# Health and Wellbeing Board Sub-Committee

Date: Thursday 22 September 2022
Time: 2.00 pm
Council Chamber, North Warwickshire Borough Council, South Street, Atherstone CV9 1DE

## 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 Judy Falp

Warwickshire County Council Officers: Shade Agboola and Nigel Minns

Coventry and Warwickshire Integrated Care Board: Danielle Oum

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: Emma Daniell (Deputy PCC)

Items on the agenda: -

**1. General**

**(1) Apologies**

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

**(3) Chair's Announcements**

**2. Better Care Fund** 5 - 66

For the Health and Wellbeing Board's Sub-Committee to consider and approve the final version of the Better Care Fund Plan for 2022/23, for submission to NHS England in line with the recommendation and delegation of the Board on 7th September 2022.

**Monica Fogarty**
Chief Executive
Warwickshire County Council
Shire Hall, Warwick

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- Not participate in any discussion or vote
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# Health and Wellbeing Board Sub-Committee

# 22 September 2022

# Better Care Fund (BCF) Plan 2022/23

## Recommendation(s)

1. The Board's Sub-Committee approves the final version of the Better Care Fund Plan for 2022/23, for submission to NHS England in line with the recommendation and delegation of the HWBB on 7th September 2022.

## 1. Executive Summary

1.1 This is an update to the report discussed at the Health and Wellbeing Board (HWB) on 7th September 2022, (HWB) on the draft Better Care Fund Plan. Following feedback from the Regional Better Care Fund Manager, minor amendments have been made to the BCF Narrative Plan, shown as tracked changes to Appendix 1.

1.2 The Better Care Fund (BCF) is a programme spanning both 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 2022/23

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

1.4 The Better Care Fund 2022/23 Planning Requirements published on 19th July 2022, set out the template for Health and Wellbeing Boards (HWBs) to submit their annual plans for approval.

For 2022-23, 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.
- An intermediate care capacity and demand plan

1.5 The deadline for submission of the BCF plan to NHS England is 26th September 2022. Agreement is therefore sought for approval of the final version of the plan to be delegated to a Sub-Committee of the Health and Wellbeing Board, once it has been approved by the ICB and the Council.

National Conditions

1.6 The Better Care Fund Policy Statement for 2022-23 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 has 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 Integrated Care Boards (ICBs).
2. **NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution** - The contribution to social care from the ICB via the BCF is agreed and meets or exceeds the minimum expectation. In 2022/23 for Warwickshire the minimum contribution is £15.273m.
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 2022/23 for Warwickshire the minimum contribution is £12.206m.
4. **Implementing the BCF Policy Objectives** – National condition 4 requires that local partners should have an agreed approach to implementing the two policy objectives for the BCF, set out in the Policy Framework: i. Enable people to stay well, safe and independent at home for longer. ii. Provide the right care in the right place at the right time.

1.7 For the first time, systems are also required to agree high level capacity and demand plans for intermediate care services, covering both BCF and non-BCF funded services. As a first step, areas are asked to jointly develop a single picture of intermediate care needs and resources across health and social care funded by the BCF and other sources for quarters 3 and 4 of 2022/23. These capacity and demand plans will need to be submitted with main BCF plans, but the content will not form part of the overall BCF assurance process.

1.8 The Coventry and Warwickshire Integrated Care Board ('ICB', previously known as Coventry and Warwickshire Clinical Commissioning Group) and the 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 plan. Spend

applicable to these national conditions is be calculated in the planning template based on scheme-level expenditure data.

1.9 The ICB 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 2022 to 2023. 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

2.1 **Improved Better Care Fund (iBCF)** – In advance of the 2022/23 financial year and publication of the BCF Policy Framework, the Health and Wellbeing Board at its meeting on 12th January 2022 reviewed and supported the list of schemes to be funded from the IBCF for 2022/23.

2.2 These schemes have now been assured against the Policy Framework and it has been confirmed that they continue to meet the required conditions of the grant.

2.3 The grant conditions remain broadly the same as 2021/22. 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.

2.4 **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:

| | | 2022/23 | | |
|---|---|---|---|---|
| | | **Pooled Contribution** | **Aligned Allocation** | **Total Budget** |
| | | **£'000** | **£'000** | **£'000** |
| Minimum NHS ring-fenced from ICB allocation | ICB (SW Place) | 20,154 | 61,290 | **81,444** |
| | ICB (WN Place) | 14,344 | 32,743 | **47,087** |
| | ICB (Rugby Place) | 8,286 | 18,091 | **26,377** |
| Disabled Facilities Grant (DFG) | | 5,124 | - | **5,124** |
| Warwickshire County Council Improved Better Care Fund (iBCF) | | 15,133 | - | **15,133** |
| Warwickshire County Council | | - | 71,308 | **71,308** |
| **Total Pooled Contribution** | | **63,040** | | |
| **Total Additional Aligned Allocation** | | | **183,432** | |
| **Total Budget** | | | | **246,472** |

* 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 2022/32 have been prepared by the Finance Sub-Group in which Finance Leads from both the Local Authority and ICB 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 ICB 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 the ICB, 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 2022/23:

| **Funding Sources** | **2022/23** |
|---|---|
| DFG | £5,124,786 |
| Minimum NHS Contribution | £42,782,742 |
| iBCF | £15,133,281 |
| **Total** | **£63,040,809** |

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 (2022/23: £63m). The former comes from the Department of Health and Social Care through the ICB, 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 Integrated Care Board 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 Integrated Care Board to support closer integration as part of plans for moving to an Integrated Care System.

2.12 The iBCF is temporary. 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.

2.13 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

None.

## 4. Supporting Information

Metrics

4.1 The BCF Policy Framework sets national metrics that must be included in BCF plans in 2022/23. Ambitions should be agreed between the local authority and the ICB 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 measure of avoidable admissions (unplanned hospitalisation for chronic ambulatory care sensitive conditions per 100,000 population) introduced last year has also been retained. 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 – Improving the proportion of people discharged from acute hospital to their usual place of residence has also been retained.

4.5 HWBs are no longer required to set targets relating to reducing length of stay measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days. Despite this there is an expectation that local areas will continue to monitor their performance and so performance will be reported through the Joint Commissioning Board.

4.6 The proposed ambitions for 2022/23 and rationale are set out in the Planning Template and Narrative Plan.

4.7 Locally we will continue to monitor progress quarterly against the BCF metrics set out above through the Joint Commissioning Board and Coventry and Warwickshire Urgent and Emergency Care Board.

## 5. Timescales associated with the decision and next steps

5.1 Prior to final review by the Health and Wellbeing Board on 22nd September, the BCF Plan for 2022/23 has been reviewed and approved by:

| Organisation | Board | Date |
|---|---|---|
| Partnership | Joint Commissioning Board | 17/08/22 |
| WCC | People Directorate Leadership Team | 31/08/22 |
| WCC | Corporate Board | 07/09/22 |
| ICB | Finance and Performance Committee | 07/09/22 |
| WCC | Cabinet | 08/09/22 |
| ICB | Governing Body | 21/09/22 |
| **Submission date** | | **26/09/22** |

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 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. A cross-regional calibration meeting will be held after regions have submitted their recommendations, bringing together representatives from each region. Once approved - NHS England, as the accountable body for the NHS minimum contribution to the fund, will write to areas to confirm that the NHS minimum funding can be released.

Assurance activity

| Assurance activity | Date |
|---|---|
| BCF planning requirements received | 19th July 2022 |
| Optional draft BCF planning submission submitted to BCM | By 18th August 2022 |
| BCF planning submission from local HWB areas (agreed by ICB and WCC) sent to national BCF Team at NHS England | 26th September 2022 |
| Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation | 26th September to 24th October 2022 |
| Cross regional collaboration | 1st November 2022 |
| Approval letters issued giving formal permission to spend (NHS minimum) | 30th November 2022 |
| All section 75 agreements to be signed and in place | 31 December 2022 |

## Appendices

1. Appendix 1 – BCF Narrative Plan
2. Appendix 2 – BCF Planning Template
3. Appendix 3 – BCF Capacity and Demand Plan

## Background Papers

1. None

| | Name | Contact Information |
|---|---|---|
| Report Author | Rachel Briden<br>Integrated Partnership Manager | rachelbriden@warwickshire.gov.uk |
| Assistant Director | Becky Hale<br>Chief Commissioning Officer (Health and Care) | beckyhale@warwickshire.gov.uk |
| Strategic Director | Nigel Minns<br>Strategic Director for People | nigelminns@warwickshire.gov.uk |
| Portfolio Holder | Councillor Margaret Bell<br>Portfolio Holder for Adult Social Care & Health | margaretbell@warwickshire.gov.uk |

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

Local Member(s): None
Other members: None

# Integration and Better Care Fund (BCF) Plan

Better Care Fund Plan 2022/23 Submission – FINAL VERSION

Health and Wellbeing Board (HWBB):

Warwickshire

# National Condition 1: A jointly agreed plan

## Planning Requirement 1 - A jointly developed and agreed plan

### Key Line of Enquiry: Organisations involved in preparing the plan

The following organisations/partnerships have been involved in developing the schemes and joint integration activities as set out in this Better Care Fund (BCF) Plan for 2022/23 (and supporting BCF Planning Template), that will be submitted to NHS England for assurance:

- Representatives on the Warwickshire 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 Integrated Care Board (CWICB) previously known as the Coventry and Warwickshire Clinical Commissioning Group (CWICB);
    - Operational and contracting leads from South Warwickshire University NHS Foundation Trust (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 University NHS Foundation Trust, George Eliot Hospital NHS Trust and University Hospitals Coventry and Warwickshire NHS Trust) and Coventry City Council through the Coventry and Warwickshire Urgent and Emergency Care 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 mutual aid discussions, providers forums and targeted discussions related to specific schemes/initiatives.
- The Councils Learning and Development Partnership distribute a virtual newsletter every month to all commissioned providers. This is full of local and national updates and issues that are current to the provider market at a specific point in time. It also offers local training courses that the provider workforce is able to access.
- The Warwickshire Homecare Association Partnership acts as the spokesperson for domiciliary care providers and Commissioning colleagues have monthly meetings with the Association and contracted provider members. Ongoing dialogue also takes place regularly between the Association and the Council to share strategic updates and problem solve current issues.
- VCS organisations through Place Based Partnerships, the Warwickshire Ageing Well Programme and Board, neighbourhood Place Based Teams and Health and Wellbeing Board.

Warwickshire Health and Wellbeing Board members considered proposed schemes at their meeting on the 12th January 2022.

### Key Line of Enquiry: How we have gone about involving these stakeholders

#### 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 November 2021 and January 2022 with the partners listed above, ready for the start of the 2022/23 year.

#### Preparing the BCF Plan

Following receipt of the BCF Planning Requirements on the 19th July 2022 – the stakeholders represented on the Joint Commissioning Board and Coventry & Warwickshire Urgent and Emergency Care Board (listed above) have been re-engaged during August 2022 to reaffirm and update, where required, the schemes, activities, and metrics. In addition, during August the Warwickshire Care Collaborative Development Group, as part of the Coventry and Warwickshire Integrated Care System (ICS) have been involved in our BCF plans.

## 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, ICB minimum contribution and iBCF) and set out in more detail in the Planning Template.

## Approval timetable

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

| **Organisation** | | Review and Decision / Approval Date |
|---|---|---|
| Wider Partnership | Joint Commissioning Board | 17/08/22 |
| WCC | People Directorate Leadership Team | 31/08/22 |
| WCC | Corporate Board | 07/09/22 |
| WCC | Cabinet | 08/09/22 |
| CW ICB | Integrated Care Board | 21/09/22 |
| Partnership | Health and Wellbeing Board – review, and approval | 07/09/22 & 22/09/22 |
| | **Submission deadline** | **26/09/22** |

## Responsibilities for preparing this plan

**Accountable:** Chief Commissioning Officer (Health and Care), Warwickshire County Council and South Warwickshire University NHS Foundation Trust

**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 ICB Executive Team and Board, Coventry and Warwickshire's Urgent and Emergency Care Delivery Board, Care Collaborative Development Group.

**Informed:** Warwickshire Health and Wellbeing Board

## Document History

| Version | Summary of changes | Author | Date |
|---|---|---|---|
| **V0.1** | Draft version shared within WCC | Rachel Briden | 08/08/22 |
| **V0.2** | Draft version shared with partners on the JCB & Regional Better Care Fund Manager for feedback | Rachel Briden | 16/08/22 |
| **V.03** | Includes feedback received from Regional Better Care Fund Manager and is the version for review and sign off by People DLT, Corporate Board, Cabinet and CWICB F&P Committee | Rachel Briden | 25/08/22 |
| **V0.4** | Includes amends following feedback received from UHCW and the Regional BCF Manager and is the final version for approval by the HWBB for submission to NHS England | Rachel Briden | 08/09/22 |

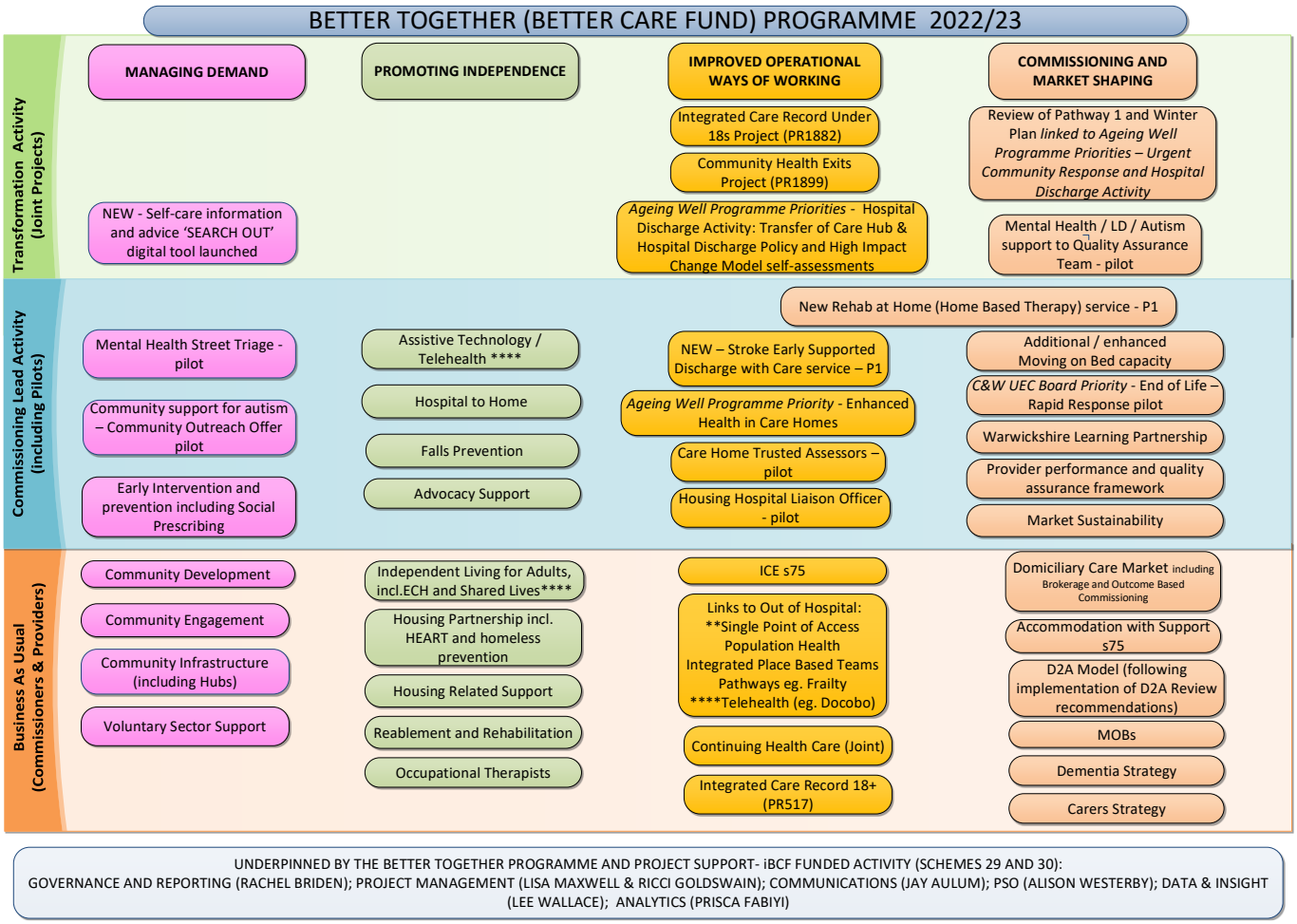
# Executive Summary

## Background

The Better Care Fund has been one of the key contributors over the last seven 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. These foundations have enabled the services currently commissioned through the Better Care Fund to commence with plans to move responsibility into the geographical collaboratives of the new Coventry and Warwickshire Integrated Care System during phase 1 development.

Locally our BCF Plan for 2022/23 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 2016-22.

The majority of schemes and activities in our BCF plan for 2022/23 continue on from previous years. The illustration below summarises the schemes in our BCF Plan, new activity and the links to NHS programme activity:



## Joint Priorities for 2022/23

At the beginning of the year, the following new schemes were agreed to support the two BCF Objectives to 1. Enable people to stay well, safe and independent at home for longer and 2. Provide the right care in the right place at the right time:

1. Transformation project activity being delivered through the Better Together Programme:
    a. Extension of the integrated care record in WCC (already delivered for Adults in March 2022) for under 18s; and
    b. Streamlining access to social care for those patients requiring on-going support on exit from Community Health pathways (Home Based Therapy, Home First, Urgent Community Response or Stroke ESD)
2. Hospital Discharge improvement activity relating to trusted assessments, the High Impact change Model and transfer of care hub to be delivered through the System Operational Discharge Delivery Group facilitated by WCC through the Better Together Programme and assured through the Warwickshire Ageing Well Programme governance.

## Key Changes since the previous BCF plan and how we will continue to implement a joined up approach to integrated services

As the new architecture for the Coventry and Warwickshire Integrated Care System have started to be implemented, increased focus on joint delivery (in addition to joint commissioning which has been in place for a while) has resulted in some of the duplication in previous years being removed, as operational and commissioning activity delivered through both the BCF and Ageing Well Programmes are now embedded in the new arrangements.

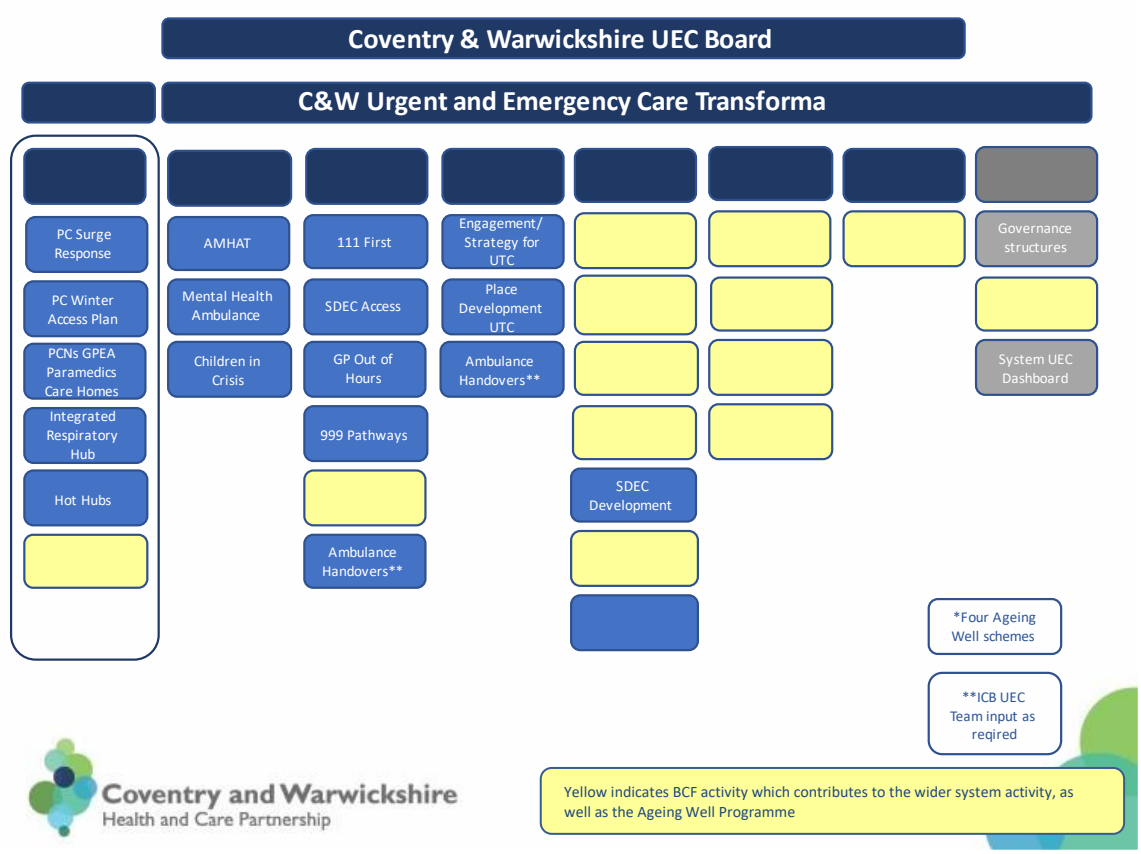
A good example of this is, through the Enhanced Health in Care Homes Ageing Well Programme workstream there has been considerable development of Telehealth Remote Monitoring (Docobo) in Coventry and Warwickshire

- This includes the roll out of Docobo in care homes for older people across Coventry and Warwickshire. It first worked with homes in North Warwickshire and following a very successful implementation is now also well-established and still growing in the Rugby and South areas of Warwickshire as well as getting underway more recently in Coventry and in care homes for younger age adults with disabilities in North Warwickshire.
- The table below shows summarises the current level of involvement by care homes for older people in Coventry and Warwickshire.

| | Live Homes | Active Residents | Delivery Status |
|---|---|---|---|
| Warwickshire North Older People Care Homes | 24 | 1036 | 89% |
| Warwickshire South Older People Care Homes | 8 | 314 | 80% |
| Warwickshire Rugby Older People Care Homes | 24 | 433 | 73% |
| Coventry Older People Care Homes | 2 | 49 | 14% |
| Warwickshire North Disabilities Care Homes | 19 | 96 | 95% |
| **TOTAL** | **77** | **1,928** | |

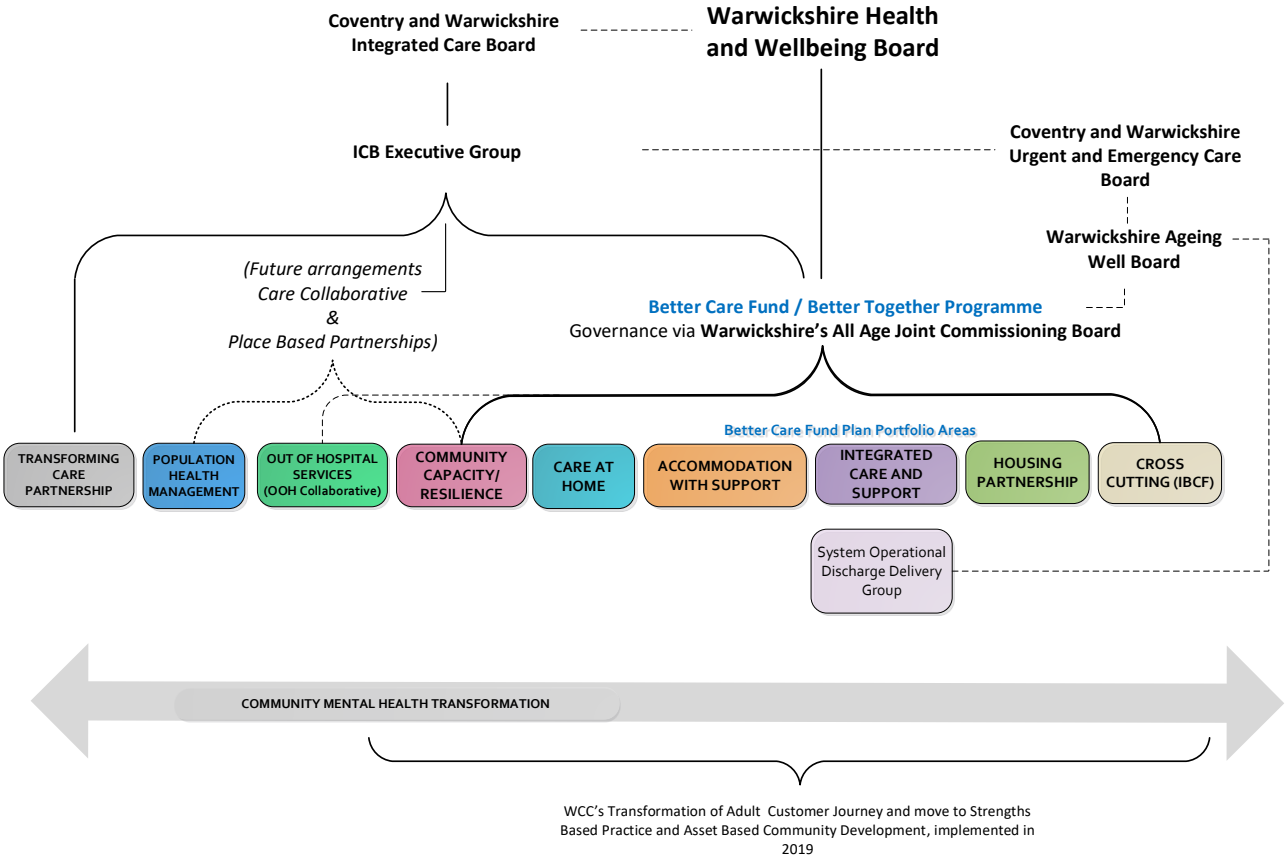
- Deteriorating patients in care homes, has been built into Docobo and where this is in use the current response time to any alerts is around 96% within 2 hrs of the alert.
- Due to the success in care homes, Docobo at Home is also now being planned as part of the Anticipatory Care workstream in the Ageing Well Programme.
- Digital infrastructure has focussed on sign up to the data security and protection toolkit and the use of NHS mail. This supports the use of electronic proxy ordering of medicines which is also being rolled out across Warwickshire.

The key cross-cutting and joint priorities are highlighted in yellow in the illustration below, along with the ICS reporting arrangements:


Coventry & Warwickshire UEC Board
C&W Urgent and Emergency Care Transforma
PC Surge Response
PC Winter Access Plan
PCNs GPEA Paramedics Care Homes
Integrated Respiratory Hub
Hot Hubs
AMHAT
Mental Health Ambulance
Children in Crisis
111 First
SDEC Access
GP Out of Hours
999 Pathways
Ambulance Handovers**
Engagement/ Strategy for UTC
Place Development UTC
Ambulance Handovers**
SDEC Development
Governance structures
System UEC Dashboard
*Four Ageing Well schemes
**ICB UEC Team input as reqired
Coventry and Warwickshire
Health and Care Partnership
Yellow indicates BCF activity which contributes to the wider system activity, as well as the Ageing Well Programme

## Governance of the BCF Plan and implementation in Warwickshire

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




Governance decisions regarding the BCF for Warwickshire are endorsed by Warwickshire County Council Cabinet and the Coventry and Warwickshire ICB with ultimate accountability for signing off BCF commitments made by Warwickshire Health and Wellbeing Board.

Governance of implementation of the Better Care Fund, BCF Plan and Better Together Programme is currently through the Warwickshire Joint Commissioning Board; underpinned by a Section 75 agreement.

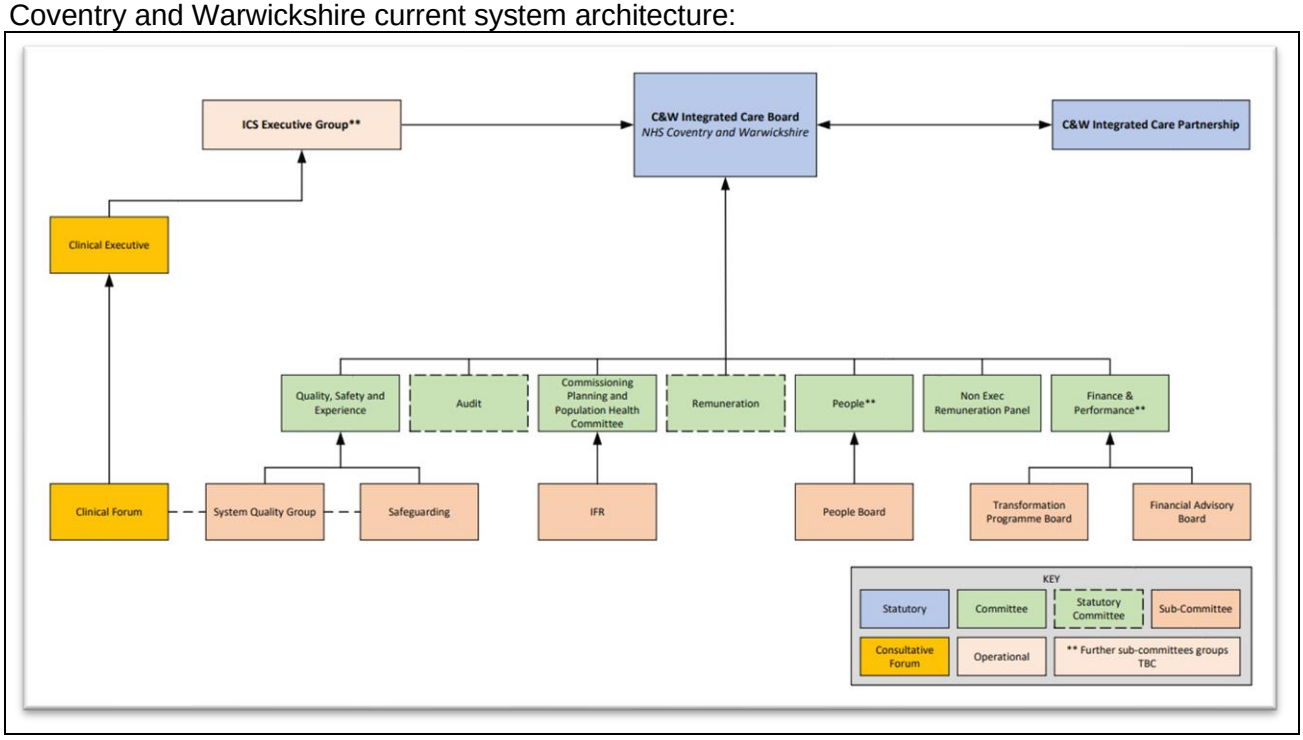
Our BCF Plan comprising of the pooled/aligned budgets, list of schemes, metrics and priorities outlined in the Planning Template and this Narrative Plan have been developed by the Joint Commissioning Board, as part of these wider partnership and system governance arrangements.

The Board is supported by a Finance Sub-Group (comprising of Finance Leads from the local authority and CWICB) which leads on scheme level spending plans for the pooled (base BCF) and aligned budgets, managing the impact of the end of the Covid-19 related Hospital Discharge Grant, risk share and associated Section 75 arrangements.

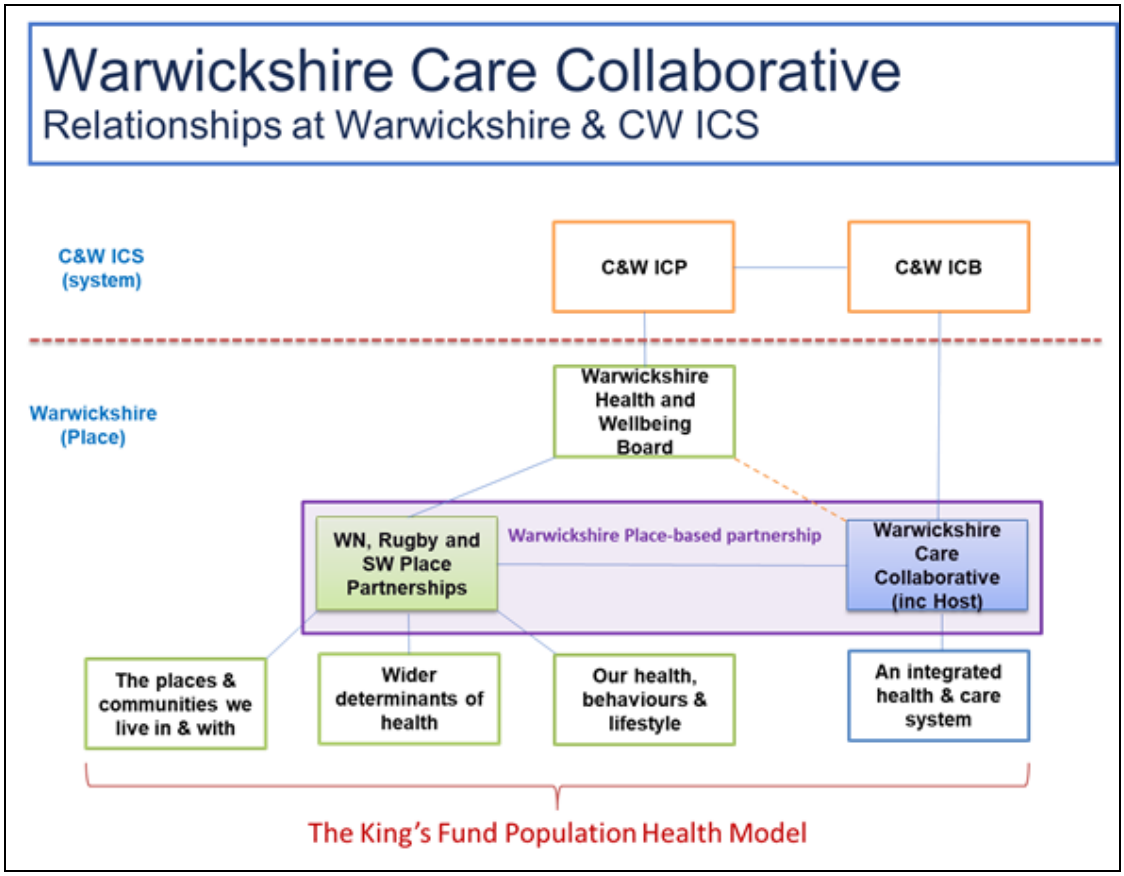
### Integrated Care System governance arrangements

The illustration below summarises the current Coventry and Warwickshire Integrated Care System architecture, which is included in both Coventry and Warwickshire's separate BCF Plans and are endorsed by the two respective Health and Wellbeing Boards. *Please refer to **Appendix 2 – C&W ICS Functions and Decisions Map** – which sets out the governance arrangements that support collective accountability between partner organisations to the whole system.*

Coventry and Warwickshire current system architecture:




The following illustration outlines the developing architecture for Warwickshire:



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

### Key Line of Enquiry: Overall BCF plan and approach to integration

Health, social care and wider partners within Warwickshire and Coventry have previously through the BCF developed a variety of integrated and joint working arrangements, which have formed the foundation of the Coventry and Warwickshire ICS.

In last year's plan we provided a summary of the extensive current arrangements in place for the BCF and wider services, including joint commissioning, partnerships, funding and strategies, lead commissioning arrangements and integrated approaches to quality assurance, training and market management. These arrangements continue with a joint commitment that the BCF for Warwickshire (and Coventry) will be one of the functions that transitions from the ICB to Care Collaboratives as part of phase 1 priorities. Proposals for how this will happen will be developed from quarter 3 of 2022/23.

Integrated commissioning is well embedded in Warwickshire supported by established integrated roles:

- 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 for Integrated and Targeted Commissioning and Out of Hospital Services,
- An Integrated Commissioning team for People with Disabilities, (WCC/CWICB/Coventry City Council),
- An Integrated Partnership Manager responsible for the Better Care Fund on behalf of WCC and CWICB.

Within Warwickshire the commitment to integrate commissioning resource between the NHS and local authority was further strengthened with the joint appointment of a Chief Commissioning Officer (Health and Care) for Warwickshire County Council and South Warwickshire University NHS Foundation Trust on the 1st April 2022.

Through the BCF, a new co-production model was agreed and implemented in August 2021, to strengthen our local approach to collaborative commissioning and ensure services and support are co-produced with people with lived experience, promoting a focus on reducing health inequalities, particularly for people with protected characteristics. A framework of co-production providers has now been commissioned by Warwickshire County Council on behalf of NHS and local authority partners to support co-production activity and build capacity in the system.

Work continues across health and care partners to support development of the Coventry and Warwickshire Integrated Care System (ICS). The Integrated Care Board (ICB) and Integrated Care Partnership (ICP) are now formally constituted and there remains commitment to the establishment of 2 geographical care collaboratives as the system's primary "place-based partnerships". A key component of the ICS, these care collaboratives will be made up of the partnership of organisations responsible for organising and delivering health and care within Coventry and Warwickshire respectively. In Warwickshire the current intention is that the collaborative will be hosted by South Warwickshire University NHS Foundation Trust (SWFT).

The Care Collaboratives will be:

- The foundation for the integration of health, social care and public health services; and population health at Coventry level and Warwickshire level.

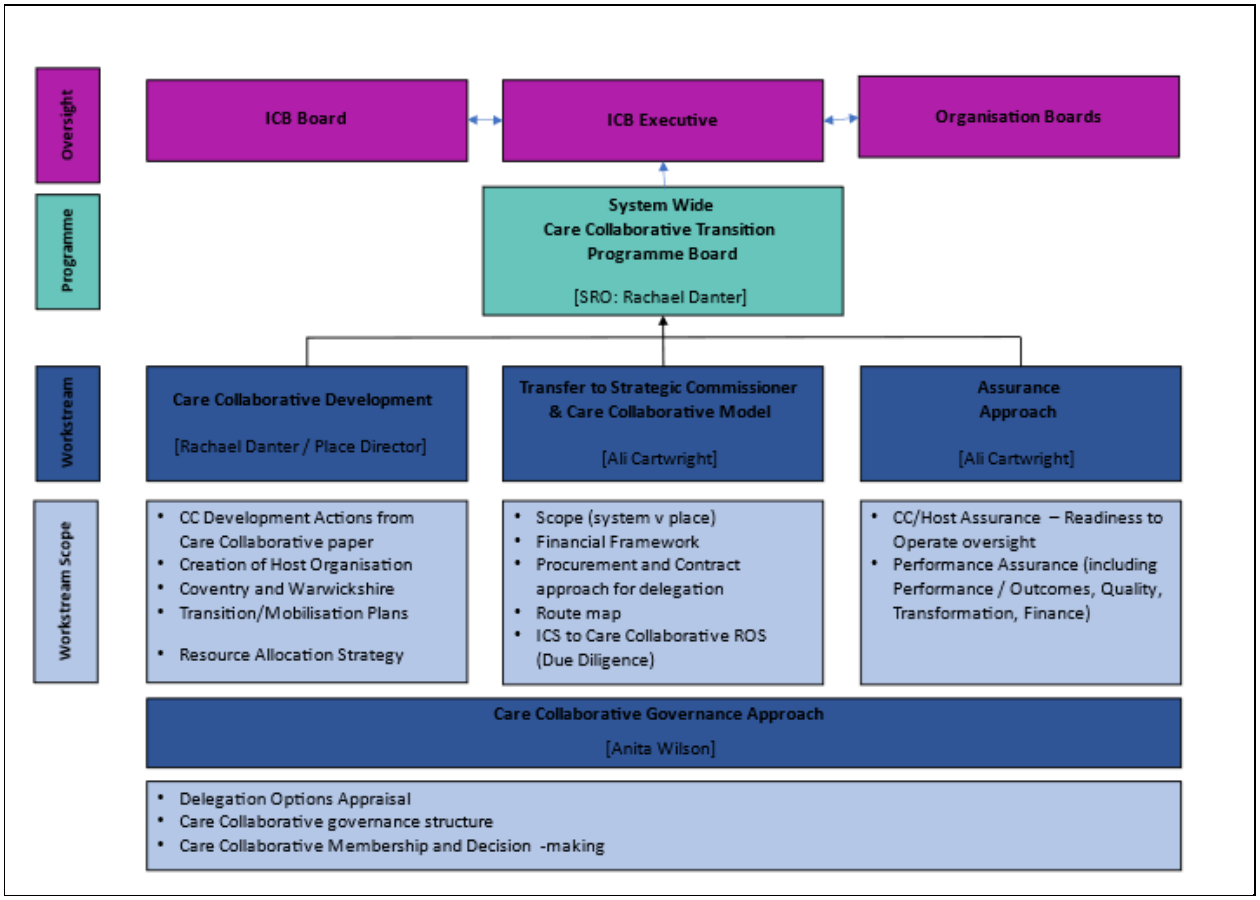
- The entities that the ICB will ultimately delegate the majority of NHS resource (from April 2023 subject to assurance of readiness to operate).
- Held to account by the ICB for the delivery of identified metrics/outcomes associated with functions and resources delegated to them.

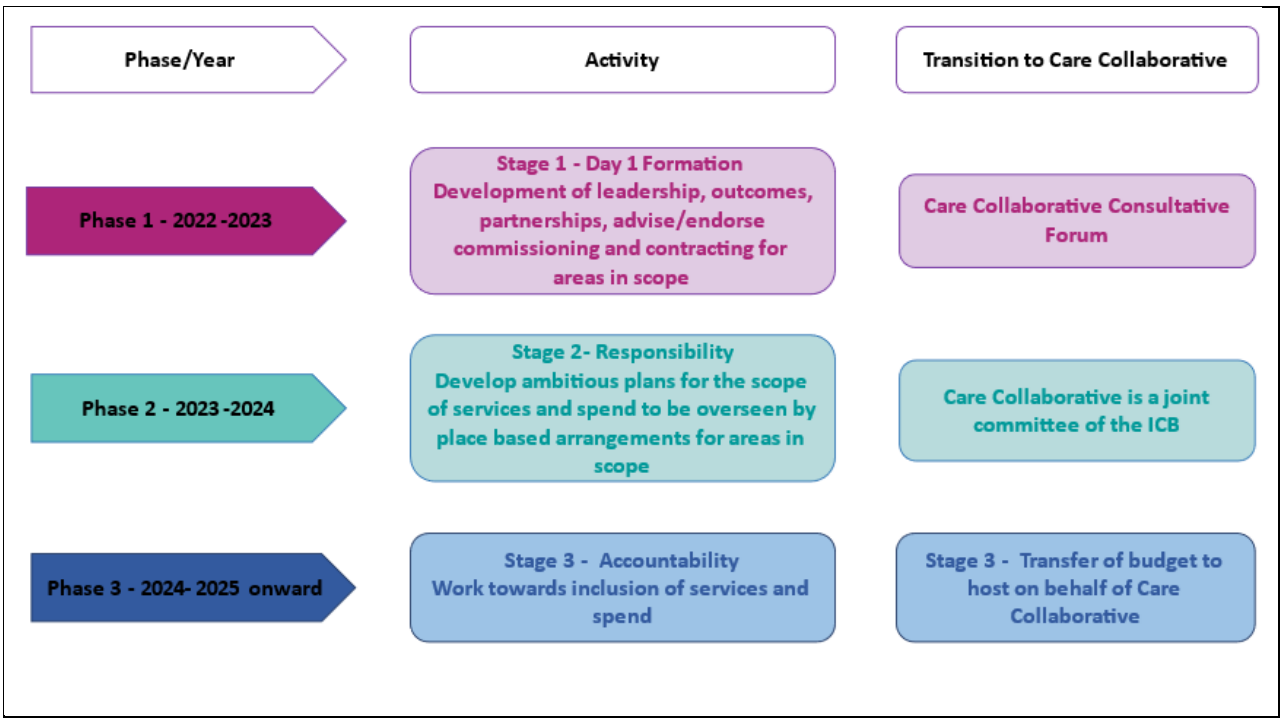
In Warwickshire we have endorsed the primacy of place and as such a key function of the Warwickshire Care Collaborative will be to support and enable integrated planning and delivery across the three place partnerships in Warwickshire North, Rugby and South Warwickshire; channelled through the NHS primary providers in those places.

**Activity has been prioritised and is centred on supporting the following programmes of work:**

1. Coventry and Warwickshire Care Collaborative Development Programme

Coventry and Warwickshire ICB are facilitating 3 workstreams focused on Care Collaborative development including transfer of responsibilities, governance and assurance. The workstreams are overseen by a Programme Board. An outline of the work programme is provided below alongside the current intentions for phasing work and associated governance arrangements from the ICB to Care Collaboratives.






2. Warwickshire Care Collaborative Development Group

The Warwickshire Care Collaborative Development Group has been established to bring together partner representatives who will form part of the Warwickshire Care Collaborative. The group is taking action to shape the collaborative and support the establishment of the functional and governance arrangements required to take on delegated powers and functions from the ICB from March 2023 onwards. The group has a split agenda and split action plan to accommodate development of both the Care Collaborative and the proposed hosting arrangements.

A key part of the Warwickshire Care Collaborative action plan is the establishment of the Care Collaborative consultative forum/joint committee. This is currently planned for quarter 3 of this year as there are some key inter-dependencies with the Coventry and Warwickshire Care Collaborative work programme. Terms of reference and role profiles will be co-developed for the Care Collaborative partnership members.

**For phase 1 (2022/23)** the focus for geographical care collaboratives has been agreed as follows:

1. Urgent and Emergency Care,
2. Out of Hospital Services,
3. Continuing Healthcare, and
4. **the Better Care Fund.**

As a consultative forum the Care Collaborative will have its own plan linked to the above and the Integrated Care Strategy and will be creating the conditions for the delivery of place partnership priorities and plans to:

- improve outcomes across Warwickshire;
- ensuring a robust population health management approach;
- arrangements for performance and assurance; and
- effective partnership engagement including with the Voluntary and Community Sector, residents and communities.

3. Host Provider Development

The Warwickshire Care Collaborative host organisation will play a critical role in supporting the Warwickshire Care Collaborative to discharge its functions. The host will work in collaboration with the ICB, local providers of healthcare services, local authorities, and wider partners and will ultimately act as a prime convenor, integrator and facilitator. It will take on some functions delegated from the ICB on behalf of the Care Collaborative as mutually agreed between partners,

e.g., planning, commissioning and contracting for health and care services across the Warwickshire footprint.

4. Provider Collaborations

Provider Collaborations are being considered within the Coventry and Warwickshire ICS where there is a clear scope and benefit. A Coventry and Warwickshire Primary Care Collaborative has been created and a Mental Health Collaborative approach endorsed.

Changes to services commissioned through the BCF from 2022-23.

- Following a successful pilot in Warwickshire North place in 2021/22, implementation of a new Rehab at Home (Home Based Therapy) service. Re-design of D2A Pathway 2 bed-based therapy to Pathway 1 Rehab at Home (Home Based Therapy) in South Warwickshire and in September 2022 extension of this offer to Rugby place. These services are being commissioned by integrated commissioners working across WCC and SWFT as the NHS out of hospital provider on behalf of the ICB and involve rehab from NHS teams and domiciliary care commissioned by the local authority.
- As part of the wider changes to and centralisation of, Stroke services across the Coventry and Warwickshire ICS, introduction of a new Stroke Early Supported Discharge with Care pathway, for patients with low level needs requiring neuro therapy and domiciliary care. This addresses a known gap for the local population to date. Piloted in August with implementation planned for September 2022.
- This year, we are supporting more patient's to receive reablement starting on the same day as discharge, by expanding the commissioned hospital to home service to this service and will evaluate the impact on outcomes and service capacity (e.g. by reducing length of stay in the service).
- Additional night-time support needs have now been extended to more Extra Care Housing facilities, commissioned proportionate to the level of needs in the scheme and more person centred, with resources targeted flexibly, to reduce the risk of hospital admissions for schemes with high care hours.

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

### Key Line of Enquiry: How the plan will contribute to Equality and reducing Health Inequalities

Warwickshire has a robust approach to health inequalities that capitalises on the strategic and operational expertise of our cross-sector partners. Taking action to reduce inequalities at a system, county, place and organisational level occurs through the following mechanisms:

- Coventry and Warwickshire ICS Health Inequalities Strategic Plan
- Warwickshire Health and Wellbeing Strategy 2021-2026
- Director of Public Health Annual Report 2020/21
- Evidence and data gathering through Joint Strategic Needs Assessment (JSNA)
- Warwickshire County Council Equality Impact Assessment (EqIA)

System Approach (Coventry and Warwickshire)

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.

We share a Health and Care Partnership system with Coventry, and all strategy, prioritisation and implementation of work is endorsed through it. The Integrated Care System (ICS) has three core purposes:

1. Improve outcomes in population health and healthcare
2. Tackle inequalities in outcomes, experience and access
3. Enhance productivity and travel for money

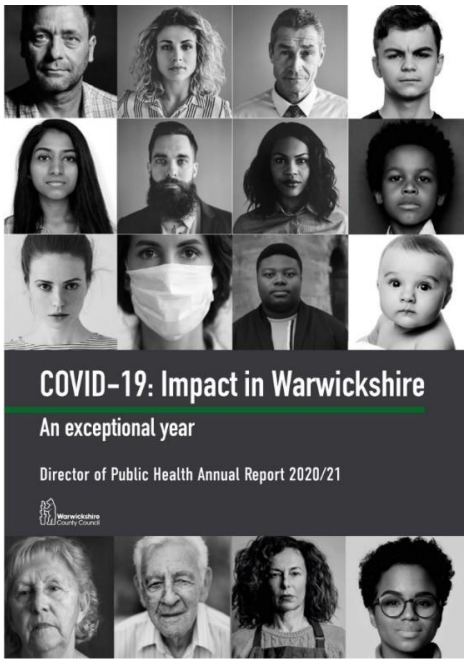
The recently agreed Health Inequalities Strategic Plan for Coventry and Warwickshire (2022-2027), sets out how, as a system, we will reduce health inequalities in Coventry and Warwickshire. The Strategic Plan outlines how it will take into account delivery of the key elements of the NHS Long Term Plan and the NHS CORE20+5 framework. As part of our CORE20+5 approach we will be working to improve the health of those in the 20% most deprived lower super output areas (LSOAS), plus inclusion health groups including gypsies, roma and traveller communities, people experiencing homelessness, newly arrived communities and for Warwickshire those experiencing difficulty in accessing services as a result of rural isolation.

Services and schemes commissioned through the BCF will support delivery of this Strategy, and in particular two of the Major Inequalities Work Programmes ***(please refer to pages 18 to 22 of Appendix 1 as part of the Supporting Information):***

- Long term conditions and prevention
- Urgent Care Development

As well as the 'Transient and newly arrived communities' Plus Group through the work of the Housing Partnership and the links to Assistive Technology, Virtual Wards with the Digital Transformation Strategy; and the Strengths / Asset based approach, self-management, social prescribing and personal health budgets with the Personalistion enabling workstreams.

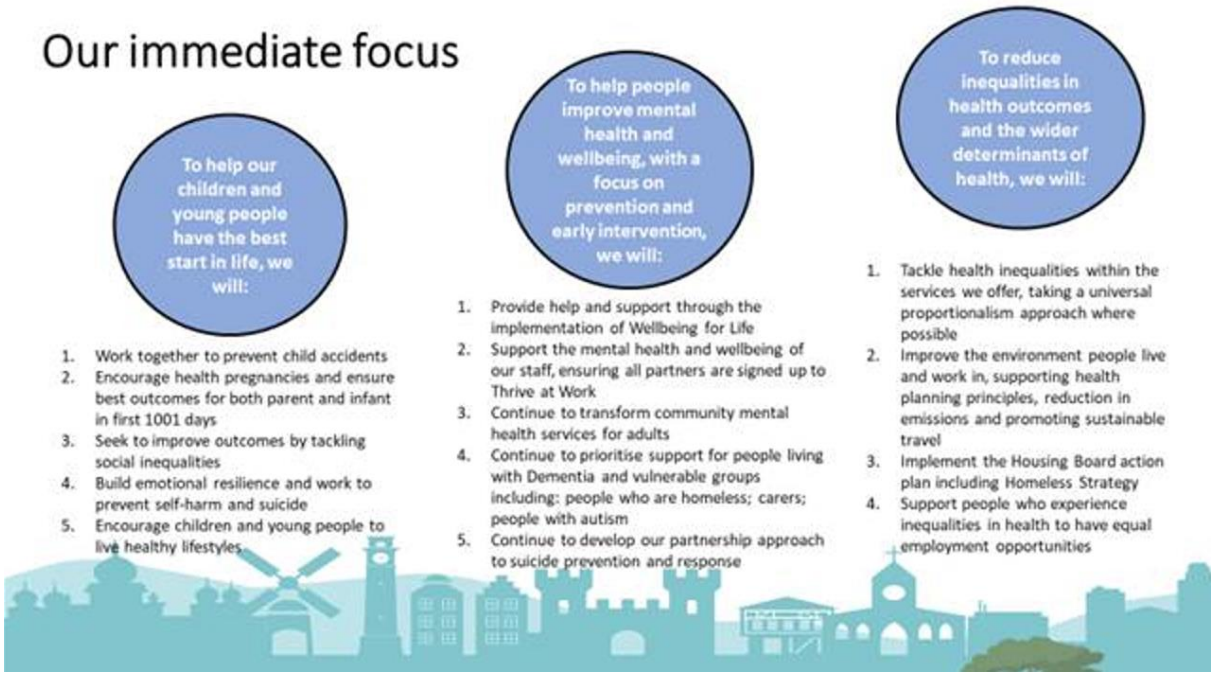
County level (Warwickshire)




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. The implementation plan included three place-based workshops for Warwickshire's Health and Wellbeing Partnerships (Warwickshire North, Rugby, South Warwickshire. As well as this a HiAP website with open access has been developed and promoted, and WCC Public Health continue to promote an offer of support and direction to all colleagues as they begin to implement HiAP. There are a number of tools that can be used to help implement HiAP, including undertaking Health Equity Assessment Tool (HEAT). Within Warwickshire County Council HEAT has been embedded into the Equality Impact Assessment (EQIA), and therefore any EQIA form that is completed has a strong health inequalities section. 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. An audit of responses to the health inequalities section of the EQIA is currently underway and will help identify areas for improvement.

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. A public facing 'Monitoring Health Inequalities in Warwickshire' dashboard has been developed to monitor inequalities over time. This dashboard has been developed to display indicators around the HWBB priorities and is aligned to the King's Fund Population Health Framework.




The Better Together Programme is one of our local delivery programmes which support addressing the inequalities in the HWB Strategy and pilots/pump-primes new admission avoidance schemes. This is evidenced by for example the IBCF funding for the Community Outreach Offer for Adults with Autism, Dementia services, Carers support, an increasing focus on social prescribing and homelessness. Housing inequalities which impact health continue to be a key focus within our delivery plan, and the BCF Housing Action Plan outlines this.

## Place (North, Rugby, South)

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. JSNA and Health Inequalities dashboard data is programmed into the forward plans for each place to ensure that the latest data and intelligence is shared and can be factored into local decision making., Health inequalities is a key priority for all three of these places.

## 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.

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 Home Based Therapy pathway, which was piloted first in the north of the county,
and enhancement of support for the wider determinants of health such as self-neglect around Hoarding.

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'

## Planning Requirement 3 - A strategy and joined up plan for Disabled Facilities Grant Spending

### Key Line of Enquiry: 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) | 2022/23 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 bringing together health, social care and housing

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 continued to be used for wider purposes. Warwickshire Housing Authorities have agreed harmonised financial assistance policies under an 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. Following the independent review of the HEART Service and supporting governance arrangements, Paul Smith, Director of Foundations was appointed as an Independent Chair of the HEART Board in April 2022. Areas of focus for the service outlined in the HEART Strategic Development Plan for 22-23 include: options around a self-serve model to support more prevention activity and improve access, implementation of a new ICT system to improve speed of processing and updating the Housing Assistance Policy.

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.
- 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.

Activities of the Housing Partnership Board

As mentioned in last year's BCF Plan the joint (health, social care, VCS and housing) activities for 2022/23 are outlined in the Housing Partnership action plan. Some key deliverables in 21/22 included development of the countywide Homelessness Strategy, extension of the Preventing Homelessness Improving Lives service, expansion of the Housing Hospital Liaison offer to A&E and ED in acutes to support admission prevention and housing partnership involvement in development of the county's joint Safe Accommodation Strategy and provision, supporting Domestic Abuse.

Key joint areas of focus and changes for 2022/23 relate to addressing health inequalities through housing as outlined in the Health Inequalities Strategic Plan for Coventry and Warwickshire *(please **refer to Appendix 1 as part of the Supporting Information)*** and include:

- Housing support for refugees and asylum seeker / migrant communities
- Green homes: poor housing, damp and cold – support/grants and accessible preventative information
- Implementation of the Transforming care, Learning Disabilities and Autism Housing Plan
- Increasing access to Specialised Housing Schemes for adults with Learning or Physical Disabilities
- Re-design of Housing Related Support services, and
- Implementation of a Young Person's Protocol re: homelessness and young people

as well as for example, training for acute ward and discharge teams on Duty to Refer and homeless support and homeless prevention support as part of Early Discharge Planning (High Impact Changes 1 and 9).

## National Condition 4 - Implementing the BCF Policy Objectives

### Planning Requirement 6 – An agreed approach to implementing the BCF Policy objectives, including a capacity and demand plan for intermediate care services

#### Key Line of Enquiry: Overarching approach to supporting people to remain independent at home

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 through the BCF is well embedded within Warwickshire. This is evidenced by:

- The 'Home First' approach, commissioning and delivery model which is in place across community NHS services and the local authority, aligned to our Discharge to Assess commissioning and operational model. Evidenced by: Strong performance against the 'discharge to normal place of residence BCF metric' (95.5% in 21/22 for all ages, 95.37% for Minority Ethnic, 95.47% for 61-80 and 90.53% for 81+).

- Consistently strong performance against the national Discharge to Assess metrics:

| % patients discharged to | National D2A Target | Example for July 2022/23 | | | | | |
|---|---|---|---|---|---|---|---|
| | | All Age | | | 65+ | | |
| | | SW | WN | Rugby | SW | WN | Rugby |
| P0 | 50% | 96.0% | 84% | 91.28% | 93.10% | 80% | 83.48% |
| P1 | 45% | 2.10% | 12% | 5.77% | 3.60% | 14% | 11.41% |
| P2 | 4% | 1.70% | 3% | 2.25% | 3.10% | 4% | 4.20% |
| P3 | 1% | 0.10% | 1% | 0.70% | 0.30% | 2% | 0.90% |

- 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 University 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.

- Promoting the use of digital tools and Telehealth or Assistive Technology in the community by NHS community and Adult Social Care including Care Homes to benefit both health and social care outcomes and early intervention are key to our offer e.g., *Docobo* and *MySense* as part of our carers offer for Dementia patients in their own homes.

- On the 31st March 2022, Warwickshire launched https://searchout.warwickshire.gov.uk/ to enable people to support themselves in their community without the need to contact health or social care services and enables health and care staff through place based asset based approaches support people to make use of local community resources to reduce health inequalities, including those with protected characteristics. This digital tool, along with Community Powered Warwickshire was delivered through the Better Care Fund Community Capacity and Resilience Portfolio with IBCF funds from previous year's plans.

- As a system, the 'Tribe' tool is also being evaluated as a potential tool to support people to remain independent for longer in their own homes, where a person/family/informal carer can enter the support requirements and a list of providers who might be able to support, as well as volunteers are matched.

- Warwickshire County Council jointly with Coventry City Council have led the development of a revised local Dementia Strategy in 2022. This strategy: Coventry and Warwickshire's Living Well with Dementia Strategy 2022 - 2027 highlights a number of areas for improvement priorities aligned to the national Well Pathway for Dementia and identifies the following 6 priority areas for the local system. 1. Reducing the risk of developing dementia, 2. Diagnosing Well, 3. Supporting Well, 4. Living Well, 5. End of life care, 6. Training Well. An estimated 11,500 people in Coventry and Warwickshire live with dementia, but only around 56% of these have a formal diagnosis.

- New work on Urgent Community Response; including support for un-paid carers for admission prevention. As a system, as part of the Ageing Well programme, NHS partners, the local authority and charity/voluntary sector are developing new ways of working, linked to the Frailty Assessment Areas in Emergency Departments and the Carers Services with support delivered through the Better Care Fund to reduce attendance, prevent admission and reduce length of stay.

- As part of our improvements to ensure as a system we are ***'providing the right care in the right place at the right time'*** a review of demand and capacity modelling and capability within community health and social care services supporting discharges in Warwickshire was undertaken from November 2021 to February 2022. This review was carried out by an independent consultant supporting the Better Together Programme and System Operational Discharge Delivery Group.
    - The review built on the place based discharge dashboard (data shown by pathway and length of stay) available for system use since the beginning of the pandemic, and expanded in 2021 to include community health and care services. Through dashboards established and managed by the Better Together Programme resources, detailed data is already shared across the system on length of stay, outcomes, by age and ethnicity for exits from sub-pathways supporting discharge, to more effectively manage flow into and out of community services, and prevent blockages.
    - Through the Ageing Well - Hospital Discharge Workstream, the next step this year (in 22/23) is to develop real time demand and capacity data and capability, which is currently inconsistent across different community health and social care pathways (P0-3). Whilst options are being considered (not just for Intermediate Care, but all services to support P1-3 discharges), basic demand and capacity plans are in place and those for Intermediate Care are detailed in the BCF Capacity and Demand Template included as part of this submission.
- Preparations for delivery of anticipatory care are also being progressed by health and care partners engaged on the Ageing Well Programme's Anticipatory Care workstream.

Business as usual services funded through the core/base BCF and delivered through our BCF Plan which '***enable people to stay well, safe and independent at home for longer***' include:

- Domiciliary Care - continues to provide support to people leaving hospital and those already at home that have been identified as requiring some support with intimate personal care tasks and daily living activities. A geographical zonal model is in operation which comprises of a number of providers operating in a specific zone with an allocated percentage of business. Our domiciliary care market also supports the health pathways; Home Based Therapy and Stroke.
- The Integrated Community Equipment Service – which continues to develop and evolve to meet on-going pressures both within the community and also to support discharges, particularly due to the increased demand due to the C&W Accelerator site status to reduce the NHS elective surgery backlog.
- Out of hospital and intermediate care provision including HomeFirst (planned and urgent response), community nursing and the recently transformed therapy services supporting D2A Pathway 1 discharges (Home Based Therapy).
- The Falls Prevention pathway and single point of access for support for people identified as moderate and high risk of falls, implemented as part of last year's BCF plan.

- The HEART Housing Equipment Assessment and Response Team (refer to pages 17&18)
- In addition to social prescribing support delivered via PCNs, social Prescribing is also available for patients discharged home under P0 and P1, to support re-admission prevention with a focus on reducing health inequalities.

Workforce Planning

In response to the workforce challenges that many local areas are experiencing, a number of key pieces of work to attract, retain and grow the health care sector been agreed by the local system. The Learning and Development Partnership for providers funded from the IBCF supports this activity e.g. provider workforce recruitment campaigns and retention through training and support.

Coventry and Warwickshire's Integrated Care System also commissioned Clever Together to support development of a "One People Plan". The plan will help ensure our population has access to excellent and compassionate care and health services, provided and supported by happy, healthy people. A series of "big conversations" with people leaders and managers from across the entire system took place during July and August, plus a review of documents and good practice. This is informing the co-creation of a One People Plan with key system-level priorities and potential action areas; a review of governance arrangements with recommendations to help assure delivery of the plan and the core Organisational Development (OD) interventions needed. Key elements of the plan will help address common workforce challenges which may risk delivery of BCF schemes, e.g. incentives to attract and retain staff and better connections with the VCS sector.

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

The System Operational Discharge Delivery Group have also completed local joint assessment against the National Hospital Discharge Policy each time this has been refreshed and the latest version of the High Impact Change Model for managing transfers of care. This is completed at a Warwickshire system and place level. These activities were refreshed during July to August 2022 and there are four key follow on actions relating to the Hospital Discharge Policy:

| **Hospital Discharge Policy Requirement** | **Planned HDG Actions** | **Links to planned HICM actions** |
|---|---|---|
| 1. Transfer of Care Hub | a. Evolution of local MDT approach<br>b. Pathway 1 review and recommendations under consideration<br>c. New project to streamline operational processes and earlier notification of demand relating to NHS services enabled by domiciliary care at Project Proposal Stage<br>d. Expansion of system wide data through the Enhanced Discharge Tracker and Discharge Services Review Dashboard to all pathways | Change 3 – MDTs<br>Change 4<br><br>Changes 1, 2 – Responsive Capacity & 4<br><br>Change 2 – Effective Information Sharing and System view of flow and blockages |
| 2. Single Co-ordinator / Point of Contact | a. New streamlined discharge referral processes in pilot across the system<br>b. Streamlined access points into social care now in place<br>c. Rehab at home support now merged | Change 1<br><br>Changes 3 and 4<br><br>Change 4 |
| 3. Case Management arrangements | a. New trusted assessment approach for community health exits in pilot<br>b. Review of D2A P2 Nursing/CHC Assessment Beds underway including the role of Discharge Teams | Change 6 – Trusted Assessments to be extended wider than just Care Homes |
| 4. More patients offered Rehab or Reablement | a. Review of capacity and demand - tools and capability completed<br>b. New Rehab at Home and Stroke Rehab pathways commissioned | Change 2 – Capacity does not always match demand<br>Changes 1, 2 and 4 |

Whilst there are examples of 'Exemplary' commissioning and operational activity in each place and across the county, the overall High Impact Change Model self-assessment identifies three key areas of focus, which are shown below.

Note: Change 8 is delivered via the Enhanced Health in Care Homes Ageing Well Programme Workstream and Change 9 via the Housing Partnership Board.

| Warwickshire High Impact Change Model self-assessment | Not yet established | Plans in place | Established | Mature | Exemplary |
|---|---|---|---|---|---|
| | Processes are typically undocumented and driven in an adhoc reactive manner | Developed a strategy and starting to implement, however processes are inconsistent | Defined and standard processes are in place, repeatedly used, subject to improvement over time | Processes have been tested across variable conditions over a period of time, evidence of impact beginning to show | Fully embedded within the system and outcomes for people reflect this, continual improvement driven by incremental and innovative changes |
| Change 1 - Early discharge planning | | | | | |
| Change 2 - Capacity and Demand Planning | | | | | |
| Change 3 - Multi-disciplinary working (MDTs) | | | | | |
| Change 4 - Home first Discharge to Assess | | | | | |
| Change 5 - Flexible Working Patterns | | | | | |
| Change 6 - Trusted assessment | | | | | |
| Change 7 - Engagement and Choice | | | | | |
| Change 8 - Improved discharge to care homes | | | | | |
| Change 9 - Housing | | | | | |

Our approach to commissioning services to support Discharge to Assess 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 University NHS Foundation Trust. This post also leads on the commissioning of Discharge to Assess Services for Pathways 1 & 2. Commissioning of Pathway 3 continues to be shared between the local authority and the ICB.

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, was completed in 2020/21 and the recommendations implemented in 2021/22. 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. Since our last BCF Plan, the funds were secured to enable all of the recommendations from the review to be implemented.

In terms of priorities for 22/23:

1. a commissioning led review of Community Hospitals in South Warwickshire is in progress;
2. a joint review of Pathway 1 has been completed with associated proposals to support 2022/23 winter pressures endorsed;
3. a review of the different place based operational processes and disparities across Coventry and Warwickshire for D2A Pathway 2 Nursing is underway; and
4. agree system wide commissioning intentions for D2A.

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 and Discharge to Assess Beds; the Hospital to Home Scheme; additional enhanced Moving on Beds etc. New for 22/23 is a small allocation to cover costs associated with the impact of self-neglect e.g. deep cleaning or clearing of properties due to hoarding, which is

increasingly presenting as an issue preventing carers be able to access a property to provide either step-down or step-up care and support.

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

## Key Line of Enquiry: Changes to our BCF Plan and local priorities in response to the Covid-19 pandemic and Covid-19 recovery plan

The health and care system in Warwickshire 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 were 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, from a bed based to home based rehab model.

The local authority's relationship with our provider market was crucial too. Effective two-way communication and a clear focus on understanding the market, its pressures and the opportunities were key enablers to partnership preparedness and response. We continue to maintain a focus on engaging with and supporting the care market particularly with the pressures and demands it continues to face in relation to workforce. This is recognised in the draft workforce plan for adult social care, draft market sustainability plan and some of the targeted activities we have undertaken, e.g., response to fuel crisis in domiciliary care.

As part of local Covid Recovery Plans, implementation of the Integrated Care Record across health and social care in Warwickshire was highlighted as a priority. As mentioned earlier, this was implemented in March 2022 for adults and the focus in 22/23 is to roll-out for Under 18s, to support health inequalities around mental health in young people exacerbated during the pandemic.

## Planning Requirement 7 - Supporting unpaid carers

The All Age Carers Contract will go live in October 2022 with a redesigned model comprised of core funding through WCC to provide specific elements of support, that is proportionate to the carers needs;

- **Universal Offer** – information and advice, signposting and community inclusion
- **Targeted Adults** – Statutory Carers Assessment and Support Planning
- **Targeted Young Carers** – Carers Assessment and support planning

BCF funding has been invested within the contract model to enhance the core services and increase support for unpaid carers, which includes;

- **Innovation Fund** – Carers/providers are supported to access funding to promote innovation, local carer networks and place-based activities that support and maintain carers wellbeing. Supporting with initial investment to support carer groups - activities and innovation
- **Urgent and Planned Breaks -** Carers can access up to 36 hours of replacement care to support with short breaks
- **Digital support** – funding via IBCF to support the West Midlands region wide buy-in to digital offer to carers through Mobalise
- **Coproduction and Comms** – To support ongoing coproduction and continued engagement with carers, to support service development, peer review and the redesign of the Joint Carers Strategy
- **Delegated Assessments** – Provision of IT devices to contracted providers to undertake delegated assessment via Mosaic
- **Direct payments** – Supporting the funding of one off payments to carers to support them with maintaining their own wellbeing
- **Service Contingency** – Retained for discretionary use, service pressures, service pilots

Further work specifically to support unpaid carers through development of the wider out of hospital Urgent Community Response service will continue during 22/23.

| | Budget | Agreed Planned Spend |
|---|---|---|
| Carer Breaks – Respite | Base BCF – minimum NHS contribution | £1,021,000 |
| All Age Carers Contract Model | Aligned adult social care budget | £510,000 |
| Carers Support | IBCF – W-IBCF Scheme 10 | £281,000 |
| Respite Charging Enables WCC to cease charging based on standard residential care protocols (which have regard to property wealth) and charge based on community care charging protocols (which do not consider property wealth). This change is proven to encourage respite take up and therefore prevent or reduce the likelihood of carer breakdown. | IBCF – W-IBCF Scheme 17 | £250,000 |
| **Total** | | **£2,062,000** |

## Planning Requirement 7 - Meeting Care Act Responsibilities

Similar to previous years, £180k has been allocated from the IBCF scheme 11 to deliver Care Act Responsibilities relating to acute based service costs for hospital based advocacy, a contribution to maintain the block Independent Mental Health Advocacy (IMCA) provision and also provide SPOT IMCA provision. Similar to previous years £5.6m is allocated from the Base BCF – minimum NHS contribution for Reablement. This is detailed in the Planning Template.

# Better Care Fund 2022-23 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 NHS Contribution | £42,782,742 | £42,782,742 | £0 |
| iBCF | £15,133,281 | £15,245,281 | -£112,000 |
| Additional LA Contribution | £71,308,000 | £71,196,000 | £112,000 |
| Additional ICB Contribution | £112,124,000 | £112,124,000 | £0 |
| **Total** | **£246,472,809** | **£246,472,809** | **£0** |

Expenditure >>

**NHS Commissioned Out of Hospital spend from the minimum ICB allocation**

| | |
|---|---|
| Minimum required spend | £12,206,206 |
| Planned spend | £23,141,000 |

**Adult Social Care services spend from the minimum ICB allocations**

| | |
|---|---|
| Minimum required spend | £15,273,989 |
| Planned spend | £15,274,000 |

**Scheme Types**

| | | |
|---|---|---|
| Assistive Technologies and Equipment | £6,438,742 | (2.6%) |

| | | |
|---|---|---|
| Care Act Implementation Related Duties | £1,446,000 | (0.6%) |
| Carers Services | £1,271,000 | (0.5%) |
| Community Based Schemes | £5,302,281 | (2.2%) |
| DFG Related Schemes | £5,124,786 | (2.1%) |
| Enablers for Integration | £1,252,000 | (0.5%) |
| High Impact Change Model for Managing Transfer of C | £1,034,000 | (0.4%) |
| Home Care or Domiciliary Care | £49,306,008 | (20.0%) |
| Housing Related Schemes | £629,000 | (0.3%) |
| Integrated Care Planning and Navigation | £0 | (0.0%) |
| Bed based intermediate Care Services | £2,198,000 | (0.9%) |
| Reablement in a persons own home | £5,662,000 | (2.3%) |
| Personalised Budgeting and Commissioning | £14,326,000 | (5.8%) |
| Personalised Care at Home | £56,521,000 | (22.9%) |
| Prevention / Early Intervention | £382,000 | (0.2%) |
| Residential Placements | £95,579,992 | (38.8%) |
| Other | £0 | (0.0%) |
| **Total** | **£246,472,809** | |

Metrics >>

## Avoidable admissions

| | 2022-23 Q1 Plan | 2022-23 Q2 Plan | 2022-23 Q3 Plan |
|---|---|---|---|
| Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population) | | | |

## Discharge to normal place of residence

| | 2022-23 Q1 Plan | 2022-23 Q2 Plan | 2022-23 Q3 Plan |
|---|---|---|---|
| Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence<br><br>(SUS data - available on the Better Care Exchange) | 95.5% | 95.5% | 95.5% |

## Residential Admissions

| | | 2020-21 Actual | 2022-23 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 | 596 | 620 |

## Reablement

| | | 2022-23 Plan |
|---|---|---|
| Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | Annual (%) | 94.2% |

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: Implementing the BCF policy objectives** | **PR6** | Yes |
| **Agreed expenditure plan for all elements of the BCF** | **PR7** | Yes |
| **Metrics** | **PR8** | Yes |

# Better Care Fund 2022-23 Template

**4. Income**

Selected Health and Wellbeing Board: Warwickshire

| Local Authority Contribution | |
|---|---|
| Disabled Facilities Grant (DFG) | Gross Contribution |
| Warwickshire | £5,124,786 |
| | |
| DFG breakdown 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 | £15,133,281 |
| | |
| **Total iBCF Contribution** | **£15,133,281** |

| Are any additional LA Contributions being made in 2022-23? 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 | £71,308,000 | Aligned budget in the BCF Plan relating to older |
| | | |
| | | |
| **Total Additional Local Authority Contribution** | **£71,308,000** | |

| NHS Minimum Contribution | Contribution |
|---|---|
| NHS Coventry and Warwickshire ICB | £42,782,742 |
| | |
| | |
| | |
| | |
| | |
| | |
| **Total NHS Minimum Contribution** | **£42,782,742** |

| | |
|---|---|
| Are any additional ICB Contributions being made in 2022-23? If yes, please detail below | Yes |

| Additional ICB Contribution | Contribution | Comments - Please use this box clarify any specific uses or sources of funding |
|---|---|---|
| NHS Coventry and Warwickshire ICB | £32,743,000 | Aligned out of hospital budget in the BCF Plan - |
| NHS Coventry and Warwickshire ICB | £61,290,000 | Aligned out of hospital budget in the BCF Plan - |
| NHS Coventry and Warwickshire ICB | £18,091,000 | Aligned out of hospital budget in the BCF Plan - |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| **Total Additional NHS Contribution** | **£112,124,000** | |
| **Total NHS Contribution** | **£154,906,742** | |

| | 2021-22 |
|---|---|
| **Total BCF Pooled Budget** | **£246,472,809** |

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

The minimum requirement for the pooled budget for Warwickshire's BCF is £63m. 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 in 2021/22 totalled £209m. For 2022/23 the pooled bugdet is £63m and the aligned budget is £183m totalling £246m which is detailed in this plan.

# Better Care Fund 2022-23 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 NHS Contribution | £42,782,742 | £42,782,742 | £0 |
| iBCF | £15,133,281 | £15,245,281 | -£112,000 |
| Additional LA Contribution | £71,308,000 | £71,196,000 | £112,000 |
| Additional NHS Contribution | £112,124,000 | £112,124,000 | £0 |
| **Total** | **£246,472,809** | **£246,472,809** | **£0** |

**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 ICB allocation | £12,206,206 | £23,141,000 | £0 |
| Adult Social Care services spend from the minimum ICB allocations | £15,273,989 | £15,274,000 | £0 |

>> Link to further guidance

**Checklist**

Column complete:

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |

**One or more Funding Sources have an underspend/overpend (see first table at top of this sheet)**

| | | | | | | 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) | Packages of care | Home Care or Domiciliary Care | Domiciliary care packages | | Social Care | | LA | | | Private Sector | Minimum NHS Contribution | £7,100,000 | Existing |
| 2 | Reablement (base BCF) | Reablement - 95% of which supports hospital discharges | Reablement in a persons own home | Reablement to support discharge - step down | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | £5,662,000 | Existing |
| 3 | Integrated Community Equipment (ICE) | Community Equipment for social care | Assistive Technologies and Equipment | Community based equipment | | Social Care | | LA | | | Private Sector | Minimum NHS Contribution | £1,916,000 | Existing |
| 4 | Moving on Beds (base BCF) | MOBs used primarily for social care and housing related step down | Bed based intermediate Care Services | Step down (discharge to assess pathway-2) | | Social Care | | LA | | | Private Sector | Minimum NHS Contribution | £596,000 | Existing |
| 5 | ICE - Health (base BCF) | Health equipment to support step down discharges and step up | Assistive Technologies and Equipment | Community based equipment | | Community Health | | LA | | | Private Sector | Minimum NHS Contribution | £4,367,742 | Existing |
| 6 | Carers Breaks (base BCF) | Cares respite | Carers Services | Respite services | | Community Health | | CCG | | | NHS Mental Health Provider | Minimum NHS Contribution | £1,021,000 | Existing |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 7 | Out of hospital - WN, Rugby and SW (base BCF) | OOH community step up and step down support | Personalised Care at Home | Physical health/wellbeing | | Community Health | | CCG | | | NHS Community Provider | Minimum NHS Contribution | £15,970,000 | Existing |
| 8 | Discharge to Assess Beds - D2A (base BCF) | P2 step down beds | Bed based intermediate Care Services | Step down (discharge to assess pathway-2) | | Community Health | | CCG | | | Private Sector | Minimum NHS Contribution | £1,308,000 | Existing |
| 9 | Joint Funded Packages (base BCF) | Joint Funded Packages | Home Care or Domiciliary Care | Domiciliary care packages | | Continuing Care | | CCG | | | Private Sector | Minimum NHS Contribution | £2,606,008 | Existing |
| 10 | Joint Funded Packages - base BCF | Joint Funded Placements | Residential Placements | Supported living | | Continuing Care | | CCG | | | Private Sector | Minimum NHS Contribution | £421,412 | Existing |
| 11 | Joint Funded Packages - base BCF | Joint Funded Placements | Residential Placements | Care home | | Continuing Care | | CCG | | | Private Sector | Minimum NHS Contribution | £585,403 | Existing |
| 12 | Joint Funded Packages - base BCF | Joint Funded Placements | Residential Placements | Nursing home | | Continuing Care | | CCG | | | Private Sector | Minimum NHS Contribution | £1,229,177 | Existing |
| 13 | Disabled Facilities Grant (base BCF) | Passported to the Tier 2 District and Borough Councils | DFG Related Schemes | Adaptations, including statutory DFG grants | | Social Care | | LA | | | Local Authority | DFG | £5,124,786 | Existing |
| 14 | W-IBCF 1- Hospital Social Care Team | Supporting timely discharges including to care homes | High Impact Change Model for Managing Transfer | Home First/Discharge to Assess - process | | Social Care | | LA | | | Local Authority | iBCF | £704,000 | Existing |
| 15 | W-IBCF 2 - Housing Hospital Liaison & W-IBCF 9 | Housing related support to support early discharge planning and | High Impact Change Model for Managing Transfer | Housing and related services | | Social Care | | LA | | | Local Authority | iBCF | £103,000 | Existing |
| 16 | W-IBCF 3 - Hospital based Social Prescribing | Access to social prescribing on discharge to support re-admission | Prevention / Early Intervention | Social Prescribing | | Social Care | | LA | | | Charity / Voluntary Sector | iBCF | £140,000 | Existing |
| 17 | W-IBCF 4 - Trusted Assessments | Support for discharges into care homes and exits from intermediae | High Impact Change Model for Managing Transfer | Trusted Assessment | | Social Care | | LA | | | Local Authority | iBCF | £152,000 | Existing |
| 18 | W-IBCF 5 - Domiciliary Care Referral Team | Brokerage of packages of care to enable discharge | High Impact Change Model for Managing Transfer | Multi-Disciplinary/Multi-Agency Discharge | | Social Care | | LA | | | Local Authority | iBCF | £75,000 | Existing |
| 19 | W-IBCF 6 - Hospital to Home Service | Hospital to home, including falls prevention for the vulnerable | Community Based Schemes | Low level support for simple hospital discharges | | Social Care | | LA | | | Local Authority | iBCF | £444,000 | Existing |
| 20 | W-IBCF 7 - Moving on Beds | Enhanced and additional Moving on Bed capacity | Bed based intermediate Care Services | Step down (discharge to assess pathway-2) | | Social Care | | LA | | | Private Sector | iBCF | £294,000 | Existing |
| 21 | W-IBCF 8 - Integrated Community | Supports same day and urgent delivery cost pressures (health & | Assistive Technologies and Equipment | Community based equipment | | Social Care | | LA | | | Private Sector | iBCF | £155,000 | Existing |
| 22 | W-IBCF 10 - Carers support | Planned and emergency short breaks service, carers support grant, | Care Act Implementation Related Duties | Carer advice and support | | Social Care | | LA | | | Charity / Voluntary Sector | iBCF | £281,000 | Existing |
| 23 | W-IBCF 11- Advocacy | Acute based service costs for hospital based advocacy, contribution | Care Act Implementation Related Duties | Independent Mental Health Advocacy | | Social Care | | LA | | | Charity / Voluntary Sector | iBCF | £180,000 | Existing |
| 24 | W-IBCF 12 Occupational Therapy | Occupational Therapists in the community. | Community Based Schemes | Multidisciplinary teams that are supporting | | Social Care | | LA | | | Local Authority | iBCF | £310,000 | Existing |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 25 | W-IBCF 13 End of Life Rapid Response | End of Life rapid response costs in the community (hospice | Personalised Care at Home | Physical health/wellbeing | | Community Health | | LA | | | Charity / Voluntary Sector | iBCF | £249,000 | Existing |
| 26 | W-IBCF 14 - Falls Prevention | Contribution to falls care-coordination and Multi-Factorial Assessments | Community Based Schemes | Multidisciplinary teams that are supporting | | Community Health | | LA | | | NHS Community Provider | iBCF | £35,000 | Existing |
| 27 | W-IBCF 15 - Mental Health Street Triage | Mental Health Street Triage | Community Based Schemes | Multidisciplinary teams that are supporting | | Mental Health | | CCG | | | NHS Mental Health Provider | iBCF | £263,000 | Existing |
| 28 | W-IBCF 16 - Adults with Autism | Community Outreach Offer supporting Admission Prevention by | Community Based Schemes | Multidisciplinary teams that are supporting | | Community Health | | LA | | | Local Authority | iBCF | £280,000 | Existing |
| 29 | W-IBCF 17 - Residential Respite Care Charging | Enables WCC to cease charging based on standard residential care | Carers Services | Respite services | | Social Care | | LA | | | Local Authority | iBCF | £250,000 | Existing |
| 30 | W-IBCF 19 - Protecting older people community | Contributions to: Residential and nursing care fee rates | Residential Placements | Care home | | Social Care | | LA | | | Private Sector | iBCF | £2,900,000 | Existing |
| 31 | W-IBCF 20 - Protecting older people community | Contributions to: Care at Home fee rates | Home Care or Domiciliary Care | Domiciliary care packages | | Social Care | | LA | | | Private Sector | iBCF | £2,350,000 | Existing |
| 32 | W-IBCF 21 - Protecting NHS budgets through | Contributions to: Extra Care Housing Waking Nights Cover | Home Care or Domiciliary Care | Domiciliary care packages | | Social Care | | LA | | | Private Sector | iBCF | £502,000 | Existing |
| 33 | W-IBCF 22 - Provider Learning and Development | Funds provider (health and social care) support, training and learning and | Enablers for Integration | Workforce development | | Community Health | | LA | | | Local Authority | iBCF | £515,000 | Existing |
| 34 | W-IBCF 24 wider support to maintain the | Develop, stabilise and strengthen the Provider Market | Enablers for Integration | Integrated models of provision | | Continuing Care | | CCG | | | Private Sector | iBCF | £375,000 | Existing |
| 35 | W-IBCF 25, 27 and 28 - Demand pressures relating | Direct funding contributing towards budget pressures and | Community Based Schemes | Other | Community social care staffing | Social Care | | LA | | | Local Authority | iBCF | £3,851,281 | Existing |
| 36 | W-IBCF 26 - Dementia Support in the community | Dementia days ops, dementia navigators and dementia carer support | Care Act Implementation Related Duties | Other | Dementia services | Social Care | | LA | | | Private Sector | iBCF | £475,000 | Existing |
| 37 | W-IBCF 18, 29 & 30 Resources | Resources to support joint commissioning, the BCF Programme and | Enablers for Integration | Programme management | | Social Care | | LA | | | Local Authority | iBCF | £362,000 | Existing |
| 38 | Domiciliary Care (WCC 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 | £13,925,000 | Existing |
| 39 | Residential Care (WCC aligned budget) | Residential care long-term placements | Residential Placements | Care home | | Social Care | | LA | | | Private Sector | Additional LA Contribution | £38,867,000 | Existing |
| 40 | Nursing Care (WCC aligned budget) | Nursing care long-term placements | Residential Placements | Nursing home | | Social Care | | LA | | | Private Sector | Additional LA Contribution | £13,088,000 | Existing |
| 41 | Direct Payments (WCC aligned budget) | DPs for adults (e.g. instead of dom care PoC) | Personalised Budgeting and Commissioning | | | Social Care | | LA | | | Private Sector | Additional LA Contribution | £3,950,000 | Existing |
| 42 | Carers (WCC aligned budget) | Carers schemes supporting admission prevention and long | Care Act Implementation Related Duties | Carer advice and support | | Social Care | | LA | | | Charity / Voluntary Sector | Additional LA Contribution | £510,000 | Existing |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 43 | Social Prescribing (WCC aligned budget) | Aligned to Strengths Based Practice and Community Assets | Prevention / Early Intervention | Social Prescribing | | Social Care | | LA | | | Charity / Voluntary Sector | Additional LA Contribution | £108,000 | Existing |
| 44 | Contributions towards HEART staff and service, | Workforce additional costs to support the HEART service deliver | Housing Related Schemes | | | Social Care | | LA | | | Local Authority | Additional LA Contribution | £629,000 | Existing |
| 45 | Falls Prevention (WCC aligned budget) | Falls care co-ordination and support for Moderate to High Risk | Community Based Schemes | Multidisciplinary teams that are supporting | | Community Health | | LA | | | NHS Community Provider | Additional LA Contribution | £119,000 | Existing |
| 46 | Out of Hospital (ICB aligned budgets) | OOH community step up and step down support | Personalised Care at Home | Physical health/wellbeing | | Community Health | | CCG | | | NHS Community Provider | Additional NHS Contribution | £40,302,000 | Existing |
| 47 | Personal Health budgets (ICB aligned budgets) | PHBs to provide eg. domiliary care for patients with long term | Personalised Budgeting and Commissioning | | | Continuing Care | | CCG | | | Private Sector | Additional NHS Contribution | £10,376,000 | Existing |
| 48 | Residential Care placements (ICB aligned budgets) | Residential care long-term placements | Residential Placements | Care home | | Continuing Care | | CCG | | | Private Sector | Additional NHS Contribution | £5,417,045 | Existing |
| 49 | Nursing care placements (ICB aligned budgets) | Nursing care long-term placements | Residential Placements | Nursing home | | Continuing Care | | CCG | | | Private Sector | Additional NHS Contribution | £30,666,096 | Existing |
| 50 | Residential placements supported living | Supported Living placements | Residential Placements | Supported living | | Continuing Care | | CCG | | | Private Sector | Additional NHS Contribution | £2,405,859 | Existing |
| 51 | Domicilary Care (ICB aligned budgets) | Domiliary care for patients with long term needs | Home Care or Domiciliary Care | Domiciliary care packages | | Continuing Care | | CCG | | | Private Sector | Additional NHS Contribution | £22,823,000 | Existing |
| 52 | Social Prescribing (ICB aligned budgets) | Prevention activity to support admission avoidance and | Prevention / Early Intervention | Social Prescribing | | Community Health | | CCG | | | Charity / Voluntary Sector | Additional NHS Contribution | £134,000 | Existing |
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# Further guidance for completing Expenditure sheet

## National Conditions 2 & 3

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:

- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:

- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

## 2022-23 Revised Scheme types

| Number | Scheme type/ services | Sub type | Description |
|---|---|---|---|
| 1 | Assistive Technologies and Equipment | 1. Telecare<br>2. Wellness services<br>3. Digital participation services<br>4. Community based equipment<br>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<br>2. Independent Mental Health Advocacy<br>3. Safeguarding<br>4. Other | Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF. |
| 3 | Carers Services | 1. Respite Services<br>2. Other | Supporting people to sustain their role as carers and reduce the likelihood of crisis.<br><br>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<br>2. Multidisciplinary teams that are supporting independence, such as anticipatory care<br>3. Low level support for simple hospital discharges (Discharge to Assess pathway 0)<br>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)<br><br>Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home' |

| | | | |
|---|---|---|---|
| 5 | DFG Related Schemes | 1. Adaptations, including statutory DFG grants<br>2. Discretionary use of DFG - including small adaptations<br>3. Handyperson services<br>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.<br><br>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<br>2. System IT Interoperability<br>3. Programme management<br>4. Research and evaluation<br>5. Workforce development<br>6. Community asset mapping<br>7. New governance arrangements<br>8. Voluntary Sector Business Development<br>9. Employment services<br>10. Joint commissioning infrastructure<br>11. Integrated models of provision<br>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.<br><br>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<br>2. Monitoring and responding to system demand and capacity<br>3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge<br>4. Home First/Discharge to Assess - process support/core costs<br>5. Flexible working patterns (including 7 day working)<br>6. Trusted Assessment<br>7. Engagement and Choice<br>8. Improved discharge to Care Homes<br>9. Housing and related services<br>10. Red Bag scheme<br>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<br>2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)<br>3. Domiciliary care workforce development<br>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<br>2. Assessment teams/joint assessment<br>3. Support for implementation of anticipatory care<br>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.<br><br>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.<br><br>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)<br>2. Step up<br>3. Rapid/Crisis Response<br>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<br>2. Reablement to support discharge -step down (Discharge to Assess pathway 1)<br>3. Rapid/Crisis Response - step up (2 hr response)<br>4. Reablement service accepting community and discharge referrals<br>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<br>2. Physical health/wellbeing<br>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<br>2. Risk Stratification<br>3. Choice Policy<br>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<br>2. Supported accommodation<br>3. Learning disability<br>4. Extra care<br>5. Care home<br>6. Nursing home<br>7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3)<br>8. Other | Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home. |
| 18 | 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 2022-23 Template

**6. Metrics**

Selected Health and Wellbeing Board: Warwickshire

## 8.1 Avoidable admissions

| | | 2021-22 Q1 Actual | 2021-22 Q2 Actual | 2021-22 Q3 Actual | 2021-22 Q4 Actual | Rationale for how ambition was set | Local plan to meet ambition |
|---|---|---|---|---|---|---|---|
| Indirectly standardised rate (ISR) of admissions per 100,000 population | Indicator value | 214.7 | 186.2 | 191.1 | 169.8 | Variance of 2.4% between Better Care Exchange data and local SUS feeds - therefore acceptable confidence in data. Warwickshire is maintaining a better annual level than the England value at 761 | Winter plans in place (acute trusts, ICB and local authority) include include admission avoidance activity eg. investment in Community Urgent Response (2 hr and same day) and Community Therapy by the |
| | | 2022-23 Q1 Plan | 2022-23 Q2 Plan | 2022-23 Q3 Plan | 2022-23 Q4 Plan | | |
| (See Guidance) | Indicator value | 212 | 187 | 192 | 170 | | |

>> link to NHS Digital webpage (for more detailed guidance)

## 8.3 Discharge to usual place of residence

| | | 2021-22 Q1 Actual | 2021-22 Q2 Actual | 2021-22 Q3 Actual | 2021-22 Q4 Actual | Rationale for how ambition was set | Local plan to meet ambition |
|---|---|---|---|---|---|---|---|
| Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence | Quarter (%) | 95.8% | 95.5% | 95.2% | 95.7% | 1.5% variance in Better Care Exchange data and local SUS feeds - relatively good confidence in data. Warwickshire remains better performing that national, 95.5% to 92.6%. Therefore plan to maintain current performance but with added consistency as there is no evidence of seasonal patterns in this metric. Note: Slow start to discharge volumes in Q1 | BCF schemes that support this metric: Market sustainability initiatives Daily multi-agency discharge team (MDT) working Following a sucessful pilot, the new Rehab at Home - Home-Based Therapy pathway (Pathway 1); and The new Stroke Early Supported Discharge with Care pathway (Pathway 1) Integrated Community Equipment |
| | Numerator | 12,767 | 12,731 | 12,137 | 11,556 | | |
| | Denominator | 13,331 | 13,330 | 12,752 | 12,075 | | |
| | | 2022-23 Q1 Plan | 2022-23 Q2 Plan | 2022-23 Q3 Plan | 2022-23 Q4 Plan | | |
| (SUS data - available on the Better Care Exchange) | Quarter (%) | 95.5% | 95.5% | 95.5% | 95.5% | | |
| | Numerator | 12,400 | 13,105 | 12,524 | 11,908 | | |
| | Denominator | 12,979 | 13,717 | 13,109 | 12,464 | | |

## 8.4 Residential Admissions

| | | 2020-21 Actual | 2021-22 Plan | 2021-22 estimated | 2022-23 Plan | Rationale for how ambition was set | Local plan to meet ambition |
|---|---|---|---|---|---|---|---|
| Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population | Annual Rate | 595.5 | 646.1 | 606.4 | 620.5 | Actuals for 2020/21 and 2021/22 were impacted by the Covid-19 pandemic. The ambition for 2022/23 therefore reflects pre-pandemic levels which were consistently over 800 admissions per year, (where the target of 780 equates to an average 65 | BCF schemes that support this metric: Market sustainability initiatives Daily multi-agency discharge team (MDT) working Following a sucessful pilot, the new Rehab at Home - Home-Based Therapy pathway |
| | Numerator | 722 | 799 | 750 | 780 | | |
| | Denominator | 121,235 | 123,673 | 123,673 | 125,709 | | |

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**

| | | 2020-21 Actual | 2021-22 Plan | 2021-22 estimated | 2022-23 Plan | Rationale for how ambition was set | Local plan to meet ambition |
|---|---|---|---|---|---|---|---|
| Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | Annual (%) | 93.6% | 91.7% | 93.7% | 94.2% | Actuals for 2020/21 were 323 of 345 discharges in the period Oct-Dec 2020 - 93.6% which was artificially inflated due to the emergency measures put in place during the pandemic. Performance in 2021/22 was 93.7% and reflects an | BCF schemes that support this metric: Reablement Service – where 95% of reablement capacity is currently utilised supporting hospital discharge Assistive Technology |
| | Numerator | 323 | 275 | 298 | 291 | | |
| | Denominator | 345 | 300 | 318 | 309 | | |

Please note that due to the demerging of Northamptonshire, information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- 2020-21 actuals (for **Residential Admissions** and **Reablement**) for North Northamptonshire and West Northamptonshire are using the Northamptonshire combined figure;
- 2021-22 and 2022-23 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2020-21 estimates.

## Better Care Fund 2022-23 Template

**7. Confirmation of Planning Requirements**

Selected Health and Wellbeing Board: Warwickshire

| Theme | Code | Planning Requirement | Key considerations for meeting the planning requirement<br>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 ICB(s) and LA; been submitted?<br><br>Has the HWB approved the plan/delegated approval?<br><br>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?<br><br>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<br><br>Cover sheet<br><br>Narrative plan<br><br>Validation of submitted plans | Yes | 1. A jointly agreed BCF Plan has been agreed.<br>2. The HWBB was engaged in reviewing and developing the BCF Plan at its meeting on the 7th September and then approved it on the 22/09/22<br>3. An inclusive and partnership approach including a range of | | |
| | 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:<br><br>• 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<br><br>• The approach to collaborative commissioning<br><br>• How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include<br>- How equality impacts of the local BCF plan have been considered<br><br>- Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the document will address these.<br><br>The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. | Narrative plan | Yes | 1. Pages 19-23 of the Narrative Plan describes the local approach to integrated, person centred services.<br>2. Pages 9 &12 of the Narrative Plan describes the approach to collaborative commissioning and page 22 specifically relating to commissionng for D2A & Discharges.<br>3. Pages 13-16 of the Narrative Plan describe the local approach to reducing Health Inequalities and actions re: Core20Plus 5. A copy of the Cov & Warks ICS Health Inequalities Strategy is also provided as supporting information.<br>4. Changes as a result of the Covid-19 pandemic are detailed on page 23 of the Narrative Plan. | | |
| | PR3 | **A strategic, joined up plan for Disabled Facilities Grant (DFG) spending** | Is there confirmation that use of DFG has been agreed with housing authorities?<br><br>• Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home?<br><br>• In two tier areas, has:<br>- Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or<br>- The funding been passed in its entirety to district councils? | Narrative plan<br><br>Confirmation sheet | Yes | 1. Use of the DFG is agreed through the well established Housing Partnership Board and HEART Board.<br>2. Pages 17&18 of the Narrative Plan detail the approach to housing support and DFG, managed via the HEART service on behalf of the 6 councils in Warks.<br>3. The DFG has been passed in it's entirety to the 5 District and Borough Councils. | | |
| NC2: Social Care Maintenance | PR4 | **A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift in the overall contribution** | Does the total spend from the NHS 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 | 1. Tab 5a. Expenditure shows that the forecast total spend and budget matches the £15.273m required contribution. A detailed breakdown of schemes | | |
| 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 NHS minimum BCF contribution?** | Does the total spend from the NHS 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 | Tab 5a. Expenditure shows that the forecast total spend and budget of £15.9m exceeds the £12.2m required contribution.A detailed breakdown of schemes | | |

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|---|---|---|---|---|---|---|---|---|
| NC4: Implementing the BCF policy objectives | **PR6** | **Is there an agreed approach to implementing the BCF policy objectives, including a capacity and demand plan for intermediate care services?** | Does the plan include an agreed approach for meeting the two BCF policy objectives:<br>- Enable people to stay well, safe and independent at home for longer and<br>- Provide the right care in the right place at the right time?<br><br>• Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year?<br><br>•Has the area submitted a Capacity and Demand Plan alongside their BCF plan, using the template provided?<br><br>• Does the narrative plan confirm that the area has conducted a self-assessment of the area's implementation of the High Impact Change Model for managing transfers of care?<br><br>• Does the plan include actions going forward to improve performance against the HICM? | Narrative plan<br><br>Expenditure tab<br><br>C&D template and narrative<br><br>Narrative plan<br><br>Narrative template | Yes | 1. Pages 19-22 of the Narrative Plan detail the approach to meeting the BCF objectives.<br>2. Tab 5a.- provides a detailed breakdown shows schemes which support Prevention/Early Intervention, Community Schemes, Support for the High Impact Change Model etc.<br>3. A completed Capacity and Demand Template has been | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 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)<br><br>• Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 31 – 43 of Planning Requirements) (tick-box)<br><br>• Has the area included a description of how BCF funding is being used to support unpaid carers?<br><br>• Has funding for the following from the NHS contribution been identified for the area:<br>- Implementation of Care Act duties?<br>- Funding dedicated to carer-specific support?<br>- Reablement? | Expenditure tab<br><br>Expenditure plans and confirmation sheet<br><br>Narrative plan<br><br>Narrative plans, expenditure tab and confirmation sheet | Yes | 1. Please refer to page 23 of the BCF Narrative Plan re: support to unpaid carers<br>2. Pages 23 & 24 of the Narrative Plan also details the schemes to deliver Care Act Duties, Carer Support and Reablement, the amount and source of the funding. | | |
| Metrics | **PR8** | **Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?** | • Have stretching ambitions been agreed locally for all BCF metrics?<br><br>• Is there a clear narrative for each metric setting out:<br>- the rationale for the ambition set, and<br>- the local plan to meet this ambition? | Metrics tab | Yes | Please refer to the detail provided in Tab 6. To ensure the BCF metrics align with NHS and local authority ASCOF measures - Helen Lancaster, Director of System | | |

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# Better Care Fund 2022-23 Capacity & Demand Template

**3.1 Demand - Hospital Discharge**

Selected Health and Wellbeing Board: Warwickshire

## 3. Demand

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template uses the pathways set out in the Hospital Discharge and community support guidance - https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance

If there are any 'fringe' trusts taking less than say 10% of patient flow then please consider using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2022-23
- Data from the NHSE Discharge Pathways Model.

| Totals Summary (autopopulated) | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|---|---|---|
| 0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0) | 85 | 85 | 85 | 85 | 77 | 85 |
| 1: Reablement in a persons own home to support discharge (D2A Pathway 1) | 564 | 561 | 485 | 490 | 434 | 506 |
| 2: Step down beds (D2A pathway 2) | 175 | 165 | 185 | 165 | 164 | 166 |
| 3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3) | 23 | 28 | 26 | 26 | 29 | 26 |

| Any assumptions made: | Data includes:<br>P0-Hospital Based Social Prescribing activity<br>P1-HomeFirst, Reablement, Rehab at Home (Home based therapy) and Stroke ESD with care<br>P2-Step Down Therapy Beds including Campion Ward and Nicol Unit for SW, Arbury for |
|---|---|

!!Click on the filter box below to select Trust first!!

| Trust Referral Source (Select as many as you need) | Demand - Discharge Pathway | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|---|---|---|---|
| (Please select Trust/s.....) | 0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0) | | | | | | |
| SOUTH WARWICKSHIRE NHS FOUNDATION TRUST | | 49 | 49 | 49 | 49 | 44 | 49 |
| UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE | | 12 | 12 | 12 | 12 | 11 | 12 |
| GEORGE ELIOT HOSPITAL NHS TRUST | | 24 | 24 | 24 | 24 | 22 | 24 |
| (Please select Trust/s.....) | 1: Reablement in a persons own home to support discharge (D2A Pathway 1) | | | | | | |
| SOUTH WARWICKSHIRE NHS FOUNDATION TRUST | | 338 | 330 | 258 | 280 | 238 | 275 |
| UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE | | 82 | 95 | 93 | 72 | 78 | 83 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| GEORGE ELIOT HOSPITAL NHS TRUST | | 144 | 136 | 134 | 138 | 118 | 148 |
| (Please select Trust/s.....) | **2: Step down beds (D2A pathway 2)** | | | | | | |
| SOUTH WARWICKSHIRE NHS FOUNDATION TRUST | | 102 | 87 | 85 | 94 | 84 | 89 |
| UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE | | 28 | 26 | 30 | 23 | 39 | 37 |
| GEORGE ELIOT HOSPITAL NHS TRUST | | 45 | 52 | 70 | 48 | 41 | 40 |
| (Please select Trust/s.....) | **3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3)** | | | | | | |
| SOUTH WARWICKSHIRE NHS FOUNDATION TRUST | | 7 | 8 | 8 | 8 | 8 | 8 |
| UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE | | 8 | 11 | 9 | 9 | 12 | 9 |
| GEORGE ELIOT HOSPITAL NHS TRUST | | 8 | 9 | 9 | 9 | 9 | 9 |

# Better Care Fund 2022-23 Capacity & Demand Template

**3.0 Demand - Community**

Selected Health and Wellbeing Board: Warwickshire

## 3.2 Demand - Community

This worksheet collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. This includes the NICE Guidance definition of 'intermediate care' as used for the purposes of this exercise.

| Any assumptions made: | Data includes:<br>VCS-Carers Emergency response - Pre registered carers can access up to 36 hours of support per year<br>Urgent Community Response is provided by the integrated HomeFirst service which covers both non-urgent and urgent activity and is not separated and so is shown here under |
|---|---|

**Demand - Intermediate Care**

| Service Type | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|---|---|---|
| Voluntary or Community Sector Services | 6 | 6 | 6 | 6 | 6 | 6 |
| Urgent community response | 0 | 0 | 0 | 0 | 0 | 0 |
| Reablement/support someone to remain at home | 409 | 406 | 307 | 303 | 285 | 285 |
| Bed based intermediate care (Step up) | 2 | 2 | 2 | 2 | 2 | 2 |

# Better Care Fund 2022-23 Capacity & Demand Template

**4.0 Capacity - Discharge**

Selected Health and Wellbeing Board: Warwickshire

## 4.1 Capacity - discharge

This sheet collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step down)
- Residential care that is expected to be long-term (collected for discharge only)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

| Any assumptions made: | Data includes:<br>VCS to support discharge -Hospital Based Social Prescribing commissioned provision<br>P0-Urgent Community Response - is provided by the integrated HomeFirst service which covers both non-urgent and urgent activity and is not separated out and so is included under P1 below<br>P1-HomeFirst, Reablement, Rehab at Home (Home based therapy) and Stroke ESD with care |
|---|---|

| Capacity - Hospital Discharge | | | | | | | |
|---|---|---|---|---|---|---|---|
| Service Area | Metric | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **VCS services to support discharge** | Monthly capacity. Number of new clients. | 80 | 80 | 80 | 80 | 72 | 80 |
| **Urgent Community Response (pathway 0)** | Monthly capacity. Number of new clients. | 0 | 0 | 0 | 0 | 0 | 0 |
| **Reablement or reabilitation in a person's own home (pathway 1)** | Monthly capacity. Number of new clients. | 568 | 561 | 471 | 467 | 438 | 495 |
| **Bed-based intermediate care (step down) (pathway 2)** | Monthly capacity. Number of new clients. | 65 | 68 | 72 | 60 | 49 | 53 |
| **Residential care that is expected to be long-term (discharge only)** | Monthly capacity. Number of new clients. | 6 | 6 | 7 | 7 | 7 | 7 |

# Better Care Fund 2022-23 Capacity & Demand Template

**4.2 Capacity - Community**

Selected Health and Wellbeing Board: Warwickshire

## 4.2 Capacity - community

This sheet collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 5 types of service:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or rehabilitation in a person's own home
- Bed-based intermediate care (step up)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

| Any assumptions made: | Data includes:<br>VCS-Carers Emergency response - Pre registered carers can access up to 36 hours of support per year<br>Urgent Community Response is provided by the integrated HomeFirst service which covers both non-urgent and urgent activity and is not separated and so is included under Reablement/Support to someone to remain at home<br>Reablement/Support to someone to remain at home - No capacity from the reablement service is included, as all |
|---|---|

| Capacity - Community | | | | | | | |
|---|---|---|---|---|---|---|---|
| Service Area | Metric | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Voluntary or Community Sector Services** | Monthly capacity. Number of new clients. | 6 | 6 | 6 | 6 | 6 | 6 |
| **Urgent Community Response** | Monthly capacity. Number of new clients. | 0 | 0 | 0 | 0 | 0 | 0 |
| **Reablement or rehabilitation in a person's own home** | Monthly capacity. Number of new clients. | 390 | 386 | 292 | 287 | 270 | 320 |
| **Bed based intermediate care (step up)** | Monthly capacity. Number of new clients. | 2 | 2 | 2 | 2 | 2 | 2 |

# Better Care Fund 2022-23 Capacity & Demand Template

**5.0 Spend**

Selected Health and Wellbeing Board: Warwickshire

**5.0 Spend**

This sheet collects top line spend figures on intermediate care which includes:

- Overall spend on intermediate care services (BCF and non-BCF) for the whole of 2022-23
- Spend on intermediate care services in the BCF (including additional contributions).

These figures can be estimates, and should cover spend across the Health and Wellbeing Board (HWB). The figures do not need to be broken down in this template beyond these two categories.

## Spend on Intermediate Care

| | 2022-23 |
|---|---|
| Overall Spend (BCF & Non BCF) | £24,000,000 |
| BCF related spend | £24,000,000 |

| | |
|---|---|
| Comments if applicable | Intermediate Care is included in wider out of hospital block contracts, the total values of which are included here. Totals for base and aligned budgets plus IBCF specific schemes. |