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

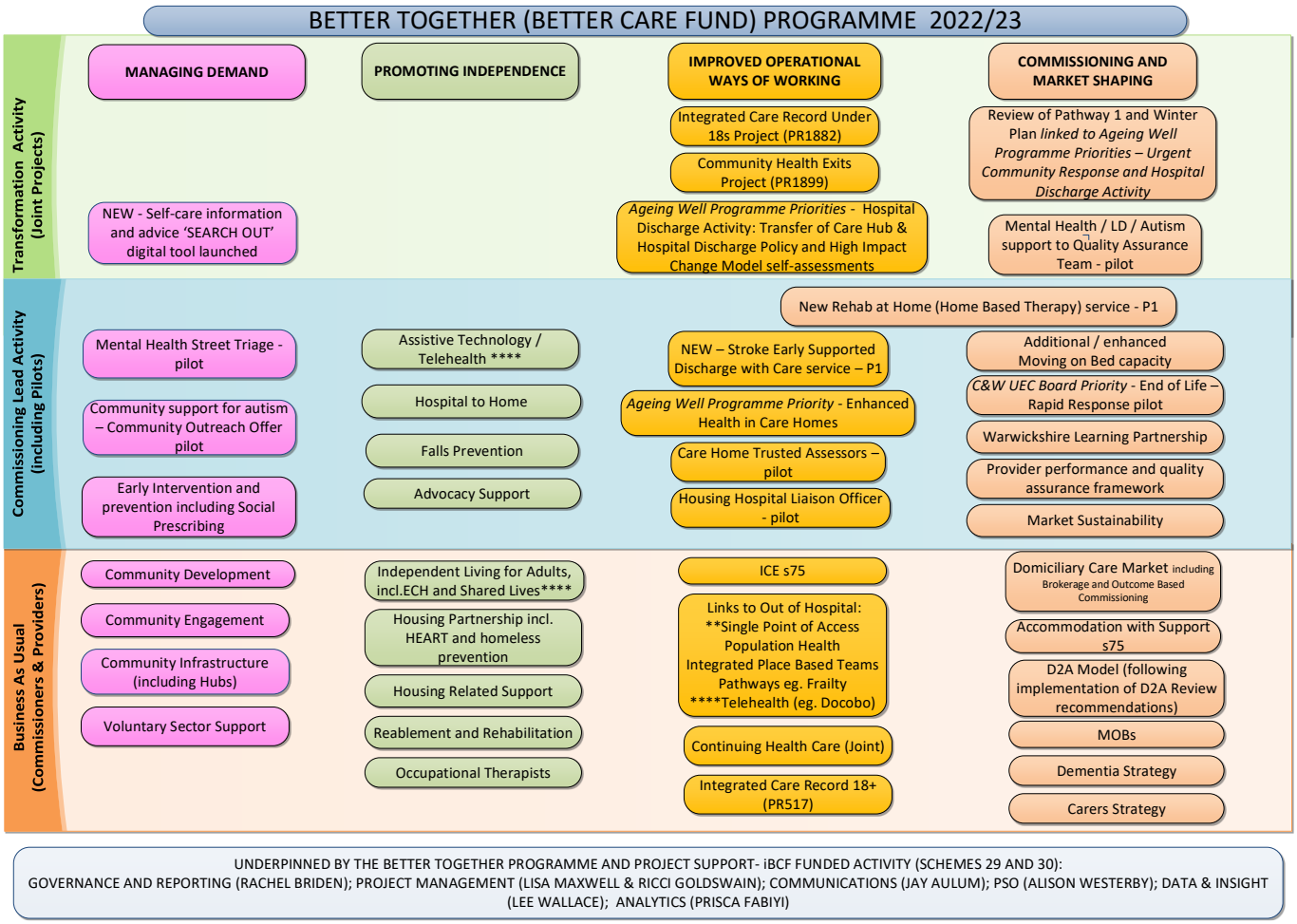
Executive Summary

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.

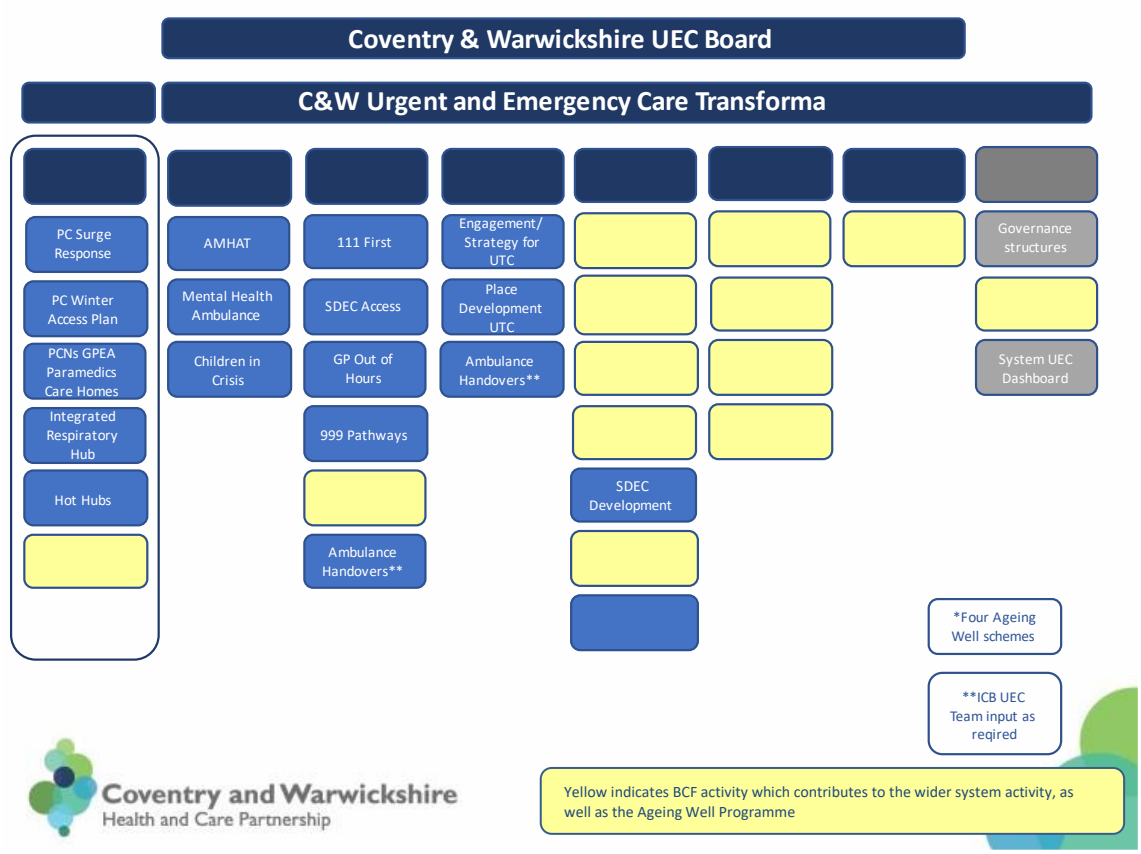
A good example of this is, through the Enhanced Health in Care Homes Ageing Well Programme workstream there has been considerable development of Telehealth Remote Monitoring (Docobo) in Coventry and Warwickshire

- 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**	

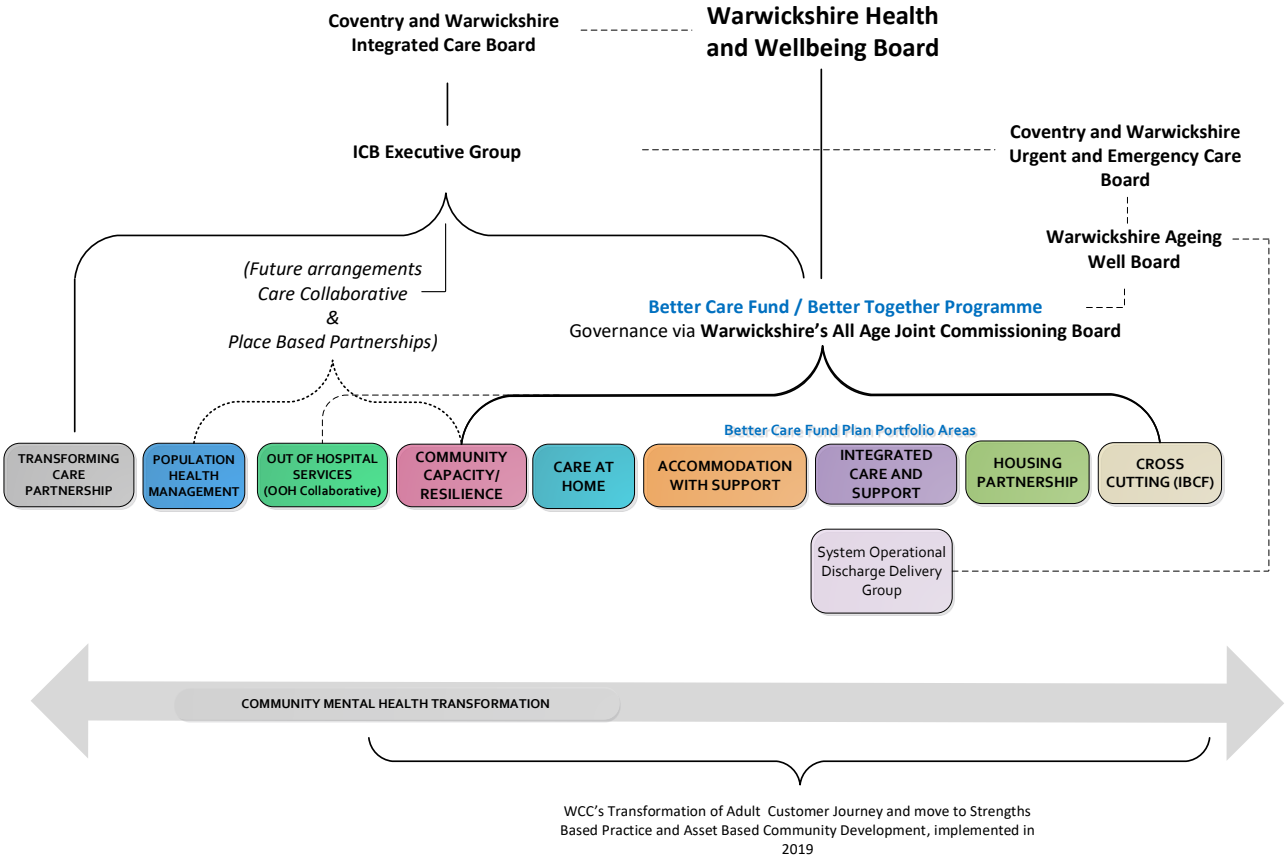
- Deteriorating patients in care homes, has been built into Docobo and where this is in use the current response time to any alerts is around 96% within 2 hrs of the alert.
- Due to the success in care homes, Docobo at Home is also now being planned as part of the Anticipatory Care workstream in the 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.

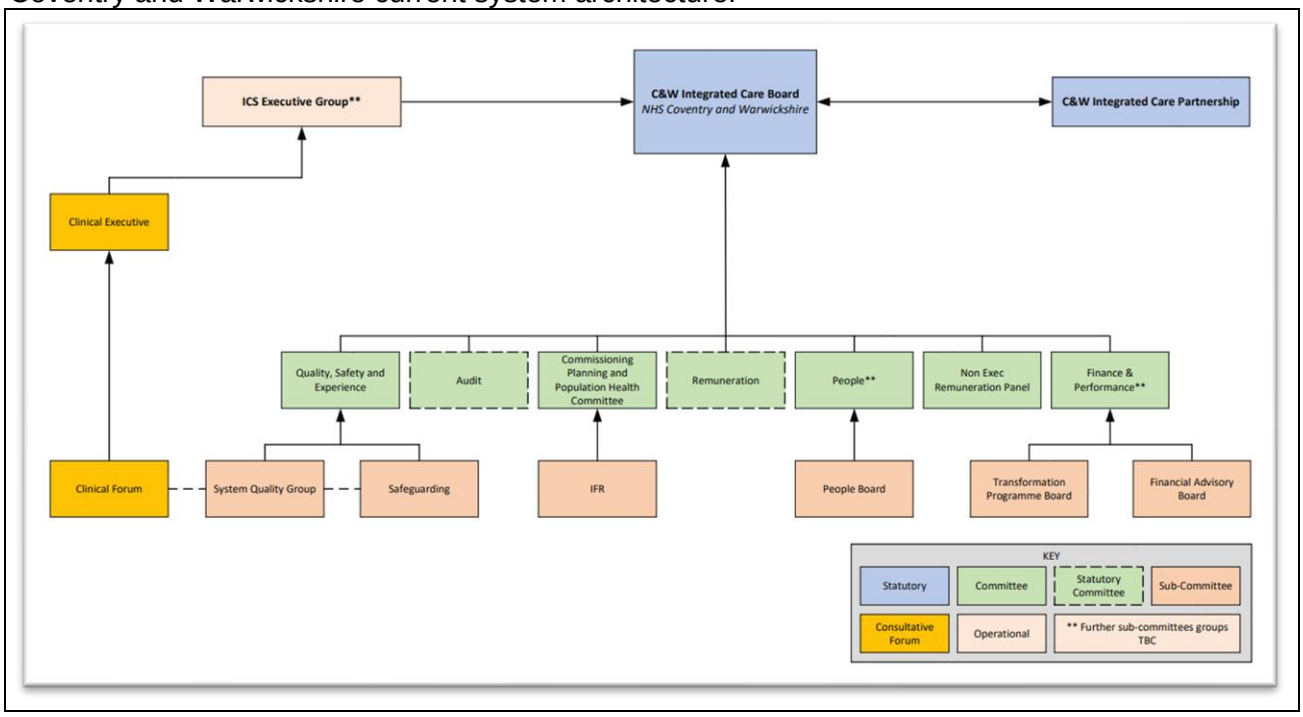
Our BCF Plan comprising of the pooled/aligned budgets, list of schemes, metrics and priorities outlined in the Planning Template and this Narrative Plan have been developed by the Joint Commissioning Board, as part of these wider partnership and system governance arrangements.

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.

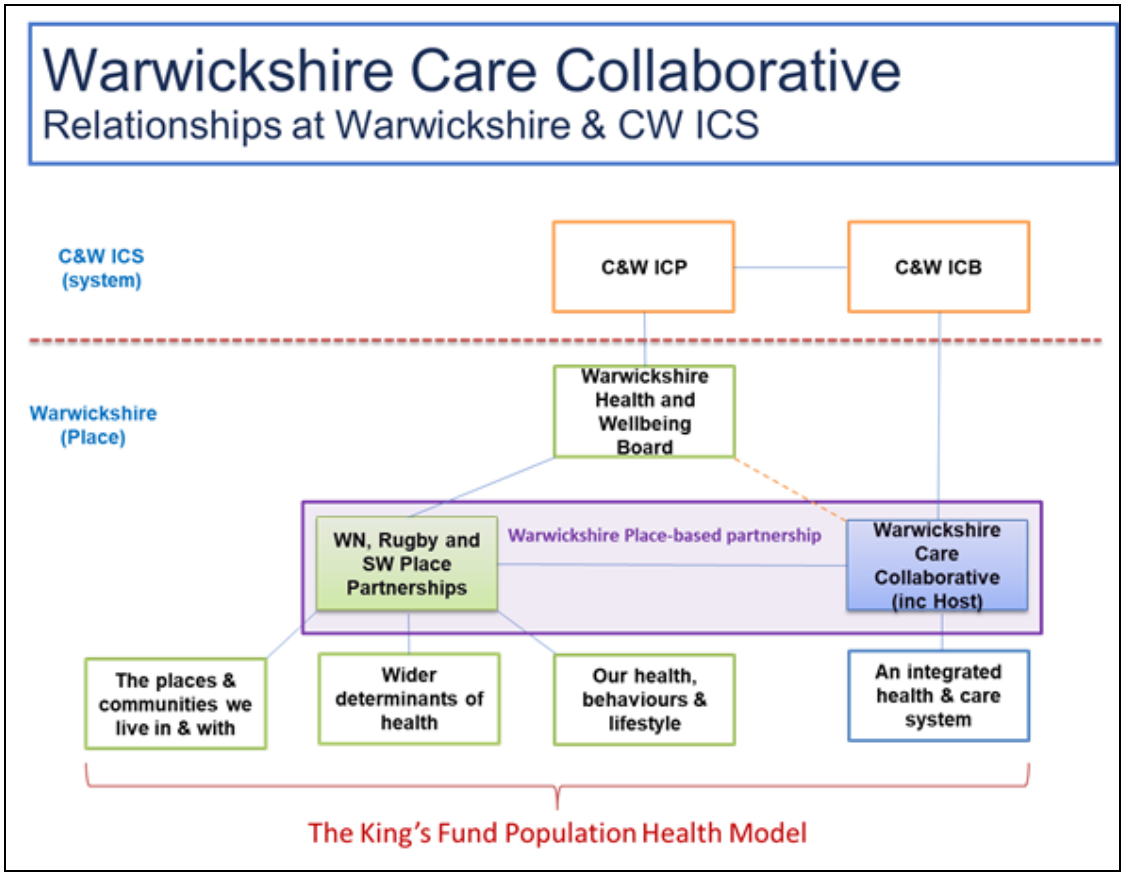
Integrated Care System governance arrangements

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.

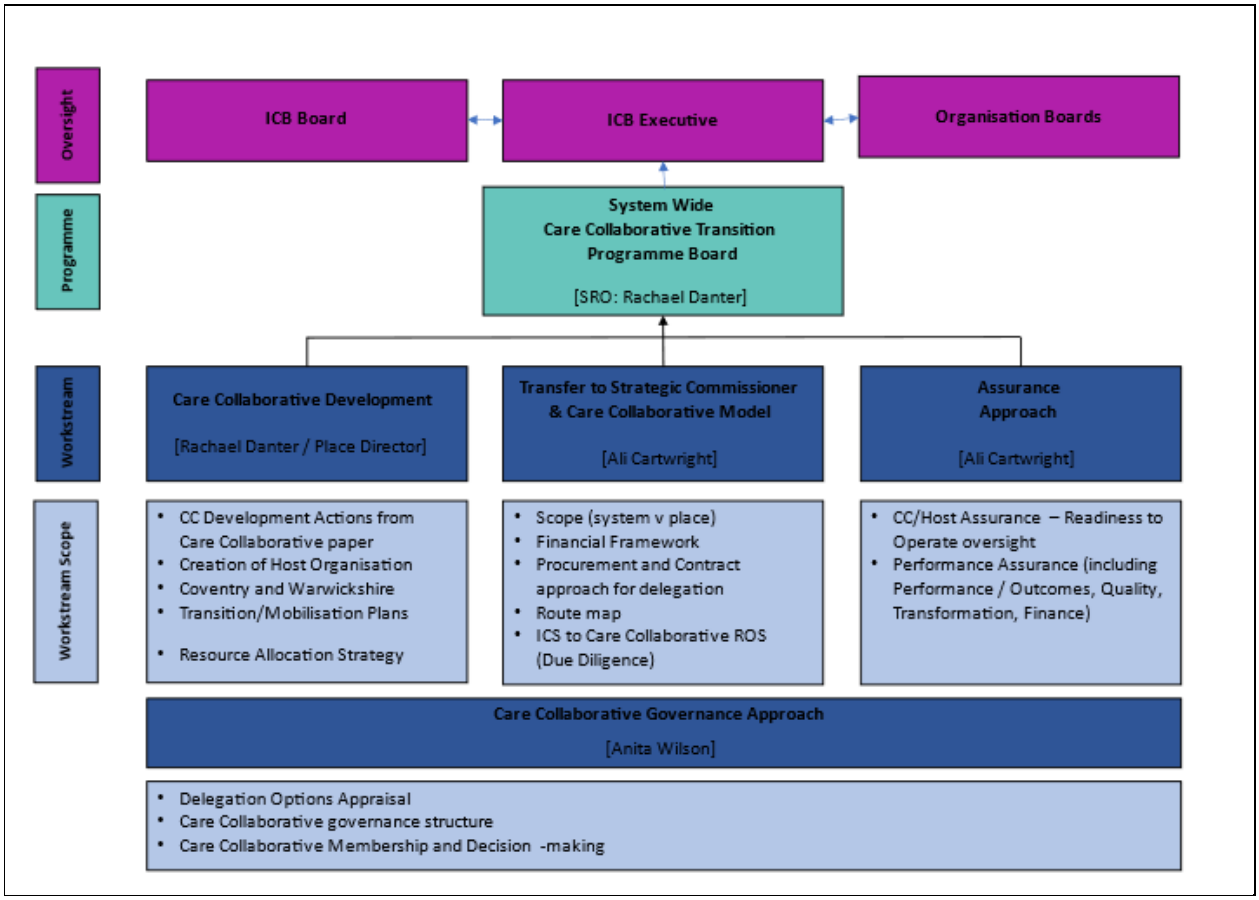
- The entities that the ICB will ultimately delegate the majority of NHS resource (from April 2023 subject to assurance of readiness to operate).
- Held to account by the ICB for the delivery of identified metrics/outcomes associated with functions and resources delegated to them.

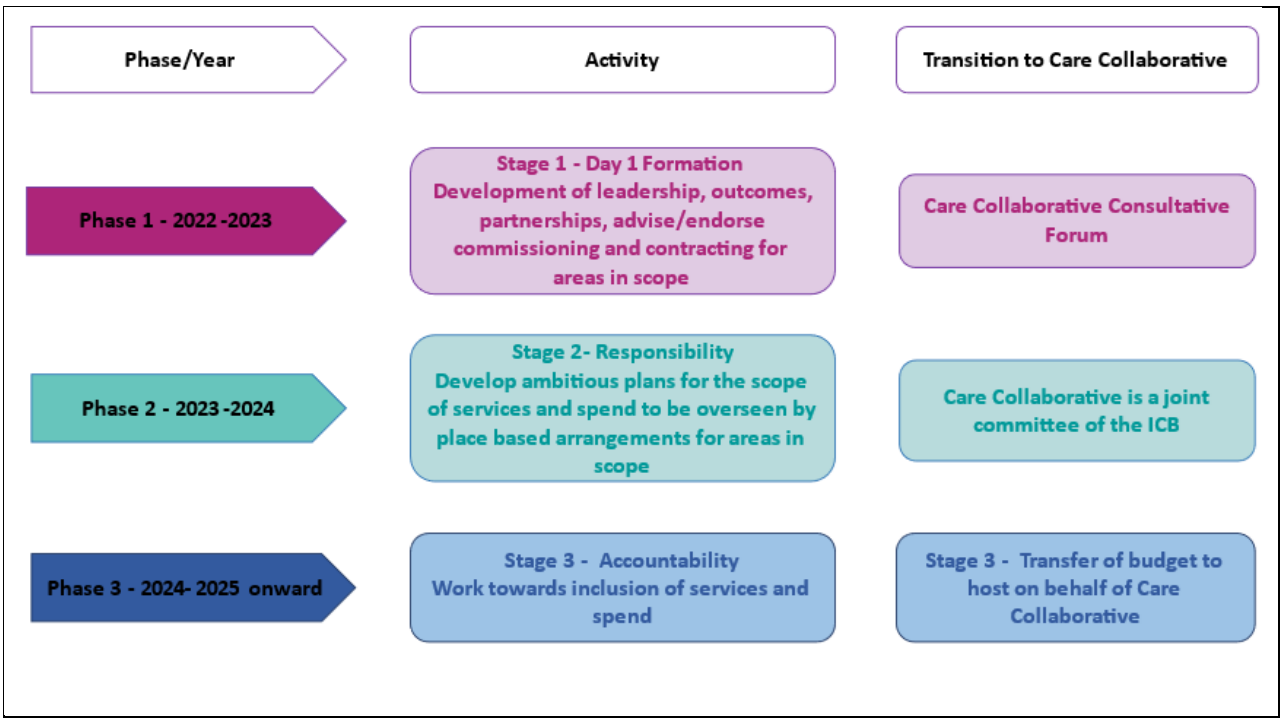
In Warwickshire we have endorsed the primacy of place and as such a key function of the Warwickshire Care Collaborative will be to support and enable integrated planning and delivery across the three place partnerships in Warwickshire North, Rugby and South Warwickshire; channelled through the NHS primary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

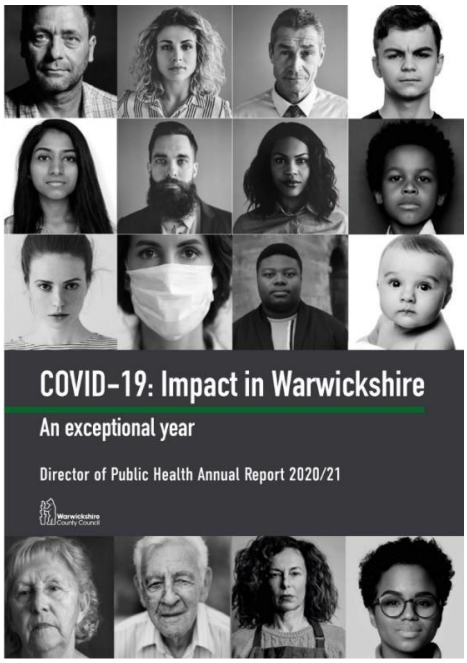
The recently agreed Health Inequalities Strategic Plan for Coventry and Warwickshire (2022-2027), sets out how, as a system, we will reduce health inequalities in Coventry and Warwickshire. The Strategic Plan outlines how it will take into account delivery of the key elements of the NHS Long Term Plan 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.

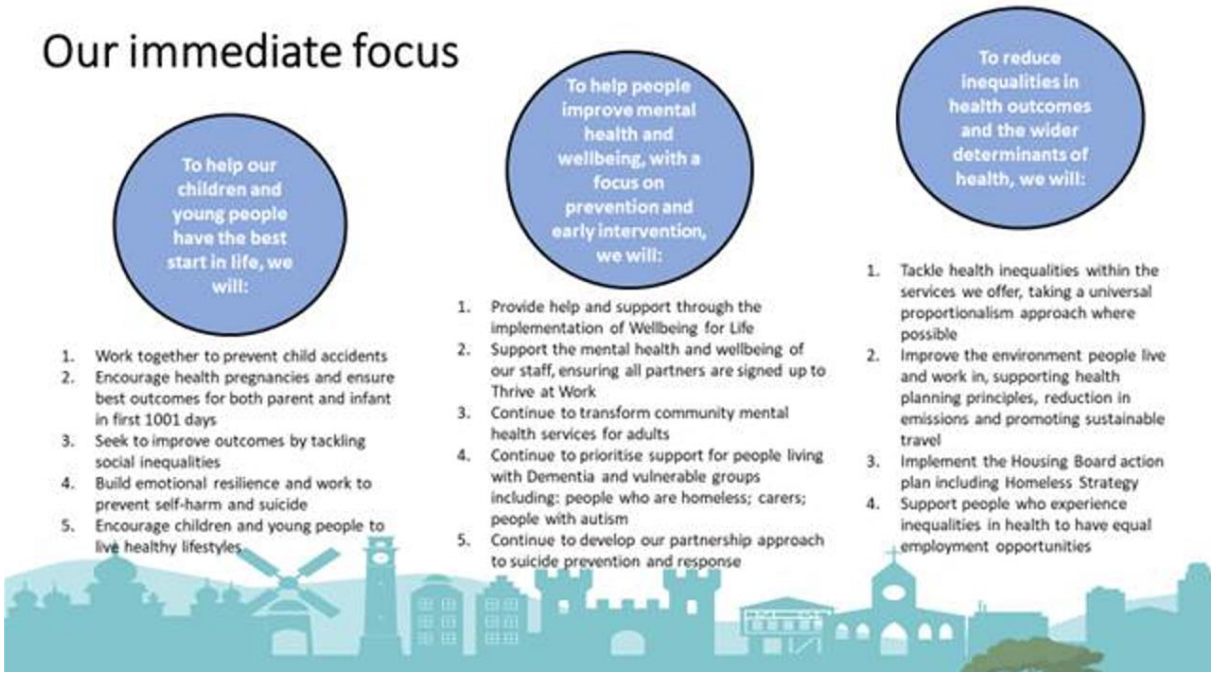
County level (Warwickshire)



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 b. Pathway 1 review and recommendations under consideration c. New project to streamline operational processes and earlier notification of demand relating to NHS services enabled by domiciliary care at Project Proposal Stage d. Expansion of system wide data through the Enhanced Discharge Tracker and Discharge Services Review Dashboard to all pathways	Change 3 – MDTs Change 4 Changes 1, 2 – Responsive Capacity & 4 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 b. Streamlined access points into social care now in place c. Rehab at home support now merged	Change 1 Changes 3 and 4 Change 4
3. Case Management arrangements	a. New trusted assessment approach for community health exits in pilot 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 b. New Rehab at Home and Stroke Rehab pathways commissioned	Change 2 – Capacity does not always match demand 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.