Cover

Worcestershire Health & Wellbeing Board

Ongoing discussions and meetings have enabled a range of key stakeholders to be involved in the preparation and review of proposals that sit within the BCF plan including Herefordshire & Worcestershire Health & Care Trust, Herefordshire & Worcestershire CCG, Primary Care Networks, Worcestershire Healthwatch, voluntary and community organisations along with Worcestershire council stakeholders.

Engagement and involvement has been through a variety of system and internal meetings, including the Worcestershire Executive Committee, which brings partners together at "Place" level as part of developing the Integrated Care System in Herefordshire and Worcestershire, and through sharing of data and wider documentation.

The BCF guidance 2021-22 sets out national conditions, which are the key requirements for the better care fund plan 2021-22.

a. a jointly agreed plan between local health and social care commissioners, signed off by the HWB
b. NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution
c. invest in NHS-commissioned out-of-hospital services
d. a plan for improving outcomes for people being discharged from hospital

The BCF also has key national metrics for 2021-22.

Avoidable admissions to hospital	Unplanned admissions for chronic ambulatory care sensitive conditions
Admissions to residential and care homes	Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes
Effectiveness of reablement	People over 65 still at home 91 days after discharge from hospital with reablement
Length of stay	Reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days or more
Discharge destination	Improving the proportion of people discharged home using data on discharge to their usual place of residence

Executive Summary

The priorities for 2021-22 are:

- Hospital Discharge and Flow
- Development of an Integrated Care System
- Care Market Development
- Management of Social Care Demand

21/22 for Pathway 1 to enable people to be discharged within 24 hours in line with National Discharge Targets. Investment in supporting people to go home and remain at home, should result in reducing admissions to long term care.

2. Sustaining delivery and future model for the Onward Care Team - a multi-disciplinary approach to identify the right discharge pathway and care and support plan to improve length of stay and ensure national hospital discharge targets are achieved.

3. Development of Pathway 3 to reduce the use of care home provision through the creation of an Intensive Rehabilitation and Assessment Unit to support people through bed-based reablement to return home.

4. Development of an Intermediate Care Service which facilitates effective partnership working and the ability to analyse flow across the system and identify opportunities to integrate services where there are benefits to flow and efficiency.

In addition to the main BCF resources and plans, the improved better care fund (iBCF) allocation for Worcestershire Adult Social Care in 2021-22 includes funding to be spent for the following purposes:

a) meeting adult social care needs.
b) reducing pressures on the NHS including seasonal winter pressures.
c) supporting more people to be discharged from hospital when they are ready; and
d) ensuring that the social care provider market is supported

The formal allocation of the iBCF is established as part of the BCF budget setting process, £1m of the total contribution has historically been transferred to the CCG to assist with pressures on the NHS in the relevant areas. The remainder of the grant is used to meet adult social care needs and ensuring that the market is supported, examples of these include:

- Financially supporting the domiciliary care market with the aim to avoid hospital admissions (metric 8.1), and increasing patient flow across the system
- Funding permanent recruitment within the Onward Care Team streamlining hospital discharge and reduce DToC
- Additional investment in the community reablement service with the aim of preventing / delaying admission to long term care or hospital. This supports metric 8.5 (Clients remaining at home after 91 days following hospital discharge).
- Use to fund pressure of externally purchased Pathway 3 placements, whilst long term care planning for clients.

BCF funding is used for key core social care and NHS community services - operational social work, integrated discharge, community health and care services short-term and long-term placements in home care and care homes, and discharge to assess; it is central to the delivery of health and social care in the community.

Worcestershire County Council's People Strategy and transformation programmes, focus on promoting people's independence through high quality community-based support, focussing on individuals' strengths. The focus on strength-based social work is delivered through the Three Conversation Model and development of one Front Door, focussing on prevention though early

targeted advice, information, and support to enable people to remain safely in their own homes for as long as possible.

Key changes since the previous BCF Plan

Overall, the BCF plan remains focussed on supporting hospital discharge but it is evolving to bring in more activities to prevent admissions to hospital and to long-term care placements.

Governance

Worcestershire Health and Wellbeing Board is responsible for agreeing the BCF plans and for overseeing delivery through quarterly reports.

Oversight and responsibility for the BCF is embedded within the Senior Leadership Teams of both the People Directorate within the Council and Herefordshire and Worcestershire Clinical Commissioning Group. In each organisation, this is led by Chief Officers, who are able to maintain the profile of the shared agendas and ensure linkages to wider health and social care commissioning and delivery, with formal governance and decision making via monthly ICEOG.

Overall approach to integration

Joint priorities for 2021-22 include:

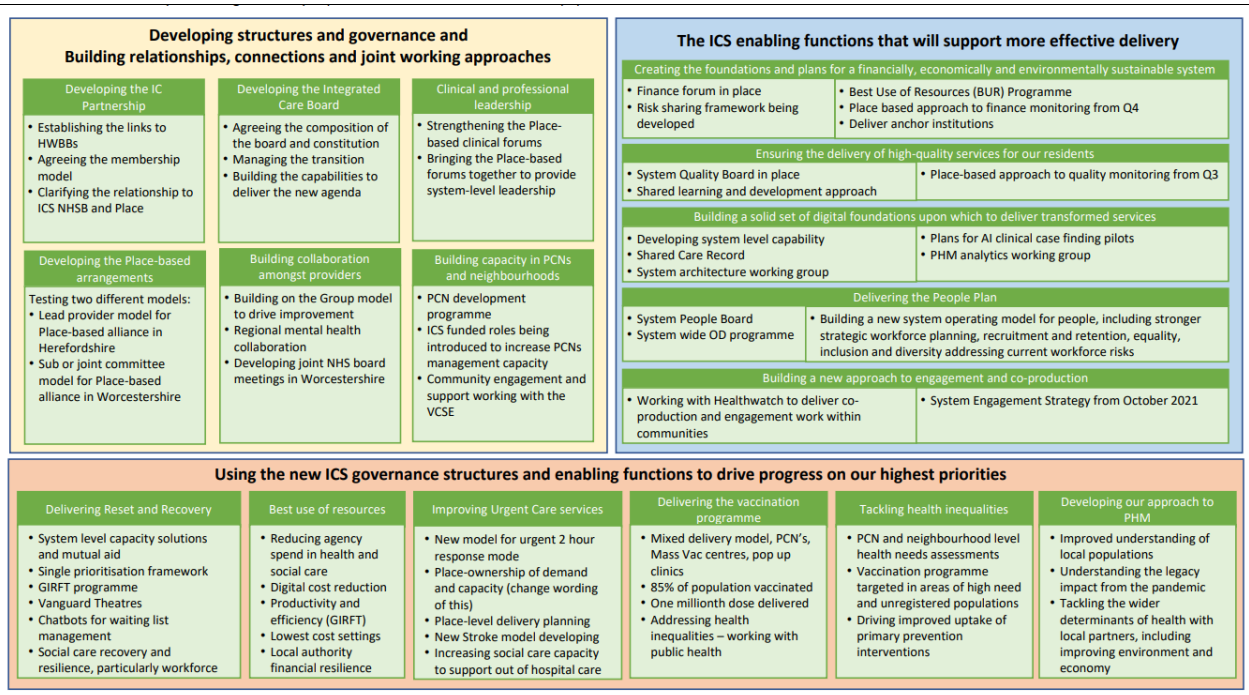
- Adherence to the National Discharge Targets
- Covid recovery
- Admission avoidance and prevention.

The integrated care system (ICS)

The Herefordshire and Worcestershire system has built a strong record of delivery and improvement over the last 3 years. The system has stable leadership across our two places and our primary care networks, with excellent support from our local authority and voluntary sector partners.

Integration has enabled the delivery of a successful COVID vaccination programme, which has proactively targeted reducing health inequalities by working with patient representatives, communities, PCNs, local authorities and NHS providers to increase uptake. By working collectively, it has been possible to develop mutual aid and secure Vanguard Theatres in both counties, which support a Reset and Recovery Programme. With a commitment to improve clinical productivity through implementing 'Getting it right first time' and deliver an ambitious Best Use of Resources programme.

The plan on a page shows a summary of the development plan. The top left section describes the key six strategic development initiatives that will shape the overall operating model for the ICS going forward. The top right describes the enabling functions that are required to support delivery of this operating model and the bottom section is the way in which this new way of working will be used to deliver improved services and outcomes for the local population.



Integrated Equipment.

Worcestershire Council and NHS Herefordshire and Worcestershire Clinical Commissioning Group (CCG) have statutory requirement duties under various legislation to provide community equipment for people with an assessed eligible social or health care need.

The Worcestershire Community Equipment Service (WCES) is central to the delivery of the prevention and wellbeing priorities of the council and its partners with changing demand in social and health care, this service continues to evolve to meet the demands of stakeholders.

The service continues to see an increase in both client numbers and overall equipment spend compared to monthly averages in 2020/21. The increase evidences the on-going focus to provide equipment to enable people to remain in their own homes, to reduce the need for the interventions of domiciliary care, care home placements and avoidable hospital admissions, whilst facilitating hospital discharge.

Integration Agenda.

Health and social care partners are committed to working together to provide an integrated approach to support residents of Worcestershire to:

- provide demand management through a strength-based approach and developing models and services that will support independence at home.
- create versatile, cost effective and sustainable services.
- increase and improve services that support complex and challenging behaviours, such as autism or dementia.
- work across health services, children and young people and adult services to integrate our commissioning and market management approach where appropriate.
- invest in early help, prevention, and community services.
- improve and embed mental health and wellbeing in all service design.
- support and develop the health, family support and social care workforce.
- embed technology where it delivers benefits across pathways and services, and
- promote an inclusive customer focus to ensure fair access to services.

Targets

- LOS
- percentage of people who return to their normal place of residence on discharge from acute hospitals
- community hospital targets

The reablement metric of increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, will be further stretched by increasing capacity in the teams, from Oct-21 result is 86.1% against target 82%, with national target of 80%

Key to the successful delivery of the plan are health and social care initiatives to support admission avoidance and timely discharge, including 2-hour response service and investment in pathways, aiming to provide sufficient support in the community to enable people to remain independent in their own homes for longer, thereby reducing hospital admissions and support discharges.

Virtual wards

The system is continuing to develop its approach to virtual wards, using the relationships between NHS providers, including primary care and social care, as well as the growing maturity of PCNs.

Flow and Discharge dashboard

The system is developing a system wide flow and discharge dashboard for Worcestershire that supports ongoing monitoring and identifies areas for improvement, including the development of SHREWD and the Patient Tracker. This will support targeted intervention, both on an operational basis and also through tactical review to adjust resource distribution across the pathways.

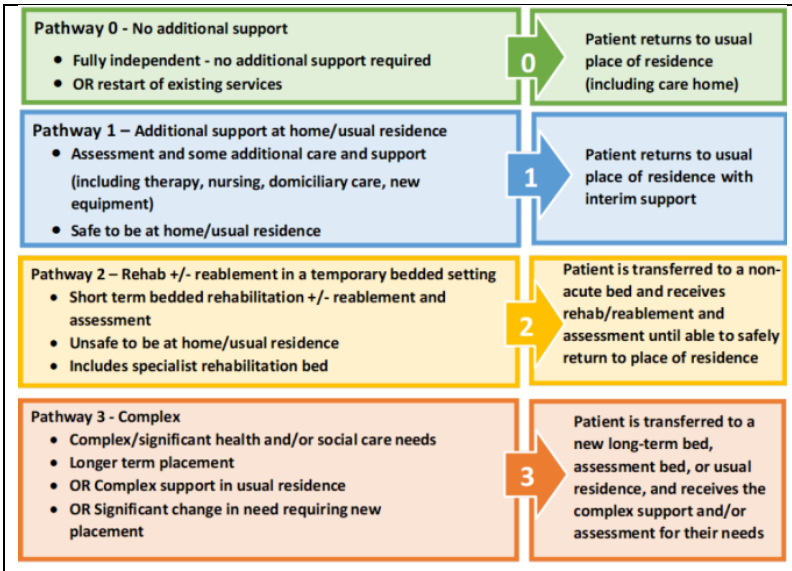
Supporting Discharge (national condition four)

Worcestershire County Council continues to provide a Reablement service which offers therapy-led services aligned with a Reablement model. People are discharged from a hospital setting through a fully integrated discharge team who provide a proportionate assessment in line with the Discharge to Assess (D2A) model. Pathway 1 (Home) being the optimum pathway with a £4m investment to expand this service to enable more people to return home, where safe to do so, and reduce the number of people sent to a bed-based facility.

Provision of a dedicated unit to provide enhanced reablement support to avoid Pathway 3 care home admission. The model developed, and supported by ICEOG, is that Pathway 3 provision will be provided in 21 beds at WCIPU (Worcester City in-patient unit) from December 2021. This means that the Health and Care Trust will be adapting 21 beds at the unit to provide Pathway 3 rather than the more traditional community hospital offer. The remaining 25 beds will remain available as either step up or step-down beds for the local population.

A period of assessment, recovery, re-ablement and rehabilitation will be provided for up to 28 days

Intermediate Care Service – Strengthening integration with health teams has been the aim throughout. Worcestershire is piloting an integrated intermediate care service with a view to a more permanent approach.



Note, to reflect the latest definitions: anyone going home with something (inc. restarts) are PW1 and anyone going to a care home, whether its returning to their usual place of residence or to a new placement will be classified as PW3.

Disabled Facilities Grant (DFG)

The DFG is a capital grant pooled into the BCF to promote joined-up approaches to meeting people's needs to help support more people of all ages to live in suitable housing so they can stay independent for longer. Creating a home environment that supports people to live safely and independently can make a significant contribution to health and wellbeing, and should be an integral part of integration plans, including social care and strategic use of the DFG can support this. In Worcestershire, this Grant is passported out to the District Councils to meet their statutory housing duties.

Each District Council is responsible for their own Housing Assistance Policy to make local needs and DFG is used in accordance with these policies.

The 6 District Councils and the County Council have jointly procured a Home Improvement Agency. Millbrook Healthcare won the contract for Promoting Independent Living and started to deliver the new Countywide HIA on 1st April 2021. The service covers: -

- information and advice
- housing options
- minor adaptations/handyperson
- making homes healthier
- mandatory Disabled Facilities Grant (DFG)
- OT/Trusted Assessor Development
- Assistive technology
- Able to pay customers

There is a multi-agency Promoting Independence Strategic Group to steer the work and oversee issues within the system

In the first year the contract achieved the following outcomes

Facilitate hospital discharge	6
Prevent hospital admission	1019
Reduce pressure on informal carers	161
Reduce/delay packages of care	620
Reduce/prevent falls	1770
Promote independence	193
Support to remain in own home	219

In 2021/22

We are working with the Health and Care Trust on a recovery plan for the Occupational Therapy input to adaptations following the pandemic.

Work has also commenced to do more detailed work on able to pay customers, with the aim of preventing individuals needing more extensive adaptation, health and care in later life.

Equality and Health inequalities

The system has established an Integrated Care System Inequalities Collaborative which includes senior representation from all partners in our ICS.

All partners are committed to equality and diversity using the scope of the Equality Act 2010 to eliminate unlawful discrimination, advance equality of opportunity and foster good relations, and demonstrate that we are paying 'due regard' in our decision making in the design and delivery of services.

It is not envisaged that the content of this plan will negatively disadvantage the following nine groups with protected characteristics: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

It is fundamental that individuals are at the heart of all activities and services. All partnerswill work to ensure all people have access to services, ensuring those people requiring additional support due to, for example a learning disability and/or autism have equal access to services and are supported to be as independent as possible in the community wherever possible.