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METRICS AND TARGETS

1 Total number of specific acute non-elective spells per 100,000 population

Warwickshire's Better Care Fund Non Elective Admissions (NEA) metric target and plans are based on and consistent with the NEA Clinical Commissioning Group (CCG) Operating plans.

The 2019/20 Warwickshire target of 60,067 is 1.4% higher than the target for 2018/19. However, when split by CCG, the 2019/20 target for Coventry and Rugby CCG (C&RCCG) is 2.6% lower than that for 2018/19, 2.1% higher for South Warwickshire CCG (SWCCG) and 2.9% higher for Warwickshire North CCG (WNCCG).

The overall Warwickshire 2019/20 target is 1.9% lower than the actual performance for 2018/19, making it an extremely stretching target given that the volume of Warwickshire non-elective admissions grew by 6.6% in 2018/19 compared to the previous year.

When split by CCG, this target will require a reduction in volumes of Warwickshire non-elective admissions of 3.1% for CRCCG, 4.5% for WNCCG and 0.4% for SWCCG.

In addition to on-going work by CCGs with acute partners to reduce attendances at A&E and non-elective funding from the Improved Better Care Fund and ASC Winter Fund is also being used to either fully or part fund a number of prevention and admissions avoidance schemes to support the work of the CCGs.

2 Delayed Transfers of Care (DTOC) per day (daily delays) from hospital (aged 18+)

The target is set by the national Better Care Fund team at NHS England. Warwickshire's target has been increased from 43.2 to 44.4 average daily days delayed and there is now no longer a requirement to split this target between Health, Social Care and Both (Joint). The health and care system in Warwickshire is well on track to meet this target. Overall Warwickshire performance has been at or below the lower target since December 2018 with the exception of February 2019.

In 2019/20 we will continue to embed a proactive approach to managing and reducing DTOC levels through the work of the Better Together Programme DTOC Board, a system-wide partner group comprising of operational and commissioning leads from the 3 CCGs, 3 acute trusts, Coventry and Warwickshire Partnership Trust and Warwickshire County Council.

Areas of focus for 2019/20 include: reducing mental health and out of area delays through improved ways of working with partners; implementing Red2Green and reducing length of stay at George Eliot Hospital; and improving consistency of working by Hospital Social Care Teams working across 7 acute and community sites.

Funding from the Improved Better Care Fund and ASC Winter Fund is being used to support a number of initiatives providing additional capacity and support in the system, which can be flexed during pressure points to improve flow and reduce delays.

3 Residential Admissions - Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population

The target for this metric for 2018/19 was reset by the Better Together Programme Board in August 2018. The Board has agreed to maintain this reset target rate of 606 admissions per 100k population for 2019/20 which equates to 728 admissions given an updated forecast population for 19/20. The health and care system in Warwickshire is on track to continue to meet this target.

Funding from the Improved Better Care Fund and ASC Winter Fund is being used to support a number of integrated initiatives and approaches that support people to remain independent at home or return to independence after an episode in hospital, reducing the need for 24 hour care.

4 Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

The positive outcomes for people discharged from hospital who receive support from our Reablement Service continues, with 96.8% of people still at home 91 days after discharge in 2018/19. For 2019/20 we plan to increase our target slightly from 89% in 2018/19 to 90% in 2019/20, to reflect our aim to continuously improve outcomes whilst at the same recognising that we are planning to expand our reablement offer to enable more people to benefit from the service.

To support our reablement / rehabilitative services, in 2019/20 we will be investing and promoting assistive technology (digital tools, technology and innovative solutions). Our Reablement Service have been piloting some exciting pieces of AT with patients they are working with, with fantastic outcomes relating to reducing the amount and length of reablement support needed and also on-going care needs.

HIGH IMPACT CHANGE MODEL (HICM)

During 2019/20 our focus is on continuing to identify opportunities to progress changes 5 to 8 which are currently at 'Established' status and further embed changes 1 to 4, which are currently at 'Mature' status. The Better Care Fund Planning Requirements require all areas to achieve at least Established Status, which Warwickshire has already achieved. During quarters three and four our plan is to achieve 'Mature' status for changes 7 and 8.

Lessons learnt from previous plans / years have identified that trying to focus on all eight changes at once is challenging for commissioning and operational staff and perhaps more importantly providers. For example, feedback from Coventry who went live with the Red Bag Scheme before Warwickshire was that the change did not progress as fast as planned as care home providers needed much more support post go-live to embed the change than expected.

Our plan has therefore used this learning to have a much more robust and joined up communications campaign and additional navigator support (funded through the IBCF) to support providers with a number of changes and new ways of working; to deliver a number of HICM Changes including for example:

- the EMS+ Bed Visibility Tool
- Trusted Assessors
- Care Homes accepting returning residents back from hospital and new residents at weekends; and
- the new plans we are currently developing for roll-out of NHS email in care homes.

Last year the DTOC Board also identified that it is not enough for only the acute sites to have HICM action plans and that to support flow through the system, the community and sub-acute sites also needed to deliver the HICM. In 2019/20 action plans have therefore been developed for these sites and progress is monitored through the local A&E Delivery Boards.

Significant efforts continue to be made to reduce Delayed Transfers of Care (DTOC) by:
a) health colleagues through each acute site's local improvement plans;
b) Warwickshire County Council local improvement activity; and
c) Joint improvements, co-ordinated by the DTOC Board as part of the Better Together Programme (Better Care Fund).

The impact of this work has been a steady, consistent and sustainable reduction in DTOC. In 2018/19 total DTOC reduced by 7,980 days delayed compared with 2017/18. This is a 33.5% reduction. Over the same period, Social Care DTOC reduced by 7,705 days delayed compared with 2017/18. This is a 55% reduction. In 2019/20 we have maintained these improved levels and current Delayed Transfers of Care (DTOC) performance in Warwickshire remains under target, in part due to implementation of the HICM as well as other initiatives including additional Moving on Bed capacity, the schemes listed above, additional D2A pathways and capacity, more co-ordinated support from housing colleagues and our expanded Brokerage Team. In December 2018 the Adult Social Care and Support teams also started to implement the agreed actions following an independent DTOC Assurance Framework Review carried out by iMPOWER in the summer of 2018. The focus of this work was specifically on discharge and focused on Social Care aspects of the system.

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	Change	Current position of maturity	Maturity level for March 20	Plans to achieve mature status
1	**Early discharge planning**	Mature	Mature	Continue to embed.
2	**Systems to monitor patient flow**	Mature	Mature	
3	**Multi-disciplinary / Multi-agency discharge teams**	Mature	Mature	
4	**Home first / (D2A) discharge to assess**	Mature	Mature	
5	**Seven-day service**	Established	Established	At present 7 day working is in place where necessary, however most services operating hours are tailored based on current demand (5, 6, 7 day working) with on-call and emergency/crisis support. An audit is currently underway to review this. However initial feedback from front-line services is that prompt responsiveness of services to referrals is perhaps more important to support flow.
6	**Trusted Assessors**	Established	Established	Focus to date has been on embedding Trusted Assessors for Care Homes and following a successful pilot, additional resource has been rolled out in 2019/20. This along with other initiatives has helped halve residential and nursing delays. During 2019/20 we will continue to streamline operational processes and look to expand this offer to realise even more benefits.
7	**Focus on choice**	Established	Mature	Acute Trust's Choice Policies have recently been reviewed and updated, with work due to take place in 2019/20 to support the workforce to embed this. Other initiatives include strengthening our acute based advocacy and social prescribing offers.
8	**Enhancing health in care homes**	Established	Mature	Through the strength of the See, Hear, Act Partnership, Quality Assurance Framework and joint working some elements of Mature Status are already in place and so the area of focus will primarily be on reducing un-necessary admissions from Care Homes at weekends. Our plan includes for example: A pilot working with West Midlands Ambulance Service (WMAS), testing a model of diverting lower urgency calls to WMAS in to community services to respond; the new GP 'Flying Squad' in South Warwickshire, which supports care homes which have been prioritised for support such as Poly Pharmacy Reviews, Falls and UTI prevention, advanced care planning etc; and new admissions avoidance related training and support now being delivered through the Learning and Development Partnership such as 'Love to Move' and hydration and nutrition which includes using Assistive Technology to support falls prevention; and Observation Skills for staff, to identify changes quickly.

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BCF PLAN - STRATEGIC NARRATIVE SUMMARY

To meet condition one of the national Better Care Fund Policy Statement, Warwickshire County Council and Clinical Commissioning Groups are required to agree a plan for use of the pooled budget. Locally our plan for 2019/20 will continue to build on our long term vision, as outlined in our original submission in 2015/16, our updated 2017-19 plan, and builds on the progress made from 2016-19.

Detailed below is a summary of developments since 2017/19 and specific areas of focus for 2019/20 aimed at wrapping support around people closer to home or in their own home, rather than in an acute based or 24 hour setting.

A) Person-centred outcomes (1500 word count limit)
Our approach to integrating care around the person, includes (but is not limited to):

- **Prevention and Self-Care**
- **Promoting choice and independence**

The Coventry and Warwickshire Place Forum comprises of the two Health and Wellbeing Boards of Coventry and Warwickshire and in 2019/20 the 'Year of Wellbeing' has a specific focus on prevention. The Better Together (BCF) Programme Board, is one of several delivery boards, working to stimulate a step change in prevention across the health and wellbeing system.

Funding from the pooled budget is being used to support a number of integrated initiatives and joint approaches including with the voluntary and community sector to support some of the common themes identified through the Joint Strategic Needs Assessment of (housing and homelessness; information sharing/single point of access; mental health services, ageing population) including:

<u>Prevention and Self-Care</u>

- Piloting with the voluntary and community sector in areas identified through the JSNA profiles where social isolation is prevalent such as North Warwickshire, Nuneaton, Bedworth and Rugby (in part due to geographic isolation, access to transportation etc) loneliness interventions such as Community Friendship Groups and Information Network Services. This is new in 2019/20 as loneliness due to the impact on health inequalities has been identified as a key priority as part of the Year of Wellbeing.
- A new Hospital Based Social Prescribing Service, will start in December 2019, following a review of current service to understand what works and what needed to be improved to deliver a more joined up system-wide prevention and self-care offer. Lessons learnt from the evaluation of the existing service is that better links into community based services including the new Primary Care Networks, providing continuation of support are needed.
- To proactively promote prevention and self-care, in 2019/20 we will be investing in assistive technology (digital tools, technology and innovative solutions). Following a series of pilots carried out by our Reablement Service, Dementia Navigators, experienced Social Prescribers and selected residential care homes who have piloted some exciting pieces of Assistive Technology (AT) to for example, improve hydration and nutrition, medication management, memory and cognition. In September 2019 Warwickshire County Council are launching AskSara - the assistive technology/equipment self-assessment, advice and information and ability to purchase website as part of our improved self-care offer and in Dec 2019/Jan 2020 will be rolling out to front-line staff and practitioners, training/ support to up-skill staff to think 'digital first', along with proportionate and streamlined assessment, procurement and fulfilment processes to ensure AT

becomes part of our mainstream offer. This new way of working has been identified to directly support our teams to promote selfcare in new and innovative ways.

- In 2019/20 WCC is also developing a new digital platform which will include to support self care.
- Further investment in our well-established integrated 7 day integrated community equipment service (ICE), which continues to evolve and develop with same day and next day deliveries to support crisis and hospital discharges / admissions avoidance.
- Based on evidence from a similar scheme in Coventry and local needs, in 2019/20 we are now piloting in Warwickshire North (with multi-agency system partners from Warwickshire Police, Coventry and Warwickshire Partnership trust, social care and CCG commissioners), a Mental Health Street Triage service during 5pm to 2am (Friday to Monday), which will, provide swift access to a specialist mental health professional, to attend the scene or provide specialist advice to reduce admissions, the risk to police, the public and the individual of experiencing violence, aggression or suicidal or self-harming behaviours, inappropriate detentions and improve access to appropriate care and support, patient experience and outcomes.
- In collaboration with the Out of Hospital Collaborative and as an enhancement to the Frailty pathway, a system-wide approach to falls prevention and a falls pathway for repeat falls is now being developed. Fear of falls and repeat falls has been identified as a significant contributor to cause of injury, loss of confidence, independence and social isolation and is one of the top 4 causes of ambulance call outs in Warwickshire. Our work through the BCF is seeking to link in with the Integrated Single Point of Access and Place Based Teams which support populations of c30-50k, where personalised care and support including from the voluntary and community sector is discussed and agreed.

<u>Promoting Choice and Independence</u>

- During quarters 3 and 4, 2019/20 Warwickshire County Council will also be rolling out county-wide Strengths and Asset-Based Practice across front-line social care teams, changing the conversation with customers, their families and carers from a deficit based model to one which focuses on the outcomes they want to achieve and different ways of achieving this including through their own networks and communities. This transformation activity, underpinned through investment in staff training and supporting systems/tools is a key enabler which further new ways of working will then build on.
- Personal Health Budgets (PHBs)-During 2018 South Warwickshire CCG established a nursing and administration team to actively increase the number of PHBs. The baseline in August 2018 was 12 PHBs which has now increased to 87 PHBs in August 2019. Options are also being explored regarding Warwickshire County Council administering PHBs on behalf of CCGs.
- Housing Liaison Officers based in Warwick and George Eliot Hospitals since Q4 2018/19 are part of a cross-partnership approach to care and support (Integrated Discharge Teams - WCC social care and NHS and Housing colleagues from the 5 x District and Borough councils) and are supporting early prevention advice and support around: hoarding, handy-person services, low level / minor adaptations; major adaptations, and emergency housing response.
- Investment in non-statutory and acute-based Advocacy Support has been positively received by staff across the health and care system by helping customers make informed choices, with the right information and support in a more timely manner.
- Carers Support – New in 2019/20 is additional support and innovative new digital tools for Carers are also being provided including: a) the Carer's Response Emergency Support Service (CRESS); b) Care Companion (a digital resource for informing, supporting and enabling informal carers which is designed to address the limited information and support for carers at crucial points during their caring role (e.g. at night or at weekends), and the detrimental effect this can have on quality of life and wellbeing together with avoidable NHS activity, hospital and care home admissions); and c) Miralife, an innovative approach to population level health surveillance using technology,

which through a collaborative approach with the 3rd sector and carer groups, provides a proportionate and responsive in-reach support, when required, by recognising subtle but important early changes in a person's cognitive and physiological reserve in a timely manner to an illness episode before the need for hospitalisation occurs. This digital tool offers significant opportunities to transform the experiences of patients and their carers and to radically improve their outcomes by delivering monitoring across the full spectrum of patient pathways, empowering people to take greater control of their own health at home. This is being piloted for two key pathways: End of life patients led by clinicians from South Warwickshire Foundation Trust and for Catheter Patients led by Mary Ann Evans Hospice.

- Supporting and maintaining the domiciliary (home care) and residential/nursing care provider market through the See, Hear, Act Learning and Development Partnership which is fully funded by the IBCF, joint Quality Assurance, Market Management (including fee rates) and expanded Brokerage Team. Whilst much of this work continues from previous years, new in 2019/20 is a three tiered approach to Autism training for providers.

B) HWB level (800 word count limit)
(i) Your approach to integrated services at HWB level (and neighbourhood where applicable), this may include (but is not limited to):

- **Joint commissioning arrangements**
- **Alignment with primary care services (including PCNs (Primary Care Networks))**
- **Alignment of services and the approach to partnership with the VCS (Voluntary and Community Sector)**

Delivery through Integrated Services and joint commissioning, with Clinical Commissioning Groups, South Warwickshire Foundation Trust as the Out of Hospital provider and District and Borough Councils is well embedded in Warwickshire and will be strengthened further through three new integrated commissioning posts recently appointed:

- A jointly funded (between Warwickshire County Council and South Warwickshire Foundation Trust) Lead Public Health Consultant for Long Term Conditions, whose role is aligned to the Out of Hospital Collaborative acting as public health lead for advice and leadership in delivery of the strategy specifically addressing Health and Wellbeing. This role will support to move the focus from a reactive, crisis intervention approach to a more timely integrated proactive, preventative approach. This new role will work alongside our 3 existing jointly funded consultants.
- A jointly funded (between Warwickshire County Council and South Warwickshire Foundation Trust), Lead Commissioner for Out of Hospital services.
- An Integrated Commissioner for People with Disabilities, across Warwickshire County Council, the three Clinical Commissioning Groups and Coventry City Council.

As Coventry and Warwickshire move towards an Integrated Care System, a Coventry and Warwickshire wide Task and Finish Group has also recently been established to undertake a robust options appraisal to further develop integrated commissioning arrangements, taking into account available options (shared Commissioning Lead and single commissioning plan, aligned/shadow budgets, pooled budgets, Lead Commissioner etc). This is being overseen by the Coventry and Warwickshire Collaborative Commissioning Board.

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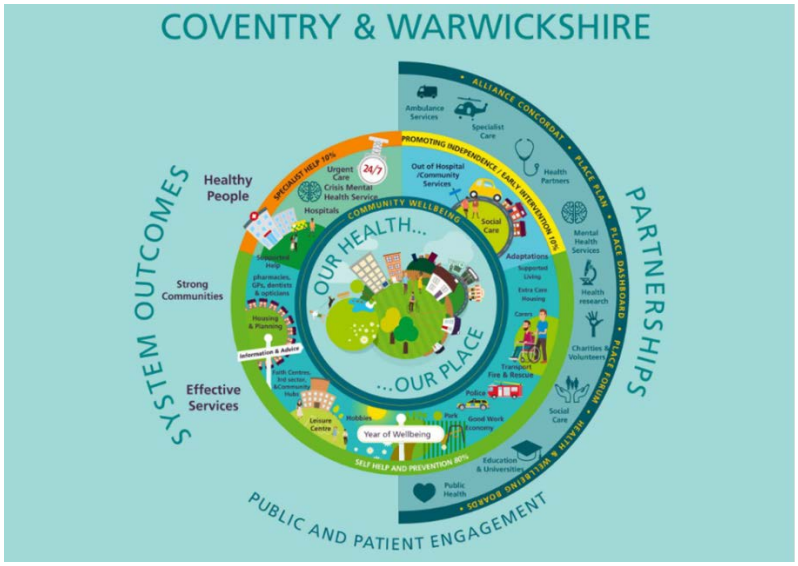
Coventry and Warwickshire Health and Care Model for our Place



Alignment at System and Place Level

18 neighbourhoods/primary care networks now make up Coventry and Warwickshire, in which GP practices work together with community and social care services to offer integrated health and care services for populations of 30-50k people. These integrated neighbourhood services focus on preventing ill health, supporting people to stay well, and providing them with high quality care and treatment when they need it.

Neighbourhood services sit within each of our four local Places, Rugby, South Warwickshire and Warwickshire North in Warwickshire and Coventry. These places are the primary units for partnerships between NHS services, Warwickshire County Council, charities and community groups. These place-based partnerships work together to agree how to improve people's health and improve the quality of their health and care services.

The focus of these partnerships is moving away from simply treating ill health to preventing it, and to tackling the wider determinants of health, such as housing, employment, social inclusion and the physical environment. In doing so, they draw on the work of Warwickshire County Council and other public sector agencies, using for example the local area Joint Strategic Needs Assessments (JSNAs), which identify the specific health needs of these local neighbourhoods.

The Out of Hospital Place Based (Community) Teams are now working to re-align to match the PCNs, ensuring that community assets from local areas (e.g. social prescribers, the voluntary and community sector, housing) are used to best effect when discussing and making decisions about individual patients/residents health and care.

Alignment with the voluntary and community sector is delivered through the Place Based Partnerships, the local Working Together Boards as part of the Out of Hospital Collaborative and the neighbourhood Place Based Teams. The Partnerships for each of the four places that make up Coventry and Warwickshire bring together the councils (commissioners and operations), voluntary and community sector organisations, and NHS commissioners and providers, in each Place, including the newly appointed Primary Care Network Clinical Directors, and other primary care providers, to take responsibility for the

cost and quality of care for the population in their area. These partnerships focus on population health management, integration between providers of services around the individual's needs, and a focus on care provided much closer to where people live in primary and community settings.
Arrangements at place build on existing established partnership working, such as the Better Together Programme (BCF) and Out of Hospital Collaborative, by bringing those commissioning and providing services into even stronger alignment with each other and with a wide range of other partners. The Place Forum has a consistent outcomes framework at both a system and place level focussed on: 'Healthy People; Stronger Communities and Effective Services'. Many of the commissioned services or service delivery for Effective Services such as Rehabilitation, Readmissions, Residential Care and Delayed Transfers of Care are through the pooled budgets in Better Together (BCF) Programme.

Through the BCF pooled budget the following joint commissioning arrangements are already in place in Warwickshire:

- Care Home Quality – Warwickshire County Council, Warwickshire North Clinical Commissioning Group and South Warwickshire Clinical Commissioning Group have a shared approach for the quality assurance of adult residential and nursing home provision, via a Section 75 agreement.
- Care Home Learning & Development - The Learning and Development Service led by Warwickshire County Council commissions fully funded learning opportunities for social care providers to meet needs identified by Clinical Commissioning Group colleagues. This is funded through the IBCF.
- Discharge to Assess (D2A) - Warwickshire County Council commission nursing beds on behalf of South Warwickshire Foundation Trust and South Warwickshire Clinical Commissioning Group via a section 75 agreement.
- Integrated Community Equipment Services (ICE) - Warwickshire County Council leads on commissioning and contracting for countywide integrated community equipment service and associated monitoring via a S75 agreement (Warwickshire County Council and Clinical Commissioning Groups).
- HEART (Disabled Facilities Grant and Housing Improvement Related Services) - Managed via a section 101 partnership comprising all five District and Borough Councils and Warwickshire County Council.
- HomeFirst - Warwickshire County Council Reablement and South Warwickshire Foundation Trust Community Intermediate Care Teams are co-located.
- Extra Care Housing (ECH) - Pilot project x 4 ECH units with wrap-around health and care services (Warwickshire County Council, South Warwickshire Clinical Commissioning Group and South Warwickshire Foundation Trust).
- Residential / Nursing Care Commissioning - Warwickshire County Council undertakes commissioning and contracting of residential and nursing placements for WCC and Clinical Commissioning Groups via a s75 agreement.

Through the BCF pooled budget the following lead commissioning arrangements are in place:

- Care at Home commissioning - Warwickshire County Council and the 3 Clinical Commissioning Groups entered into a joint procurement process for Care at Home Services. This has resulted in 4 service areas being delivered under the Care at Home Contract: Domiciliary Care, Live In Care, Supported Living and Clinical Care.
- Dementia - Warwickshire County Council leads the implementation of the 'Living well with Dementia Strategy' in Warwickshire and a Dementia Navigator Service that links into primary and mental health services.

- Housing Related Support - Aligned approach to commissioning and delivery of HRS, led by Warwickshire County Council through a steering group with the five District and Borough Councils.
- Moving on Beds - Warwickshire County Council are the lead commissioner for MOBs.
- Social Prescribing - Warwickshire County Council and Clinical Commissioning Groups are working towards alignment or jointly commission a model of hospital and community based care navigation/social prescribing. WCC are leading on this from a commissioning perspective.

These sit alongside other integrated commissioning arrangements in place for children and young people and younger adults.

(ii) Your approach to integration with wider services (e.g. Housing), this should include (800 word count limit):

- **Your approach to using the DFG to support the housing needs of people with disabilities or care needs.** This should include any arrangements for strategic planning for the use of adaptations and technologies to support independent living in line with the (Regulatory Reform Order 2002)

HEART

The Home Environment Assessment and Response Team (HEART) provides all age (children and adults) assessment of their home environment to enable them to provide solutions to continue to live at home eg. adaptations to the house. HEART is a legal partnership (section 101) between all six councils within Warwickshire.

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,
- deliver prevention activity, including advice and information,
- provide equipment and major / minor adaptations, and
- emergency support.

More recent developments include a handy person service and closer links with commissioned Carers Support services.

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

Our multi-agency approach, with direct involvement from Warwickshire County Council (public heath, commissioners and social care operations) and the five district and borough councils ensures the contribution suitable housing makes to reducing inequalities. Strategic direction and assurance of the work of the partnership is set through the Housing Partnership Board, a sub-group of the Better Together Programme, which also includes wider representation from Clinical Commissioning Groups. Housing representatives are also a key member of the Better Together Programme Board (BCF) and therefore integral to our integration and joint health, housing and social care commissioning and provider plans and activities.

An independent assessment of the service is currently underway, which includes options to focus more on early identification of customers, through improving networks (with for example Place Based Teams, Social Prescribers and Warwickshire Fire and Rescue Service who deliver the Hospital to Home Service

and Safe and Well Checks), and simpler referral processes and pathways to deliver more preventative activity. An identified gap in our current service offer is around hoarding. The review is covering the following 5 Key Lines of Enquiry: Demand; Service Offer and Capability; Processes; Data and Information; and Leadership, Governance and Operational Management.

A key deliverable of the review, which is due to report in October 2019 is a gap analysis against the 45 recommendations from the national best practice guidance and independent review of the DFG commissioned by the government (published in December 2018).

Housing Liaison Officers

Housing Liaison Officers based in Warwick and George Eliot Hospitals, are part of a new cross-partnership approach to care and support (Integrated Discharge Teams - WCC social care and NHS; and Housing colleagues from the 5 x District and Borough councils) who are supporting early prevention advice and support around: hoarding, handy-person services, low level / minor adaptations; major adaptations, and emergency housing response. This new way of working has helped reduce housing related delayed transfers of care where the person's accommodation is unsuitable to return to, by proactively including housing at admission and when discharge planning.

Extra Care Housing

Alternative types of accommodation including Extra Care Housing, and Supported Living, continue to be expanded. Extra Care Housing Waking Nights cover is now available in all ECH older people's scheme, providing reassurance and diverting residents away from moving to 24 hour residential care. Assistive Technology pilots are currently being developed with ECH providers and developers and District and Borough councils to identify alternative ways to provide support.

Addressing health inequalities

The Housing Board arranged for 'Making Every Contact Count Training' with a specific focus on mental health to be delivered to all front line housing staff during Q4 2018/19 and Q1 2019/20 due to identified support needs particularly for families with children and younger adults. (Note: Warwickshire is an outlier for suicide and hospital admissions as a result of self-harm and unintentional and deliberate injury in children). Re-fresher training will be repeated later this year for any new starters or returners to work.

C) System level alignment, for example this may include (but is not limited to) (1500 word count limit):

- **How the BCF plan and other plans align to the wider integration landscape, STP/ICS plans**
- **A brief description of joint governance arrangements for the BCF plan**

The wider integration landscape

In preparing to become an accredited Integrated Care System (ICS), there has been a review of governance arrangements in the Coventry and Warwickshire Health and Care Partnership. The objective of this review was to ensure that any future architecture would enable efficient and effective decision making (as close to our communities as possible) and that there was alignment across the system with regards to our agreed vision and purpose. This review has included the existing integrated and joint commissioning and delivery arrangements covered by the Better Care Fund section 75, and form part of the wider Commissioning Strategy and Intentions, and Delivery Plans in the future.

The arrangements described below highlight how we are organising ourselves across Coventry and Warwickshire to provide the best health and care, ensuring that decisions are always taken in the interest of the patients, communities and populations we serve.

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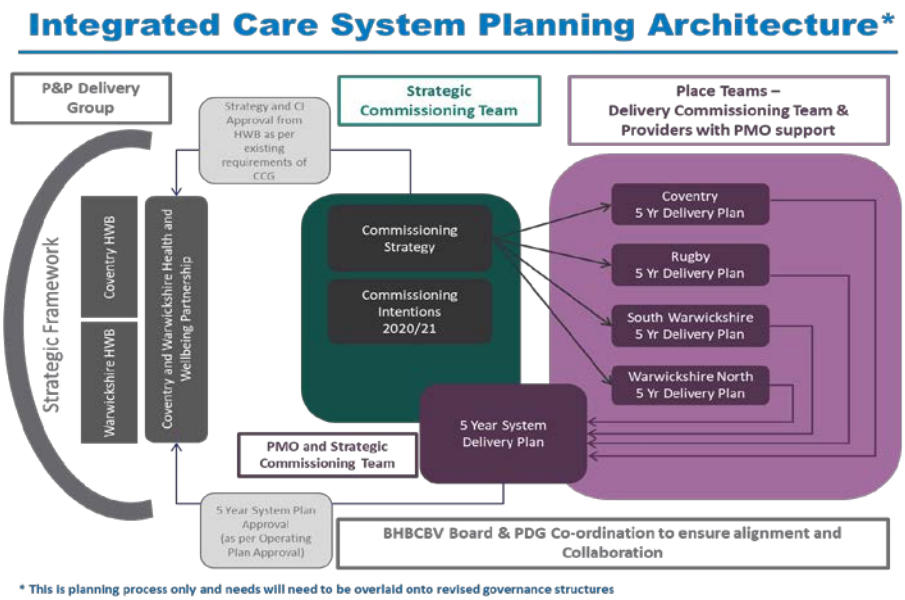

The revised partnership governance arrangements to support the future Integrated Care System is:

<u>Partnership Board</u>

A new Partnership Board will be established to provide the formal leadership for the Health and Care Partnership. This will be strongly aligned to and heavily influenced by the Health and Wellbeing Boards, their Concordat and the Place Forum. The Partnership Board will be responsible for setting strategic direction. It will provide oversight of all Partnership business and make recommendations as partners on collaborative action. This includes plans for using resources to improve health and care and proposals to align organisational and service arrangements to support implementation of these plans.

The Partnership Board works alongside the Place Forum which provides leadership across Coventry and Warwickshire on population health and wellbeing. The developmental work of the Place Forum will continue under the leadership of the chairs of the two Health and Wellbeing Boards with support from public health directors and their NHS colleagues.

The Partnership Board will oversee the emergence of the Coventry and Warwickshire Integrated Care System and will be chaired by the independent chair of the Partnership. Membership of the Place Forum and Partnership Board will be closely aligned.

The Partnership Board will be made up of chairs and chief executives from all NHS organisations, elected member Chairs of Health and Wellbeing Boards, and chief executives or designated deputies of Local Authorities. Other members will include primary care leaders, senior representatives of other relevant partner organisations such as universities, Healthwatch, voluntary and community sector organisations, independent sector providers, NHS England, NHS Improvement, Health Education England, and Public Health England.

The Partnership Board has no formal delegated powers from the organisations in the Partnership. It will work by building agreement with leaders across partner organisations to take forward the ambitions of the Integrated Care System and in so doing to improve the health and care of the population of Coventry and Warwickshire.

Partnership Executive Group

The current Better Health, Better Care, Better Value (STP) board will be replaced by a new Partnership Executive Group (PEG) whose members will be drawn from NHS organisations, Warwickshire County Council and Coventry City Council. PEG will report to the Partnership Board.

Each organisation will be represented by its chief executive or accountable officer. PEG will also require attendance from the System Clinical Lead, the System Finance Lead and the System Transformation Director and will invite NHSE/I representation.

Members of PEG will be expected to recommend that their organisations support agreements and decisions made, always subject to each Partner's compliance with internal governance and approval procedure.

Place Based Partnerships

Partnerships arrangements for the four places that make up Coventry and Warwickshire bring together the councils, voluntary and community sector organisations, and NHS commissioners and providers in each Place, including GPs and other primary care providers, to take responsibility for the cost and quality of care for the whole population.

They will provide a greater focus on population health management, integration between providers of services around the individual's needs, and a focus on care provided much closer to where people live in primary and community settings. They will be a means of involving elected members, members of NHS boards and others in providing local leadership of the Partnership with the support of executive leaders.

Arrangements at place build on existing partnership working by bringing those commissioning and providing services into even stronger alignment with each other and with a wide range of other partners. The four places are where most of the ambitions of the Coventry and Warwickshire Health and Care Partnership will be delivered. The four places will report to the Partnership Board.

Clinical Forum

Clinical leadership is central to all we do. Clinical leadership is built into each of our programmes, and our Clinical Forum provides formal clinical advice and expertise to all of the workstreams. The Forum will supersede the Clinical Design Authority and will report to the PEG and the Partnership Board.

The purpose of the Clinical Forum is to be the primary forum for clinical leadership, advice and challenge for the work of the partnership in meeting the Triple Aim: improving health and wellbeing; improving care and the quality of services; and ensuring that services are financially sustainable.

The Clinical Forum ensures that the voice of clinicians, from across the range of clinical professions and partner organisations, drives the development of new clinical models and proposals for the transformation of services. It also takes an overview of system performance on quality.

The Clinical Forum operates at two levels with a core Executive membership overseeing the development of all proposals that are shared with either place or the system and a wider membership who provide the clinical expertise and input into designing any proposals. The wider membership includes clinical leaders from NHS trusts, CCGs and primary care networks together with public health and social care leaders from local authorities. It will include clinicians from a wide range of professional backgrounds.

Other governance arrangements between Partners

The three local CCGs in Coventry and Warwickshire have established a Joint Strategic Commissioning Committee, which has delegated authority to take decisions collectively. The Joint Committee is a sub-committee of the CCGs, and each CCG retains its statutory powers and accountability. The Collaborative Commissioning Board brings together CCGs with local authority commissioners. The Better Together Programme reports into the Collaborative Commissioning Board as well as the Health and Wellbeing Board. The Chair of the Better Together Programme Board and lead for the Better Care Fund in Warwickshire is also the lead (Assistant Director) for Strategy and Commissioning in the People Directorate (Children and Adults) at Warwickshire County Council and a member of the Collaborative Commissioning Board. The Board has committed to considering ways to streamline and strengthen governance processes for joint commissioning activity ensuring an all age and prevention focus; and alignment to the new ICS arrangements.

NHS providers meet together as the Provider Alliance which is governed by a Memorandum of Understanding (MOU) which defines the objectives and principles for collaboration. The arrangement provides the forum for working together and making recommendations that are then formally approved by each Trust Board individually in accordance with their own internal procedures. Coventry and Warwickshire providers also meet with providers in Hereford and Worcestershire to discuss issues of common concern.

Next Steps

Subject to the agreement of Health and Wellbeing Boards and NHS boards, these new arrangements will be adopted from September 2019, alongside the 5-year system plan and the overarching System Framework being developed under the aegis of the Place Forum. The new arrangements will be reviewed after 12 months to ensure that they are fit for purpose.

Joint Governance Arrangements for the BCF Plan

In Warwickshire the mechanism for joint health, housing and social care planning is through the Better Together Programme. Our joint governance arrangements remain as in previous years and are now well established. Board members of the Better Together programme representing: Coventry and Rugby Clinical Commissioning Group (C&R CCG), South Warwickshire Clinical Commissioning Group (SWCCG), Warwickshire North Clinical Commissioning Group (WN CCG), George Eliot Hospital (GEH), South Warwickshire Foundation Trust (SWFT), Coventry and Warwickshire Partnership Trust (CWPT), University Hospital Coventry (UCH) and Warwickshire; Warwick District Council (Housing), and Public Health, Community Capacity and Social Care Commissioners and Operational Leads at Warwickshire County Council. And includes the views of additional key partners including: Stratford-Upon-Avon District Council, Nuneaton and Bedworth Borough Council, Rugby Borough Council and North Warwickshire Borough Council, the Voluntary and Third sector, and Care providers.

The wide membership of our board means that partners also representing the local A&E Delivery Boards, acute and community providers and housing are engaged and involved in shaping our commissioning and delivery plans and activities.

To help us achieve the national and local priorities we are continuing to structure our programme under five portfolio areas:

- Community Capacity / Resilience
- Care at Home

- Accommodation with Support
- Integrated Care and Support
- Housing

In 2019/20, the Board agreed to focus on three specific elements of these portfolios: Social Prescribing, Residential and Nursing Care Commissioning and the HEART Service (Housing), which require further attention and support.

Supporting the Board is a number of sub-groups which lead on the commissioning and delivery of joint/integrated services eg. The Social Prescribing Steering Group, Care at Home Board, Accommodation with Support Board, Delayed Transfers of Care Board (DTOC), Integrated Community Equipment (ICE) Board and Housing Partnership Board. Underpinning all Board and Sub-Group activity are a Finance Sub-Group and system-wide Business Intelligence Analysts Group. Decision-making and assurance is through the programme board. Any services commissioned through the BCF (pooled or aligned budget) or delivered through the Better Together Programme must produce an equality impact assessment to identify how it is contributing to reducing either general health inequalities for older people or more targeted interventions for specific communities or cohorts of residents/patients. Please refer to the 'Director of Public Health Annual Report 2019' - attached to this submission as a separate appendix for more information.

Our Better Care Fund Plan, pooled and aligned budgets, the agreed list of schemes, metrics and priorities for 2019/20 outlined in this document and the supporting appendices have been developed following a series of meetings with partners represented on:

- the Better Together Programme Board; and
- the Finance Sub-Group (Warwickshire County Council, and the three Clinical Commissioning Groups) which leads on developing the scheme level spending plans, including the Improved Better Care Fund and Adult Social Care Winter Fun and approach to risk share.

The plans prepared and agreed by the Better Together Programme Board and Finance-Sub-Group are then submitted to the relevant governing bodies for approval (Warwickshire County Council's Corporate Board and the three Clinical Commissioning Groups Governing Bodies) before being signed off by the Health and Wellbeing Board.