Integration and Better Care Fund (BCF) Plan

Better Care Fund Plan 2022/23 Submission

Health and Well Being Board: Coventry

September 2022

National Condition 1: A jointly agreed plan

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

This narrative plan is produced part way through the year to which it applies and as such much of the content has been determined through the work we undertake with partners across Health and Care, within the spirit of working together to support the individual. We operate within a dynamic environment and through working constructively with NHS partners have been able to adapt and flex the plan in real time dependant on pressures and priorities. In this spirit, which we consider is at the essence of collaborative and user focussed working the organisations and people within them who contribute and influence how BCF is applied locally is much greater than the chief officers who 'sign off'.

The following organisations/partnerships have been involved in the use of BCF and integration activities include:

- Representatives on the Coventry Adult Commissioning Group – commissioning and finance leads from the City Council and the Integrated Care Board (ICB formerly CCG) Note: this is the agreed S75 governance arrangement which has not been varied so remains in place
- NHS operational teams across discharge, admission avoidance and hospital flow – influences BCF indirectly through feedback on system issues and how resolved. This input is a specific reason why iBCF has been used to mitigate the impact of Hospital Discharge Grant withdrawal
- Coventry Care Collaborative – a newly formed group as part of our 'place arrangements' who have been briefed on the purpose and outturn from previous years BCF to influence future delivery. This influence has led to the decision to use carry forward BCF to part resource a significant change programme titled 'Improving Lives'
- System SRO/Urgent Care lead – to support review and challenge on how BCF/iBCF can be deployed differently to focus more of system priorities while continuing to play the critical role of resources to manage day to day challenges (which is a priority)

Approval timetable

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

Organisation		Review and Decision / Approval Date
ICB	Finance and Performance committee	07/09/22
CW ICB	Integrated Care Board	21/09/22
Partnership	Health and Wellbeing Board – review, and Approval	03/10/22
	Submission deadline	**26/09/22**

Responsibilities for preparing this plan

Accountable: Pete Fahy, Director of Adult Services and Housing, Coventry City Council

Responsible: Ewan Dewar, Lead Accountant, Coventry City Council

Executive Summary

Background

The Better Care Fund has been one of the key contributors over the last seven years towards building stronger partnerships and integration between the commissioners and providers of health and care services in Coventry.

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. The use of the iBCF/BCF has been a significant factor as to how the City Council has been able to increase capacity in the hospital discharge team, increase discharge destination capacity and avoid the need for service reduction proposals with NHS colleagues for a number of years.

By working together, the expertise and strengths within the system have been acknowledged and resulted in opportunities to adapt how services are commissioned and delivered in response to local needs and pressures.

Since the 2021/22 plan was submitted the Integrated Care System (ICS) has come into being along with the move to geographical collaboratives of the new Coventry and Warwickshire Integrated Care System. These are currently in a 'collaborative committee' stage without formal delegated responsibility. It is however anticipated the BCF will be one area for which collaboratives will have some responsibility. The extent of this responsibility and how it is achieved is to be determined given the HWBB remains the sign off and therefore ultimate accountability. The Coventry Care Collaborative is engaged on BCF and this engagement will grow to the point where a more active role can be played in future years plans.

Locally our BCF Plan for 2022/23 will support the Health and Care Partnership vision of '*'We will do everything in our power to enable people across Coventry and Warwickshire to pursue happy, healthy lives and put people at the heart of everything we do.'* and builds on the progress made from 2016-22.

The majority of schemes and activities in our BCF plan for 2022/23 continue on from previous years.

Priorities for 2022/23

The following priorities are in place to support the two BCF Objectives to 1. Enable people to stay well, safe, and independent at home for longer and 2. Provide the right care in the right place at the right time:

1. Improvement activity being delivered through the Better Care Fund
    a. Implementation of the Integrated Care Record in Social Care – will improve information sharing and access to records held in health and social care and ultimately enhance patient/resident experience
    b. Improvement on Disabled Facilities Grant (DFG) processing and activity to improve ability to support people at home through adaptations, including adaptations to temporary accommodation
    c. Mitigating the impact of the ending of Hospital Discharge Grant
    d. Developing the 'Improving Lives for Older People' focussed on a whole pathway improvement from admission avoidance through to discharge. A core objective of this programme is to provide health care and support to people at home and prevent issues of 'flow' through reducing the need for people to transfer to hospital in the first place.

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

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

- This includes the roll out of Docobo in care homes for older people across Coventry and Warwickshire. It first worked with homes in North Warwickshire in now being rolled out within Coventry 2 care homes within Coventry are currently using Docobo with a further 11 signed up for phases 2/3 of roll out and 16 homes include in phase 4.(planned completion 30th October 2022).

In Coventry the 'Improving Lives for Older People' programme has been, and will be a significant transformation programme, to be part funded from BCF with each of the three main health and care organisations making a contribution on top of this. Since the last plan this programme has progressed from diagnostic to design and in now going through approval stage (due to financial commitment approval is required from all Coventry organisations and then NHSE).

The outcomes expected from the programme, which will be delivered over three financial years include:

- Objective One: Promote and deliver independence by helping more people live at home
- Objective Two: Collaboration and integration with partners to deliver simple and more effective care for people in their own homes rather than in a combination of health and care settings
- Objective Three: Support moving towards the health and care system being in an operationally & financially sustainable position for the future

The leadership and oversight of this programme is through Coventry Care Collaborative reporting to all funding organisations (CCC, ICB, CWPT and UHCW).

As a consultative forum the Care Collaborative will produce a delivery plan linked to the Integrated Care Strategy (not yet developed)

Funding is also identified in the BCF to develop population health management tools and progress use of this to support decision making.

Through close working with Housing and Homelessness teams DFG resources have also been programmed to support funding adaptations to temporary accommodation to enable vulnerable people to have improved access to more suitable housing support options. The use of the DFG has also been expanded through the recently approved Housing Assistance Policy.

The revised policy maintains the focus on longstanding support to the warm homes agenda but broadens the scope of the DGF to enable one off adaptations to be provided within a threshold, and:

- Increases the top up grant to enable adaptations
- Enables the development of an 'At Home Safely Scheme' supporting residents with necessary remedial works
- Introduces a relocation grant enabling residents to move to more suitable or adapted property
- Enables arrangements to be made to support respite provision whilst necessary works are carried out

The mitigation of the removal of the Hospital Discharge Grant enables the City Council to continue to offer extended support into the Hospital Discharge process through additional domiciliary support to enable recovery at home and where necessary temporary alternative step down accommodation. This is possible by utilising non recurrent funding. This supports flow within acute care and is used flexibly at times of increased surge activity or infection control outbreaks within existing contracted resources. It has enabled the services to keep pace with discharge activity, increased numbers supported to leave hospital at the right time and enables discharge across 7 days a week.

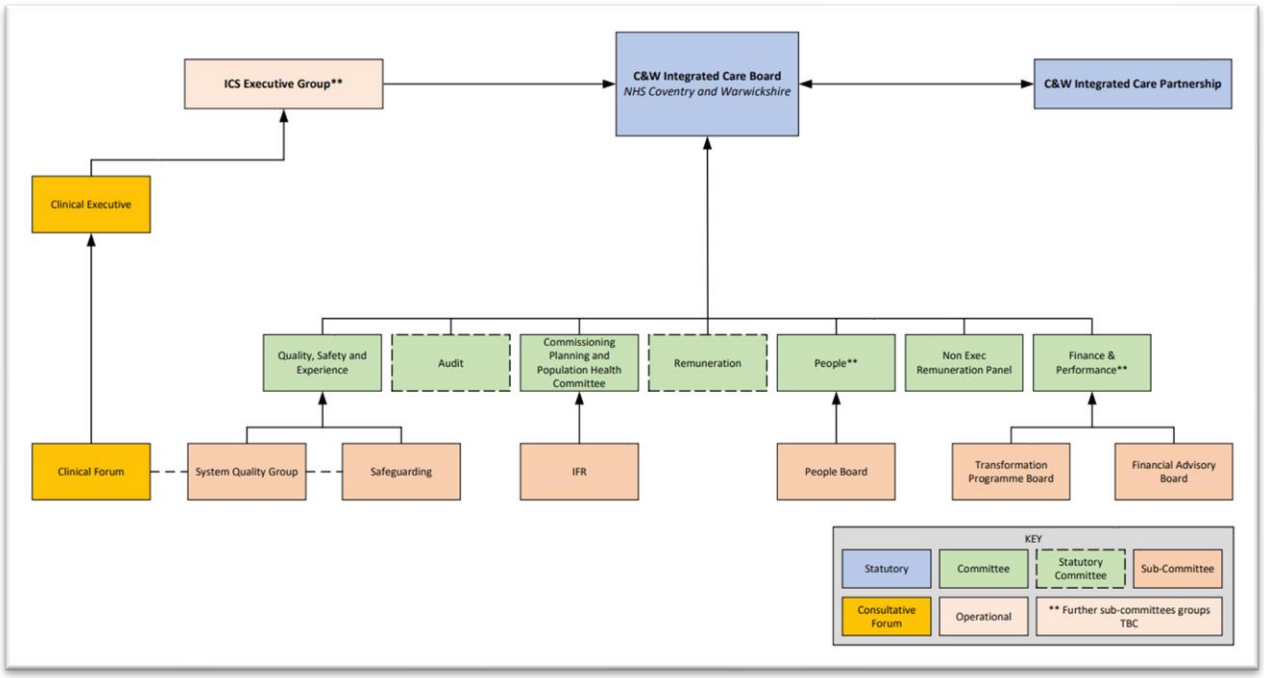
Governance of the BCF Plan and implementation in Coventry

Governance of implementation of the BCF Plan is through the Coventry Adult Joint Commissioning Group with increasing links to the Coventry Care Collaborative.

Integrated Care System governance arrangements

The illustrations below summarise the Coventry and Warwickshire Integrated Care System architecture, which are included in both Coventry and Warwickshire's separate BCF Plans.

Coventry and Warwickshire



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

Overall BCF plan and approach to integration

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

In last year's plan we provided a summary of the 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 will support with oversight to potentially transfer to Care Collaboratives. Proposals for how this will happen will be developed in readiness from progressing beyond 'consultative committee' stage.

Whilst it is not specifically stated the intentions are to ensure health activity incorporates Mental Health and BCF in Coventry has provided financial support into the Mental Health system through Street Triage and the provision of an additional Approved Mental Health Professional (AMHP) supporting the Acute Hospital in-reach teams (AMHAT) reflecting the integrated approach to support that exists through the successful S75 agreement in place between the City Council and Coventry and Warwickshire Partnership Trust.

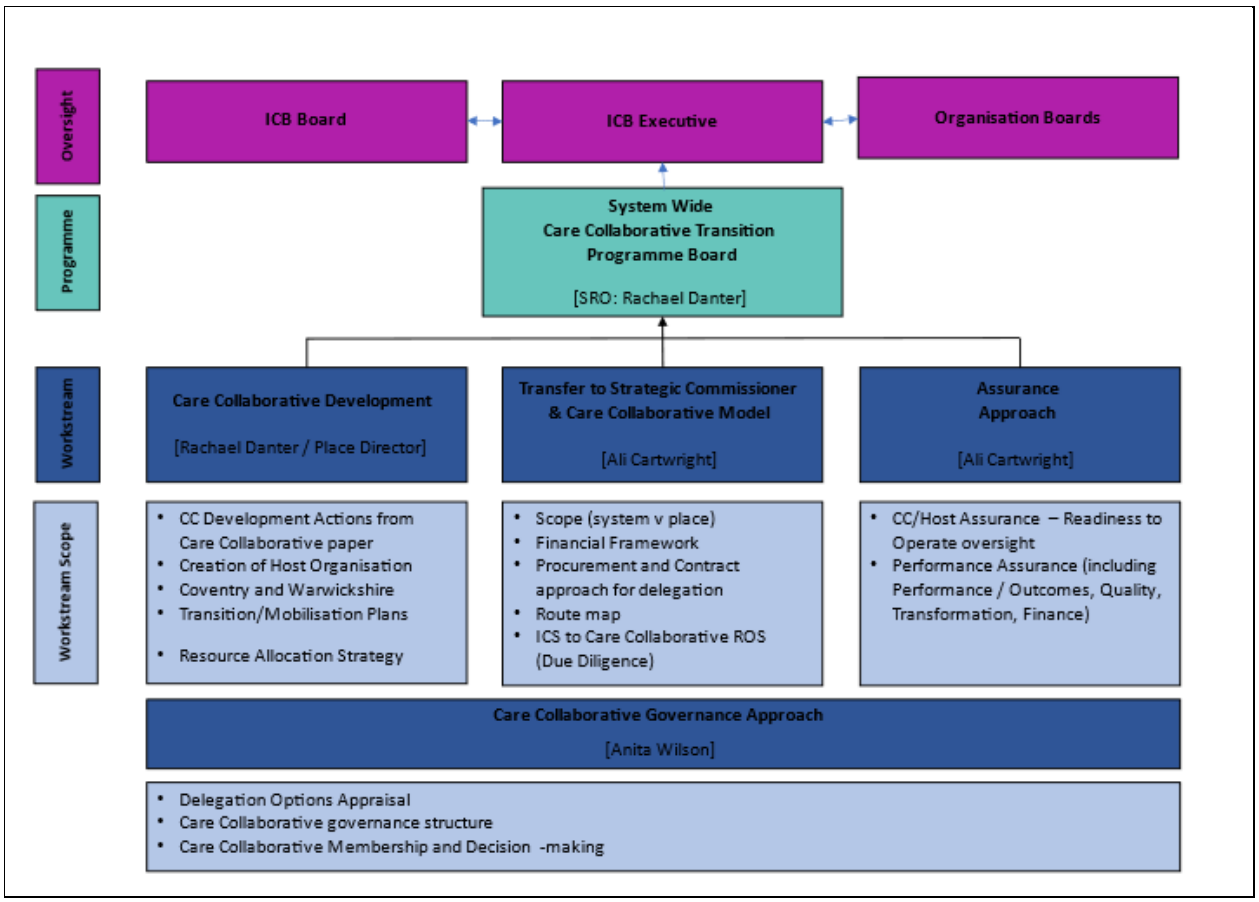
Integrated commissioning is well embedded in Coventry supported by established integrated roles:

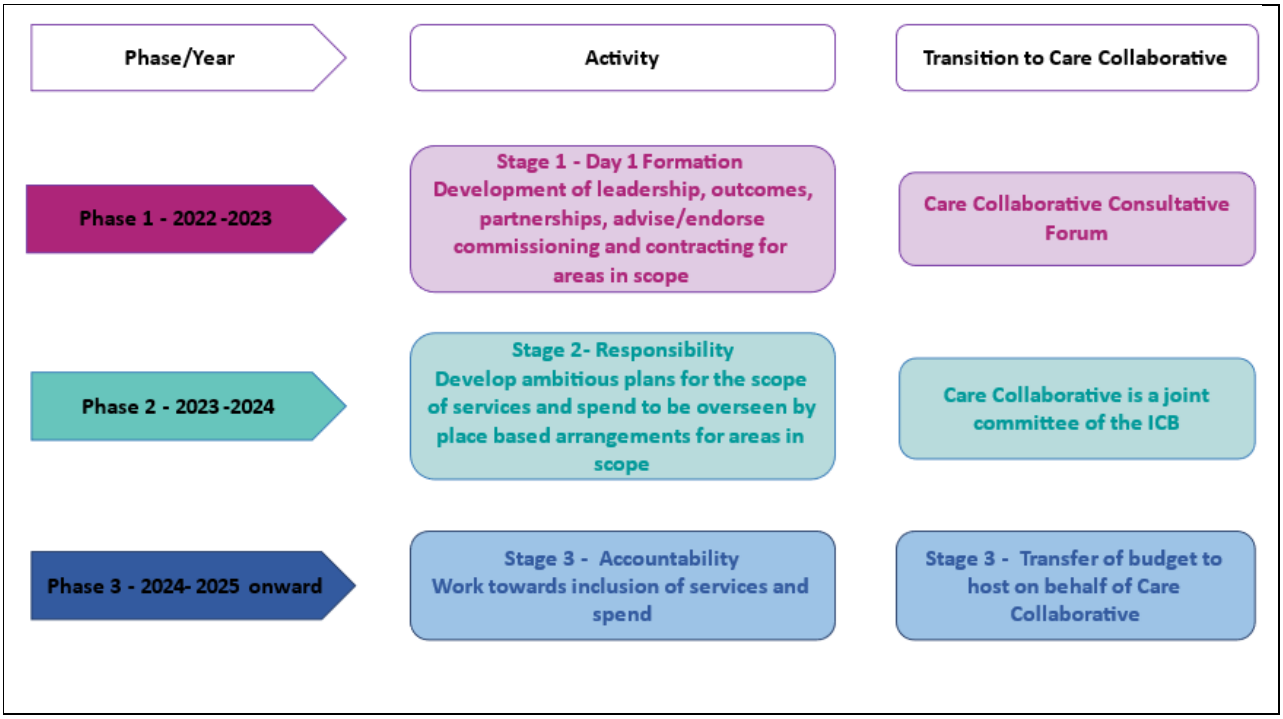
- A joint Commissioning Manager post Learning Disabilities (CCC/ICB)
- A joint Commissioning Manager post Dementia & Mental Health (CCC/ICB)
- An integrated care quality team (CCC/ICB)
- An Integrated Commissioning team for People with Disabilities, (WCC/CWICB/Coventry City Council),
- A Public Health Senior Commissioning Manager line managed through adult social care commissioning

From 2021 the Council introduced 7 day brokerage cover. This has served to improve flow from hospital particularly at weekends and for extended hours during the week. Although not an integrated health and care function there is alignment between the two with shared market intelligence specifically supporting Pathway 3 (ICB) discharges at weekends and over bank holidays as needed. In addition, the Council formalised the interim support to care homes by including Care Home Liaison within the Community Discharge Offer following on from the successful BCF pilot previously in place.

Work continues across health and care partners to support development of the Coventry and Warwickshire Integrated Care System (ICS). The Integrated Care Board (ICB) and Integrated Care Partnership (ICP) are now formally constituted and there remains commitment to the establishment of 2 geographical care collaboratives (one for Coventry and one for Warwickshire). A key component of the ICS, these care collaboratives will be made up of the partnership of organisations responsible for organising and delivering health and care within Coventry and Warwickshire respectively. In Coventry it is proposed that the collaborative will be hosted by University Hospital Coventry and Warwickshire (UHCW).

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





A recently established Coventry and Warwickshire Joint Commissioning Group which has its origins in a Care Expert Advisory group set up during start of the Covid -19 Pandemic, will support Care Collaboratives with work in relation to market shaping and sustainability, commissioning, quality and workforce issues.

There are existing integrated service arrangements that exist and offer a firm basis to develop integrated partnerships and/or working arrangements further. The formal S75 arrangements across

Coventry and Warwickshire with Coventry and Warwickshire Partnership Trust (CWPT) being one example of how the system has approached collaboration and cooperation to secure best outcomes for local people.

National Condition 4 - Implementing the BCF Policy Objectives

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

A previous review of the High Impact Change model was completed which is subject to review as part of the wider review of discharge arrangements.

A hospital discharge programme group exists and is represented by all primary organisations supporting patients from hospital. Information in respect of discharge and delays are monitored on a regular basis through the forum with regular reporting into the aging well board and the local urgent and Emergency Care Board. This considers the elements of the high impact change model.

There is a strategic, tactical and operational oversight of demand and capacity across the system six days a week. Enabling robust management of required actions to secure discharge at earliest opportunity, using “why not home, why not today” ethos.

BCF funding continues to be used for a number of preventative initiatives that support people in their own homes through , for example, investment in affordable warmth initiatives, amelioration of loneliness, targeted funding for deprived communities including through our Healthier Communities together initiative. This funding supplements the Councils Preventative Support Grant funding which supports a range of coproduced outcomes largely through voluntary sector grants. Our close working between Adult Social Care and Public Health commissioners joins up preventative support particularly in the areas of drugs and alcohol, healthy lifestyles and sexual health.

Our integrated approach to commissioning of pathway support has reablement, strengths based working and promotion of independence at its heart supporting both step up and step down support. We have recently retendered our short term bedded support with new contracts to commence from early October 2022 and which have centred on the twin aims of ensuring sufficiency of provision and improving outcomes for people.

Joint preparatory work has commenced for recommissioning of pathway 1 home support services by October 2023 with different models being considered and again an emphasis on improved independence outcomes.

The City Council are leading, in collaboration with ICB colleagues and Skills for Care, a project looking at the possibilities around delegated health tasks with an initial focus on home support which is intended will lead to better integrated health and care support delivered at home.

The Integrated Community Equipment Service, provided through the City Council, but joint funded by the Council and ICB continues to provide an effective service with targets met or exceeded in relation to a range of measures including 96% of standard stock and 94% of special orders delivered within 5 days.

As well manual aids and adaptations the ICES provides a range of assistive technology that helps people to remain living independently and/or provide assurance to family carers. This has more recently been supplemented by telehealth solutions (Docobo) supporting residents in Coventry Care homes as a systemwide approach to improving outcomes for residents and efficiency in primary care support. 2 care homes are currently using Docobo with a further 11 signed up for phases 2/3 of roll out and 16 homes include in phase 4. (planned completion 30th October 2022).

The Council have worked in partnership with Coventry and Warwickshire Partnership Trust to support Urgent care response with an initial 100 hours per week delivered through short term home support contracts.

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

The local authority is supporting the development of virtual wards/ hospital at home and will work during 2022/23 to understand the role of home support in ensuring appropriate care and support that aids recovery and reduces the need for or volume of ongoing support thereby promoting independence.

Preparations for delivery of anticipatory care are also being progressed by health and care partners engaged on the Ageing Well Programme's Anticipatory Care workstream.

September 2022 will see the introduction of Integrated Care records, a key enabler to enabling people to stay at home with the support of joined up health and social care.

Discharge performance

In impact of our investment of BCF and collaborative working with system colleagues can be evidenced through the data below.

23/05/22 - 26/06/22			27/06/22 - 31/07/22	
Section 2 - Average no of **days** from receipt of referral into Social Care to Discharge	5.67		Section 2 - Average no of **days** from receipt of referral into Social Care to Discharge	6
PW1 average no of **minutes** from receiving Referral into ASC and forwarding to Brokerage	31		PW1 average no of **minutes** from receiving Referral into ASC and forwarding to Brokerage	29
PW2 average no of **minutes** from receiving Referral into ASC and forwarding to Brokerage	34		PW2 average no of **minutes** from receiving Referral into ASC and forwarding to Brokerage	32
PW1 average no of days from Brokers receiving referral to point of service offer	0		PW1 average no of days from Brokers receiving referral to point of service offer	0

PW2 average no of days from Brokers receiving referral to point of service offer	1		PW2 average no of days from Brokers receiving referral to point of service offer	2
PW1 average no of days from Brokers making offer and actual discharge	2		PW1 average no of days from Brokers making offer and actual discharge	2
PW2 average no of days from Brokers making offer and actual discharge	3		PW2 average no of days from Brokers making offer and actual discharge	3

This data provides evidence that for pathway one, home support the timescale from referral to discharge is approximately 2 days for home support with care identified same day and 3 days for a short-term residential placement. Most of this time is taken after a provider has been identified for that provider to make the arrangements for a safe discharge.

The social care referrals tend to be more complex and a higher proportionate relate to safeguarding matters influencing the overall time from referral to safe and effective discharge.

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

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

We have continued to utilise non recurrent money to support the NHS recovery plan and to sustain discharge activity at the level during the pandemic. Eg increased short term home support and bedded capacity.

Early on in the pandemic Coventry implemented a seven day 8-8 discharge service based at UHCW. This required the Council, UHCW and CWPT to quickly work together and align the model. The learning from this was significant and as a result the City Council mainstreamed this way of working. This model, combined with effective commissioning and market management are why we are able to assess, source care and achieve a discharge within a minimal number of days (2 for home support and 4 for residential care)

The local authority's relationship with the provider market is crucial to this. Effective two-way communication and a clear focus on understanding the market, its pressures and the opportunities were key enablers to partnership preparedness and response. We continue to maintain a focus on engaging with and supporting the care market particularly with the pressures and demands it continues to face in relation to workforce.

Supporting unpaid carers

All Coventry City Council Adult Carer resources are pooled in the Better Care Fund alongside those from the ICB.

Carer Services in Coventry has included a number of support options for many years including:

- Information, Advice and Signposting

- Carers assessments and support planning
- Urgent and planned breaks
- Respite Services
- Carer Direct Payments

The impact of the pandemic influenced the availability of services and support to carers, and various schemes/enhancements were tested to enhance the available offer.

Following successful rollout a number of schemes have been continued in 2022/23:

- Working carers project – Working with employers to develop a carer friendly workplace/encouraging care champions/setting up of peer networks and providing carer assessments within the workplace
- Emotional support & resilience officer – Supporting delivery of resilience training to carers/engaging communities in support offer available
- Extension of Direct Payment Support

Alongside this the local Carers support organisation has continued a further scheme of Carer Support and secured funding to support engagement with hard-to-reach communities.

Early preparation of a refreshed Coventry and Warwickshire Carer's strategy has commenced. This will aim to ensure the optimum support for family carers within available resources recognising where systemwide approaches are of benefit and clarity on place based variance

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

Disabled Facilities Grant (DFG) spending and wider services

Housing and Homelessness Services in Coventry were moved under the remit of the Director of Adult Social Services enabling even closer working between of the teams, which was already in place. This has already led to innovative solutions for individuals that may otherwise have been placed in a residential home.

Our housing function is connected to hospital discharge work where a place of residence may be a reason for delay and through our vulnerable persons panel, we have in place a multi-agency forum to discuss particularly challenging complex cases.

Our use of DFG is targeted on adaptations that support people to remain in their own homes although a challenge has existed in capacity in the local contractor market to complete required works during the pandemic. Further revisions to our existing RRO policy now provide further opportunities to support people that due to existing DFG restrictions may not have been financially achievable. The Regulatory Reform has also enabled us to provide a Warm Homes Scheme to insulate the properties of vulnerable people most impacted by low temperatures through either a health or social care need.

As well as individual private dwellings we have used DFG flexibilities for making improvements to dwellings within group settings such as housing with care enabling us to use DFG to benefit as many people as possible.

This year's programme includes a new scheme to fund adaptations in temporary accommodation to enable vulnerable people to have improved access to more suitable housing support options.

Planning Requirement 2

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

Coventry 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, City and organisational level occurs through the following mechanisms:

- Coventry and Warwickshire ICS Health Inequalities Strategic Plan
- Coventry Health and Wellbeing Strategy 2019-2023
- Director of Public Health Annual Report 2020/21
- Evidence and data gathering through Joint Strategic Needs Assessment (JSNA)

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 rive the foundational principle of equity through every aspect of system working.

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

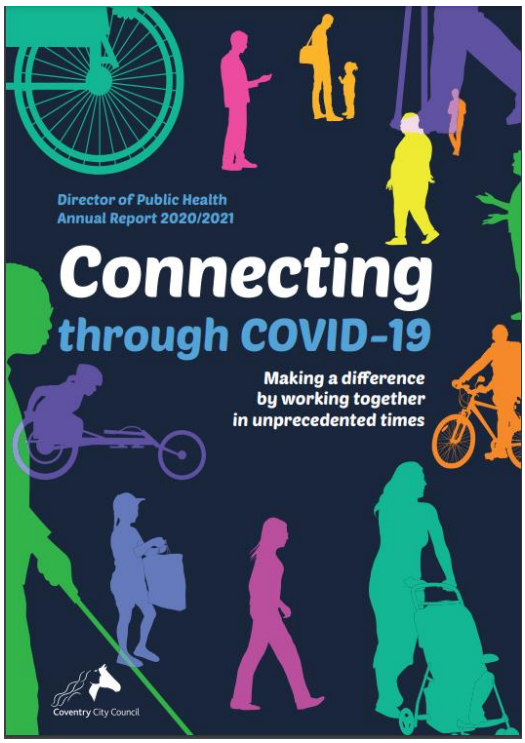
1. Improve outcomes in population health and healthcare
2. Tackle inequalities in outcomes, experience and access
3. Enhance productivity and travel for money

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

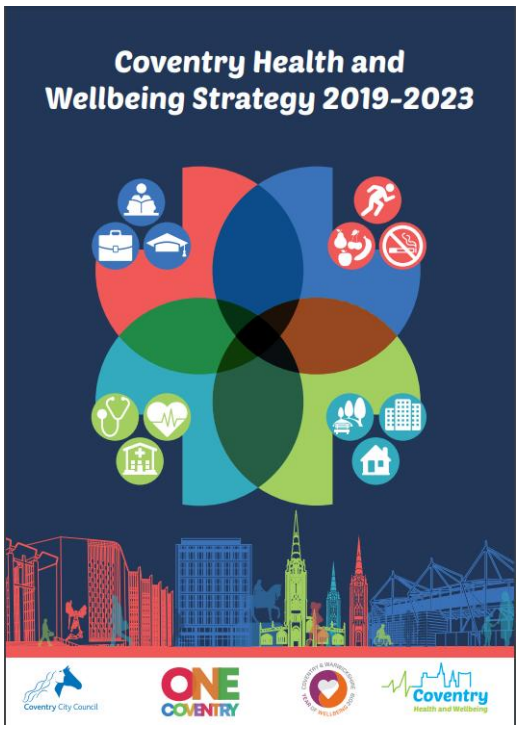
Services and schemes commissioned through the BCF will support delivery of this Strategy, and in particular two of the Major Inequalities Work Programmes ***(please refer to pages 18 to 22 of Appendix 1 as part of the Supporting Information):***

- Long term conditions and prevention
- Urgent Care Development

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



COVID-19 and the necessary lockdown restrictions to control its spread have had an impact on our health, the economy, and how we function as a society. COVID-19 has replicated existing health inequalities with the burden falling on the most vulnerable, the most deprived and the more marginalised, and, in some cases, has increased them. Understanding both the positive and negative impact of COVID-19 will help us to recover from the pandemic and protect and improve the health and wellbeing of Coventry residents. Following the Coventry and Warwickshire COVID-19 Health Impact Assessment, the Director of Public Health annual report focused on the impact of COVID-19. on health inequalities and made a series of recommendations to the Coventry Health and Wellbeing Board (HWBB) based around community connections (community messengers), partnerships and engagement.



The Coventry Health and Well-Being Strategy for 2019-2023 identifies three objectives based on reducing health inequalities:

- People are healthier and independent for longer
- Children and young people fulfil their potential
- People live in connected, safe and sustainable communities

Reducing Health inequalities run through this strategy and have a long an embedded history of how we work in Coventry back to being a Marmot City. Essentially, this work is part of the DNA of how we do things.

How is the BCF plan is contributing to reducing health inequalities in Coventry?

The BCF Plan is one of a number of vehicles for how we are reducing health inequalities in Coventry, a number of the projects funded through the BCF are specifically supporting community and voluntary sector organisations to reach out to diverse communities to provide preventative support that improves long term health outcomes. Our commissioning work around D2A increasingly challenges providers of social care on how they are providing services that are culturally appropriate for the range of people that may use them.

A public health consultant is a key member of the Joint Commissioning Group which oversees the 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.

Three projects previously mentioned in this plan that have a direct contribution to reducing health inequalities are:

- We used BCF funding to pump prime HOECT (Heart of England Carers Trust) to commence work to reach out to hard to reach communities – as a result of this HOECT have secured further funding to continue and embed this work
- Our DFG grant is being used to undertake adaptations to temporary accommodation. This will directly improve our support to people who are homeless who require adaptations to live independently
- In order to promote workforce diversity in the context of meeting the needs to new communities we have undertaken targeted recruitment for refugees in the City. As well as an equality impact this also has an economic impact in supporting people into employment.
- Preventative support grants enable a range of support directed to vulnerable adults experiencing inequalities this includes people with mental ill health and hard to reach communities.
- Specific services such as Street Triage reach out to those experiencing mental ill-health and offer support, guidance and where necessary secure statutory based provision for those who are harder to reach via more traditional services

End