelligence to identify areas for improvement across the three acute NHS trusts for both health and social care. This includes streamlining duplication of roles, services and referral processes.

The Better Together (BCF) Programme Team supports the system wide operational improvements by facilitating the Discharge Delivery Group, developing the dashboard and co-ordinating joint activity.

Our approach to commissioning services to support discharge and Home First

The local authority is the lead commissioner for the Out of Hospital Collaborative. This is through a joint funded Lead Commissioner post with South Warwickshire Foundation Trust. This post also leads on the commissioning of Discharge to Assess Services for Pathways 1 and 2. Commissioning of Pathway 3 is currently shared between the local authority and the CCG.

The Warwickshire Joint Commissioning Board and Out of Hospital Collaborative commissioned a system wide review of Discharge to Assess in 2019, which following a pause during Covid-19 pandemic wave 1, has now been completed. Warwickshire has a well-established D2A offer that is collaborative in nature. It is built on principles of supporting people that have had an acute hospital stay to the most appropriate place, to ensure their recovery needs and ability to rehabilitate is maximised. D2A services in the South of the county have been in place since 2013.

The following services were within scope of the review:

Home based provision (Pathway 1):

- Restricted Mobility Pathway countywide
- D2A Home Based (north)
- D2A Pathway 1, countywide.

Accommodation/bed-based provision (Pathway 2):

- D2A Pathway 2, countywide
- D2A CHC Assessment beds (now defined as Pathway 2), countywide
- D2A Pathway 2 with nursing, Community Hospitals (South only)
- Moving on Beds (MOB), countywide

The review analysed Discharge to Assess (D2A) pathways and related services in Warwickshire and has set out a number of recommendations to help ensure that D2A pathways and services are sustainable, resilient, and fit for purpose. Immediate changes to support winter pressures and enable more patients to be discharged to their normal place of residence under Pathway 1 have already been put in place eg:

- To transfer the D2A Home based pilot in the North to a BAU service and fully extend this model to the South
- To continue to commission D2A pathway 2 beds in Rugby on a flexible spot agreement increasing to up to 6 beds at time of pressure.

Subject to funding, further medium-term improvements include for example:

- To extend the D2A Home based pilot to Rugby
- To approve the direction of travel for Pathway 2 residential and Community Hospital and Pathway 2 with nursing which are both led by SWFT as host provider
- To redesign and retender the provision currently provided as MOB ECH (as part of the wider ECH re-tender for care that is led by Orbit and HC21) to ensure this bedded offer aligns to operational demand and supports flow
- To work together across the Warwickshire system on a joined-up commissioning plan around CHC assessment beds.
- To agree system wide commissioning intentions for D2A.

Discharge Leads from the three acute trusts and community hospitals were fully engaged and involved in the review to ensure alignment with acute plans.

How BCF funded activity supports safe, timely and effective discharge

The detail in the Planning Template clearly sets out the number of schemes funded through the Better Care Fund which support safe, timely and effective discharge.

These range from core services in the ‘base BCF’ such as Reablement, Home First, a contribution to Domiciliary Care, Moving on Beds, Integrated Community Equipment etc to schemes funded from the Improved Better Care Fund which support implementation of the High Impact Change Model e.g. Trusted Assessors for Care Homes, Brokerage Support (Domiciliary Care Referral Team), Hospital Social Care Team Staff supporting an MDT approach for Out of Area Patients, Frailty Units in ED, Discharge to Assess Beds, the Hospital to Home Scheme, additional enhanced Moving on Beds etc.

In addition, the Support Staff funded from IBCF schemes 29 and 30 support delivery of discharge related improvement activity, analysis and data on behalf of the system.

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Agreed Expenditure Plan

Planning Requirement 7: The Better Care Fund pool is planned and used for an agreed purpose

The funding contributions for the BCF have been agreed and we can confirm that our agreed BCF Plan for 2021/22 meets the total minimum BCF Pooled Budget of £60,304,106 and also meets the national conditions. A detailed breakdown of the planned scheme budgets is provided in the supporting Planning Template.

Note: amounts are rounded up for reporting purposes.

	Minimum BCF Pooled Budget 2021-22	Total Agreed Pooled Budget 2021-22
Warwickshire	**£60,304,106**	**£60,304,106**

CCG minimum contribution
The planned CCG contribution to the BCF pooled budget meets the minimum contribution in line with the required inflationary increases ranging from 5.2 to 5.7% across the 3 places.

CCG Minimum Contribution	Minimum Contribution to the Pooled Budget 2021/22	Agreed Contribution to the Pooled Budget 2021/22
NHS Coventry and Warwickshire CCG (Rugby Place)	£7,841,773	£7,841,773
NHS Coventry and Warwickshire CCG (South Warwickshire Place)	£19,073,632	£19,073,632
NHS Coventry and Warwickshire CCG (Warwickshire North Place)	£13,575,548	£13,575,548
Total CCG Contribution	**£40,490,953**	**£40,490,953**

Social care maintenance
The planned spend on social care from the BCF CCG minimum contribution is also set out in line with inflation. This equates to 5.4% in 2021/22.
In setting the contribution to social care from the CCG minimum contribution, partners have provided assurance that the local provider market and health and system will not be destabilised.

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

	Minimum Required Spend	Agreed Planned Spend
Adult Social Care services spend from the minimum CCG allocations	£14,455,792	£14,455,792
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£11,552,343	£26,035,161

The following funds have also been identified and agreed for Carers Breaks and Reablement specified funding as well as local authority spending which supports meeting our duties under the care act:

	Agreed Planned Spend
Carer Breaks	£966,000
Reablement	£5,359,000
Meeting Care Act responsibilities	£270,000
Total	**£6,595,000**

Improved Better Care Fund (iBCF)

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

IBCF Grant Conditions	Outcome	Summary of schemes	IBCF 2021/22 £'000
Reducing Pressure on the NHS	Supporting discharge and reduced length of stay	Schemes include additional support around: Trusted Assessors for Care Homes, Moving on Beds, HSCT staff based in the acute settings, Brokerage staff, social prescribers based in acute settings, restricted mobility pathway and ICE inflationary cost increases etc	**£2,223**
	Admissions Avoidance	Schemes include carer support, OTs to support moving and handling reviews and hoists, hospice at home services, hospital to home service, advocacy support, falls prevention, Mental Health Street Triage and Community Outreach Support Offer for Adults with Autism etc.	**£1,839**
Endursing that the social care provider market is supported	Fee rates / increases	Fee rates and inflationary increases relating to residential and nursing, domiciliary care, waking night and sleeping nights cover	**£5,199**
	Market support and development	Schemes include the Provider Workforce training arm operating costs and bursary to improve quality, reduce provider costs and prevent admissions, market sustainability etc	**£865**
Meeting Adult Social Care needs	Supporting adult social care pressures	Schemes where direct funding contributes towards adult social care budget pressures as a result of demand growth including dementia, social care capacity and housing related support	**£4,238**
Support	Enablers for integration	This scheme funds the resources (programme, project, analytical, comms and commissioning) to meet the BCF governance and reporting requirements and joint integration transformation and commissioning activity.	**£324**
			£14,688

Agreed Expenditure Plan

Planning Requirement 8: Stretching metrics have been agreed and there are clear and ambitious plans to deliver these

Please refer to more detail on the metrics in the Planning Template.

In collaboration with the Coventry and Warwickshire and A&E Delivery Board and Urgent and Emergency Care Leads of the three acute NHS Trusts the following ambitions against the three new BCF metrics have been set:

<table>
<tr><th>Avoidable Admissions</th><th>2020/21 Actual</th><th>2021/22 Ambition</th></tr>
<tr><td>Performance:</td><td>4,491.0</td><td>4,851.0</td></tr>
<tr><td>Rationale:</td><td>n/a</td><td>The CCG have extracted actual admissions for 2020-21 and generated a Forecast outturn for 2021-22 based on April-August data.
Based on this forecast Warwickshire will continue to have a lower ISR for Avoidable Admissions when compared to the Region and England. This is, therefore, the ambition that has been set, which is considered sufficiently challenging to achieve during winter pressures.</td></tr>
<tr><td>Monitored by:</td><td colspan="2">C&W CCG</td></tr>
<tr><td>BCF schemes that will impact on this metric:</td><td colspan="2">Falls Prevention Pathway
Hospital Social Prescribing
Mental Health Street Triage
Integrated Community Equipment
Domiciliary Care
Carers support, respite and short breaks
Dementia support
End of Life Rapid Response
Community Support for Adults with Autism
Contributions to Sleeping Nights and ECH Waking Nights</td></tr>
</table>

<table>
<tr><th>Length of Stay – 14+ and 21+ days</th><th>2020/21 Actual</th><th>2021/22 Ambition</th></tr>
<tr><td>Performance:</td><td>n/a</td><td><table><tr><td></td><td>Q3 21/22</td><td>Q4 21/22</td></tr><tr><td>14+ days</td><td>11.1%</td><td>10.8%</td></tr><tr><td>21+ days</td><td>6.4%</td><td>6.1%</td></tr></table></td></tr>
<tr><td>Rationale</td><td>n/a</td><td>Based on the forecast produced by CCG analysts on 14+ days and 21+ days the figures show that Warwickshire's performance remains the same as the national % of each LoS category. Noting winter pressures, the increasing Covid19 positive cases, increases in hospital admissions and usage of ITU, a stretching ambition has therefore been set to maintain the objective of keeping in line with current national performance and current actual Warks performance for the remainder of the year.</td></tr>
<tr><td>Monitored by:</td><td colspan="2">C&W CCG</td></tr>
<tr><td>BCF schemes that will impact on this metric:</td><td colspan="2">Domiciliary Care and Brokerage sourcing team (DCRT)
Discharge to Assess Model – D2A step down P2 beds
Restricted Mobility Pathway
Advocacy Support
Moving on Beds
Embedding the High Impact Change Model</td></tr>
</table>

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Discharge to normal place of residence	2020/21 Actual	2021/22 Ambition
Performance:	95.3%	95.5%
Rationale	n/a	On average from 2019 to present, 95.5% of Warwickshire LA residents return to their usual place of residence. This continues to be above both the national and regional averages. A stretching ambition will be to maintain this level throughout the rest of the year, taking into account current pressures in the domiciliary care market supporting Pathway 1 and usual winter pressures. This is therefore what has been proposed.
Monitored by:	C&W CCG. The System Operational Discharge Delivery Group monitor this performance and a local dashboard has been developed to provide performance against the national D2A ambitions on a daily basis	
BCF schemes that will impact on this metric:	Daily multi-agency discharge team (MDT) working New Home-Based Support pilot (D2A P1) Integrated Community Equipment HEART and housing aids and adaptations Dementia and Carers Support	

Residential Admissions	2020/211 Actual	2021/22 Ambition
Performance:	702	799
Rationale	n/a	Performance in 2020/21 was significantly impacted by the Covid-19 pandemic. The ambition for 2021/22 therefore reflects pre-pandemic levels of an average 66.5 admissions per month, despite continuing to see sustained levels of increased complexity of need including dementia. Increased pressures on the domiciliary care market may also result in some additional permanent placements for customers requiring larger and more complex packages of care.
Monitored by:	Warwickshire County Council	
BCF schemes that will impact on this metric:	Trusted Assessors Learning Development Partnership Support to the provider market and market management Extra care housing	

Reablement	2020/21 Actual	2021/22 Ambition
Performance:	93.6%	91.6%
Rationale	n/a	Both the overall number and the proportion who remained at home in 2020/21 are artificially inflated due to emergency measures put in place during the pandemic including reablement providing a bridging service until packages of care could be sourced. The proposed ambition for 2021/22 therefore reflects an improvement on pre-pandemic business as usual activity.
Monitored by:	Warwickshire County Council	
BCF schemes that will impact on this metric:	Reablement Service – 95% of reablement capacity is utilised supporting hospital discharge Assistive Technology	

Additional Supporting Information

Please refer to the following separates appendices for more information relating to:

Appendix 1 – Joint Working Arrangements

Appendix 2 – Housing Partnership Action Plan

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Better Care Fund 2021-22 Template

1. Guidance

Overview

Note on entering information into this template

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

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

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

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2021-22. It will be pre-populated with the minimum CCG contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from local authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be used to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net

5. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Conditions 2 and 3 are met.
The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:
1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.
3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned.
4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important to our understanding of how BCF funding is being used and levels of investment against different priorities.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.
5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.
6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns.
7. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the CCG or Local authority
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.
9. Expenditure (£) 2021-22:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2021-22 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's performance plans for each of the BCF metrics in 2021-22. The BCF requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for the last two quarters of 2021-22.
The previous measure of Non Elective Admissions is being replaced with a measure of Unplanned Admissions for Chronic Ambulatory Care Sensitive Conditions. Performance data on this indicator up to 2019-20, by local authority can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

A data pack showing breakdowns of data for new metrics (discharge and avoidable admissions) is available on the Better Care Exchange.

For each metric, systems should include a narrative that describes:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.
1. Unplanned admissions for chronic ambulatory sensitive conditions:
- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf

2. Length of Stay.
- Areas should agree ambitions for minimising the proportion of patients in acute hospital who have been an inpatient for 14 days or more and the number that have been an inpatient for 21 days or more. This metric should be expressed as a percentage of overall patients.
- The ambition should be set for the HWB area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the average percentage of inpatient beds occupied by patients with a length of stay of 14 days and over and 21 days and over for Q3 2021-22 and for Q4 2021-22 for people resident in the HWB.

- Plans should be agreed between CCGs, Local Authorities and Hospital Trusts and areas should ensure that ambitions agreed for 21 days or more are consistent across Local Trusts and BCF plans.

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric
3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay.

- The ambition should be set for the healthand wellbeing board area. The data for this metric is obtained from the Secondary Uses Service database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.

4. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.
5. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2021-22 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.
1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2021-22 Template

2. Cover

Version 1.0

Please Note:

- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".

- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.

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

Health and Wellbeing Board:	Warwickshire
Completed by:	Rachel Briden, Integrated Partnership Manager
E-mail:	rachelbriden@warwickshire.gov.uk
Contact number:	07768332170

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Chair of the Health and Wellbeing Board
Name:	Councillor Margaret Bell

Has this plan been signed off by the HWB at the time of submission?	No	
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Wed 17/11/2021	<< Please enter using the format, DD/MM/YYYY Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Margaret	Bell	margaretbell@warwickshire.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)	Chief Officer	Phil	Johns	philip.johns@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers	Chief Finance Officer	Adrian	Stokes	adrian.stokes5@nhs.net
	Local Authority Chief Executive	Chief Executive	Monica	Fogarty	monicafogarty@warwickshire.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Strategic Director	Nigel	Minns	nigelminns@warwickshire.gov.uk
	Better Care Fund Lead Official	Assistant Director	Becky	Hale	beckyhale@warwickshire.gov.uk
	LA Section 151 Officer	Strategic Director	Rob	Powell	robpowell@warwickshire.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->	Leader of the Council	Councillor	Isobel	Seccombe	isobelseccombe@warwickshire.gov.uk

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

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

#REF!

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	#REF!
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Warwickshire

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£5,124,786	£5,124,786	£0
Minimum CCG Contribution	£40,490,953	£40,490,953	£0
iBCF	£14,688,367	£14,688,367	£0
Additional LA Contribution	£68,590,000	£68,590,000	£0
Additional CCG Contribution	£80,637,000	£80,637,000	£0
Total	**£209,531,106**	**£209,531,106**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£11,552,343
Planned spend	£26,035,161

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£14,455,792
Planned spend	£14,455,792

Scheme Types

Assistive Technologies and Equipment	£6,078,000	(2.9%)
Care Act Implementation Related Duties	£870,000	(0.4%)
Carers Services	£1,382,000	(0.7%)
Community Based Schemes	£1,092,000	(0.5%)
DFG Related Schemes	£5,124,786	(2.4%)
Enablers for Integration	£1,264,000	(0.6%)
High Impact Change Model for Managing Transfer of (	£2,751,000	(1.3%)
Home Care or Domiciliary Care	£36,329,102	(17.3%)
Housing Related Schemes	£626,000	(0.3%)
Integrated Care Planning and Navigation	£386,000	(0.2%)
Bed based intermediate Care Services	£912,000	(0.4%)
Reablement in a persons own home	£5,359,000	(2.6%)
Personalised Budgeting and Commissioning	£10,972,000	(5.2%)
Personalised Care at Home	£39,618,000	(18.9%)
Prevention / Early Intervention	£367,000	(0.2%)
Residential Placements	£92,548,218	(44.2%)
Other	£3,852,000	(1.8%)
Total	**£209,531,106**	

Metrics >>

Avoidable admissions

	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	4,491.0	4,851.0

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients	LOS 14+	11.1%	10.8%
	LOS 21+	6.4%	6.1%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	0.0%	95.5%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	579	646

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	91.7%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Warwickshire

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Warwickshire	£5,124,786
DFG breakerdown for two-tier areas only (where applicable)	
North Warwickshire	£794,560
Nuneaton and Bedworth	£1,652,119
Rugby	£717,236
Stratford-on-Avon	£961,444
Warwick	£999,427
Total Minimum LA Contribution (exc iBCF)	**£5,124,786**

iBCF Contribution	Contribution
Warwickshire	£14,688,367
Total iBCF Contribution	**£14,688,367**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Warwickshire	£68,590,000	Aligned budget in the BCF Plan relating to older
Total Additional Local Authority Contribution	**£68,590,000**	

CCG Minimum Contribution	Contribution
NHS Coventry and Rugby CCG	£7,841,773
NHS South Warwickshire CCG	£19,073,632
NHS Warwickshire North CCG	£13,575,548
Total Minimum CCG Contribution	**£40,490,953**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	Yes

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
NHS Coventry and Rugby CCG	£22,568,000	Aligned out of hospital budget in the BCF Plan -
NHS South Warwickshire CCG	£44,344,000	Aligned out of hospital budget in the BCF Plan -
NHS Warwickshire North CCG	£13,725,000	Aligned out of hospital budget in the BCF Plan -
Total Additional CCG Contribution	**£80,637,000**	
Total CCG Contribution	**£121,127,953**	

	2021-22
Total BCF Pooled Budget	**£209,531,106**

Funding Contributions Comments
Optional for any useful detail e.g. Carry over

The minimum requirement for the pooled budget for Warwickshire's BCF is £60.3m. As a partnership in 2017, we took the decision to align further budgets to represent the majority of spend for all out of hospital services. In 2018/19 the total pooled and aligned budget for the BCF was £120m, in 2019/20, we continued to develop the transparency and visibility of costs and spend across the system, and as a result our budget increased bringing the total pooled and aligned budget to £189m. In 2020/21 this work continued to £192m and for 2021/22 the pooled budget is £60.3m and the aligned budget is £121.1m totalling £209m. This is a key mechanism supporting our system

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Warwickshire

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£5,124,786	£5,124,786	£0
Minimum CCG Contribution	£40,490,953	£40,490,953	£0
iBCF	£14,688,367	£14,688,367	£0
Additional LA Contribution	£68,590,000	£68,590,000	£0
Additional CCG Contribution	£80,637,000	£80,637,000	£0
Total	**£209,531,106**	**£209,531,106**	**£0**

Please note:
Scheme Types categorised as 'Other' currently account for approx. 6% of the planned expenditure from the Mandatory Minimum. In order to reduce reporting ambiguity, we encourage limiting this to 5% if possible.
While this may be difficult to avoid sometimes, we advise speaking to your respective Better Care Manager for further guidance.

Required Spend
This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£11,552,343	£26,035,161	£0
Adult Social Care services spend from the minimum CCG allocations	£14,455,792	£14,455,792	£0

Checklist
Column complete:

#REF!	#REF!	#REF!	#REF!	Yes	Yes	#REF!	Yes	#REF!	Yes		#REF!	#REF!	#REF!	#REF!

!!! Critical errors detected !!!
This is usually due to cutting and pasting into cells - Please start over from the last working copy of this template or contact the BCF Team for support: england.bettercarefundteam@nhs.net

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Domiciliary Care (base BCF)		Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	Minimum CCG Contribution	£6,718,792	Existing
2	Reablement (base BCF)		Reablement in a persons own home	Reablement to support discharge - step down (Discharge to Assess pathway 1)		Social Care		LA			Local Authority	Minimum CCG Contribution	£5,359,000	Existing
3	Integrated Equipment Service (base BCF)		Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Private Sector	Minimum CCG Contribution	£1,814,000	Existing
4	Moving on Beds (base BCF)		Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	Minimum CCG Contribution	£564,000	Existing
5	Falls Prevention (aligned budget)	Falls care co-ordination and support for Moderate to High Risk	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess pathway 0)		Social Care		LA			NHS Community Provider	Additional LA Contribution	£119,000	Existing

6	Domicillary Care (aligned budget)	Supports hospital discharges and community step up	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	Additional LA Contribution	£13,632,000	Existing
7	Residential Care (aligned budget)		Residential Placements	Care home		Social Care		LA			Private Sector	Additional LA Contribution	£38,413,000	Existing
8	Nursing Care (aligned budget)		Residential Placements	Nursing home		Social Care		LA			Private Sector	Additional LA Contribution	£10,692,000	Existing
9	Direct Payments (aligned budget)		Personalised Budgeting and Commissioning			Social Care		LA			Private Sector	Additional LA Contribution	£4,400,000	Existing
10	Carers (aligned budget)		Care Act Implementation Related Duties	Carer advice and support		Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£600,000	Existing
11	Social Prescribing (aligned budget)		Prevention / Early Intervention	Social Prescribing		Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£108,000	Existing
12	Contributions towards HEART staff and service, supporting housing assessments (aligned)		Housing Related Schemes			Social Care		LA			Local Authority	Additional LA Contribution	£626,000	Existing
13	ICE (Health) Base BCF - Integrated Equipment Service		Assistive Technologies and Equipment	Community based equipment		Community Health		CCG			Private Sector	Minimum CCG Contribution	£4,135,000	Existing
14	Carers Breaks (base BCF)		Carers Services	Respite services		Community Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£966,000	Existing
15	Out of hospital (WN, Rugby and SW - base BCF)		Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£15,115,000	Existing
16	Discharge to Assess Beds - D2A (base BCF)		High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs		Community Health		CCG			Private Sector	Minimum CCG Contribution	£1,238,000	Existing
17	Joint Funded Packages - base BCF		Home Care or Domiciliary Care	Domiciliary care packages		Continuing Care		CCG			Private Sector	Minimum CCG Contribution	£857,310	Existing
18	Joint Funded Packages - base BCF		Residential Placements	Supported living		Continuing Care		CCG			Private Sector	Minimum CCG Contribution	£2,381,987	Existing
19	Joint Funded Packages - base BCF		Residential Placements	Supported accommodation		Continuing Care		CCG			Private Sector	Minimum CCG Contribution		Existing
20	Joint Funded Packages - base BCF		Residential Placements	Learning disability		Continuing Care		CCG			Private Sector	Minimum CCG Contribution		Existing
21	Joint Funded Packages - base BCF		Residential Placements	Extra care		Continuing Care		CCG			Private Sector	Minimum CCG Contribution		Existing

22	Joint Funded Packages - base BCF		Residential Placements	Care home		Continuing Care		CCG			Private Sector	Minimum CCG Contribution	£864,221	Existing
23	Joint Funded Packages - base BCF		Residential Placements	Nursing home		Continuing Care		CCG			Private Sector	Minimum CCG Contribution	£477,643	Existing
24	Joint Funded Packages - base BCF		Personalised Budgeting and Commissioning			Continuing Care		CCG			Private Sector	Minimum CCG Contribution		Existing
25	ASC Winter Fund - scheme 1 - Additional Trusted Assessors for Care Homes	Supporting Discharge using Trusted Assessment	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes		Social Care		LA			Local Authority	iBCF	£74,000	Existing
26	ASC Winter Funds - Schemes 2 & 3 - Reduced Mobility Pathway	Additional placements (home and bed based) to support therapy	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core		Social Care		LA			Private Sector	iBCF	£340,000	Existing
27	ASC Winter Fund - Scheme 4 - Additional acute	Supporting Discharge	High Impact Change Model for Managing	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	iBCF	£440,000	Existing
28	ASC Winter Funds - Schemes 5 & 6 - Acute based Advocacy support	Supporting Discharge	Care Act Implementation Related Duties	Independent Mental Health Advocacy		Social Care		LA			Private Sector	iBCF	£145,000	Existing
29	ASC Winter Funds Scheme 7 - hospital to Home Service	Supporting Discharge - transport, settling in and falls prevention joint offer	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess pathway 0)		Acute		LA			Local Authority	iBCF	£186,000	Existing
30	ASC Winter Funds scheme 8 - Carers one-off payments	Admission Prevention	Carers Services	Other	Direct payments	Social Care		LA			Private Sector	iBCF	£61,000	Existing
31	ASC Winter Funds scheme 9 - Mental Health Street Triage	Admission Prevention	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care		Mental Health		CCG			NHS Mental Health Provider	iBCF	£258,000	Existing
32	ASC Winter Fund scheme 10 - Community support for Autism	Admission Prevention by reducing waiting lists	Community Based Schemes	Other	Community Outreach Offer	Mental Health		LA			Private Sector	iBCF	£280,000	Existing
33	ASC Winter Fund scheme 11 - Additional commissioning resources to progress joint funded initiatives	Discharge to Assess Model & commissioning	Enablers for Integration	Joint commissioning infrastructure		Social Care		LA			Local Authority	iBCF	£43,000	Existing
34	iBCF scheme 1 - Residential & Nursing home fee rates		Residential Placements	Other	Contribution to fee increases to stabilise the provider market	Social Care		LA			Private Sector	iBCF	£2,600,367	Existing

35	iBCF Scheme 2 - Home Care fee rates		Home Care or Domiciliary Care	Other	Contribution to fee increases to stabilise the	Social Care		LA			Private Sector	iBCF	£1,050,000	Existing
36	iBCF scheme 3 - Learning & Development	Provider workforce training and development	Enablers for Integration	Workforce development		Social Care		LA			Private Sector	iBCF	£465,000	Existing
37	iBCF schemes 6 & 7 - Night cover (Sleeping nights in		Home Care or Domiciliary Care	Other	Contribution to fee increases to stabilise the	Social Care		LA			Private Sector	iBCF	£1,549,000	Existing
38	iBCF scheme 8 - Carers Support (CRESS)	Emergency planning, response & support	Carers Services	Respite services		Social Care		LA			Private Sector	iBCF	£105,000	Existing
39	iBCF scheme 10 - Services to support dementia	Dementia support and navigators	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		LA			Charity / Voluntary Sector	iBCF	£386,000	Existing
40	iBCF schemes 9, 11 & 12 - Mitigation of		Other		Mitigation of savings	Social Care		LA			Local Authority	iBCF	£3,852,000	Existing
41	iBCF scheme 14 - Supporting flow and discharge	Movings on Beds	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	iBCF	£348,000	Existing
42	iBCF schemes 15 & 17 - Managing flow in and out of acute settings and OT provision	Includes Housing Liaison Officers supporting acutes	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		Social Care		LA			Local Authority	iBCF	£588,000	Existing
43	iBCF scheme 16 - Brokerage Team		High Impact Change Model for Managing Transfer of Care	Other	Sourcing packages of care for Discharge and Community	Social Care		LA			Local Authority	iBCF	£71,000	Existing
44	iBCF scheme 19 - Residential Respite Care charging policy		Carers Services	Respite services		Social Care		LA			Local Authority	iBCF	£250,000	Existing
45	iBCF scheme 20 - End of Life rapid response support	EOL support at home	Personalised Care at Home	Physical health/wellbeing		Social Care		LA			Charity / Voluntary Sector	iBCF	£207,000	Existing
46	iBCF scheme 21 - Improving flow and discharge		Enablers for Integration	Joint commissioning infrastructure		Mental Health		LA			CCG	iBCF	£75,000	New
47	iBCF scheme 22 - Hospital to Home Service & scheme 33 - falls prevention	Supporting Discharge - transport, settling in and falls prevention joint offer	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess pathway 0)		Acute		LA			Local Authority	iBCF	£249,000	Existing
48	iBCF scheme 23 - Enhancing social prescribing		Prevention / Early Intervention	Social Prescribing		Social Care		LA			Charity / Voluntary Sector	iBCF	£131,000	Existing
49	iBCF scheme 24 - Provider Market Sustainability		Enablers for Integration	Integrated models of provision		Continuing Care		CCG			Local Authority	iBCF	£400,000	Existing

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50	iBCF scheme 25 - Increasing the capacity of non-statutory Advocacy support		Care Act Implementation Related Duties	Independent Mental Health Advocacy		Mental Health		LA			Private Sector	iBCF	£125,000	Existing
51	iBCF schemes 29 & 30 - Support for the BCF and Adult Social Care Transformation programmes		Enablers for Integration	Programme management		Social Care		LA			Local Authority	iBCF	£281,000	Existing
52	iBCF scheme 34 - ICE contract increases relating to same day/next day delivery	Inflationary cost increases	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Private Sector	iBCF	£129,000	Existing
53	Disabled Facilities Grant (base BCF)		DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Local Authority	DFG	£5,124,786	Existing
54	CCG aligned budget - Out of Hospital		Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Community Provider	Additional CCG Contribution	£24,296,000	Existing
55	CCG aligned budget - Personal Health budgets		Personalised Budgeting and Commissioning			Continuing Care		CCG			Private Sector	Additional CCG Contribution	£6,572,000	Existing
56	CCG aligned budget - Residential Care		Residential Placements	Care home		Continuing Care		CCG			Private Sector	Additional CCG Contribution	£5,771,928	Existing
57	CCG aligned budgt - Nursing care placements		Residential Placements	Nursing home		Continuing Care		CCG			Private Sector	Additional CCG Contribution	£25,845,619	Existing
58	CCG aligned budgets - Residential placements supported living		Residential Placements	Supported living		Continuing Care		CCG			Private Sector	Additional CCG Contribution	£5,501,453	Existing
59	CCG aligned budget - Residential placements - Supported Accommodation		Residential Placements	Supported accommodation		Continuing Care		CCG			Private Sector	Additional CCG Contribution		Existing
60	CCG aligned budget - Residential placements - LD		Residential Placements	Learning disability		Continuing Care		CCG			Private Sector	Additional CCG Contribution		Existing
61	CCG aligned budget - Residential placements - ECH		Residential Placements	Extra care		Continuing Care		CCG			Private Sector	Additional CCG Contribution		Existing
62	CCG aligned budget - Domicilary Care		Home Care or Domiciliary Care	Domiciliary care packages		Continuing Care		CCG			CCG	Additional CCG Contribution	£12,522,000	Existing
63	CCG aligned budget - Social Prescribing		Prevention / Early Intervention	Social Prescribing		Community Health		CCG			Charity / Voluntary Sector	Additional CCG Contribution	£128,000	Existing

2021-22 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
3	Carers Services	1. Respite services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.

16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
17	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Warwickshire

8.1 Avoidable admissions

		19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)		Available from NHS Digital (link below) at local authority level. Please use as guideline only	4,491.0	4,851.0	Standardised figures not available for 2020-21. Published in 2022. Therefore CCG analysts have been unable to provide a Indirect Standardised Rate as not all the data is available. The extracted data from SUS and compared to observed values in published reports highlights a variance of 106 admissions in 2019-20. This

>> link to NHS Digital webpage

Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	11.1%	10.8%	Based on the forecast produced by CCG analysts on 14+ days and 21+ days the figures show that Warwickshire's performance remains the same as the national % of each LoS category. Noting winter pressures, the increasing Covid19 positive cases, increases in hospital admissions and usage of ITU, a stretching ambition has therefore been set to maintain the objective of keeping in line with current national performance and current actual Warks performance for the remainder of the
	Proportion of inpatients resident for 21 days or more	6.4%	6.1%	

Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.3 Discharge to normal place of residence

	21-22 Plan	Comments
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	95.5%	On average from 2019 to present, 95.5% of Warwickshire LA residents return to their usual place of residence. This continues to be above both the national and regional averages. A stretching ambition will be to maintain this level throughout the rest of the year, taking into account current pressures in the domiciliary

Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	606	716	579	646	Actuals for 2020/21 were 702 and were significantly impacted by the Covid-19 pandemic. The ambition for 2021/22 therefore reflects pre-pandemic levels of an average 66.5 admissions per month, despite continuing to see sustained levels of increased complexity of need including dementia. Increased pressures on the
	Numerator	728	861	702	799	
	Denominator	120,173	120,273	121,235	123,673	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	90.0%	94.1%	91.7%	Actuals for 2020/21 were 323 of 345 discharges in the period Oct-Dec 2020 - 93.6% which is artificially inflated due to the emergency measures put in place during the pandemic. The proposed ambition for 2021/22 therefore reflects an improvement on pre-pandemic business as usual activity.
	Numerator	251	273	275	
	Denominator	279	290	300	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Warwickshire

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes	The HWBB are meeting to approve our Plan on the day after the submission deadline - 17/11 - and have therefore already received and reviewed the Plan submitted in advance of their meeting. Rachel Briden will confirm their		
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes	Please refer to the following pages in the Narrative Plan: - Joined up and integrated approach - Pages 8-10 - Approach to collaborative commissioning - Page 10, 17 and Appendix 1 - How BCF funding is used to support independence - Pages 4,5 and 9 - Health Inequalities - Pages 11-14		
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes	Please refer to pages 15 & 16 in the Narrative Plan and Appendix 2		
NC2: Social Care Maintenance	PR4	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes	The minimum contribution is £14,455,792 pooled into the BCF		
NC3: NHS commissioned Out of Hospital Services	PR5	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes	The minimum contribution is £11,552,343 is pooled into the BCF		
NC4: Plan for improving outcomes for people being discharged from hospital	PR6	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes	A Lead Integrated Commissioner for D2A is well embedded in Warks and a recent review of the D2A commissioning and delivery model has recently been completed - Sept 2021. Trusts have been engaged via the		

Agreed expenditure plan for all elements of the BCF	PR7	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes	The expenditure tab (5a) provides a detailed breakdown of all schemes delivered through the Pooled BCF Budget AND aligned budget. Implementation of Care Act Duties eg. Advocacy, Carer Specific support and Reablement are clearly		
Metrics	PR8	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes	Ambitions have been set for each metric, taking account of rising C19+ cases, admissions to hospital and ITU. Therefore as a system we are planning to maintain existing performance over the remaining 2 quarters of 2021/22, which will mean that as a system we are		

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