Integration and Better Care Fund (BCF) Plan

Better Care Fund Plan 2023/25 Submission
Final Draft V0.4

Health and Wellbeing Board (HWBB):

Warwickshire

KEY

NATIONAL CONDITIONS

Planning requirements and Key Lines of Enquiry set out the main areas that need to be covered.

National Condition 1 – Jointly agreed plan

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

Key Line of Enquiry: Organisations involved in preparing the plan

The following organisations/partnerships have been involved in developing and reviewing the schemes and joint integration activities as set out in this Better Care Fund (BCF) Plan for 2023 - 2025 (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);
    - 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;
    - Headteacher representatives.
- Acute Trusts (George Eliot Hospital NHS Trust, South Warwickshire University NHS Foundation 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 and voluntary and community sector providers through provider forums and targeted discussions related to specific schemes/initiatives.

Representatives on the Warwickshire Care Collaborative consultative forum have considered the plan. The forum is chaired by the Director of Public Health and includes:

- 2x Coventry and Warwickshire ICB representatives
- Rugby Place Partnership representative
- South Warwickshire Place Partnership representative
- Warwickshire North Place Partnership representative

- 3x representatives from general practice and the Coventry and Warwickshire Primary Care Collaborative
- Representative from the Voluntary and Community Sector
- Representative from the Adult Social Care Sector linked to a provider reference group.
- Representative from the Mental Health Collaborative
- Representative from the Learning Disability and Autism Collaborative
- George Eliot NHS Trust representative
- South Warwickshire University Foundation Trust representative
- University Hospitals Coventry and Warwickshire representative
- Representative from Coventry and Warwickshire Partnership Trust
- Adult Social Care, Children and Families and People Strategy and Commissioning representative
- Warwickshire Healthwatch
- District and Borough Council representative

Warwickshire Health and Wellbeing Board members considered and endorsed proposed schemes at their meeting on the 19th July 2023.

Preparatory Activity

In August 2022, the Warwickshire Joint Commissioning Board started an exercise to review the Better Care Fund and the Improved Better Care Fund (iBCF). As part of this exercise, twenty iBCF schemes were prioritised for in-depth review with a prioritisation tool used to assist the process. The joint review comprised staff from the local authority and Integrated Care Board (ICB) and ran from the October 2022 to January 2023, and focused on jointly reviewing iBCF schemes to the value of £3.96m.

The review focussed on assuring that schemes continue to meet the BCF conditions and iBCF grant conditions, respond to current system pressures/priorities and health inequalities and are as efficient and effective as possible; taking into account whether there are alternative ways of achieving similar outcomes or alternative funding arrangements.

High level review outcomes and recommendations were as follows:

- The majority of schemes are well established with positive impact evidenced across health and social care and if withdrawn would have a detrimental impact to our population.
- Potential efficiencies to the iBCF budget for nine schemes would release approx. £500k for reinvestment in existing schemes from 2023/24 and contribute to the inflationary cost pressures.
- One existing scheme should continue but instead be funded from the Mental Health budget outside of the iBCF.

As such 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 with the partners listed above, ready for the start of the 2023/24 year.

Preparing the BCF Plan

Following receipt of the BCF Planning Requirements in April 2023, the stakeholders represented on the Warwickshire Joint Commissioning Board and Coventry & Warwickshire Urgent and Emergency Care Board (listed above) have been re-engaged to reaffirm and update, where required, the schemes, activities, and metrics. In addition, the Warwickshire Care Collaborative Consultative Forum, as part of the Coventry and Warwickshire Integrated Care System (ICS), have been involved in shaping and approving our BCF plan. As such a wide range of partners including health, social care and the voluntary sector have had the opportunity to shape the plan and approve the content.

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	06/06/23
	Warwickshire Care Collaborative	08/06/23
CW ICB	Integrated Care Board Executive	13/06/23
WCC	People Directorate Leadership Team	21/06/23
WCC	Corporate Board	20/06/23
	Submission deadline	28/06/23
WCC	Cabinet	13/07/23
Partnership	Health and Wellbeing Board – review, and approval	19/07/23

Responsibilities for preparing this plan

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

Responsible: Ali Cole, Strategy and Commissioning 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, Warwickshire Care Collaborative Consultative Forum.

Informed: Warwickshire Health and Wellbeing Board

Document History

Version	Summary of changes	Author	Date
V0.1	Draft version shared with stakeholders	Ali Cole	10/5/23
V0.2	Draft incorporating comments from Stakeholders including WCC, ICB, Care Collaborative, Place Health and Wellbeing Partnerships, Housing Partnership and NHSE	Ali Cole	26/5/23
V.03	Final draft following proofread and incorporating update to D2A metrics	Ali Cole	20/6/23
V0.4	Final draft incorporating feedback from Corporate Board and Warwick District Council	Ali Cole	22/6/23

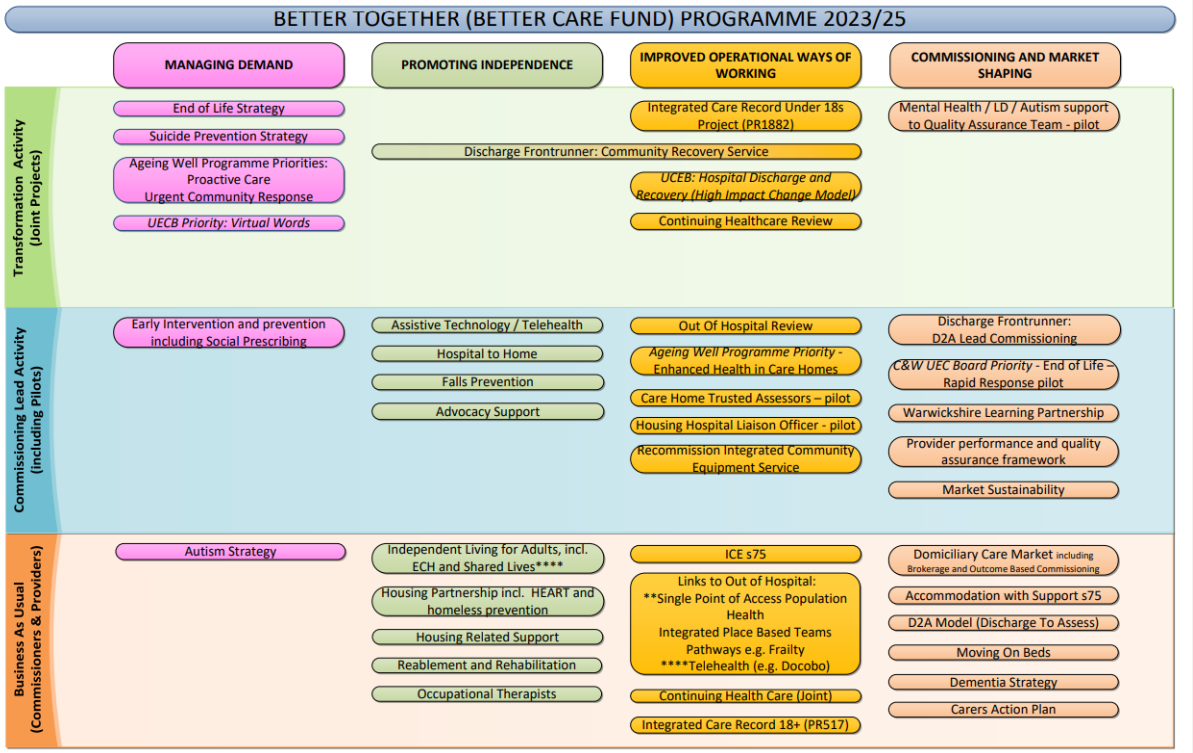
Executive summary

Background

The Better Care Fund has been one of the key contributors over a number of years towards building stronger partnerships and integration between the commissioners and providers of health, care and housing 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 2023/25 will continue to build on our long-term vision, as outlined in our original submission in 2015/16, our updated 2017-19 and 2022-23 plans, and builds on the progress made from 2016-23. Interdependencies with other programmes of work including personalisation and reducing health inequalities are incorporated within the elements of the programme.

The majority of schemes and activities in our BCF plan for 2023/25 continue on from previous years, with key priorities described in the following section. The illustration below summarises the schemes in our BCF Plan, new activity and the links to NHS programme activity:



Joint Priorities for 2023/25

As outlined in our Coventry and Warwickshire ICS Five Year Joint Forward Plan, enabling and supporting people to maintain their independence at home is at the heart of our approach. The work that we are doing through our Hospital Discharge Community Recovery Frontrunner Programme in Warwickshire is underpinned by this principle and an opportunity to transform our local offer (see further detail related to this priority below).

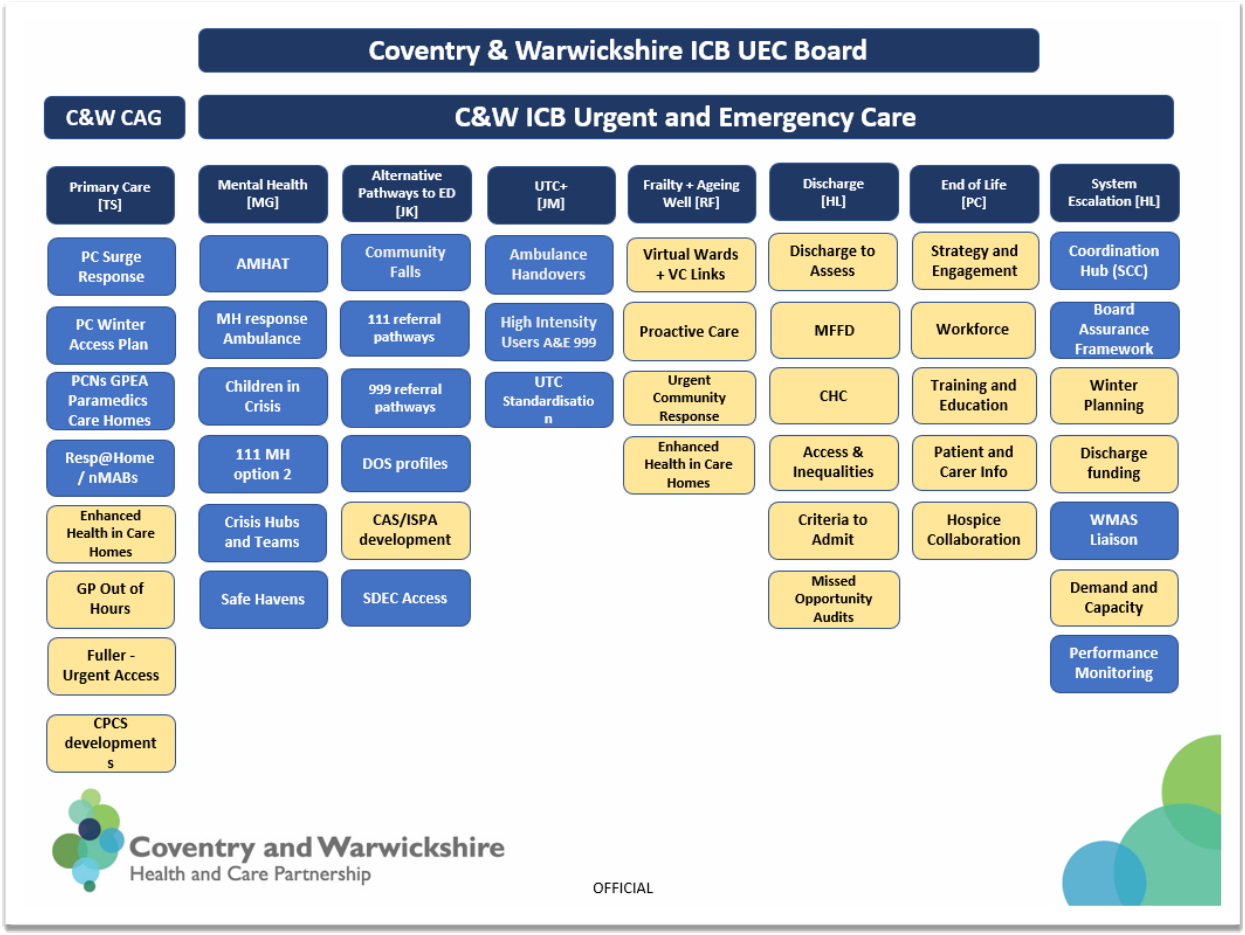
Relationships are robust across health and care partners with commitment to working together and sharing learning to improve population health and individual outcomes. We have a number of joint strategies and delivery plans that run through 2023 – 2025 that will continue to be a focus for us to improve our support offer for people, including, but not limited to, people with dementia, autism and informal carers. There is a strong commitment to co-production across partners and residents and services users are regularly engaged and involved in the development of strategies and commissioning intentions as well as service design and evaluation.

We continue to work together to consider new ways of working including how to maximise the use of remote and digital technology to meet people's health and care needs. We also collaborate to support market shaping and development to ensure that we have a sustainable care market able to meet the needs of our residents.

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

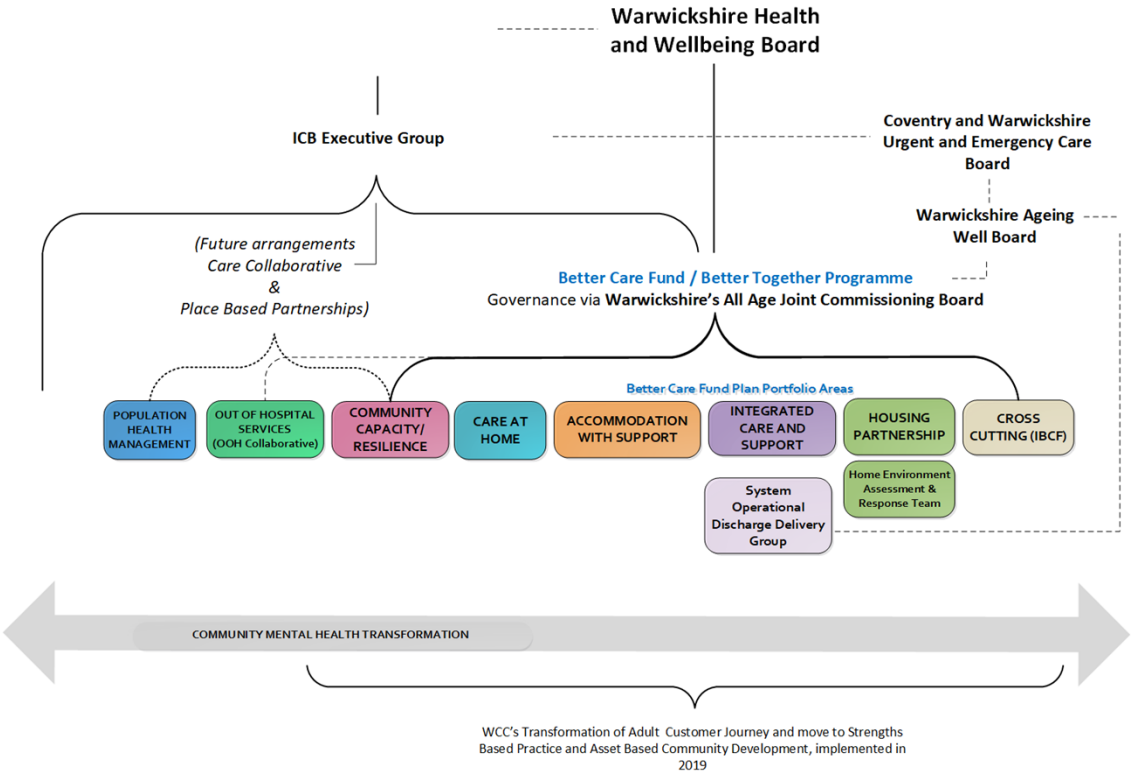
As the new architecture for the Coventry and Warwickshire Integrated Care System has started to be implemented, increased focus on joint delivery (in addition to joint commissioning which has been in place for a while) has resulted in some of the duplication in previous years being removed, as operational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

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



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.

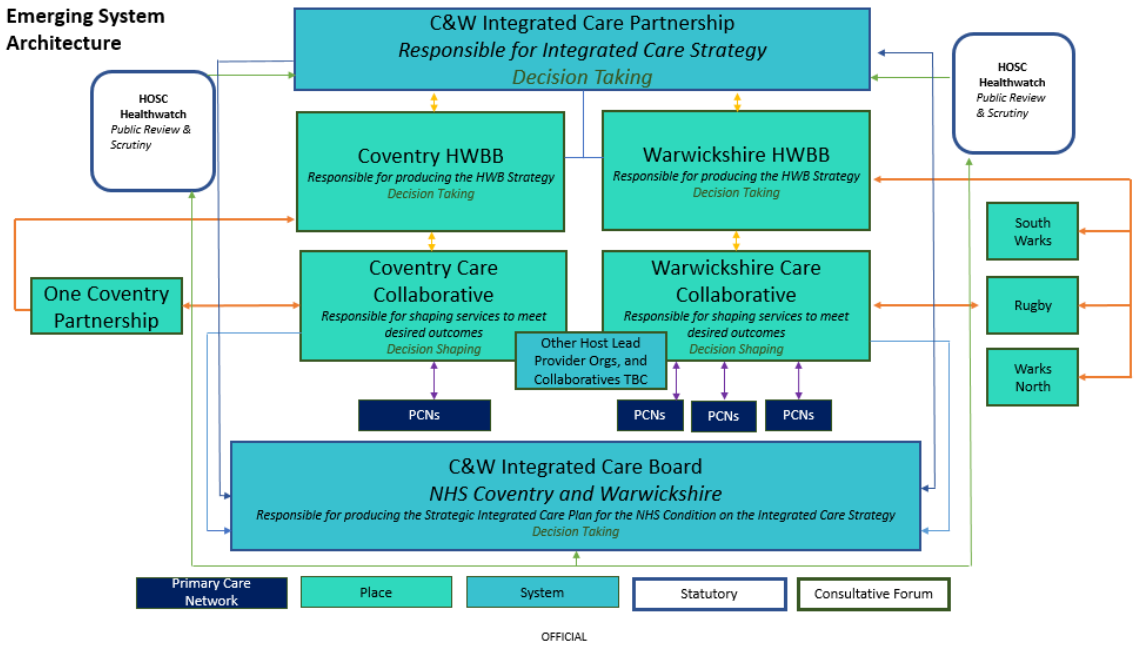
Governance of implementation of the Better Care Fund, BCF Plan and Better Together Programme is currently through the Warwickshire Joint Commissioning Board; underpinned by a Section 75 agreement.

Our BCF Plan comprising 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 Finance Leads from the local authority and CWICB) which leads on scheme level spending plans for the pooled (base BCF) and aligned budgets, risk share and associated Section 75 arrangements.

Integrated Care System governance arrangements

The illustration below summarises the emerging Coventry and Warwickshire Integrated Care System architecture.



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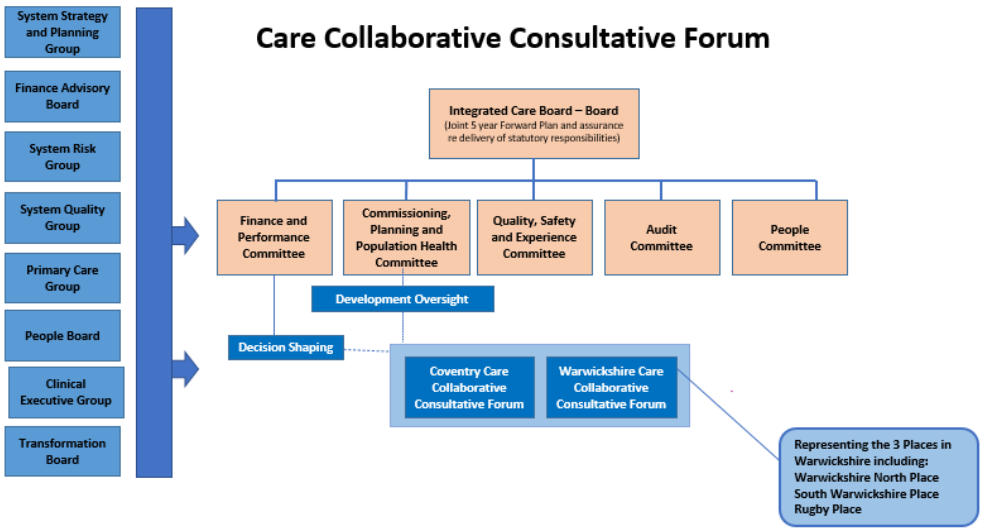

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The development and delivery of place partnership plans in Warwickshire North, Rugby and South Warwickshire are underpinned by the Joint Strategic Needs Assessments and have a focus on delivering outcomes for our population against the Kings Fund quadrants. The Council and ICB are positively engaged in the emerging Mental Health and Learning Disability and Autism Collaboratives. Prevention and promoting independence are key.

Planning Requirement 2: A clear narrative for the integration of health, social care and housing

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

Approaches to Joint / Collaborative Commissioning

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.

There are 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 geographical collaboratives as part of phase 1 delegations. As outlined above, 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. During 2023 – 2025 governance of implementation of the BCF will move to the developing Warwickshire Care Collaborative with a plan of action to support the transition. The care collaborative currently shapes decisions as a consultative forum but there are plans to move it to a formal sub-committee of the ICB, with decision making responsibilities, by January 2024.

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

- A Chief Commissioning Officer (Health and Care) for Warwickshire County Council and South Warwickshire University NHS Foundation Trust. In addition to directing commissioning activity this role is supporting the development of the Warwickshire Care Collaborative and place-based delegations.
- A jointly funded Assistant Director of Public Health between WCC and SWFT, aligned to the Out of Hospital and Warwickshire Care Collaborative acting as public health lead for delivery of the Health and Wellbeing strategy.
- 2 jointly funded public health consultants between Warwickshire County Council and the ICB. These consultants take a place lead responsibility as well as having a focus on children and young people and mental health respectively.
- 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).
- Jointly funded commissioning and quality roles for the Integrated Community Equipment Service
- An Integrated Partnership Manager responsible for the Better Care Fund on behalf of WCC and ICB.

Collaborative Development

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 embedded and the two geographical care collaboratives across Coventry and Warwickshire were formally stood up in 2022. A key component of the ICS, these care collaboratives are made up of the partnership of organisations responsible for organising and delivering health and care within

Coventry and Warwickshire respectively. In Coventry and Warwickshire, we have endorsed the primacy of place and as such a key function of the Warwickshire Care Collaborative is to support and enable integrated planning and delivery across the three place partnerships in Warwickshire North, Rugby and South Warwickshire.

The Care Collaboratives:

- Are the foundation for the integration of health, social care and public health services; and population health at Coventry level and Warwickshire level.
- Are the entities that the ICB will delegate NHS resource to for the services agreed in scope (from April 2023 subject to assurance of readiness to operate). Current services in scope for Care Collaborative delegation include urgent and emergency care, out of hospital, Continuing Healthcare for adults and the BCF.
- Will be held to account by the ICB for the delivery of identified metrics/outcomes associated with functions and resources delegated to them.

Partners across Warwickshire continue to engage in the Coventry and Warwickshire Collaborative Development Programme, facilitated and led by the Coventry and Warwickshire ICB. A roadmap for further development of collaborative arrangements has been devised (summarised in Appendix 1) to support transition of the Warwickshire Care Collaborative from a decision shaping consultative forum to a formal decision-making committee of the ICB by the January 2024. In addition to the Care Collaboratives, Coventry and Warwickshire have established provider collaboratives to support delivery of our ICS ambitions for integrated delivery. This includes collaboratives for Primary Care, Acute Care, Learning Disabilities and Autism and Mental Health.

Coventry and Warwickshire One People Plan

The **Coventry and Warwickshire One People Plan** was co-developed via an extensive multi-stakeholder engagement and research project, which demonstrated consensus of support for a **One People Plan** that spans the ICS. At the heart of this support was a call for the achievement of four priorities for system level action: **System Culture and Organisational Development; Attraction, Recruitment and Retention; People Development and Workforce Innovation.**

These priorities enable, but are not responsible for, Place based activity and deeply respect organisational autonomy. They also ensure the delivery of the **NHS People Plan 2020/21**, the 10 expectations of a People Function and the **ICB Clinical and Care Professional Leadership Framework.** Delivery of the **One People Plan is** led by the **ICB People Board,** with oversight by the ICB Board via the People Committee. It is focused on improving the things that we currently do, as well as enabling innovation and transformation.

The health and care workforce, support the delivery of all 9 strategic objectives set out in our **Integrated Care Strategy** and reflected in the **Joint Forward Plan**.

Our people are our biggest asset and value is created for our population by the skills, experience and expertise of the people working within our system. Ensuring that we have the right mix of skilled staff in all parts of our system will support the improvement of health outcomes and reduce inequalities across Coventry and Warwickshire.

Population Health Management and Prevention

The Joint Forward Plan 2023-28 for Coventry and Warwickshire includes the following ambitions:

- Population Health Management ('PHM') is embedded as business as usual across our system – meaning that there is a shared understanding of and commitment to PHM as

"everyone's business" across all system partners and PHM is built into strategic planning and decision-making at all levels of the system and across all partners.

- A system wide commitment to supporting prevention is embedded, with prevention explicitly embedded and resourced across all plans, policies and strategies for our population. This includes addressing the impact of the wider determinants of health across the life course, ensuring residents live in affordable and good quality homes, have access to good jobs, feel safe and connected to their communities, utilise green space and are enabled to use active travel.

Our PHM Roadmap sets out our local vision for PHM to *"empower everyone to live well by joined-up, proactive, data-driven health and care".* The PHM Roadmap outlines the actions that we will take to spread, scale and sustain PHM capabilities across our system, aligned to the four components of the national PHM Maturity Matrix. We have a Population Health Management Board which engages representation from across partner organisations and provides oversight of the delivery of the PHM Roadmap. The PHM Board reports to our Population Health, Prevention and Inequalities Board, which strategically aligns PHM, prevention, personalised care and health inequalities and wider determinants work. The PHM Board also links to our Digital Transformation Board. We have made significant progress in implementing a local PHM platform, through which we will ultimately be able to link near-real time data from a range of sources. Key information governance documentation is in place to support PHM activity and data has been on boarded from 40 GP practices.

Integration with Housing

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.

WCC has excellent strategic partnerships with the District and Borough local authority housing teams and is working closely with them to gain mutual benefits from continuing efforts to develop the Housing offer in the County. Examples of joint working include:

The District and Borough Councils employ three Housing Liaison Officers, who provide housing expertise to NHS and social care teams to support early discharge planning for Warwickshire patients admitted to hospital, whose discharge may otherwise be delayed. This service is now well established and is funded through the iBCF.

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. Governance of the HEART Service is through a multi-agency HEART Board and the partners have agreed to renew the partnership agreement for a further 5 years from April 2023. This is achieved 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.

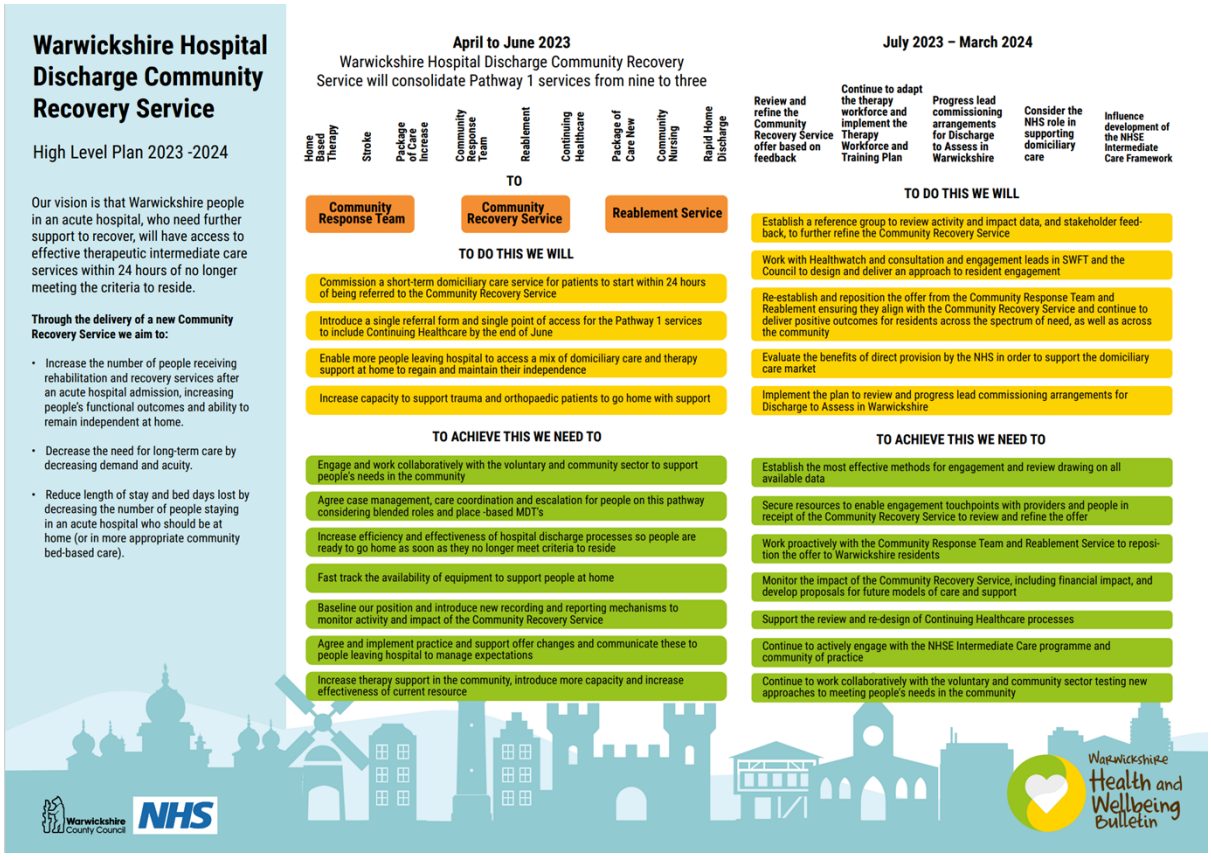
Commissioners for Housing with Care and Housing Related Support work closely with Housing Board to ensure that the services WCC commissions best support the wider strategic activity to prevent and reduce homelessness and meet care and support needs.

A Strategic Housing Action Plan (SHAP) for learning disabilities and autism is in place with a delivery group attended by stakeholders from across the system and experts by experience. The plan was co-produced with housing, health and social care to align with strategic objectives from each agency and has been refined through co-production with Experts by Experience. The plan is focussed on improving access to suitable accommodation in a timely manner, improving the approach to reasonable adjustments, clarification of applicable financial arrangements and improving networking and systems and processes across partner organisations.

Joint Priorities for 2023-25

Discharge to Assess and Community Recovery

As one of six DHSC-NHSE Discharge Integration frontrunners with a focus on intermediate care we continue to work at pace to deliver our Hospital Discharge Community Recovery Programme. The plan on a page provides a summary of the programme ambitions and activities.



The Strategic Director of People within Warwickshire County Council and Chief Executive Officer of the Coventry and Warwickshire Integrated Care Board have signed a memorandum of understanding with NHSE committing Warwickshire to deliver the pilot. In Warwickshire we are focused on:

- To further develop pathway 1 discharge to assess services in Warwickshire to enable people in an acute hospital, who need further support, to access timely therapeutic intermediate care services on discharge.

- To develop a Hospital Discharge Community Recovery Service building on existing arrangements and ensuring compliance with Hospital Discharge Guidance. To go live from April 2023.
- To identify a lead commissioner across the Place footprint and test the impact of a singular approach to commissioning intermediate care post-discharge (discharge to assess).

In addition to the above we are progressing 3 aligned work programmes under the umbrella of this work:

- Review and re-design of Continuing Healthcare for Adults
- Progressing lead commissioning arrangements for discharge to assess
- Considering the NHS as a provider of domiciliary care

Market Sustainability

Our Market Sustainability Plan was submitted to the Department for Health and Social Care and is on our website. It sets out how we are supporting our provider market given the current challenging conditions. Our offer, supported by the BCF, is made up of financial increases, quality assurance support, workforce recruitment, retention and development help and market viability interventions where providers require advice and support. The Fair Cost of Care exercise has been completed with 93% (£1.398 million) of the Council's Market Sustainability and Improvement Fund allocation made available for distribution to the provider market. Where funding schemes are available nationally on application (e.g. the current NHS Digital Transformation Fund), the Council, with the ICB as appropriate, is committed to ensuring that such additional funding and support is made available to services in Warwickshire. During 2023 – 2025 we will be implementing our commitments within the Market Sustainability Plan and further refining it in collaboration with providers.

Review and Redesign of Continuing Healthcare

Through joint working between the ICB and the two geographic Care Collaboratives, we are committed to reviewing and re-designing commissioning arrangements for NHS Continuing Healthcare ('CHC') services to support a transition to more integrated delivery at Place. Key planned activities are as follows:

- Establishing a dedicated CHC Transformation Programme;
- Evaluating options for future commissioning and delivery, and agreeing a preferred model for each Care Collaborative;
- Developing a Transition Plan for each Care Collaborative detailing the steps required and agreed timelines to achieve the agreed future configuration, and then implementing the Transition Plans;
- Establishing a market management workstream and aligned action plan for care homes, supported living, hospices, and domiciliary care;
- Establish quality, finance and performance reporting streams.

Review and recommissioning of Out of Hospital Services

Over the coming years, the ICB will transition to a commissioning infrastructure which allows for local flexibility to identify the best ways to improve population health and well-being, enables decisions to be taken closer to communities, and supports collaboration between partners to address inequalities, which not only improves outcomes but also develops sustainable joined-up value for money services. To support delivery of this approach, the contracting strategy also needs to evolve to ensure that proposals are developed in collaboration with system partners so that ICB decisions are aligned with the key priorities identified at system and place.

The Rugby, Coventry and Warwickshire North Out of Hospital Contracts will expire on 31st March 2024, and South Warwickshire contract in 2024/25. As such it is critical to undertake a review of current services to determine future commissioning decisions.

During 2023-24 the ICB will work in partnership with the Care Collaborative as they take on a more active role in shaping the commissioning of Out of Hospital services. A Joint Review Group has already been established to develop recommendations for the Care Collaborative in relation to the future commissioning of Out of Hospital services, specifically in relation to:

- Service Core Requirements
- Scope of Service
- Service Outcomes

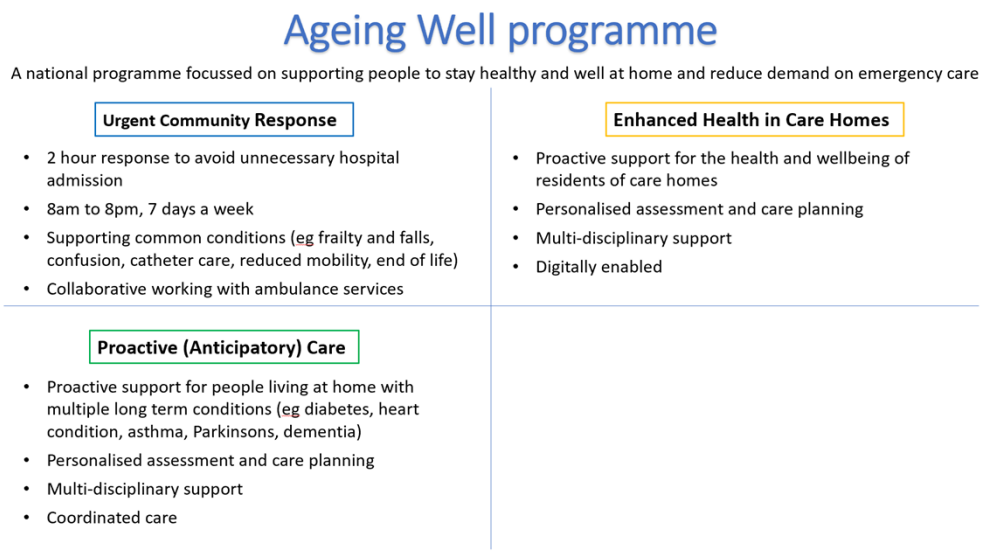
The Out of Hospital Joint Review Group will focus on:

- Overseeing the review of current service delivery to understanding the starting point. This will include:
    - Understanding the variation in services at Place level
    - Identifying integration barriers and learning opportunities
    - Sharing best practice between Places and/or Place-based Teams/PCNs
    - Taking into consideration the 5 Provider Selection Regime criteria including:
        1) Quality and innovation
        2) Value
        3) Integration, collaboration and service sustainability
        4) Access, inequalities and disparities and choice
        5) Social value
- Reviewing and identifying opportunities to expand Out of Hospital lead provider model to support integration and remove Provider contract barriers
- Undertaking a review of national policy, local Place Plans and Care Collaborative development changes to inform future core requirements eg. Fuller, Improving Lives, and Discharge Frontrunner.
- Undertaking a review of current service Outcomes with view aligning to ICS and Place outcomes, streamlining reporting and reducing overall complexity.
- Undertaking wider engagement from stakeholders to inform final recommendations

The Joint Review Group will report their findings to the Care Collaboratives in July 2023, who in turn will develop the final recommendations for the ICB on the future commissioning requirements. These will be implemented and embedded during the lifetime of this BCF plan.

Ageing Well Programme

Through the Ageing Well Joint Programme Board, activity is being coordinated to deliver three key priorities in 2023-25. In Warwickshire, activity to deliver the ageing well programme happens at the most appropriate footprint with some activity countywide, some at place partnership level and some at PCN level. All Places across Warwickshire are prioritising the ‘moderate to severe frailty cohort 2a’ as part of the case-finding for Proactive Care.



Recommissioning Integrated Community Equipment Service and Long-Term Domiciliary Care

The integrated community equipment service is being recommissioned, with a focus on continuing to support discharges while retaining capacity for timely access to equipment that supports prevention and enables people to live independently at home for longer. Work continues with the current provider to improve access to service data and customer feedback to drive service improvement and to increase recycling rates supporting greater efficiency and sustainability of the service.

Arrangements for commissioning of long-term Domiciliary Care in Warwickshire are being jointly reviewed, with new contracts planned from August 2024. The model required for long term care will be co-produced and will respond to capacity and demand modelling which will be informed by the emerging Community Recovery Service model for short term care. Demographic and population health information produced through the Ageing Well Joint Strategic Needs Analysis in 2023 will ensure the model responds to increasing ageing population in the South of the County and the higher demand in the North for care commissioned by the Council.

IBCF scheme delivery

As outlined above, during 2022 a detailed review of schemes funded through the iBCF was undertaken jointly across Warwickshire. During 2023/24 we will continue to review the effectiveness and efficiency of the schemes to support any changes in 2024/25. Appendix 2 outlines the list of schemes being progressed in 2023-25.

Joint Strategy Delivery

A number of joint strategies and action plans for Warwickshire (and Coventry) are in place or have been developed in 2022-23, with delivery being supported during 2023 – 2025 through the Better Together Programme. This includes:

- All Age Autism Strategy
- Live Well with Dementia Strategy
- End of Life Strategy, including working more broadly on compassionate communities by linking with libraries and other community services.
- Suicide Prevention Strategy

Integrated Care Record

Having introduced an integrated care record, across social care and health, for adults in 2022/23, we now are planning to deliver an integrated care record for children on the same basis in 2023/24.

Changes to the BCF for 2023 - 2025

To facilitate and support the priorities above the following changes to services commissioned through the BCF are planned for 2023-25:

- Rehab at Home (Home Based Therapy) service will transfer to the Community Recovery Service. The learning from the previous HBT service which was in place until 23rd April 2023 has been used to help shape and design the new CRS service.
- The Stroke Early Supported Discharge Care service continues to provide support for patients with low level needs requiring neuro therapy and domiciliary care but is now accessed via the Community Recovery Service as of April 2023.
- D2A Pathway 2 bed-based continues to be commissioned countywide with a flexible approach to increase capacity to support winter pressures. Some of the extra bedded pressures are also supported by the Adult Social Care Discharge Fund. These services are 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.
- More people were supported to receive reablement starting on the same day as discharge in 2022-23, by expanding the commissioned hospital to home service. Further developments are planned in 2023-25 to respond to the findings of the service evaluation and to ensure a more equitable coverage across the County.

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 Integrated Care Strategy and associated draft Joint Forward Plan (with associated alignment to NHSE Core20+5)
- Coventry and Warwickshire ICS Health Inequalities Strategic Plan
- Warwickshire Health and Wellbeing Strategy 2021-2026
- Director of Public Health Annual Report 2022
- 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. During 2023-24, a Healthy Ageing JSNA will be produced, focussed on the over 65 population in Warwickshire and will be used to inform a range of service developments to support people to live independently at home and to provide right care at the right time in the right place.

We share an Integrated Care System (ICS) with Coventry, and all strategy, prioritisation and implementation of work is endorsed through it. The Integrated Care System (ICS) has four core aims:

1. Improve outcomes in population health and healthcare
2. Tackle inequalities in outcomes, experience and access to services
3. Enhance productivity and value for money
4. Help the NHS support broader social and economic development

The Coventry and Warwickshire ICS Strategy outlines how, in order to be a system that effectively identifies, tracks and takes action to reduce entrenched inequalities in health and the wider determinants, we will take a population health approach to starting, living and ageing well. The Health and Wellbeing Strategies for Coventry and Warwickshire formed the basis for the ICS Strategy. This has helped to make sure that reducing inequalities in health is integral to the work of the ICS.

The Health Inequalities Strategic Plan for Coventry and Warwickshire (2022-2027) provides an important basis to shape our work. The Plan sets out our commitments on how we are going to reduce health inequalities in Coventry and Warwickshire, taking account of the delivery of key elements of the NHS Long Term Plan and Core20PLUS5. We have a Population Health Inequalities and Prevention Board, supported by the Inequalities Delivery Group that come together to strategically align and drive forward this work, which is also being supported by the creation of two new Health Inequalities Programme Manager posts aligned to Place.

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, and newly arrived communities. Within Warwickshire, each place-based Health and Wellbeing Board Partnership has selected additional 'plus' groups to focus on:

- Warwickshire North – people living in poor housing conditions
- Rugby – transient communities
- South Warwickshire – rural poverty and older people living in income deprivation

Services and schemes commissioned through the BCF will support delivery of the ICS Strategy and the Health Inequalities Strategic Plan, and in particular two of the Major Inequalities Work Programmes:

- **Long term conditions and prevention** – aims to ensure equitable access, experience and outcomes for CORE20+5 groups and ethnic minorities
- **Urgent care development** – aims to increase access to alternatives to emergency departments and reduce admission and attendances for high intensity users linked to CORE20+5

In addition to the major inequalities work programmes, the BCF supports a tackling health inequalities approach through the work of the Housing Partnership and the links to Assistive Technology; delivery of virtual wards, as within the Digital Transformation Strategy; by taking a strengths / asset based approach; and a focus on self-management, social prescribing and personal health budgets, as within the personalisation enabling workstream.

County level (Warwickshire)

In acknowledgment of the rising cost of living, Warwickshire's Director of Public Health Annual Report 2022 focused on health and the high cost of living. The report highlighted how certain groups of people are likely to experience the rising cost of living more acutely than others, and that they are likely to be those who already face disadvantage and experience inequalities in health outcomes and the wider determinants of health. Themes

explored within the report include housing and heating, food and eating and transport and travel. Some of the recommendations from these key themes will relate to the work of the BCF (most relevant recommendations are outlined below):

- **Overarching recommendation:** that key anchor organisations, including local authorities, NHS partners and universities focus expertise and capacity on building an inclusive, healthy and sustainable Warwickshire. To do this, all partners should focus on:
    - **Policy:** adopting, and sharing learning from, a Health in All Policies approach (link to webpage) and using Health Equity Assessment Tool (HEAT) to reduce inequalities in health
    - **Access to services:** consider opportunities to increase accessibility to healthcare services for those who will experience the impact of the rising cost of living most acutely
- **Housing recommendation:** that housing, planning and health leads work together to prevent ill health caused by poor housing and living conditions. This includes a commitment to building regulations including preventing new homes from being built with an Energy Performance Certificate (EPC) rating of less than C and working with private and public landlords to ensure existing homes have an EPC of C or above, and are mould free
- **Transport recommendation:** that transport planners and health partners work together to improve transport links for those living in areas with more rural isolation, deprivation and where rates of long-term conditions and access to transport links are poor.

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.

Warwickshire's Health and Wellbeing Strategy for 2021-26 sets out three short term priorities. Tackling inequalities in health is a golden thread throughout the Strategy, however to reflect the greater focus on inequalities which occurred during the pandemic period, reducing health inequalities is listed explicitly as one of the three short term priorities of the Health and Wellbeing Board (HWBB). 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 the local delivery programmes which supports the addressing of inequalities in the HWB Strategy and pilots new admission avoidance schemes. This is evidenced by 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 all place-based partnerships report into HWBB. The role of the place-based partnerships is to develop and oversee tailored activity related to the delivery of the three HWBB priorities. Drawing on place-based data and intelligence from place partners is key to this and supports a focus on those who experience the greatest inequalities in health within each local area, thereby providing a more nuanced approach than focusing on Warwickshire as a whole. The local

JSNA and Health Inequalities Dashboard is routinely fed into the place-based partnerships to support forward planning for each place and to make sure that the most up-to-date information is factored into local decision making.

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 longer lives in poor health – 17.6 years for men and 19.3 years for women. There are avoidable differences in health outcomes, linked to living and work conditions as well as lifestyle choices including smoking, alcohol consumption, nutrition, and 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 has a growing older population. There are more people over the age of 65 than the national average (20.6% in Warwickshire and 18.5% for England) and those over 85 are expected to almost double from around 16,600 in 2018 to 30,100 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). Those from certain ethnic minority groups and lower socio-economic backgrounds are more likely to experience inequalities in ageing well.

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. The Director of Public Health also chairs the Warwickshire Care Collaborative consultative forum where responsibility for the BCF will transition during 2023 – 2025. '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 Equality Impact Assessment in the design of the new Home Based Therapy pathway, which was designed with additional capacity in the north of the county (where there are higher numbers of falls and fractures as well as higher levels of deprivation and poorer health outcomes comparatively to the south of the county), and enhancement of support for the wider determinants of health such as self-neglect around Hoarding. Commissioning additional capacity in the north to meet demand and address identified inequalities has been replicated in the design of the Community Recovery Service.

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'

National Condition 2 Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer

Planning Requirement 4: A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home

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

Integrated programmes of work across commissioning and operational delivery are well established in Warwickshire and throughout 2023-25 will continue to develop services and support that enable people to remain independent at home, as outlined below.

The Joint Ageing Well Programme has three priority workstreams:

- Improvements delivered for **Urgent Community Response (UCR).**
    - Warwickshire has one of the highest levels of UCR activity nationally and over 82% of referrals were responded to within 2 hours. The UCR team are well established, and services are embedded 8am-8pm 7 days a week. UCR provide over 1000 2-hour responses per month, as well as offering a same day response where 2-hour response is not clinically appropriate. SWFT were the highest number of referrals in Jan by a single provider, and account for up to a quarter of the Midlands number. During 2023-25 the focus will be on maintaining this high performance and increasing capacity to meet increased demand as per the capacity and demand plan. Further innovation is planned, including developing pathways with pendant alarm companies, greater use of point of care testing equipment and exploring a direct pathway into radiology.
    - Recruitment into UCR services was ongoing during 2022/23, increasing overall capacity to respond to increasing referral numbers. Demand and capacity modelling is now underway to ensure the workforce is aligned to projected service demand in 23/24. Recruitment into clinical practitioner and advanced clinical practitioner posts has enhanced the ability of the service to respond to more complex patients. A 'grow your own' approach has been used where there is limited established workforce, with developmental posts implemented.
    - In Warwickshire, all referral routes are freely available. Care home referrals are supported by remote monitoring which is managed by SWFT's SPoA clinical triage function. Referrals direct from patients and carers are also accepted, for both known and unknown patients. The team have been working closely with 999 and 111 to establish relationships and build communication lines. Both services now have access to the WMAS CAD portal which allows the electronic referral of 999 cases appropriate to UCR services. Referrals have been further increased with the commencement of twice daily calls with the WMAS Clinical Validation Team, who share live access to the ambulance stack. Appropriate cases are discussed between the teams and once accepted can then be referred via the CAD portal. This provides earlier intervention of cases and an earlier

opportunity for UCR to support patients instead of their being an ambulance dispatched.
    - Connections are being built with local falls alarm service providers including local authorities with a view to progressing development of clearer referral routes direct to UCR. This is early development and will need to be progressed within the context of fall alarm provider response policies.

- The **Enhanced Health in Care Homes** workstream collaborates closely with local care homes and during 2022/23 has focussed on consistency across the County. This has included developing tools and information to support earlier identification of deteriorating residents and better management of falls, improved remote monitoring, and producing a recommend health training guide covering the health topics most likely to impact on care home residents. Plans for 2023-25 include promoting awareness and engagement with hospital discharge and admission process, further support and training for the workforce around care planning, common conditions, falls and end of life, and improving the use of data to target resources. Stronger links with the End of Life programme have been established to support this.

- Places have been engaged with the **Proactive Care** workstream since its launch in 2022 and all three places have agreed to focus on the moderately to severely frail cohort, with prioritisation of people who are frequent users of unplanned care. A health inequalities approach is being adopted aligned to the core 20+ 5 model and the workstream is currently focussed on development of case finding, metrics and supporting data. Pilots will be mobilised in each of the places during the first half of 2023/24 and links to the Fuller Stocktake and the development of integrated neighbourhood teams have been acknowledged will be incorporated within the development of pilot schemes.

The system continues to personalise care and develop asset-based approaches, for example 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.

The use of digital tools and Telehealth or Assistive Technology in the community is promoted 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* as part of our carers offer for Dementia patients in their own homes. Further joint work to develop commissioning frameworks to enable rapid adoption of innovative assistive technology solutions is planned in 2023/24. Funding to support digital switchover has been allocated within the disabled facilities grant.

As a system, the 'Tribe' tool is 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. Further work is planned in 2023/24 to explore how the Tribe tool can support the integrated discharge frontrunner.

Warwickshire County Council jointly with Coventry City Council are leading the delivery of the local Dementia Strategy. 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. This work is overseen by the emerging Mental Health Collaborative.

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. One of the ways that this is being achieved is supporting with hospital admissions due to falls. UCR have expanded their equipment to include emergency rising cushions in all teams countywide. This has enabled the implementation of a falls pick up service within UCR, which allows referrals to be diverted from WMAS where a resident is unable to get up but has no injury or only minor injury. This reduces demand on ambulance services while providing a more timely response to patients in under 2 hours. Since full launch in December, an increase in the number of falls responses has been seen in UCR, with over 20 each month aside from February.

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 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.
- Warwickshire has a well performing reablement service that has robust evidence of the difference it makes to people. All customers have identified goals and outcomes agreed at the start of their therapy programme. 71.4% of customers who exit the Reablement Service require no further ongoing long-term support from social care. The team have developed an In-House Therapy Outcome Measure (TOM) app to analyse outcomes with our customers, which evidences that our interventions are having a positive impact in the lives of our customers. Customer feedback indicates satisfaction is consistently over 90%. Comments are also analysed and where possible improvement are made, for example the introduction of messages to customers informing them of the time the carers will arrive.
- The Integrated Community Equipment Service – which continues to develop and evolve to ensure the service can equally support people already in the community, as well as those being discharged from hospital. This service is being recommissioned in 2023, with the new service designed to respond to these challenges.
- 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 28-29)

Key Line of Enquiry: What is the learning from the intermediate care capacity and demand planning section of the plan to ensure improved performance against this objective

Capacity for urgent community response has been increased in 2023-24 to enable more referrals into the service in line with targeted increases. Work to streamline referrals has also been initiated to adjust criteria to ensure the service is targeting people who need a two-hour response. While reablement service capacity is not being increased, the introduction of the Community Recovery Service focussed on people being discharged from hospital will enable more reablement capacity to support people already at home. Similarly additional capacity for the Integrated Community Equipment Service to support discharges through CRS will enable more of the core service capacity to target preventative activity.

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.

Key Line of Enquiry: How will BCF funded activity support delivery of this objective

The detail in the Planning Template clearly sets out the number of schemes funded through the Better Care Fund and IBCF which support people to remain at home independently for longer. These range from core services in the 'base BCF' such as Domiciliary Care, Reablement and Integrated Community Equipment, to schemes funded from the Improved Better Care Fund which support this objective, including carers support and respite, occupational therapists in the community, end of life rapid response, falls prevention, additional support to care homes and extra care housing, workforce development and specialist support for community providers. As key strategies within the prevention agenda for the system the IBCF also provides funding to support delivery of the autism and dementia strategies.

By delivering this range of schemes, the local ambition is to achieve a 15% reduction in the standardised rate of avoidable admissions compared to 2022/23 and a 6.8% reduction in the standardised rate of emergency admissions to hospital following falls compared to 2021/22, which would bring Warwickshire into the upper quartile nationally for performance in these areas. The target for rate of admissions to residential and nursing homes is based on 2022/23 activity and demand is expected to be consistent in 2023/24.

Key Line of Enquiry: Meeting Care Act Responsibilities

BCF funding and iBCF activity support Warwickshire to deliver on our Care Act responsibilities. Similarly to previous years, £190k 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 £5.2M is allocated from the Base BCF – minimum NHS contribution for Reablement. This is detailed in the Planning Template. As noted below, Care Act assessments for carers are undertaken on our behalf by Caring Together Warwickshire.

Key Line of Enquiry: Support for Unpaid Carers

The All-Age Carers Contract was awarded to Carers Trust Heart of England and went live in October 2022. The service branded Caring Together Warwickshire comprises:

- **Universal service**– includes information and advice via a freephone support, digital support via website and signposting and community partnerships to support carers. This includes support for parent carers. The new branding and feel of the website www.caringtogetherwarwickshire.org.uk was coproduced with carers. Functionality elements of the website are in development.
- **Targeted Adults** – for adults caring for adults, advisors provide 121 support including Statutory Carers Assessment and Support Planning (including direct payments)
- **Targeted Young Carers** – specialist advisors provide 121 support, transition support for young people as well as Carers Assessment and support planning

A Joint All Age Carer Action plan is currently being developed to determine the long term objectives and short term plans to support carers better. This will include areas of joint working with Coventry, improving the digital offer as well as review of access to breaks for carers.

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. During year 1 of the contract 19 community organisations have been awarded up to £3,000 to support. Initiatives includes activities for young carers of those with disability, day service provision to provide breaks for carers and group activities for carers.
- **Urgent and Planned Breaks -** Carers can access up to 36 hours of replacement care to support with short breaks. This will be reviewed during 2023/24.
- **Digital support** – funding via IBCF to support the West Midlands region wide buy-in to digital offer to carers.
- **Coproduction and Comms** – To support ongoing coproduction and continued engagement with carers, to support service development, peer review and the All Age Carers Action Plan.
- **Direct payments** – Supporting the funding of one-off payments to carers to support them with maintaining their own wellbeing following a carers assessment.
- **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 Community Recovery Service will continue during 23/24.

	Budget	Agreed Planned Spend
Carer Breaks – Respite	Base BCF – minimum NHS contribution	£1,079,845
All Age Carers Contract Model	Aligned adult social care budget	£530,821
Carers Support	IBCF – W-IBCF Scheme 10	£296,000
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		**£2,156,666**

Planning Requirement 3: A strategic, joined up plan for Disabled Facilities Grant (DFG) spending

Key Line of Enquiry: A strategic approach to using housing support, including DFG funding that supports independence at home

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)	2023/24 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

As outlined above, 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.

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 to identify collaborative working opportunities to support delivery of the District and Borough Council's statutory duties and locality Homelessness Strategies.
- Implementing the housing related elements under Change 9 of the High Impact Change Model.

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 and the partners have agreed to renew the partnership agreement for a further 5 years from April 2023. 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. The HEART Strategic Development Plan is reviewed and agreed each year by partners and in 2023-25 will look to build on the improvements

made around development of 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. Funding has been made available within the DFG to support digital switchover between 2023 and 2025 to ensure assistive technology, including pendant alarms continue to be effective in supporting people to remain at home independently.

Activities of the Housing Partnership Board

The joint (health, social care, VCS and housing) activities for 2023-25 are outlined in the Housing Partnership action plan. Key joint areas of focus and changes for 2023-25 relate to addressing health inequalities through housing as outlined in the Health Inequalities Strategic Plan for Coventry and Warwickshire 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
- Further work to implement the safe accommodation duties
- 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 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time

Planning requirement 6: A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time

Key Line of Enquiry: Overarching approach to supporting people to receive the right care in the right place at the right time

An integrated approach to commissioning and operational delivery to support people to be discharged to their usual place of residence is well embedded within Warwickshire. 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 is evidenced by strong performance against the 'discharge to normal place of residence BCF metric' (95.5% in 22/23 for all ages, 96.7% for minority ethnic, 95.3% for 61-90 and 90.7% for 81+).

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.

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 principles underpin the development of the D2A offer:

- Services and pathways are designed to support individuals to transfer home to their own bed with appropriate support wherever possible.
- D2A services will be commissioned to enable flexibility and surge options by ensuring close working with the market and collaboration with system partners.
- All individuals with an identified ability to improve their skills, functioning and independence will be offered appropriate support to enable them to achieve this.
- Opportunities to jointly plan and deliver services will be taken as we move forward to the Integrated Care System seeking to address the current complexity and difference within the D2A offer.
- The number of different services and pathways in Warwickshire will be streamlined and easy to understand and access from both a patient and staff perspective.

Warwickshire can evidence consistently strong performance against the national Discharge to Assess metrics:

% patients discharged to	**2022/23**							
	All Age (Warks patients only)					65+ (Warks patients only)		
	National D2A Target	SWFT	GEH	UHCW (Warks patients)	National D2A Target	SWFT	GEH	UHCW (Warks patients)
P0	85%	92%	84.58%	88.82%	50%	85.6%	77.97%	80.51%
P1	12%	6.2%	10.91%	7.25%	45%	11.1%	15.53%	12.70%
P2	2%	1.7%	3.31%	3.20%	4%	3%	4.73%	5.47%
P3	1%	0.1%	1.19%	0.74%	1%	0.2%	1.76%	1.33%

Warwickshire is within the upper quartile nationally for discharge to usual place of residence and the target for 2023/24 aims to maintain performance at this level. Similarly, Warwickshire has consistently performed very highly with the proportion of older people who are still at home 91 days after discharge from hospital into reablement or rehabilitation service. 'Discharge to assess' within Warwickshire has received national recognition for good practice. A need for greater capacity within intermediate care has been identified to provide rehabilitation at home and the Discharge Frontrunner Pilot, funded through the Discharge Funding, will increase the overall capacity of community services to provide care for more patients at home. Our vision is that within 5 years ALL people in an acute hospital, who need further support to recover, will have access to effective therapeutic intermediate care services within 24 hours of no longer needing to be in hospital.

The following are priorities for further developing the D2A offer in 23-25:

1. Full consideration of how individuals utilising short stay beds can access rehabilitative support to enable them to maximise recovery and independence.
2. Increase understanding of customer experience and socio-economic factors that can prevent timely exit from moving on beds. Redesign and retender extra care moving on beds to ensure it aligns to operational demand and supports flow.
3. Greater focus on end of life with D2A demand being offset with other bedded offers outside of the hospital and home-based alternatives.
4. Consideration of future joint plans for CHC assessment beds and continuing to engage primary care as key partners to the delivery of CHC assessment beds and to ensure there is adequate medical cover in the areas where this is required.

A key priority for Warwickshire over 2023 - 2025 as outlined in this plan is delivery of our intermediate care frontrunner. The Community Recovery Service that is at the core of our new offer is being funded through the Better Together Programme.

Key Line of Enquiry Assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23

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. There are four key follow on actions relating to the Hospital Discharge Policy

Discharge Policy Requirement	Planned HDG Actions	Links to planned HICM actions
Transfer of Care Hub	• Daily Bronze calls happen at each of the Acute Hospitals to discuss inpatients as a MDT to facilitate timely discharges. Escalation process in place as a System • The Council's Social Care and Support Operations and People Strategy and Commissioning Teams have worked in partnership with NHS organisations to deliver the Front Runner Pilot. Community Recovery Service (CRS). for hospital discharges. The pilot commenced in April 2023. • A Micro Commissioner role was introduced into the Dom Care sourcing team, and this had a significant impact on timely sourcing of support • Work continues on the Enhanced Discharge Tracker	Change 3 – MDTs Change 4 Change 2 – Effective Information Sharing and System view of flow and blockages
Single Coordinator / Point of Contact	• The refinement and embedding of the electronic single discharge referral continues to be progressed across the System. • Streamlined access points into social care now in place • There has been a reduction in pathways under pathway 1 for hospital discharges and consequently a reduction in referral access points • Expansion of the therapy offer under the CRS pilot since April 2023	Change 1 Changes 3 and 4 Change 4
Case Management arrangements	• Embedded the Trusted Assessors for social care short term bedded support on Pathway 2 with our local care home providers and are currently reviewing the trusted assessment with representation from our providers	Change 6 – Trusted Assessments to be extended wider than just Care Homes
More patients offered Rehab or Reablement	• Pilot of Community Recovery Service has enabled increased access to therapy. • Reablement continues to offer up to 6 weeks reablement with customers and reporting ,an average length of stay of 21 days. with 80.2% achieving their outcomes and 70.9 % not needing long term social care support • Learning from review of D2A bedded capacity	Change 1 & 4 Changes 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					

As outlined in last year's plan, capacity and demand modelling within community health and social care services was undertaken to ensure as a system we are ***'providing the right care in the right place at the right time'***. This modelling has been refreshed and builds 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 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. Further modelling will be informed by the Discharge Frontrunner Pilot throughout 2023/24 as data systems are developed to monitor activity and impact.

Business as usual services funded through the core/base BCF and delivered through our BCF Plan which provide '***right care in the right place at the right time'*** 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. In 2021-22 there were high levels of people waiting for placements, through robust partnership working and improvements to brokerage funded through the BCF the system saw significant improvement over 2022-23, which will be continued in 2023-25.
- 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. This service is being recommissioned in 2023 with the new service designed to respond to these challenges.
- Short-term Moving on and Discharge to Assess Beds continue to provide pathways from hospital to bed-based care with rehabilitation. Additional step-down beds were

commissioned over winter in 2022/23 to respond to increased demand through the ASC discharge fund. Commissioning arrangements have been put in place to enable short term bed capacity to be flexed to respond to demand and additional capacity will be mobilised again through use of discharge funding in winter 2023-24.

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 and IBCF which support safe, timely and effective discharge to their usual place of residence. These range from core services in the 'base BCF' such as 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 and additional enhanced Moving on Beds. In addition, the resources funded from IBCF scheme 30 supports delivery of discharge related improvement activity, analysis and data on behalf of the C&W system.

The Hospital to Home Scheme delivered by Warwickshire Fire and Rescue Services also supports re-admission prevention for the more vulnerable and frail patients discharged, by including follow-on safe and well checks and falls risk assessments into their offer.

Hospital social prescribing will no longer be funded from BCF from April 2024 in recognition of the opportunity to develop more efficient and joined up pathways with social prescribers in PCNs. During 2023/24 a joined up social prescribing pathway for people in hospital will be delivered, enabling the current hospital-based service to be decommissioned.

Planning Requirement 5: An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.

Key Line of Enquiry: Building additional social care and community-based reablement capacity, maximising the number of hospital beds freed up and delivering sustainable improvement for patients

In Warwickshire, we have committed to transforming our discharge to assess Pathway 1 by streamlining previously disparate pathway 1 services such as Home-Based Therapy and Stroke Early Supported Discharge. The aim is to implement a new intake service for any person leaving hospital with a new or increased care need to be supported by a care at home service. There will be access to suitable therapy interventions to support individuals' outcomes and overall levels of independence. The new service will be called 'community recovery service' (CRS) and will be commissioned via Warwickshire's existing market of contracted Domiciliary care provision.

A great deal of work has happened to mobilise the Community Recovery Service from April 2023 including:

- New arrangements for commissioning domiciliary support across the county to enable care and support to start within 24 hours of people being referred.
- Bolstering the efficiency of therapy resource and increasing capacity so more individuals have access to therapy alongside domiciliary care in line with their individual needs.

- Working with our community equipment service to support faster access to equipment to support people to go home.
- Agreeing new operational processes for hospital discharge.
- Consolidating the various care at home pathways in existence (this will be staged over the duration of the pilot) and introducing a single referral form and access point for the new Community Recovery Service.
- Working through recording and data requirements so we can monitor impact and activity.
- Financial modelling of service set up and operation (and considering how we monitor financial benefits of pilot).
- Communications plan for patients, staff and the public.

We expect the service to improve and increase people's functional outcomes and will be capturing outcome and experience information from people who access the service to support improvement and assist evaluation. We will be testing out the impact of the new service on hospital length of stay and bed days lost, use of D2A beds and the need for long term care and support with the hope we can demonstrate individual, system and financial benefits.

Discharge funding will continue to support additional capacity for winter for short term beds, enabling flexible capacity to be stood up and stood down in response to demand. Planned capacity for short term beds is informed by the review of discharge funding in 2022/23.

Discharge Funding					
	2023/24			2024/25	
	WCC	**ICB**		**WCC**	**ICB**
Community Recovery Service	£1,002,363	£1,682,908		£1,670,605	£2,804,847
Short term residential placements	£1,119,299	£1,117,092		£1,865,498	£1,861,820
Total	£2,121,662	£2,800,000		£3,536,103	£4,666,667

Community Recovery Service Capacity projections per place

Using current activity levels* to project future need it is expected that the CRS service will need to deliver the following hours per place area.

Place	Zones	Estimated number of hours required in each place at week 6
Warwickshire North	1, 2, 3	1,776 Hours
Rugby	4	522 Hours
South Warwickshire	5, 6, 7, 8	1,260 Hours

*Activity levels are projected and may change throughout the pilot. Any adjustments around block capacity will be managed with individual providers as detailed within the CRS Service Specification.

Context and assumptions regarding required capacity

- This is a pilot and therefore this capacity will be tested during the pilot duration.
- The volume of hours recommended are a baseline only and there may be fluctuations that are caused by external influences such as hospital pressures, a peak in seasonal illnesses which result in increased hospital admittance rate, more referrals being made into CRS than predicted – particularly those that are currently being referred into a Pathway 2 service or permanent residential or nursing care.

- We expect to monitor the capacity and demand closely throughout the life cycle of the pilot and adjust the commissioning arrangements to meet any increased or decreased demand.
- Flow throughout this pathway will be vital to ensure it can respond to demand and give the required capacity to patients.

CRS expected costs April 2023 – March 2024

Table 1 - Overview of expected care costs for CRS pilot Year 1. 11th of April 2023 until March 2024.

Community Recovery Service Costings		
		Annual estimated costs
Domcare Costs		
South Warwickshire	£1,374,072	
North	£1,934,900	
Rugby	£568,077	
15% contingency	£90,016	
Total Domcare costs		£3,967,065
Existing Therapy staffing costs (12mths as already in post)		£436,914
Additional Therapy staffing costs		£683,797
Other additional staffing costs (9mths)		£397,862
Equipment costs (Millbrook)		£77,428
Total cost		**£5,563,066**
Funded by:		
Agreed funding:		
Front runner pilot funding		£800,000
SC discharge funding		£316,000
Development Fund draw down		£1,430,000
South Castlebrook Re-design		£331,795
Sub total		**£2,877,795**
To be agreed:		
% allocation from WCC 23/24 discharge funding		£1,002,363
% allocation from ICB 23/24 discharge funding		£1,682,908
Total Funding		**£5,563,066**

Appendix 1 Care Collaborative Development Plan

	Care Collaborative Development Plan: Stage 1 to Stage 2
1	**ICB Strategic Commissioner**
1.1	ICB OD Strategic Commissioner Development Programme - eg. *technical capability* development for future ways of working
1.2	Refresh 'agreed' scope of services - update £ values for 23/24
1.3	Set strategic Priorities and Outcomes for UEC/OOH/CHC - linked to JFP commitments and developed in collaborations with stakeholders

1.4	Reset ICB Governance: Update SORD, Establish Care Collaborative Committees (Draft ToR - including ICB Exec membership and decision-making). Amend 'other' ICB Committees ToR to reflect strategic role for UEC/OOH/CHC
1.5	Reflect new and developing governance arrangements in Section 75's as appropriate, e.g., BCF for 23/24
1.6	Patient and Stakeholder voice - engagement on Future Model, and Service Developments
1.7	Agree resourcing model for Care Collaboratives for Stage 2
1.8	Develop and Agree Joint Working Agreement eg. how will matrix working work?
1.9	Staff Engagement
1.10	Agree future phasing for collaborative (geographical and thematic) delegation from 24/25
2	**System-wide Development**
2.1	Reset system-wide groups/forums/groups to accommodate Care Collaboratives programmes CHC/OOH/UEC - eg. Transformation Board/Discharge Front Runner/Improving Lives - including plan to consolidate groups to reduce overlap
2.2	Agree Road Map for **other** collaboratives and timeline- Phase 2, Phase 3 etc
2.3	Agree Care Collaborative relationship with Mental Health and LDA Collaboratives
2.4	Agree Care Collaborative relationship with Acute Provider Collaborative
2.5	Agree Care Collaborative relationship with Primary Care Collaborative
2.6	Agree Care Collaborative relationship with Providers
2.7	System-wide working OD Programme eg., how to set the right conditions to enable collaboration ie. System maturity matrix
3	**Care Collaborative Development**
3.1	Align Care Collaborative Consultative Forum Terms of Reference for future state
3.2	Review and refresh Care Collaborative Membership and roles and responsibilities in preparation for transfer to committee status
3.3	Agree Care Collaborative MOU to include - Decision Making, Conflicts of Interest, Risk/Gain Share approach, joint working arrangements etc
3.4	Agree Place & Care Collaborative relationship - based on the learning from Warwickshire North Pathfinder Programme, how does Place Lead Provider model work
3.5	Review design of Place arrangements and structures eg. interface with wider determinants of health and/or relationship with Committee
3.6	Care Collaborative OD Development - supporting the partnership to maximise effectiveness
3.7	Develop commissioning capability - eg. Establish regular Finance/Quality/Performance reporting, Population Health Management tools etc
3.8	Implement the Warwickshire elements of the Foundation Group provider collaborative innovator
4	**Care Collaborative Operating Model - For Stage 2 and Beyond**
4.1	Functions options appraisal: Strategic Commissioner role v Care Collaborative tactical commissioner (Tiles Diagram)
4.2	Define capability requirements
4.3	Understand resource availability within the ICB and wider system, undertake skills mapping against future capability requirements
4.4	Develop Care Collaborative Operating Model options appraisal - what resource sits where? Best value for money? Commissioning Host options?
4.5	Develop technical capability for future ways of working - eg. Population Health Management

WARWICKSHIRE - LIST OF IBCF SCHEMES FOR 2023/24

15,132

National condition	Outcome	Scheme Ref	Summary of schemes		23/24 Budget £000s
Reducing Pressure on the NHS	Reducing ICS, improving flow, supporting Discharge to usual place of residence		**Schemes include additional resources or support in acute or community based hospital settings and schemes directly supporting discharge and flow**		**2,037**
		W-IBCF 1	Hospital Social Care Team	Social Care staff working in the HSCT to support discharges	722
		W-IBCF 2	Housing Hospital Liaison	Housing Hospital Liaison Officers working across UHCW/St.Cross, GEH, SWFT and CWPT	66
		W-IBCF 3	Hospital Based Social Prescribing	Hospital based social prescribing service.	140
		W-IBCF 4	Trusted Assessments	Trusted Assessors (HICM)	168
		W-IBCF 5	Domiciliary Care Referral Team	Brokerage posts	86
		W-IBCF 6	Hospital to Home Service	Hospital to home service operated by Warwickshire Fire and Rescue Service. Includes as an enhancement to Safe and Well checks, the falls prevention (Timed Up and Go) assessments implemented as part of the Falls Prevention project	416
		W-IBCF 7	Moving on Beds	6 Moving on Beds in the Rugby area and 3 enhanced MOBS for hoisted patients, to provide social care and housing related discharge step-down support.	310
		W-IBCF 8	ICE Contract Increases (ICB)	Covers ICB inflationary cost increases relating to inflation increase, lease cost increase, more expensive equipment, increased staffing costs including to support driver retention etc.	109
		W- IBCF 9	Clearing/deep cleaning properties	Fund to support discharge and admission prevention by covering clearing & deep cleaning costs to properties to enable domiciliary care and NHS Community providers to access properties and provide support at home. Links to W- IBCF 2 - Housing Liaison Officers.	20
	Admissions Avoidance		**Schemes include specialist and targeted support and interventions in the community to support admission or readmission prevention**		**1,656**
		W-IBCF 10	Support to Carers	Includes planned short breaks service, carers support grant, direct payments for carers and young carers, carers digital offer.	296
		W-IBCF 11	Advocacy	Provides advocacy related services including acute based service costs for hospital based advocacy, a contribution to maintain the block IMCA provision and some provision for SPOT IMCA.	190
		W-IBCF 12	Occupational Therapist capacity	Occupational Therapists supporting moving and handling reviews in the community.	290
		W-IBCF 13	End of Life	Funding for hospice costs for the South, Warwickshire North and Rugby EOL schemes.	252
		W-IBCF 14	Falls prevention	Following implementation of a new falls pathway in December 2020, this scheme supports patients at moderate to high risk of falls with a contribution to falls care-coordination and Multi-Factorial Assessments delivered via the Out of Hospital provider ISPA.	37
		W-IBCF 16	Adults with Autism	Warwickshire's WCC and ICBs costs relating to the Community Outreach Offer, which directly supports waiting list reductions for adults with autism.	295
		W-IBCF 17	Residential Respite Care Charging Policy	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.	250
		W-IBCF 18	Joint Commissioning	Contribution to commissioning resource and additional costs required to commission and implement joint initiatives and activities funded via the BCF and IBCF.	46
Stabilising the market	Fee rates / increases		**Protecting older people community care budgets and NHS budgets through night support in ECH and Specialised Settings**		**6,180**
		W-IBCF 19	Residential and nursing care fee rates	Contribution towards base budget pressures caused by necessary fee increases within the residential and nursing care market. The budget for 2023/24 includes a £300k increase compared to the previous year - to factor in a contribution towards 1 year of inflation pressures. Note: ongoing risk/issues re: Providers regularly refusing WCC fee rates and requesting Top-Ups.	3,200
		W-IBCF 20	Care at Home fee rates	Contribution towards base budget pressures caused by necessary fee increases within home care, supported living including sleeping nights. The budget for 2023/24 includes a £100k increase compared to the previous year - to factor in a contribution towards 1 year of inflation pressures and the ongoing need to stabilise the dom care provider market to support safe and timely discharges.	2,450
		W-IBCF 21	Extra Care Housing Waking Nights Cover	Extra Care Housing Fee Rates ECH Night Time Support Needs - Laurel Gardens, Oakwood Gardens, Farmers Court, Web Ellis Court, Rohan Gardens, Tithe Lodge, Queensway Court, Ettington Lodge, Briars Croft and Lavendar Meadows.	530
	Market support and development		**Schemes to support the Provider Market include: Learning and Development, additional OT and specialist quality assurance resource and expertise to improve quality, reduce provider costs and prevent admissions, market sustainability and support for winter pressures etc**		**910**
		W-IBCF 22	Provider Learning and Development	Funds the Learning and Development Partnership for providers.	347
		W-IBCF 23	Specialist support for providers	OT support to upskill providers; Quality assurance staff and engagement staff to ensure providers access all the support available to them; and a MH/LD/Autism practitioner or professional resource in the Quality Assurance Team.	188
		W-ICBF 24	Market Sustainability	Fund initiatives across the system by the ICB to develop, stabilise and strengthen the Provider Market and includes funds to be used in Warwickshire, to meet local pressures.	375
			Schemes include demand pressures relating to older people community care budgets, dementia, social care capacity and housing related support		**4,353**

Meeting Social Care needs	Supporting adult social care pressures	W-IBCF 25	Protecting older people community care budgets	Direct funding contributing towards homecare and community care budget pressures as a result of demand growth. The budget for 2023/24 remains the same as 2019/20.	2,735
		W-IBCF 26	Services to support dementia in the community	Direct funding sustaining Dementia Day Ops, Dementia Navigators and Dementia Carers Support services. This is acknowledged to be a high risk area for the system with negative impact on non-elective admissions, carer breakdown and increased permanent admissions to res/nursing care.	501
		W-IBCF 27	Care Management Capacity	Direct funding contributing towards care management capacity budget pressures as a result of demand growth. This is a limiting factor in the ability to deliver service (e.g. reviews) and meet need (deliver assessments). The budget for 2023/24 is the same as 2019/20 which orginally equated to 15 x FTE Social Workers working in the community team to maintain existing capacity.	639
		W-IBCF 28	Cost transfers from housing related support	Reductions in housing related support budgets have resulted in the identification of increased adult social care needs which have to continue to be met, and therefore increasing demand on community social care. This scheme is direct funding contributing towards community care budget pressures as a result of demand growth. The budget for 2023/24 is the same as 2019/20.	478
Support arrangements	Support		**These schemes fund the resources (programme, project, analytical and insight) to meet the BCF governance and reporting requirements via the Health and Wellbeing, Adults and Better Together Programme, Joint Commissioning Board, Housing Partnership and System wide operational improvements to support discharge.**		250
		W-IBCF 30	Support	This scheme funds the Better Together programme which provides project management, analytical, insight and programme support to the Coventry and Warwickshire System Operational Discharge Delivery Group improvement activity and Better Care Fund programme.	250
				Total	**15,386**
				Total to be funded from IBCF allocation	**15,011**
				IBCF Budget	**15,132**
				Variance (under/over draft IBCF budget)	*-121*
				Total to be funded from Development Fund	**375**