Integration and Better Care Fund (BCF) Plan

Better Care Fund Plan 2021/22 Submission – version 0.6

Health and Wellbeing Board (HWBB):

Warwickshire

National Condition 1: A jointly agreed plan

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

Partnership Working and Engagement

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

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

Preparatory Activity

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

Preparing the BCF Plan

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

Approval of the BCF Plan

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

.

Approval timetable

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

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

Responsibilities for preparing this plan

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

Responsible: Rachel Briden, Integrated Partnership Manager, WCC.

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

Informed: Warwickshire Health and Wellbeing Board

Document History

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

.

Executive Summary

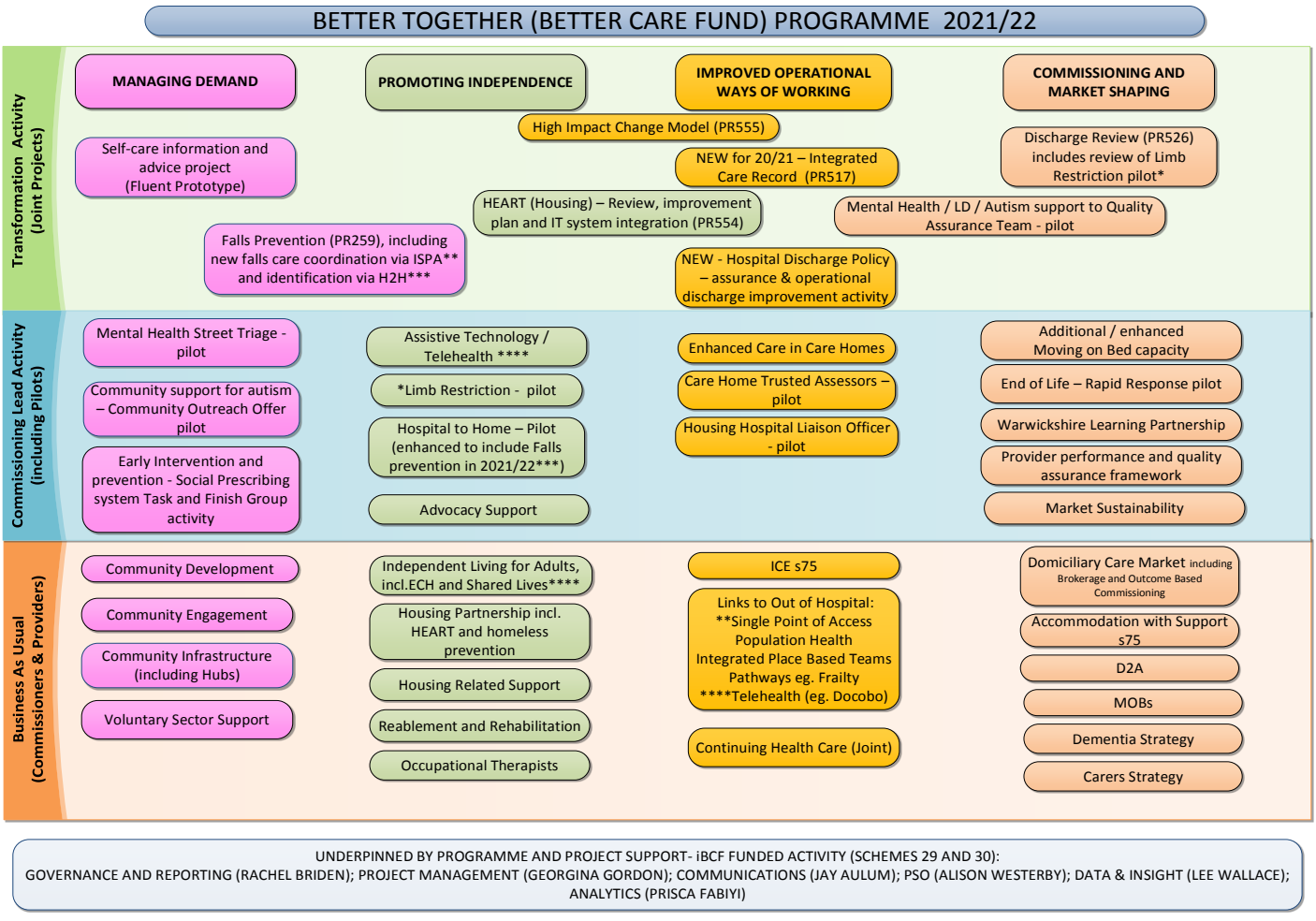
Background

The Better Care Fund has been one of the key contributors over the last six years towards building stronger partnerships and integration between the commissioners and providers of health and care services in Warwickshire. Despite significant pressures across the system including a continual reduction in social care resources and increasing acuity of need, partners have strived to make a sustained difference to the way services are organised and delivered. By working together the expertise and strengths within the system have been acknowledged and resulted in opportunities to be more innovative and reshape how services are commissioned and delivered. The foundations are therefore in place for the services currently commissioned through the Better Care Fund to move into the geographical collaboratives of the new Coventry and Warwickshire Integrated Care System, in Phase 1 (2022/23).

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

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

The illustration below summarises the schemes in our BCF Plan:

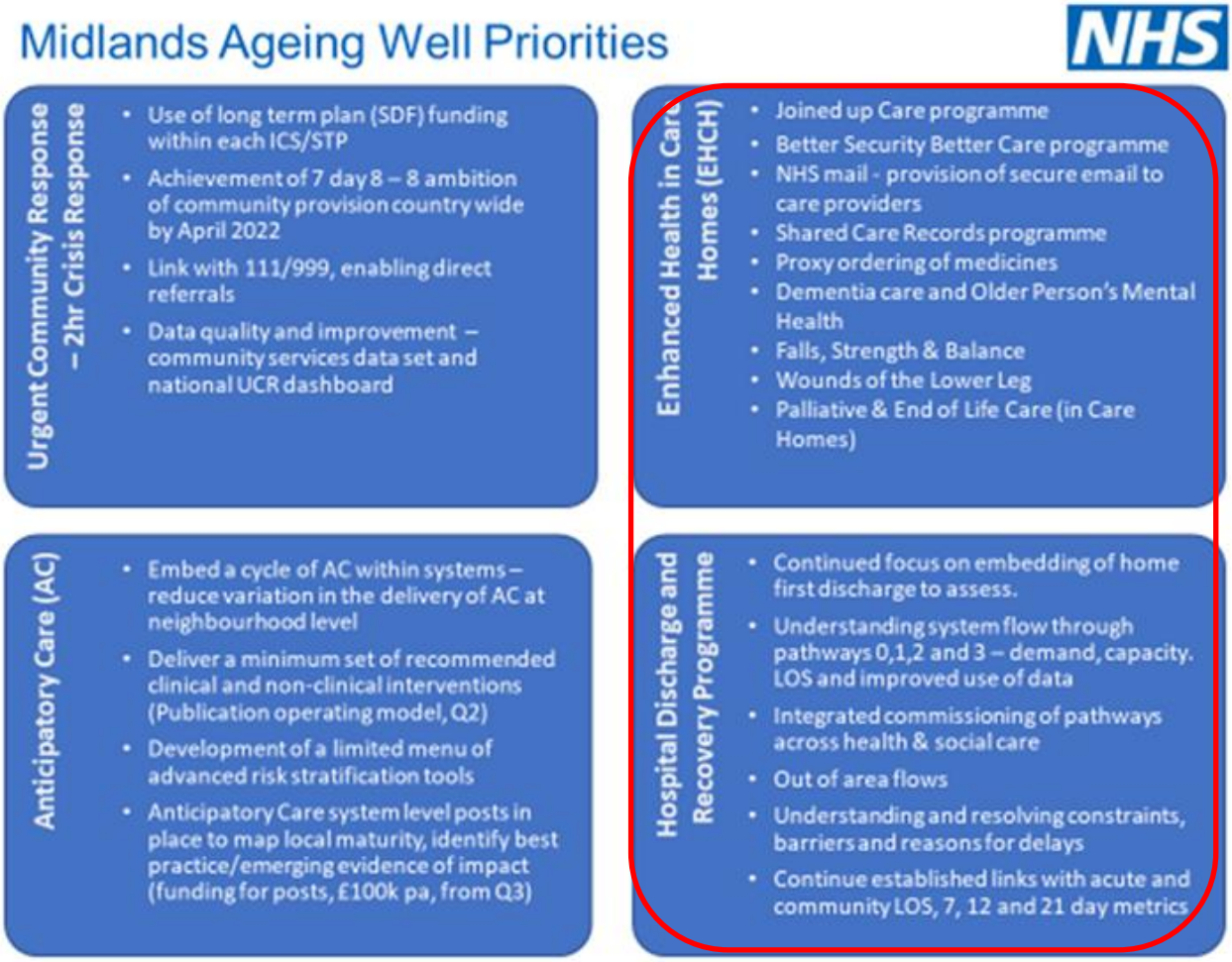


.

Joint Priorities for 2021/22

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

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

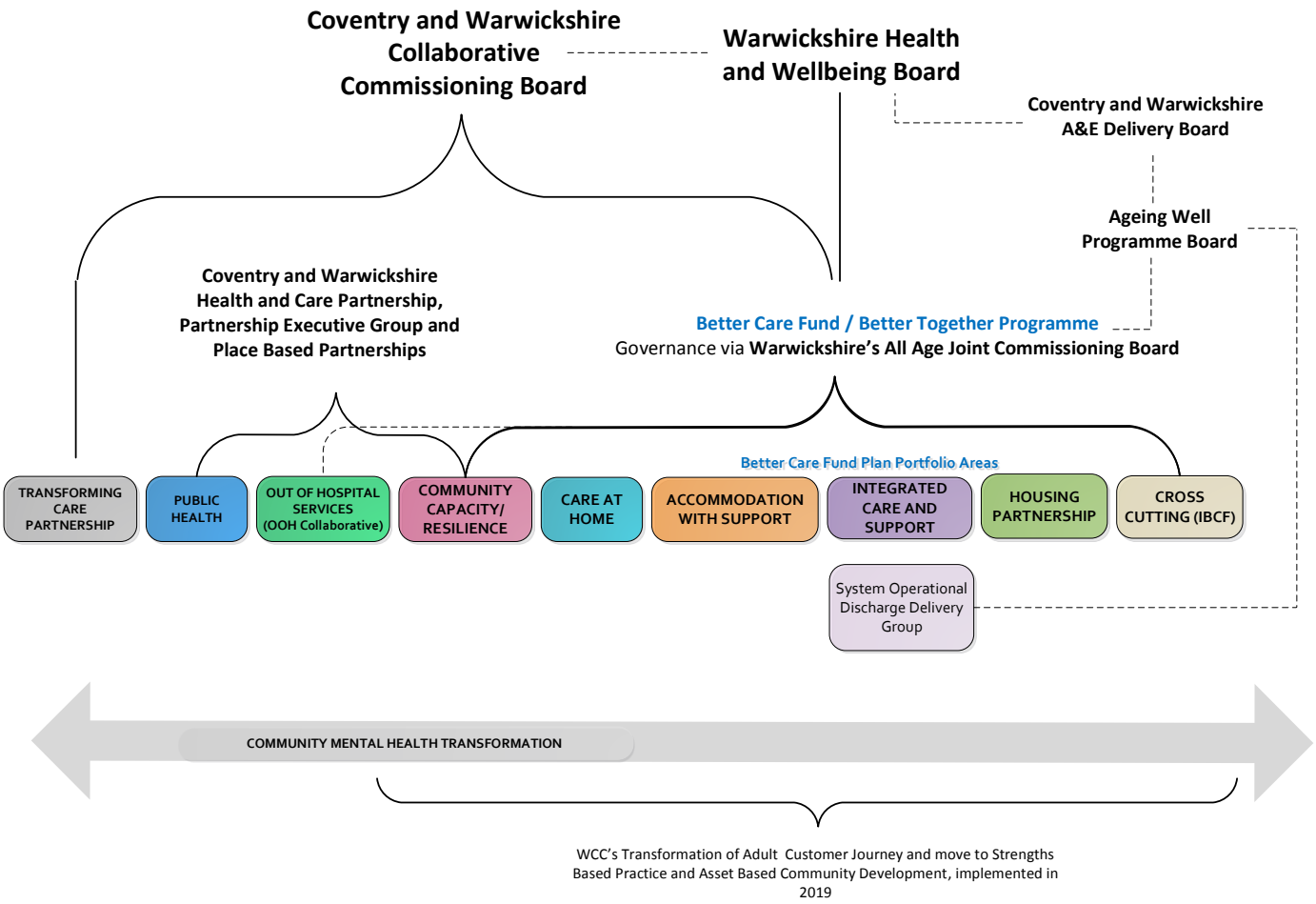


.

Governance

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

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



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

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

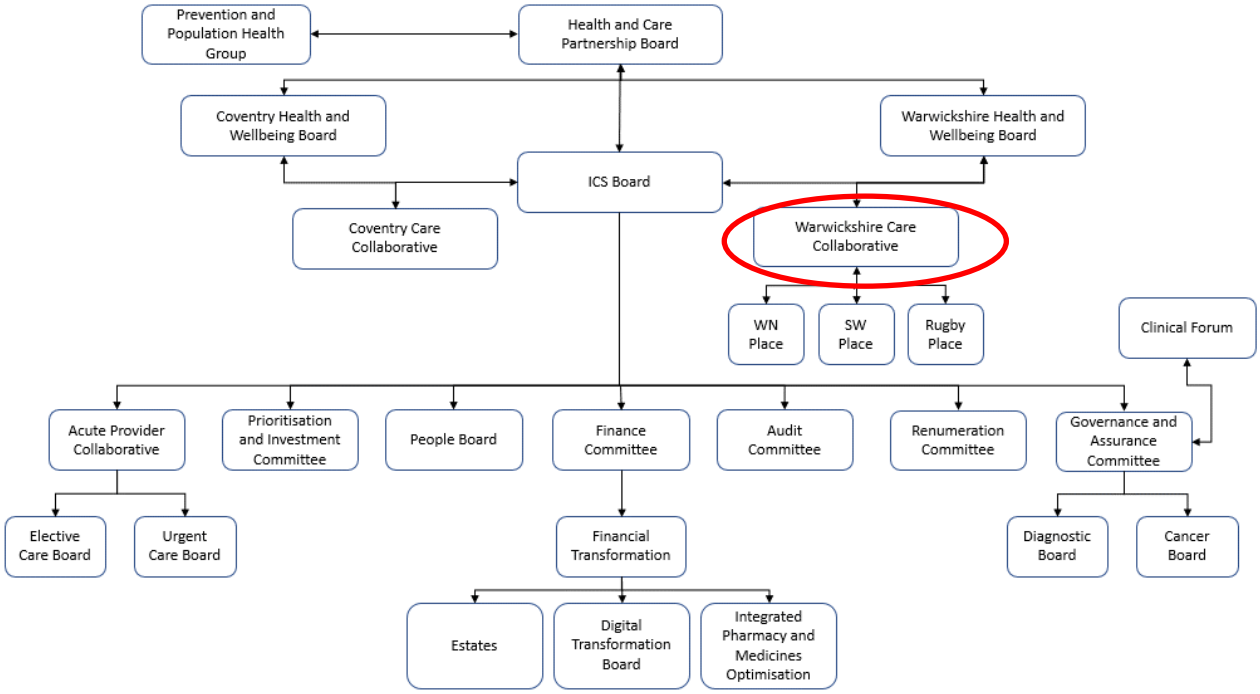
The BCF Plan prepared and agreed by the Joint Commissioning Board and Finance Sub-Group has also been approved by the relevant governing bodies (WCC's Corporate Board, and Cabinet; and the CCG's Governing Body) before being submitted and will be signed off on the day after the submission deadline by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

.

Future governance arrangements

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

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



.

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

Overall approach to integration

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

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

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

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

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

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

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

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

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

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

.

Current integration arrangements

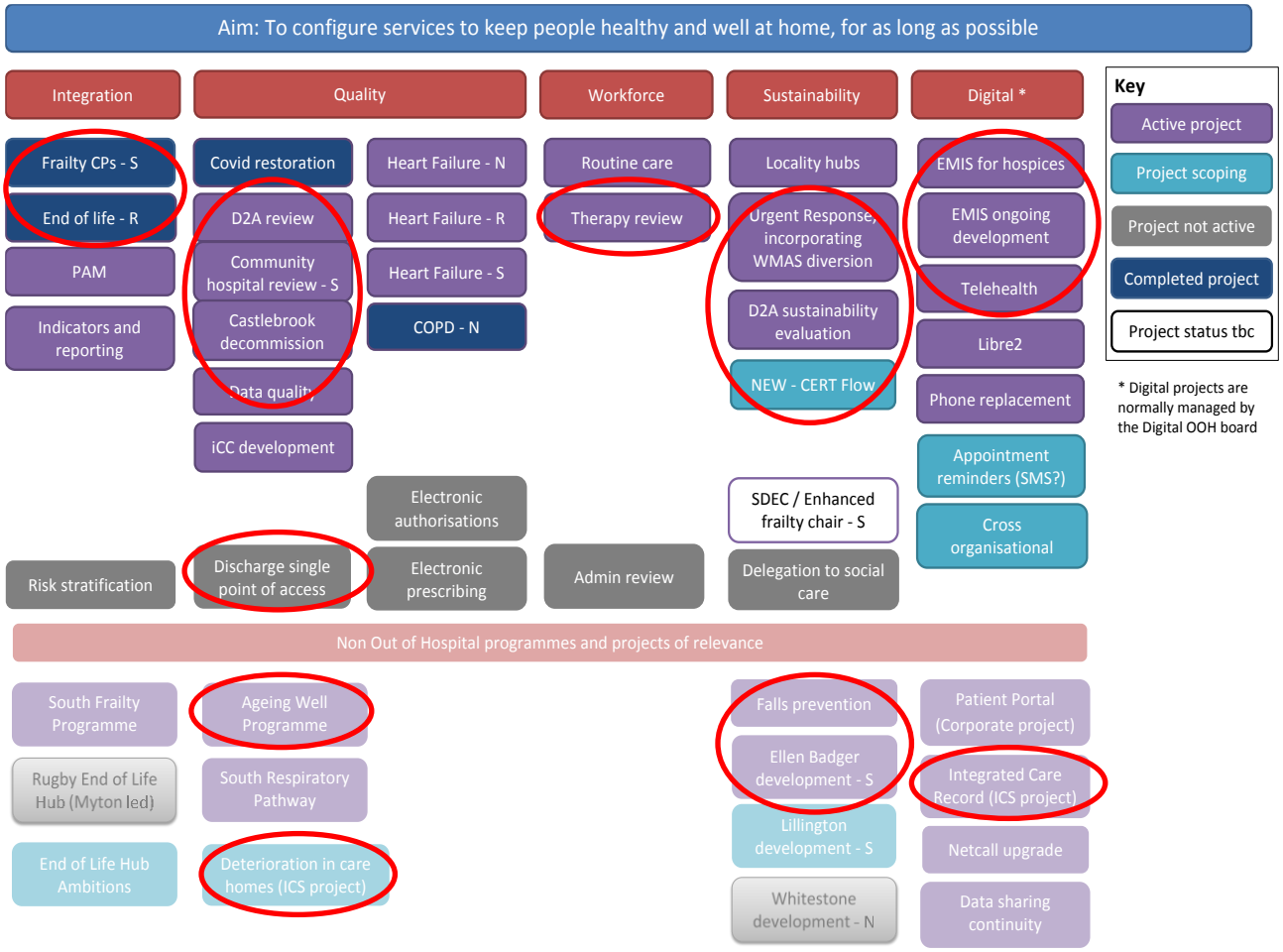
Joint Priorities for 2021/22

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

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

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

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



.

Overarching approach to supporting people to remain independent at home

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

In 2019, transformation change projects implemented:

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

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

What's important to us:

START WITH STRENGTHS

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

Better Health out of hospital COVENTRY & WARWICKSHIRE

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

Three additional integrated commissioning posts were appointed in 2019:

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

followed by a new Integrated Partnership Manager responsible for the Better Care Fund on behalf of WCC and the CCG in 2020.

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

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

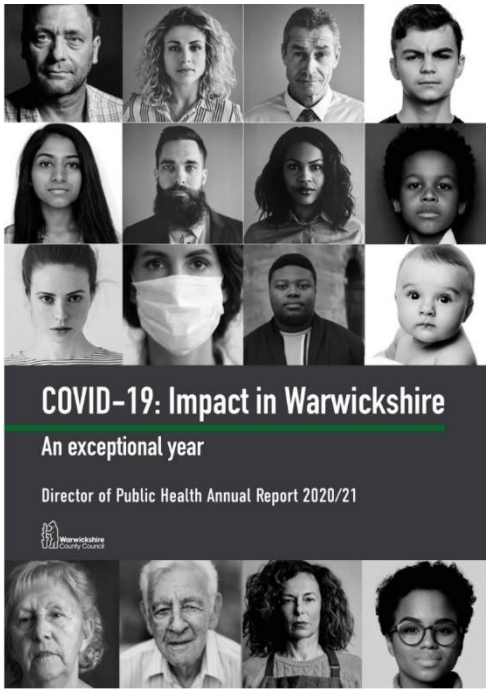
.

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

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

Equality and health inequalities

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

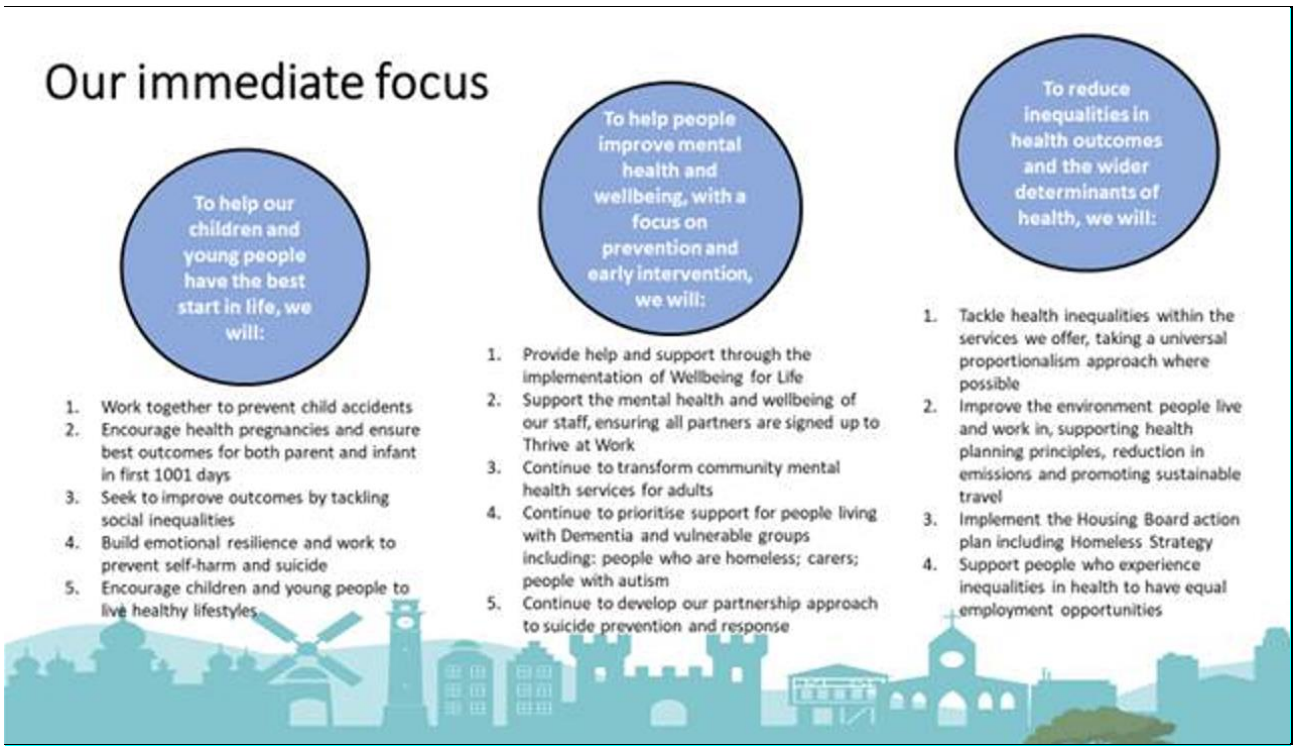


COVID-19 and the necessary lockdown restrictions to control its spread have had an impact on our health, the economy, and how we function as a society. COVID-19 has replicated existing health inequalities with the burden falling on the most vulnerable, the most deprived and the more marginalised, and,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

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

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

.



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

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

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

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

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

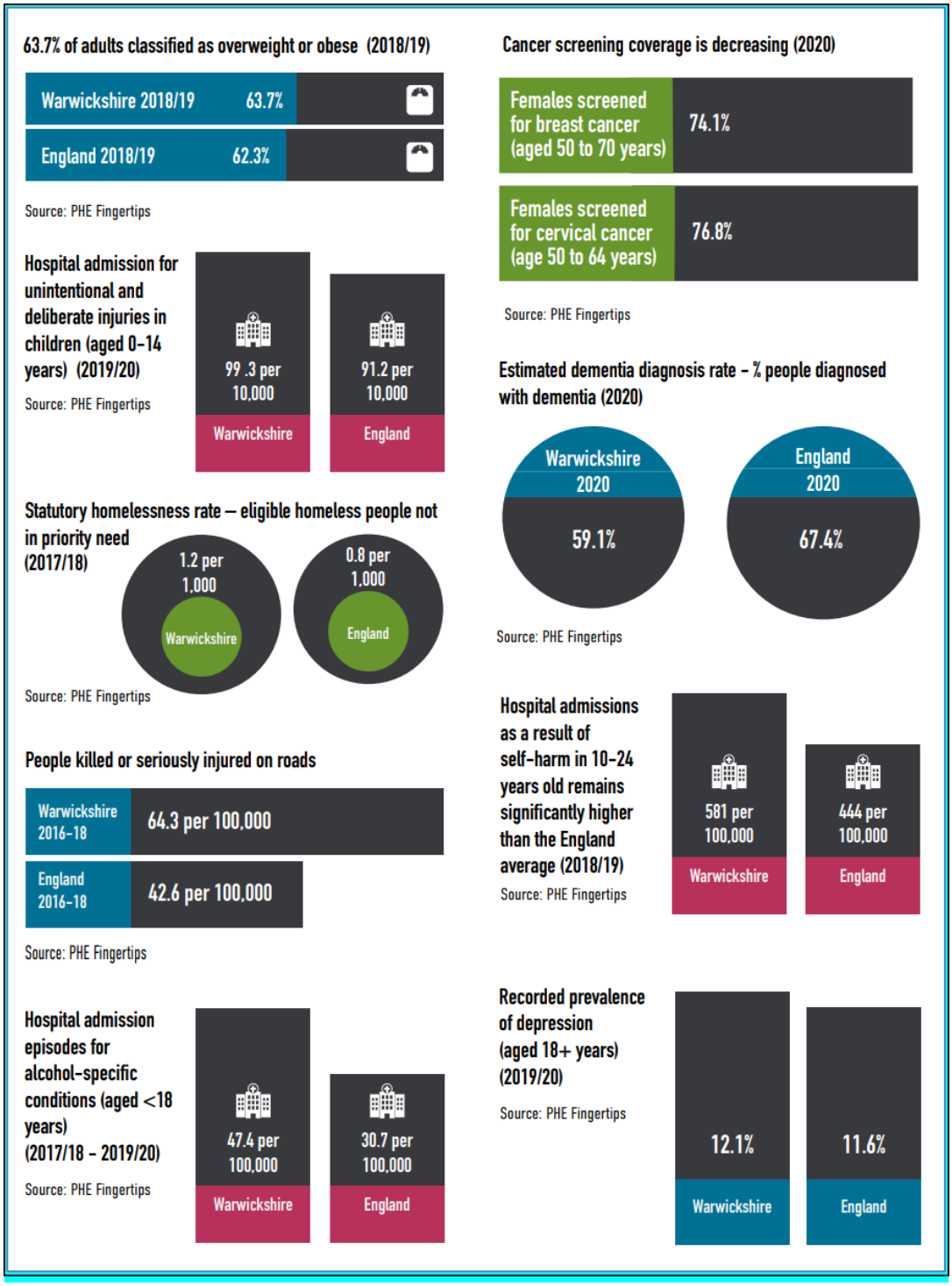
In development: Coventry and Warwickshire Health Inequalities Strategic Plan, and accompanying Prevention Strategy. The plan will set out our 'five high impact actions' as well as national NHS health inequalities initiatives such as 'Core 20+5'. The intention is that the

.

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

What are the health inequalities and challenges in Warwickshire?

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



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

.

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

Warwickshire also has a growing older population. There are more people over the age of 65 than the national average (20.8% in Warwickshire and 18.4% for England) and those over 85 are expected to almost double from 16,561 in 2020 to 30,132 in 2040. Although many people remain well, active and independent during later life, for others, increasing age brings an increasing chance of frailty, long-term medical conditions, dementia, terminal illness, dependency and disability (including falls). Importantly, COVID-19 has highlighted the importance of ethnic inequalities as well as socio-economic inequalities and the disproportionate impact that the virus, alongside control measures, have had upon people from Black and Minority Ethnic communities.

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

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

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

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

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

.

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

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

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

The strategic approach to using housing support and DFG funding

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

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

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

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

Approach to bringing together health, care and housing services

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

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

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

.

- Prevention and early intervention activities to enable people to remain happy, healthy and safe within their own homes and make more suitable housing choices before the point of crisis.
- Supporting people to smoothly transition into more appropriate housing.
- Improving choice and access to appropriate support, advice and information.
- Providing Housing Adaptations through effective use and monitoring of the Disabled Facilities Grant.
- Co-ordinating homelessness prevention activities and associated statutory duties.
- Implementing the housing related elements under Change 9 of the High Impact Change Model.

Aims of the Housing Partnership Board

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

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

Addressing health inequalities through housing

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

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

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

.

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

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

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

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

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

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

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

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

Our approach to commissioning services to support discharge and Home First

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

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

The following services were within scope of the review:

Home based provision (Pathway 1):

.

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

Accommodation/bed-based provision (Pathway 2):

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

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

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

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

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

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

<u>How BCF funded activity supports safe, timely and effective discharge</u>

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

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

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

.

Agreed Expenditure Plan

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

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

Note: amounts are rounded up for reporting purposes.

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

CCG minimum contribution

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

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

Social care maintenance

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

NHS commissioned Out of Hospital services

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

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

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

.

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

Improved Better Care Fund (iBCF)

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

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

.

Agreed Expenditure Plan

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

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

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

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

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

.

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

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

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

.

Additional Supporting Information

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

Appendix 1 – Joint Working Arrangements

Appendix 2 – Housing Partnership Action Plan