HM Government

NHS England

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Integration and Better Care Fund

Cover

Health and Wellbeing Board(s).

Coventry

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).

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 Coventry Adult Commissioning Group – commissioning and finance leads from the City Council and the Integrated Care Board (ICB) Note: this is the agreed S75 governance arrangement which remains in place
    - Membership includes:
    - Commissioning, delivery, finance and Public Health representation from Coventry City Council (CCC);
    - Clinical, commissioning and finance leads from Coventry and Warwickshire Integrated Care Board (CWICB);

- NHS operational teams across discharge, admission avoidance and hospital flow – influences BCF indirectly through feedback on system issues and how resolved.

- 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 in the previous plan has led to the dec
    - Membership includes:
    - Coventry City Council
    - Coventry and Warwickshire ICB
    - Coventry and Warwickshire Partnership Trust
    - University Hospital Coventry and Warwickshire
    - VCSE
    - Coventry Healthwatch
    - Primary Care

Coventry Health and Wellbeing Board members will be asked to approve the plan at their first meeting of the new municipal year on 26th July 2023

How have you gone about involving these stakeholders?

An exercise to review progress of existing elements of the BCF plan started in August 2022. As part of this exercise, schemes were reviewed to establish whether they were still delivering services that were a priority reflecting the challenging financial. The joint review comprised staff from the Local Authority and Integrated Care Board (ICB) with feedback from partner agencies involved in supporting the system.

The review focussed on assuring that schemes continued to respond to current system pressures/priorities 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 identified that the majority of schemes were well established with positive impact evidenced across health and social care and if withdrawn would have a detrimental impact to our population.

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.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

This narrative plan is produced when we are already into year one of its delivery, this is however not a 'brand new plan' but an evolvement of previous BCF plans based on changing requirements, priorities and resources.

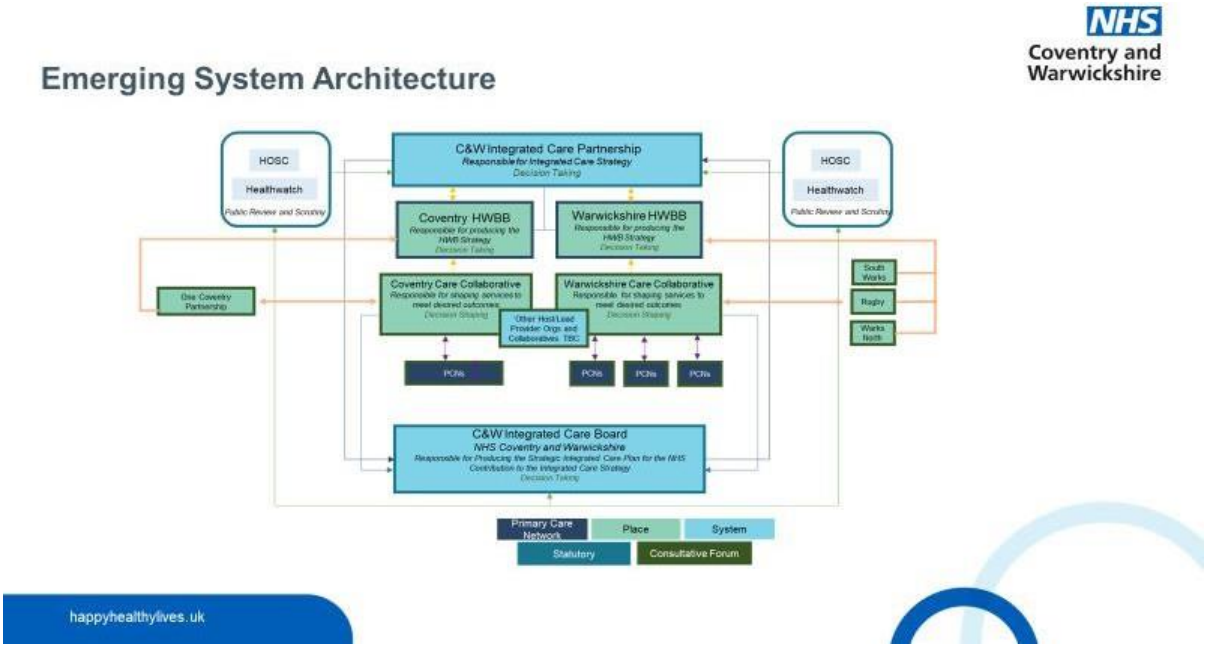
The plan evolves within the spirit of working together to support the individual. We operate within a dynamic environment and through working constructively with NHS partners have been able to adapt and flex the plan in real time dependant on pressures and priorities. In this spirit, which we consider 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'.

Governance decisions regarding the BCF for Coventry are made with Coventry and Warwickshire ICB and approved through Coventry Health and Wellbeing Board.

Governance of the implementation of the Better Care Fund is through the Adult Commissioning Group which is the agreed S75 governance arrangement

Integrated Care System governance arrangements

The illustration below summarises the emerging Coventry and Warwickshire Integrated Care System architecture. This is evolving and the Coventry Care Collaborative will have a key role in future BCF planning. This body is currently in place but operating as a 'consultative forum', and over the period of this BCF plan the Care Collaborative is expected to develop into a sub-committee of the ICB. It is not intended for the Care Collaboratives to have delegated authority for decision making in respect of BCF so these decision-making responsibilities will remain with the ICB and HWBB respectively. The Care Collaborative will however make formal recommendations to the ICB in respect of BCF once established as a sub-committee.



Approval timetable

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

Organisation		Review and Decision / Approval Date
Partnership	Adult Joint Commissioning Group	15th June 2023
ICB	Executive	27th June 2023
Partnership	Health and Wellbeing Board – review, and Approval	26th July 2023
	Submission deadline	28th June 2023

Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

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 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 and now the Hospital Discharge Fund 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 2022/23 plan was approved the Integrated Care System (ICS) has continued to develop along with the introduction to geographical collaboratives of the new Coventry and Warwickshire Integrated Care System. These are currently in a 'collaborative committee' stage without formal delegated responsibility but are intended to develop to the point of being sub-committees of the ICB within the life of this BCF plan.

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 plan, and builds on the progress made from 2016-23.

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.

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 Improving Lives Programme in Coventry 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.

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.

Priorities for 2023-25

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. Further Implementation and take up 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. Further development and implementation of 'Improving Lives for Older People' programme 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 through greater integrated working and approaches

National Condition 1: Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person-centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

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.

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 have yet to be developed.

Whilst it is not specifically stated, the intentions are to ensure health activity is established more widely through the schemes extending into Mental Health and Disability, primarily Learning Disability. The BCF in Coventry has historically 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. This will now be extended to cover elements of discharge facilitation and admission avoidance for adults with learning disability and/or autism to support the collaborative commissioning intentions of the Joint Team in place.

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 which is now well embedded alongside the Community Discharge Team offer. 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 the 2 geographical care collaboratives are now established and were formally in place from 2022. A key component of the ICS, the care collaboratives are a partnership of organisations responsible for organising and delivering health and care within Coventry and Warwickshire respectively. In Coventry it is proposed that the

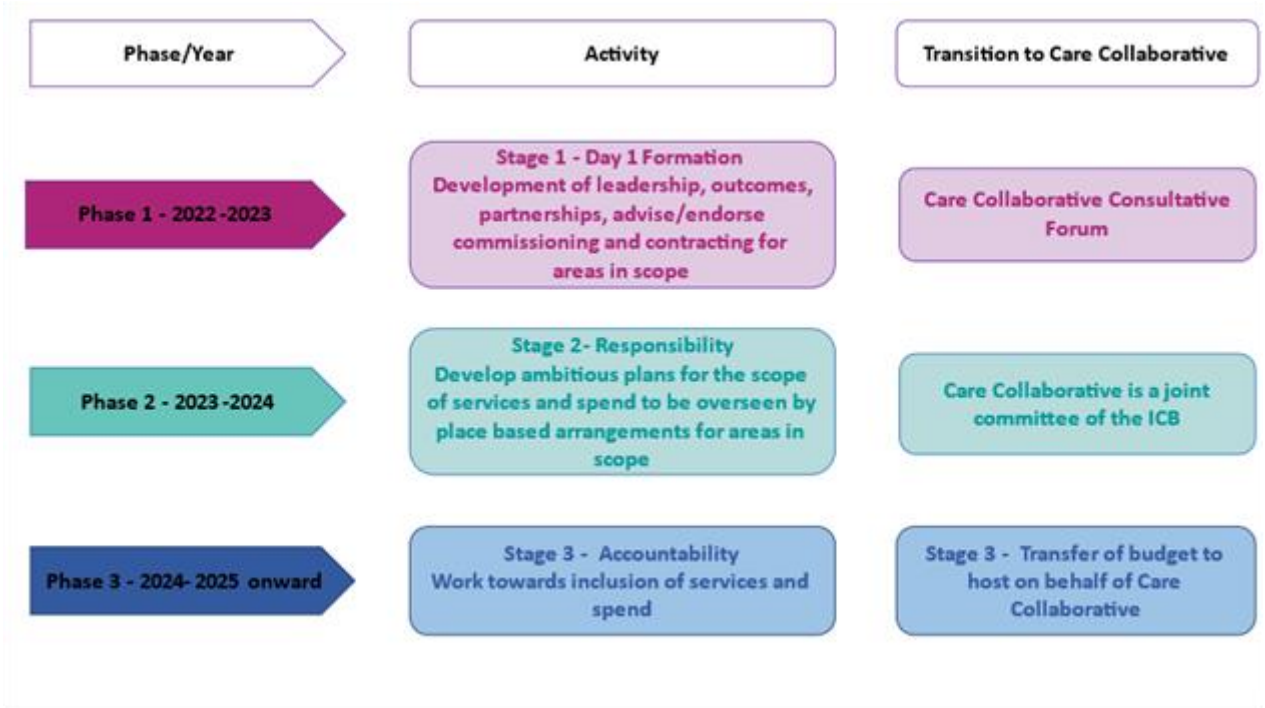
collaborative will be hosted by University Hospital Coventry and Warwickshire (UHCW) and the chair is the Director of Adult Social Care and Housing in Coventry endorsing both the partnership and the primacy of place.

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.

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.

The local collaborative is now in phase 2 with the ambitious plans for delivery detailed within the ICB strategy with both Coventry and Warwickshire Councils leading on 'supporting people at home'. Key measures of success are being developed and agreed



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 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

Adult Social Care in Coventry has adopted the ICS vision to ensure strength-based approaches are in place to enable people to live as independently as possible and optimise individual choice and control. We have a specific offer in place which is readily available to describe our intentions, how we will deliver them and what people of Coventry can expect from us.

Promoting Independence is an ethos well embedded in Coventry with therapy first approaches as being central to delivery both in terms of equipment and in reablement of those experiencing adverse events. This has been recognised at a national level and we have seen significant improvement in the numbers of people accessing this service from community and Hospital then remaining independent after intervention.

There are strong and productive partnership arrangements in place that have provided a firm foundation for the delivery of more integrated care with the Improving Lives programme building on this in terms of how we can reduce admissions through a combining efforts and resources and make discharge more effective and support greater independence, reducing reliance on long term options. Trials are currently in progress and show promising outcomes for people. Multi-disciplinary team working is embedded in our reablement offer and we have a range of co-commissioned preventive support in place including supports for unpaid carers.

Adult Social Care works closely with system partners including Primary Care to make effective plans for surge activity across the year. This is developed and monitored via the Care Collaborative and the Mental Health Collaboratives that are in place and include Primary Care representatives.

DFG application has been broadened to embrace autism and learning disability particularly focused on discharge from long stay hospital. The needs of unpaid carers is included within the assessment process to facilitate safe and effective care at home and the revised Housing Assistance Policy supports this financially by enabling provision of small adaptations without charge.
We have a jointly commissioned equipment provision, managed by ASC but agreed annually with the ICB. This provides timely support for residents to enable them to remain in the community and facilitates timely hospital discharge as 7-day working is delivered through the service.

Adult Social Care works closely with Council colleagues in support of the One Coventry plan., this includes the local development of community prototypes that will be designed to support people with Learning Disability into employment and to develop models of support from the community for family carers. That avoid the need for statutory based intervention.

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
    - how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

As part of the response to the hospital discharge reporting, improvements were made to systems to capture short term services linked to discharge/community step up. This has provided better information to demonstrate numbers of new people requiring short term services and enabling us to plot this through the year, factoring in the financial resources available to us through the Hospital Discharge Fund.

Our Market Sustainability Planning work has not highlighted any significant gaps in the market for good quality intermediate care. Our historic Short Term Home Support Block contracts have led to hours being funded that were not then needed/delivered and this is being taken into account as short term home support is re-procured later in 2023.

A base of block contracts are used to ensure a minimum level of support is always available, which is then topped up with further spot provision to reflect demand ebbs and flows. This has meant in the majority of cases short term support can be secured in reasonable timescales.

In a very few cases, however, people with more complex needs including, those with significant mental health issues and behaviours that challenge, wait longer than we would like for short term support. Our systemwide review looking at planning for the coming winter has identified this as a priority for focussed attention.

The 'Improving Living' Lives Programme is reviewing whether opportunities exist for meeting needs through more appropriate pathways, e.g. those that may have been placed in a short-term bed previously can have their needs met at home. Baseline work completed suggests opportunities do exist to improve the customer experience.

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

With funding in the main static, there is limited resource available for new schemes. In recognition of the need for further investment to support Autism diagnosis, funds were invested at the end of 22/23 which have been brought forward into 23/24 to support diagnosis. Hospital Discharge funding confirmation should ensure existing baselines of additional pathway 1 and pathway 2 activity can be maintained during 2023/24 and further expanded in 2024/25.

The Improving Lives for Older People Programme is providing a review of pathways to support more people at home following hospital admission, which will ultimately support the reduction of the number of people needing to be admitted to residential or nursing provision and ultimately influence future commissioning activity. We continue to make best use of Short-Term services following hospital admission, but in addition we are seeing an upward trend in the use of short-term services for those in the community to provide a period of enablement and to avoid a hospital admission. Approximately 70% of those accessing short term services do not require long term services.

We work jointly with partners to offer an Urgent care response, which supports people to remain healthy and as independent as possible without the need for a hospital admission. This offer, as part of UCR is demonstrating good outcomes for people as well as reducing the need for long term support. UCR also offers a falls pathway to support people to remain at home without the need for a hospital admission. This is supported through partnership working and the addition of specific domiciliary hours to facilitate urgent care.

Our enablement approach and use of short-term services to support hospital discharge and hospital avoidance is well embedded with a therapy led approach. The effectiveness and flow through the pathways are monitored via weekly MDT's, made up of internal and external partners. Therapy interventions, provision of equipment and consideration of Adaptations are core elements within our approach.

Adult Social care is working with partners in the development of proactive care model, which makes best use of population health management to understand the specific needs of the whole population and the impact of wider determinants. As well as risk stratification to identify emerging risk cohorts. Staff currently attend MDT's with PCN leads to support vulnerable people within the community to remain healthy at home. This approach will develop further with the progression of proactive care model.

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.

- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

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 retendered our short term bedded support with new contracts that were effective from early October 2022 and which have centred on the twin aims of ensuring sufficiency of provision and improving outcomes for people. This proved successful in sustaining our performance and reducing escalation during the winter period

Joint preparatory work has commenced for recommissioning of pathway 1 home support services by Spring 2024 with different models being considered and again an emphasis on improved independence outcomes. The models will be informed by the work being undertaken across the system to improve experiences for those at risk of or do find themselves admitted to hospital. Early modelling suggests a revised service offer is achievable that secures assessment at home and utilises community resources differently to achieve this.

Hospital Discharge funding confirmation for 23/24 and 24/25 should ensure existing baselines of additional pathway 1 and pathway 2 activity can be maintained during 2023/24 and further expanded in 2024/25. This alongside the delivery of the Improving Lives for Older People Programme will support discharge and free up hospital beds.

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
    - how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

THIS SECTION IS IDENTICAL TO ONE INCLUDED ABOVE UNDER NATIONAL CONDITION 2 WHERE THE SUBMISSION CAN BE FOUND

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

During the pandemic the local system had worked collaboratively and productively together to deliver the principles of effective and safe discharge. This included:

- A focus on 'home first'
- Focus on reablement and assessment outside of the acute hospital
- Establishing and monitoring the 4 discharge pathways.
- Delivery of discharges across the 7-day week

This supported the work that had already started across Coventry to address the delays, build on the improved performance during the pandemic

In January 2021 the local health and social care system embarked on a significant review of discharge to determine the effectiveness, the improvements required and to make recommendations in terms of admission and discharge activity. This work was led by Newton and the initial diagnostic findings highlighted several opportunities to improve and inform discharge practices.

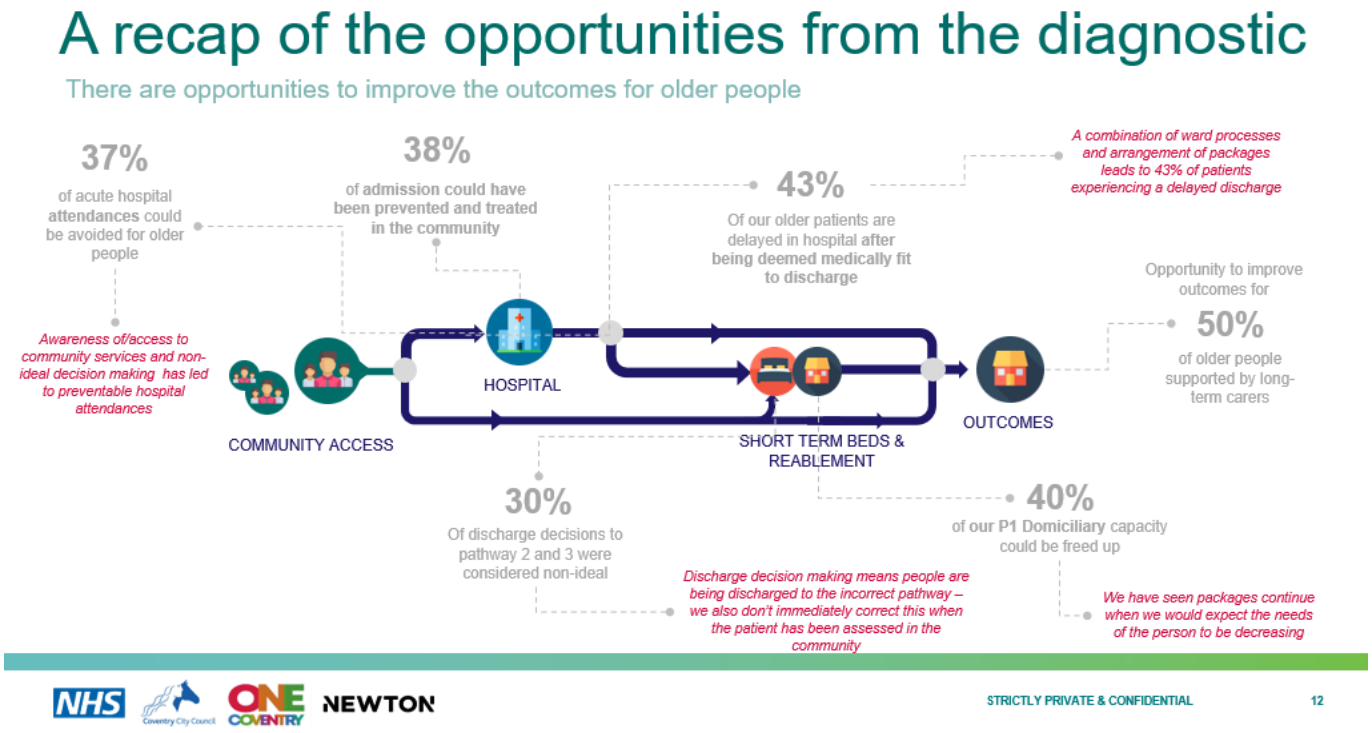
From 01/04/22 NHS bodies and local authorities were mandated to adopt discharge process that 'best suits' the local population. The work already started via Newton meant that the local system was well placed to deliver the aspirations of the revised guidance and in working systemically as part of the ICS.

The programme of work being undertaken sits firmly within the overall programme of the Discharge Delivery Board led by the Director of System Transformation/Urgent Care Lead at the ICB but exists as a specific work programme for the Coventry system.
The Programme is designed to deliver a fundamental change to the way in which we support people in Coventry so that people's experience of care is dictated by what they need either before or post admission

Initial findings:

The analysis provided by Newton was extensive measuring data from across University Hospital Coventry and Warwickshire, Coventry and Warwickshire Partnership Trust and Coventry City Council.

A summary of findings is included below:



This provided the compelling narrative for change for the local system not only to improve experience but to utilise resources more effectively and release associated savings.

Subsequent to this Newton have been engaged via formal contract to facilitate the development of new models, trial new ways and implement within a challenging time frame.

This programme of work is now included with thin the 5-year plan for the ICS and will significantly contribute to the aims and objectives of the 'supporting people at home' element of the plan. These aims are:

1. An improved and more responsive coordination and delivery of health and care within an individual's own home when urgent and emergency care is required – this will help prevent people making unnecessary visits to hospitals.
2. Where ongoing support (health or care or both) is required to enable people to continue to live independently, this will be reliable, sustainable, and responsive to change as people's requirements change.
3. Where people are required to visit hospital for treatment, this will be undertaken in a patient-centred and effective manner, with the focus on returning home as soon as possible.
4. Where people have had a change in their health as a result of deterioration or a specific episode in their life, they will be supported to recover and re-able to maximise their individual outcomes.

Objectives to be achieved in relation to acute health process for residents/registrants are:

- Developing a front door process that can accurately determine the needs of a patient and direct them to the most appropriate service. This objective is focused on reducing non-ideal admissions to UHCW.
- Reducing the delay to a patient stay in hospital, specifically their treatment time, delays in determining if they can be discharged from hospital and the discharge process. This workstream is focused on reducing the overall length of stay for an 18+ patient in UHCW.

One Coventry Integrated Team:

- This project area is focused on creating a single Coventry integrated team of professionals that can effectively and efficiently provide care to people in Coventry, providing an alternative to being admitted to UHCW and support patients after a period of care in UHCW.

A benefits realisation board is in place to track the benefits delivered by the programme with benefits to be tracked across five key areas:

- Bed based intermediate care demand
- Demand for ongoing home support
- Demand for ongoing residential/nursing care
- Demand for acute beds
- Demand on Emergency Department

The future model is now established, and this is outlined in the graphic below:

Planning the future model:

The improvement work is being delivered through work programmes with strategic leadership to each programme that enables confirm and challenge. Staff were pre-selected to enable the right input, decision making and autonomy to develop and trial new models of working. The workstreams are facilitated by Newton and formal governance in place to oversee the work with the SRO role undertaken by the Chief Strategy Officer at UHCW.

Regular programme board meetings take place alongside regular leads meetings to maintain focus, track progress and agree actions as required.

The graphic below provides the latest update shared at the 'bringing it all together' event 2023

Workstream Updates

Hospital Processes

Improving processes that happen entirely on the hospital site. This includes ED decision making, ward flow and discharge processes

Key Updates

- Agreed first flow trial with design team – begin this in wards this week. ED trial starting on 27th
- Front Door: increasing identification & referrals to UCR from ED
- Processes to drive weekend discharges determined to drive flow & P0 discharges
- Booked in the initial UCR engagement – goal to have clinician who can identify ideal UCR patients in ED

Interfaces

Making sure that every connection in Coventry works. Giving the right visibility at the right time across the hospital and community

Key Updates

- Identifying most important connections to facilitate across end-to-end urgent and emergency pathway
- Building understanding of what data visibility the local integrated teams will need to pull the right patients onto their caseload
- Initial engagement with decision-makers across key intervention points prior to hospital (WMAS, GPs etc.) to understand how we can most effectively design referral routes which work for them

One Coventry Integrated Team

Building the integrated care model ensuring that we have the ability to proactively intervene in the community and actively lead discharge planning.

Key Updates

- First trial is starting **next week** which will see us bring all organisations together to provide wrap around reablement for each individual. We will be trialling:
  - Assessments at home
  - Empowering carers to challenge POC
  - Working as an integrated team
- Starting next week, we are starting studies to access the benefit of Virtual Wards across all acute wards

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

In respect of delivery of duties under the Care Act the BCF, iBCF and ASC Discharge Fund supports the following:

Ensuring that people with the appearance of care and support needs receive services that prevent their care needs from becoming more serious, or delay the impact of their needs

The funding provides resources for a range of services that prevent or delay the care and support needs. A key element of this is the resources being used for the provision of short term reablement services. These are services provided through Discharge to Assess pathways as well as services provided to people presenting in the community who would benefit from a period of short-term support. As approximately 70% of people who receive short term support do not require an ongoing care and support service the effectiveness of using the resources to meet this requirement of the care act is significant. The resources do not simply provide home care and residential beds but also the therapy and social work support required to enable people to achieve their optimal level of functioning.

For people with lower level needs the iBCF funding resources schemes such as the Befriending service which is aimed at supporting the physical and mental wellbeing of older people and in doing so prevent the onset of care and support needs. The evidence for the effectiveness of this is more limited

Support to carers is also included within the fund and there is no question as to the importance of supporting carers to continue caring in respect of its impact on preventing both the condition of the carer and the cared for from becoming more serious.

People can get the information and advice they need to make good decisions about care and support

As part of our information and advice offer the resources enables information to be provided to people as to what they might expect when they come into contact with social care and/or are planning for discharge from hospital

The Heart of England Carers Trust, funded from the Carers element of the funding provide an extensive information and advice offer which would not be possible without the resources contained within this fund.

On a wider context the City Council has an extensive information and advice network provided through the voluntary and third sector and our library and community information services. Although not directly funded from the iBCF or ASC discharge grant it is possible that should this funding not be available the extent of information and advice services provided by the local authority would not be sustainable as a whole.

To have a range of provision of high quality, appropriate services to choose from

The iBCF and ASC Discharge Fund provides resource for an increasingly diverse range of provision. For example, within this plan short term home support will be re-commissioned with the objective of increasing the number of providers from 3 to 6. For bedded provision an increasing number of locations are available enabling people to be supported closer to family members where possible.

The use of the resource to also fund social work and occupational therapy input means that there is an increased capacity to engage with people on the outcomes they would like to achieve beyond an initial service and work with them to achieve this.

Through supporting our commissioning capacity, we are able to better monitor the standard of services and gather feedback to ensure that quality improves where required.

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

The majority of support for carers is delivered through carers Trust Heart of England (CTHE) who are commissioned by the Council to deliver assessments and jointly commissioning with Coventry and Warwickshire Integrated Commissioning Board to arrange and deliver a broad range of services which include:

- Carers short breaks
- Care provision in the event of an emergency (CRESS)
- Holistic support and advice e.g. cost of living, benefits, getting back into work, carers health etc
- Preventative Support e.g. groups dealing with grief, developing emotional resilience, social support groups (including for young carers, people from the City's diverse communities etc)
- Support for working carers
- Carers direct payments

The strong partnership working throughout the Covid pandemic with the Carers Trust continues, particularly as we support carers to face rising costs of utilities and general cost of living pressures.

Coventry carers plan is in draft form to be approved in July 2023. It outlines a number of improvement actions to support carers who are still feeling the impact of the Covid pandemic and has been designed to reflect a number of sources of feedback on carers' experiences.

The plan incorporates a review and recommissioning of residential respite care, further promotion of the use of direct payments; improving access to and quality of carers assessments and reviews; a number of initiatives to recognise and supporting carers in the community; employment support; and improvements in access to information advice and training and development opportunities.

We have recently reviewed, with ICB partners, our grant aid agreements for carers services with an up to two years extension with a likelihood of formal tendering going forward.

Feedback from our CQC readiness review has informed our approaches going forward particularly I respect of ongoing preventative support for carers

Other work continues with partners to increase awareness of needs e.g. amongst GPs, PCNs and social prescribers. This is in partnership with a recently identified ICB carers lead.

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

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 programme continues to include a new scheme to fund adaptations in temporary accommodation to enable vulnerable people to have improved access to more suitable housing support options.

In 2022 the Council revised the Housing Assistance Policy to include new options and in doing so the areas where discretionary funding could be provided has expanded enabling more flexible arrangements and support to people reinforcing our policy objective of enabling people to remain at home through promoting independence.

The discretionary ability that this enables is:
· Removal of financial assessment where the grant does not exceed £6000
· The ability to ‘top-up’ the grant where the value exceeds £30000
· Assistance to meet the client’s assessed contribution
· The provision of at home safely scheme
· Discretionary use of DFG for heating and insulation
· Assistance to move to a more suitable home
· Funding for respite care while work required to provide an adaptation is carried out

In more recent month's links have been established with the Transforming Care programme of work to look at how DFG can be used to support discharge facilitation of long stay patients or admission avoidance though adaptions to people’s homes.

We continue to work alongside Foundations to develop our DFG offer and DFG use is monitored on a regular basis within the Directorate and the City Council.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

Y

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

As a unitary authority Coventry has no districts. Specific allocations for discretionary uses have not been identified as we wanted to maintain maximum flexibility within the grant to maximise the support to people

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

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:

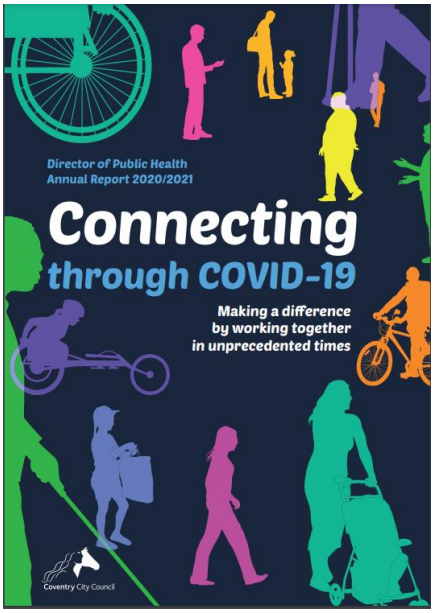
1. Improve outcomes in population health and healthcare
2. Tackle inequalities in outcomes, experience and access
3. Enhance productivity and travel for money

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.

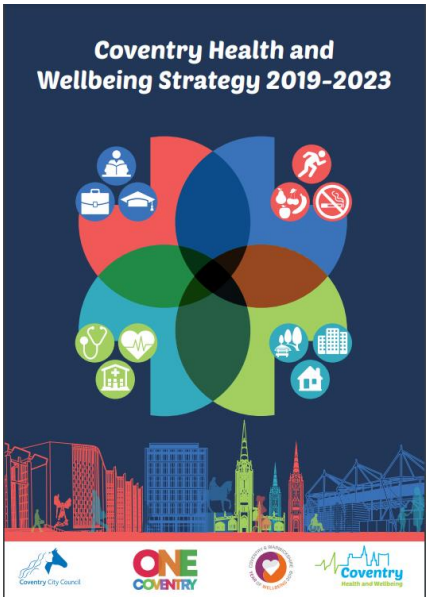
Services and schemes commissioned through the BCF will support delivery of this Strategy, and in particular two of the Major Inequalities Work Programmes ***(please refer to pages 18 to 22 of Appendix 1 as part of the Supporting Information):***

- 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