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Minutes

Name of meeting	**HEALTH AND WELLBEING BOARD**
Date and Time	**THURSDAY 28 JULY 2022 COMMENCING AT 9.30 AM**
Venue	**COUNCIL CHAMBER, COUNTY HALL, NEWPORT, ISLE OF WIGHT**
Present	Cllrs L Peacey-Wilcox (Chairman), M Legg (Vice-Chairman), D Andre, S Bryant, G Kennett, K Lucioni, R McKernan and I Stephens
Also Present	Amanda Gregory, Mark Howe, Juliet Pearce and Sarah Philipsborn
Apologies	N Arnold, D Cattell, J Pegler and W Perera

1. **Minutes**

RESOLVED:

THAT the minutes of the meeting held 28 April 2022 be confirmed.

2. **Declarations of Interest**

Cllr Karen Lucioni declared she was Personal Assistant on the PA noticeboard.

3. **Public Question Time - 15 Minutes Maximum**

No public questions were received.

4. **Chairman's Update**

The Chairman gave a verbal update on the Integrated Care System, outlining its responsibilities and aims. It was stated that the Hampshire and Isle of Wight Integrated Care System would serve a population of 1.9 million people in the combined area and had the responsibility for improving health and care for residents, with the added responsibility of strategic planning.

The Chairman explained the challenge that the NHS and its partners needed to deliver joined-up support for the growing number of older people and people living with long term conditions, which drove the need for a different approach so that the systems could work ever more closely together in order to have maximum impact, simplified governance, and decision-making structures that suited all. The statutory

transition took place on 1July 2022, which built on work that had been done over the past few years.

5. **Strategy Sign Off**

5a **Health and Wellbeing Strategy**

The Director for Public Health presented the Health and Wellbeing Strategy 2022-2027 to the Board for signing off, with the agreement that action plans were formed to progress the implementation of the Strategy, including developing and monitoring the metrics. There was also the agreement to update the Strategy annually, so that it remained relevant.

The Strategy was summarised as being a statutory requirement in the bringing together all the partners across the health and care system to work together, reflecting the joint priorities across the system

The priorities for this strategy had been identified by the Isle of Wight Joint Strategic Needs Assessment (JNSA) through intelligence and structured conversations and workshops with the Board.

The key priorities of the report were deemed as Healthy Places, Healthy People and Healthy Lives with a focus on Housing and Health, Mental health and wellbeing and health inequalities

These priorities enabled a strategic linkage, not just with each other, but also through the wider ramifications connected to health, housing, and the environment.

Discussion took place on housing needs being of extreme concern on the Island and how the issues that link health and housing needs, health and inequalities, health and poverty, needed to be dovetailed together for maximum effective action.

RESOLVED:

THAT the Health and Wellbeing Strategy 2022- 2027 be signed off by the Board.

THAT action plans are formed to progress the implementation of the Strategy, including the developing and monitoring of the metrics with the support of all members

THAT an update of the Strategy progress takes place annually to ensure that the strategy remains relevant throughout its five year duration.

5b **Health and Care Plan**

The Board received the Health and Care Plan 2022-2025 and were asked to approve and sign off the plan.

The Health and Care Plan outlined the trajectory that would need to be taken over the longer term to ensure sustainable health care that met the needs of the local

population. The plan focused on necessary steps to develop new models of care, stronger partnerships with local and mainland providers and greater productivity within the healthcare system.

The development of a strong and effective Integrated Care System and Integrated Health and Care Partnership was deemed as key to achieving the aims of the Health and Care Plan as they would enable a joint approach to improving services, benefitting from wider specialist expertise.

The Health and Care Plan 2022 – 2025 had been developed through a robust examination of the local population's health and care data, as well as looking at feedback from staff and users about what improvements were wanted drawn from the recent surveys. The plan was closely aligned with the Health and Wellbeing Strategy which ties together the quest to improve health inequalities and health outcomes on the Island.

The priorities of the Health and Care plan were set out as, preventing ill health, partnerships, productivity, and pathways.

Further discussion took place amongst the Board members regarding preventing ill health.

The Director of Children's Services for Hampshire and the Isle of Wight asked if children's mental health could be at the heart of both the Health and Wellbeing Strategy and the Health and Care Plan.

The challenge regarding access to dentistry on the Island was also brought to the attention of the Board and included in the strategy

RESOLVED:

THAT the Health and Care Plan be noted and approved.

THAT Dentistry be added to the Health and Care Plan

THAT the ICS be contacted regarding Children's Mental Health

6. Better Care Fund Update

Rachel McKernan declared an interest in this item as she informed the Board that Age UK receive money from the BCF. Amanda Gregory also declared an interest stating that her department received money from the BCF. Both interests were deemed not to be in direct conflict with the contents of the Report by the Interim Managing Director of the Hampshire and Isle of Wight Integrated Care Board.

The Board was asked to receive the update Q1 on the Better Care Fund for noting and approve the recommendation for the development of the BCF 2022-23 plan in line with local and national requirements.

The Better Care Fund had been in place since April 2017 and was based around 11 points, with the areas of Early help and prevention, Rehabilitation, Reablement and Recovery (Regaining Independence) and the Revised framework for Isle of Wight delivery of effective integrated services at locality, being under review

It was explained that the BCF was the financial vehicle on how to get the most out of available money and funding

RESOLVED:

THAT the BCF Update Q1 be noted and approved for continued areas of work.

7. **Members' Question Time**

No Members questions were received

CHAIRMAN

Committee: HEALTH AND WELLBEING BOARD

Date: 28 JULY 2022

Title: HEALTH AND WELLBEING STRATEGY 2022-2027

Report of: SIMON BRYANT, DIRECTOR OF PUBLIC HEALTH

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1. Summary

1.1 The statutory role of the Health and Wellbeing Board in bringing together partners across the health and care system means that the Board's strategy must reflect joint priorities across the system.

1.2 The priorities for this new five year Health and Wellbeing Strategy were identified through intelligence from the Isle of Wight Joint Strategic Needs Assessment (JSNA) and a series of structured conversations and workshops with Board members.

1.3 The agreed priorities in the new strategy are aligned to the overall ambition for the Isle of Wight to be a healthy place for healthy people to live healthy lives, with a focus on healthy homes, mental health and emotional wellbeing and health inequalities.

2. Key points of report

2.1 The commitments in the Health and Wellbeing Strategy are set out in three chapters – Healthy Places, Healthy People and Healthy Lives.

2.2 The priority for Healthy Places is developing safe and healthy homes for everyone on the Island through working together as a system. This priority also links across to other strategic priorities including climate change and regeneration of place.

2.3 The Healthy People chapter recognises the impact of the COVID-19 pandemic and the importance that mental wellbeing has on overall health. This chapter has a focus on mental health and emotional wellbeing across the population, with a particular emphasis on those that are at higher risk of mental ill health.

2.4 The Healthy Lives chapter sets out the Health and Wellbeing Board's commitment to tackling significant health inequalities which are apparent across the Isle of Wight. This requires consistent, long-term system action across all the factors that contribute to inequalities.

2.5 The Health and Wellbeing Strategy sits alongside and aligns with a number of other key local strategies and plans, including the Health and Care Plan.

3. Recommendations

3.1 The Board is recommended to:

- Sign off the new five year strategy for the Health and Wellbeing Board
- Agree to the formation of sub groups to progress the implementation of the Strategy, including developing and monitoring the metrics
- Agree that there will be an annual review of the Strategy to ensure it remains relevant throughout the five year period

SIMON BRYANT Director of Public Health	CLLR LORA PEACEY -WILCOX Leader

Healthy Places for Healthy People to lead Healthy Lives

The Isle of Wight Health and Wellbeing Strategy (2022 to 2027)

INTRODUCTION

- The Health and Wellbeing Strategy sets out the strategy for improving the health of the Island population, based on the needs identified in the Joint Strategic Needs Assessment.
- Many things influence our health and wellbeing – the lifestyles we lead, our social contacts, the environment around us, our jobs and homes, as well as the health and care services which support us.
- Everyone on the Island should have the right to enjoy good health and wellbeing and the majority do, however we know that some groups and communities systematically experience poorer health than others. While this strategy aims to improve the health and wellbeing of everyone on the Island, it focuses on making faster improvements for those groups who currently have worse health outcomes. The aim of this strategy is to set out a shared vision in which people live healthy and independent lives, supported by thriving and connected communities with timely and easy access to high-quality and integrated public services.
- In order to deliver improvements in health and wellbeing we need to **change our culture** to focus on prevention of ill health and tackling health inequalities. The Board and members will champion work in this area in response to the needs of the population.
- Our ambition is to create healthy places for healthy people to live healthy lives across the Island, through a focus on three system priorities:
  - Healthy Places focus - healthy homes
  - Healthy People focus - mental health and emotional wellbeing
  - Healthy Lives focus - health inequalities

ALIGNMENT WITH THE HEALTH AND CARE PLAN

- Together, the Health and Wellbeing Strategy and the Health and Care Plan have a joint aim to ensure that people on the Island live healthy and independent lives.
- The new Isle of Wight Health and Care Plan (2022-2025) sets out the strategy to achieve clinical and financial sustainability for the health and care system, enabling the best possible support for people's needs. The Health and Care Plan identifies four pillars of opportunity: prevention, partnerships, productivity and pathways.
- The priorities in the four pillars of the Health and Care Plan align across the areas of focus in the Health and Wellbeing Strategy, underpinning the commitment from all partners on the Island to prevention of ill health and tackling health inequalities.

THE HEALTH OF OUR POPULATION - WHAT DOES OUR DATA TELL US ABOUT US?

- The Isle of Wight has a population of around 142,300 individuals, of which 28.7% are aged 65 years and over. This is **older** than the England average (18.5%).
- It has **high levels of deprivation** with 12 areas in the top 20% most deprived in England.
- **Healthy life expectancy is significantly lower** than the national average and has fallen in recent years, most markedly in women.
- **Inequalities in healthy life expectancy are evident** with those living in most deprived areas of the Isle of Wight living a smaller proportion of their lives in good health.
- The Global Burden of Disease study has identified the highest risk factors driving lower quality of life due to disease on the Isle of Wight as **high body-mass index, tobacco, occupational risks and alcohol use.** The highest causes of years lived with disability in the area are **musculoskeletal disorders (22.8%) and mental disorders (17.0%).**

- Isle of Wight residents reported slightly **lower life satisfaction and lower happiness** than the national average.
- **COVID-19 and the associated restrictions** have both had an impact on the population's mental health.
- **Housing has become less affordable compared to gross median earnings** since 2002. A smaller proportion of homes are available for social renting than in England as a whole
- There are a lower proportion of people living in fuel poverty than in England as a whole (8.9% compared to 13.4%) but there are **small areas with higher fuel poverty, especially within Newport and Ryde.**

TAKING A PLACE AND PEOPLE CENTRED APPROACH

This strategy sets out a shared vision using an approach for improving health and wellbeing on the Island for all ages (the life course). It is based on the principle that a family-centred, all age approach that promotes a holistic view of an individual's total health and wellbeing is an effective means of improving the health in our communities.

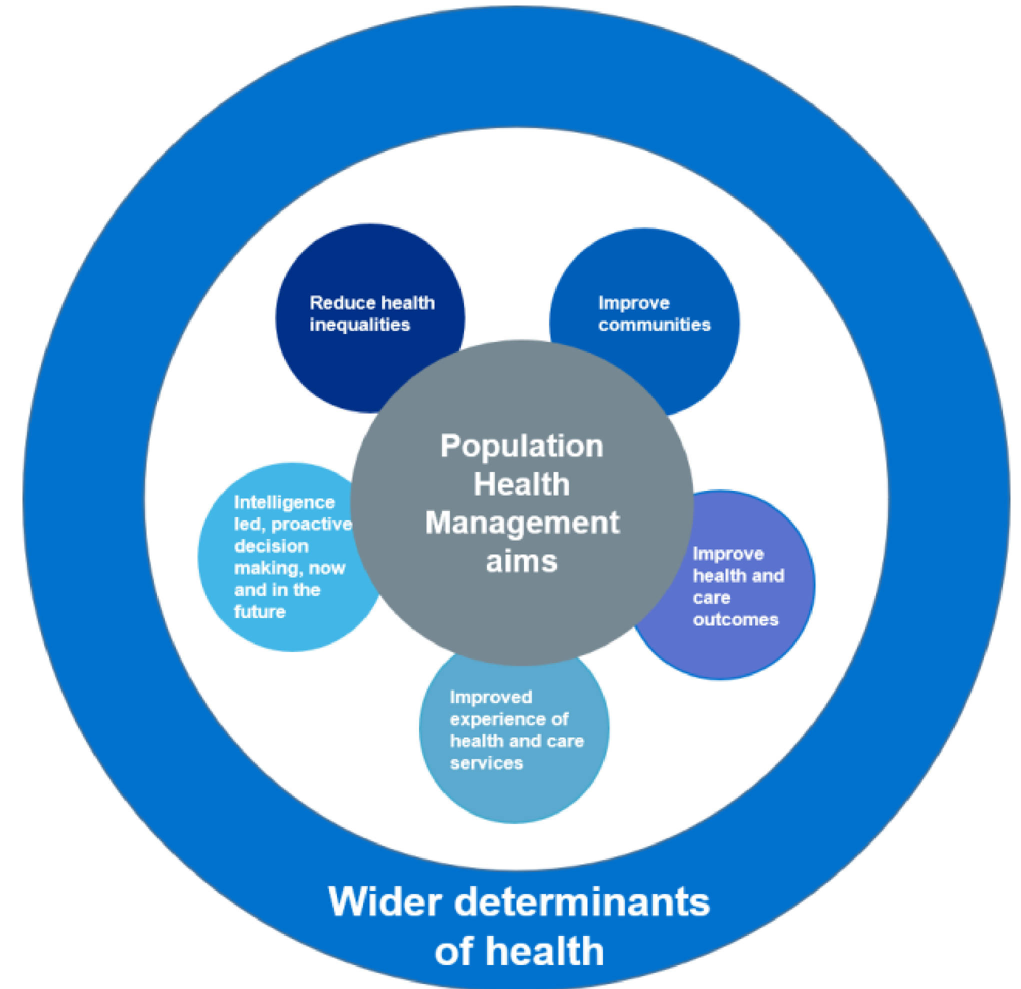
This approach emphasises the social perspective, looking back across an individual's or group's life experiences for clues to current patterns of health and disease, while recognising that both past and present experiences are shaped by the wider social, economic and cultural context.

By agreeing this approach jointly, we can all work together as individuals, groups, communities and organisations to make sure we are all working towards the same vision.

An example of this approach is recognising that many people with significant health needs will have had past trauma and react differently to situations; our services therefore need to understand the impact of past histories and respond in an appropriate way. Through this strategy, we will support a Trauma Informed Approach, working with the Office of the Police and Crime Commissioner and her team.

TAKING A DATA LED APPROACH

- We are adopting a **Population Health Management** approach, using data to improve patient-centred care, reduce health inequalities and plan improvements to services.
- Population Health Management brings together data on health, care and the wider determinants of health (such as housing and the environment) from a number of sources (including the council, police and fire services and the community and voluntary sector) into one place.
- Trends, themes and outcomes from these data enable us to make evidence-based decisions about the way we can collectively improve health and wellbeing - from setting health and care priorities, through to designing new models of care and interventions to improve health outcomes.
- This approach sits alongside valuable insight from the Island population through community conversations and engagement via our services.



HEALTHY PLACES

Where we live, work and socialise plays an important role in our health. Both the built and natural environment make up part of the wider determinants of health and influence people's physical and mental health.

The effect of the environment around us can be felt across the life course and has an impact on health inequalities. The quality of the environment can influence many aspects of people's lives, for example social connections within a neighbourhood, quality and availability of housing, food outlets, exposure to air and noise pollution or safe transport including opportunities for active travel. Thoughtful planning and management of places can help promote good health, improve access to services and reduce health inequalities.

Our focus for places in this Health and Wellbeing Strategy will be on **healthy homes**, recognising the importance that the places we live have on our health. The programme of work to improve health through homes has strong connections with other strategic priorities identified across the Island, including climate change and regeneration of place.

PRIORITY: HEALTHY HOMES

- The condition and nature of housing can have a big impact on people's lives, influencing their wellbeing and health. In fact, housing has a long partnership with efforts to improve health, such as seeking to improve sanitation and reduce overcrowding to prevent the spread of infectious disease.
- Homelessness and availability of appropriate housing continues to be a challenge for the Island and is attributable to a range of social and personal factors, including a scarcity of affordable housing, welfare system changes, mental ill health and substance misuse, family breakdown and unplanned life events.
- There are four housing themes that particularly impact on health that we will address:
  - affordability
  - quality
  - security
  - homelessness
- We will work together in line with the priority identified by the Administration of the Council to improve housing and the impact it has on the health of our populations.

Source:[Understanding Homelessness in Isle of Wight | LG Inform (local.gov.uk)]

HEALTHY PLACES – WHAT WE WILL DO

1. System approach

i. Through a 'Health Begins at Home Memorandum of Understanding (MOU)', commit all system partners to work collaboratively to ensure that residents are able to live in a healthy and safe home. This includes signing up to take action against our four main priorities; preventing homelessness through improved partnership working, ensuring everyone can stay safe in their homes, joint strategic decision making and commissioning, and processes to continually learn and improve.

2. Champion excellence

i. Promote and monitor the application of national housing standards which improve health, including Nationally Described Space Standards, Minimum Energy Efficiency Standards, Housing Health and Safety Rating System (HHSRS)

ii. Through workforce development, increase awareness and understanding of the relevant standards

3. Home safety

i. In partnership with Hampshire and Isle of Wight Fire and Rescue Service, take a coordinated approach to reducing ill health and potential fatalities from carbon monoxide, smoking-related fires and second-hand smoke

4. Climate change

i. Consider climate change in all work programmes across this strategy and identify what mitigating actions need to be taken

ii. Monitor and improve air quality across the Island

iii. In partnership with Energise Me, deliver the 'We Can Be Active' strategy on the Island, to inspire and support active lifestyles alongside developing sustainable, active transport options

MEASURING SUCCESS

- Numbers of children and families in temporary accommodation
- Number of new affordable housing unit completions
- % Take up of mental well being support services
- Relative deprivation (IMD)
- % of island covered by a community hub support mechanism
- Youth unemployment
- End rough sleeping on the IOW
- 100% of homeless population to be registered with a GP/ Dentist
- Reducing the number of households in temporary accommodation
- Increased numbers of households will be prevented from becoming homeless
- Public services adopting a no discharge/release into homelessness policy

HEALTHY PEOPLE

- The COVID-19 pandemic has had an unprecedented impact on the health of our population – through the direct impact of illness, disability and death caused by the virus, the disruption to health and care services and support and the significant impact on people's mental health and emotional wellbeing.
- The mental health impact of COVID-19 is far-reaching and will be with us for many years to come. Impacting people differently, the effects of lockdown policy such as shielding, closures and social isolation have been extensive. On the Isle of Wight, the urban populations are more likely than the rural populations to have mental wellbeing which is vulnerable as a result of COVID-19 restrictions. This is evident in Newport, Ryde, Cowes, Sandown and Shanklin and the more rural areas in the South and West of the Island.
- Recognising the importance of mental wellbeing on our overall health, our focus for healthy people in this Health and Wellbeing Strategy will be on **mental health and emotional wellbeing.** As our mental health is affected by our physical health, the strategy recognises that action to tackle mental health must be joined up and coordinated with physical health programmes.

Source: COVID-19 Health Impact Assessment | Health and social care | Hampshire County Council (hants.gov.uk)

PRIORITY: MENTAL HEALTH AND WELLBEING

- It is estimated that one in four adults will experience mental health problems and mental ill health is the single largest cause of disability in England. There are many factors which can impact on our mental wellbeing during our lives including being bereaved; change of job circumstances or change in life situations. In addition to the impact of the COVID-19 pandemic, we need to consider the usual social changes people experience and how we can support mental wellbeing at these change points.

- Loneliness is increasingly recognised as being an important factor in mental and physical health. This can affect anyone, whatever their age, but older people are particularly vulnerable. Enabling and supporting social connectivity across work programmes can be an effective way of reducing the health impacts of loneliness.

- Groups that are more vulnerable to poor mental wellbeing can be placed into four categories:
  - Demographic (young people and ethnic minorities)
  - Health (people with two or more long term conditions)
  - Economic (low earners, people working in healthcare and sectors likely to be furloughed, self employed)
  - Living situation (lone parents, renters, older people living alone and people living in institutions)

- Through our Mental Health Alliance and other partnerships, we will coordinate action to improve mental health and wellbeing across the Island, with a focus on the most vulnerable groups, and at the most important times in people’s lives

HEALTHY PEOPLE – WHAT WE WILL DO

1. Partnership approach

i. Through our Mental Health Alliance we will focus on prevention and early intervention to:

- Build community resilience including: identifying and mapping support needs and available services; developing network of mental health champions
- Training and upskilling in mental health first aid, debt and anxiety
- Coordinated communications and signposting of the partnership campaign: 'It's OK to not be OK'

ii. We will support a Trauma Informed Approach, working with the Office of the Police and Crime Commissioner and her team to ensure that our services understand the impact of people's past histories and respond in an appropriate way.

iii. Our aim is to ensure that each person who dies, each person who is bereaved, and every member of our community who has thoughts and anxieties about death, dying and bereavement is supported in an appropriate way.

2. Service improvements

i. Implement the Isle of Wight mental health strategy, '*No Wrong Door'* which has been coproduced with people who use services, staff and wider stakeholders. The strategy aims to open up access to mental health services that work together across the island system, providing holistic person-centred care. There is a particular focus on mental health crisis care, and strengthening the provision of services to people with complex needs across the life course.

ii. Work together with services that support the mental health of children and young people to improve mental health and emotional wellbeing outcomes.

3. Mental healthy workforce

i. Improve mental health and wellbeing in our workforces through policy and workforce development. For the Isle of Wight Council, this will be through the Health and Wellbeing Framework which has been designed to help staff feel well, healthy and happy at work and provides support such as Employee Assistance Programmes and Mental Health First Aiders (MHFA).

MEASURING SUCCESS

- Improved self-reported wellbeing – fewer people with low satisfaction/ happiness/anxiety
- Reduced stigma and improved awareness and conversations around mental health, suicide prevention and available support services
- Suicide, mental health and financial anxiety awareness training for communities and frontline workers
- Reduced sickness absence
- Staff feel supported with regard to mental health and wellbeing and understand how to access additional help should they need it
- Improved access to appropriate services, including for people with co-occurring mental health and substance misuse needs
- Improved physical health outcomes for people with mental health problems
- Reduced loneliness and social isolation

HEALTHY LIVES

Everyone on the Island should have the opportunity to live what they feel to be a healthy life. Unfortunately, we know that across England, some groups consistently experience poorer health than others. This is a longstanding issue which has been highlighted by the impact of the COVID-19 pandemic, the effects of which will continue to emerge for some time.

Our focus for healthy lives is **health inequalities** which are ultimately about differences in the status of people's health. But the term is also commonly used to refer to differences in the care that people receive and the opportunities that they have to lead healthy lives, both of which can contribute to their health status. Health inequalities can therefore involve differences in:

- health status, for example, life expectancy and prevalence of health conditions
- access to care, for example, availability of treatments
- quality and experience of care, for example, levels of patient satisfaction
- behavioural risks to health, for example, smoking rates
- wider determinants of health, for example, quality of housing

PRIORITY: TACKLING HEALTH INEQUALITIES

Our data show many factors contribute to health inequalities on the Island. The Institute for Fiscal Studies reports that the Isle of Wight is highly vulnerable to both the health and the economic impacts of the COVID-19 pandemic. This reflects the elderly population of the Island, its reliance on tourism and hospitality, and pockets of pre-existing socio-economic disadvantage which may be exacerbated. The Island's COVID-19 recovery plan sets out the commitment of partners to addressing inequalities, with key areas of focus on housing, mental wellbeing and poverty.

The economic climate (for example unemployment, low-paid jobs or high cost of living) has an important influence on health and health inequalities. People living in poverty will experience poorer health than people who are able to afford a decent standard of living. For example, inability to heat homes (fuel poverty) or afford sufficient, nutritious food (food poverty) will directly affect people's health. The Island as a whole has 8.9% of households living in fuel poverty, with small areas where a higher proportion of households are living in fuel poverty, especially within Newport and Ryde. There are also significant parts of the population at higher risk of food insecurity, with some areas in Ryde South, Ryde Central, Shanklin Central and Lake and Newport Central and Parkhurst West at particular risk.

Differences in the distribution of risk factors (such as smoking, weight, alcohol and physical inactivity) across the population contribute to health inequalities. Having a consistent approach to reducing these risk factors, particularly in those groups who experience poorer health, is a priority for the Board.

HEALTHY LIVES – WHAT WE WILL DO

1. Place based approach

Work with community groups on key workstreams to reduce inequalities in health:

i. Take coordinated action on food insecurity through the Holiday Activity and Food Programme (HAFP), supporting families in receipt of free school meals

ii. Implement the Healthy Hearts programme to improve the cardiovascular health of the population through primary and secondary prevention, with a focus on those most at risk

iii. Review healthcare provision in line with the NHS programme of CORE 20 plus 5

2. Tackling poverty

i. Take an Island-wide approach to identifying need in relation to poverty and ensure mitigating actions are evidence-based and joined up

ii. Halve fuel poverty across the Island by 2030 through promotion of cheapest energy tariffs, improvements in energy efficiency and proactively identifying households for Housing Health and Safety Rating System

3. Support healthy lifestyles

i. Implement a lifestyle plan (smoking, healthy weight, physical activity, alcohol) that supports and enables people to improve their health through preventive action and adopt healthy lifestyles; changing our environments so they are health promoting; and ensuring we focus on those most at risk from experiencing poor outcomes.

MEASURING SUCCESS

- Healthy life expectancy
- Each partner to demonstrate how they monitor action on inequalities in their own metrics

IMPLEMENTATION

- The Board recognises the importance of health and care services but at the same time acknowledges that as little as 10 per cent of people's health and wellbeing is linked to access to health and care services.

- Therefore our measures for success need to be wider than just the health and care metric that focuses on demand for, quality of and access to health and care services

- The delivery and monitoring of the priorities for health and care services will be through the Local Care Board

- The delivery and monitoring of the priorities for the wider determinants of health and reduction in inequalities will be developed to monitor the strategy

RELATED STRATEGIES

The strategy will cover the themes that are pivotal to the health and wellbeing of the island population. These will feed into other strategies including

- **Isle of Wight Council's Corporate Plan** - This plan sets out the wide range of what the council intends to achieve for our Island community and the values that will sit behind everything we do. Three key areas of activity:
    - Provision of affordable housing for Island residents
    - Responding to climate change and enhancing the biosphere
    - Economic recovery

- **Public Health Strategy** - This strategy sets out the ambition to improve the health and wellbeing of people living on the Isle of Wight. This strategy will focus on everyone living on the Island being able to have the same opportunities to live in good health. The recent pandemic has also highlighted the need for the council to prepare for outbreaks of infectious diseases and public health emergencies. This strategy will create a shared vision for how we can make health improvements happen over the next 5 years (2020-2025).

- **Health and Care Plan -** The plan brings together the council, commissioners, the NHS Trust and the community and voluntary sectors to improve services and make them sustainable. It sets our priorities for the next three years and will deliver much needed improvement, investment and collaboration across health and care.

RELATED STRATEGIES

- **Children and Young People's Plan**

- **ICS plan**

- **CSP Strategic Plan 2020-22 –** Written in conjunction with the Strategic Assessment, The plan focusses on addressing the following priorities:
  - Violent Crime
  - Reduce Reoffending
  - Anti-social Behaviour and Community Cohesion
  - Domestic Violence & Abuse and Serious Sexual Offences
  - Prevent
  - Road Safety

- **IOW homelessness and Rough Sleeping Strategy 2019-2024** - This strategy outlines how we will work together to make:
  - homelessness in all forms a rare occurrence
  - homelessness a brief experience
  - homelessness a one-off experience

Isle of Wight NHS Trust

ISLE of WIGHT COUNCIL

NHS Hampshire and Isle of Wight

Isle of Wight Health and Care Plan

2022-2025

People living healthy, independent lives

Foreword

Welcome to the new Isle of Wight Health and Care Plan 2022-2025.

Our Island community has shown great resilience and spirit in its response to the COVID-19 pandemic, with people coming together to support one another in a truly inspirational way.

The lessons that we have learned over the last two years show that the services and support we provide must evolve to keep pace with the changing needs of our population.

We know that people on the Isle of Wight will, on average, be older and often managing more long-term health conditions than elsewhere in the country.

Research into the health and care needs of our community shows that we need to think differently about how we plan and deliver services, especially for older people who may become increasingly frail.

Supporting the Island's physical health, mental health and wellbeing will require us to make sure our whole community is represented, so that we can tackle health inequalities and improve outcomes for local people.

Preventing ill-health is a vitally important part of this new approach to health and care on the Isle of Wight. Giving people the tools and support they need to manage their own health and wellbeing will underpin all the work we do together.

Dr Michele Legg

Clinical Chair
Isle of Wight Place for
Hampshire and IOW ICB

Wendy Perera

Interim Chief Executive
Isle of Wight Council

Darren Cattell

Chief Executive
Isle of Wight NHS Trust

Our community has shared its collective voice in the creation of this plan and the priorities we now share. We will work with local people and with our health, community care, independent care and support providers, pharmacy and voluntary sector partners to help improve access and to make sure residents have the support they need to live healthy, independent lives.

Making sure that Islanders in our local communities, have the access to the support they need, when they need it will be crucial if we are to meet the changing needs of our population.

A key measure of success will be in further improving the quality of the services that local people rely on, and we commit to engaging with residents as we set about delivering this plan.

Planning and delivering health and care services for our Island population, with local leadership and collaboration, will help make sure that we can make the ambitions set out in this plan a reality.

We look forward to working together, and with our community over the coming years. The health and wellbeing of our Island is our top priority.

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Introduction

The Health and Care Plan 2022-25, set out in this document, builds on the progress we have made over the last three years across our health and care system.

In 2019 we published a three-year plan to support people on the Island to live healthy and independent lives.

This health and care plan outlined the steps we would need to take over the longer term to ensure our healthcare system is sustainable and can continue to meet the needs of our local population.

At the heart of the plans were steps to develop new models of care, stronger partnerships with local and mainland health care organisations and greater productivity within our healthcare system.

While we have made some good progress with these aims, the COVID-19 pandemic has impacted on the delivery of some aspects of our plan as we redirected our efforts to ensure we could respond to the immense challenges the pandemic created.

The effects of the pandemic have also left a longer-lasting impact on our local population with the prevalence of long COVID and the physical and mental effects of social isolation which we will need to take into account in planning our services for the next three years.

At the same time, it has brought us together like never before with public sector, private independent and voluntary sector organisations all responding quickly to the crisis and working together to join up care for people on the Island more effectively and efficiently. These are lessons that we are determined will not be lost as we look to the next three years.

One of the key steps that will help us to achieve that is the development of a strong and effective, local Integrated Care System (ICS) and local Integrated Health and Care Partnership (IHCP).

These are being put in place across England and will see health and care organisations working more closely across a wider geographical area, in our case across Hampshire and the Isle of Wight.

They will enable us to take a joint approach to improving services where they can benefit from utilising wider, specialist expertise. In fact, this is happening already, one example being the way in which we have worked closely with Portsmouth Hospitals University Trust (PHUT) to deliver improvements in stroke services for Island residents.

The IHCP will also pave the way for more collaboration with local partners on the Island, where people live and access services in their local communities.

The Island's health and care plan and priorities to 2025 have been developed through a robust examination of our population health and care data, across all our services, to understand how these might impact future service delivery. Crucially, they are also based on the feedback of our staff and from you, as residents, about the improvements you would like to see across our healthcare system.

The plan and the priorities outlined in this summary document together with the Island's Health and Wellbeing Strategy, to which it is closely aligned, will help us develop individual service plans with specific timeframes which set out how we will tackle health inequalities and improve health outcomes in our society.

As we embark on this three-year strategy, we are committed to keeping you at the heart of our plans, helping to shape the health and care of our Island community.

Our health and care services

There are a wide range of health and care services for the 140,400* population of the Isle of Wight. These services include:

GP and primary care services provided by 12 GP practices: six in the North East Primary Care Network, three in the Central and West Primary Care Network and three in the South Wight Primary Care Network.

Community and Mental Health Care services provided by Isle of Wight NHS Trust, Isle of Wight Council, Mountbatten Hospice and the Voluntary, Community and Social Enterprise sector organisations (VCSE).

NHS Community Services for Children, Community Dental Services and Sexual Health Services provided by Solent NHS Trust.

Hospital-based services provided by Isle of Wight NHS Trust.

Ambulance services provided by Isle of Wight NHS Trust.

Social Care and Housing Need Services provided by Isle of Wight Council.

Care at home and care homes – operated by multiple private providers, Mountbatten hospice, VCSE and the Isle of Wight Council (including Wightcare).

Informal care and support provided by The Living Well Service (delivered by Aspire), informal carers and multiple private providers.

*2021 Census data

What progress has been made already?

Although the COVID-19 pandemic did impact on our progress, since the plan was introduced in 2019, we have still made improvements in a number of areas:

New models of care

- Reducing the time people stay, on average, in hospital.
- Working to achieve the four-hour target for emergency care.
- Reducing unnecessary admissions through targeted work in the community to help prevent ill health.
- Working to discharge people from hospital to home without delay and with appropriate support.
- Providing new accommodation for local people in both supported living and extra care housing developments.
- Supporting residents in residential homes that have been deregistered to move into supported living.
- Putting in place new specialist homecare providers for end-of-life care, dementia, live-in support, and nurse-led care.
- Treating some of the more complex patients in the community with nursing and social care support, releasing hospital beds.
- Making improvements to our mental health service which has improved from inadequate to good through a partnership with Solent NHS Trust and is now the second most improved mental health service in England.
- Working together to identify opportunities and commission health and social care services like the Living Well and Early Help services.

Productivity

- Launching a new online catalogue/stock system for community equipment and making improvements to the referral processes involved.
- We have made significant savings by reducing our reliance on agency and locum staff and appointing full-time equivalent staff.

Partnerships

- Working in partnership with neighbouring Trusts to provide more expertise and resilience in areas including urology, breast, mental health, stroke care, the ambulance service, and all aspects of community care.
- Establishing three primary care networks on the island – groups of GP practices that work together with a range of local health and care providers to offer more personalised, coordinated health and social care to their local populations.
- Working closely with our primary care, social care, community, independent and voluntary sector partners on the Island.

However, as a health and care system we know that there is more that we need to do to address the challenges we face and to meet our local population's health and social care needs.

What are the continuing challenges?

As an Island Health and Care system our data tells us that we face the following key challenges:

Our population's health and wellbeing

Our health and wellbeing is influenced by a range of factors including: our genes, our health behaviours, our lifestyle, our social contacts, our homes, education, employment, and the communities and environment we live in. It is also influenced by the provision and quality of the health and care services which support us.

To prevent disease and ill-health we need to consider all these factors and help create the environment in which everyone can live healthy lives.

Our population is also growing, the age profile of our residents is increasingly older, and they are living with more long-term conditions such as heart and respiratory disease, diabetes, hypertension, and dementia. These and other long-term conditions are also becoming more widespread and showing at an earlier age.

People living with long-term conditions will need more support to help them manage their own health and this will place an increasing demand on healthcare services.

Health inequalities

Our Island community is also showing significant health inequalities, both in terms of the differences in care that people access or receive, but also the opportunities they have to lead healthy lives. People living in the most deprived areas on the Island are not only dying earlier, but also living a smaller proportion of their lives in good health.

People with poorer health are also two to three times more likely to have a mental health disorder.

To improve the health and wellbeing of everyone on the island we need to collectively shift our focus to the prevention of ill health and health inequalities and focus action on making faster improvements for those groups who currently have poorer health outcomes.

- We have the highest proportion of people in England (29.3%) aged 65 and over (2021 Census).
- By 2045 this number will have increased by 45%.
- We have one of the lowest proportions (16.6%) of people aged under 18 in England (GP registered population).
- 65% of our residents aged 65 years+ have two or more long-term conditions.
- People with long-term conditions account for 50% of all Island GP appointments, 64% of all outpatient appointments and over 70% of all inpatient bed days.
- The Isle of Wight has 12 areas in the top 20% most deprived in England.
- Healthy life expectancy is significantly lower than the national average and has fallen in recent years, most markedly in women.
- A baby born today in the most deprived areas will live on average 6.3 years less compared to one born in a least deprived area.
- 1% of our population dies each year, with Cancer and Cardiovascular Disease being the main cause of death on the Island.
- Nationally about 22.5% of deaths are avoidable, of which two thirds are preventable through taking action to avert ill-health.

Impact of COVID-19

COVID-19 has exposed, exacerbated, and created health and social care needs and new inequalities and it is likely that some parts of our Island community have been disproportionately affected. We may not see the true extent of this impact for a number of years.

Months of isolation and reduced activity levels at home will have also had an immense physiological effect, particularly among older people, making them less mobile and less able than they were before the pandemic.

We are also seeing a rise in mental health concerns across all ages, particularly in the aftermath of the pandemic.

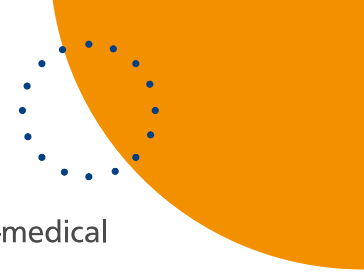
The impact of delayed screening, routine diagnostics, referrals, and surgical interventions during the pandemic is also still unknown and will require further analysis over time.

Health and care services are currently facing a significant backlog of unmet needs with people now facing long waiting times for treatment.

COVID has also impacted on the employment levels within services and the availability of care provision. Our collective workforce is stretched and emotionally and physically challenged, after the effects of the pandemic and we will need to take action to address this.

Long-COVID will also present ongoing challenges for health and care systems that we will need to consider.

- Long COVID is currently defined as people who suffer with poor health for 12 weeks or more beyond the initial acute phase of infection.
- An estimated 1,500 people on the Isle of Wight were experiencing Long Covid for 12 weeks or longer (week ending 6 March 2021).
- 40,698 Covid cases have been recorded on the Isle of Wight (as of 6 June 2022).
- As of 6 June 2022, 448 Covid-related deaths have occurred on the Island (260 in hospital).
- On 18 January 2021, the IOW NHS Trust was caring for 95 patients who had tested positive for COVID.
- Between 8 January and 8 February 2021 there were over 50 people per day in hospital who had tested positive for COVID (the average was 74 beds per day during this sustained time).
- During this same period, the average number of people in ITU with COVID was 9 with a maximum of 13 at any one time.



The way we work

We have many examples of excellent health and care practice on the Island; however, our health and care services are often not joined up with each other, and professionals are not always able to share data. This can lead to duplication but also gaps in care – a challenge being faced in most areas of the country.

On the Island, despite having the highest number of over 65s in England, we do not have a fully integrated pathway of health and care support for our ageing population, particularly those who are frail and we will need to address this as a priority.

We know that there is an opportunity to further improve the way we work together so that frail elderly people do not end up in our emergency department or being admitted to hospital for non-medical reasons.

We know that where people have access to the best quality GP, primary care, and community-based services they will have better health outcomes than those who do not.

We need to make important changes so that our primary care, community and mental health care, hospital services, social care, independent care and support providers, pharmacies and voluntary organisations are all able to work better together.

Improvements in care cannot be delivered in isolation. By working in a more integrated way, we can deliver care more efficiently and effectively.

- Approximately 16,900 residents (12% of the population) have moderate or severe frailty.
- 7% of our population account for 38% of our health and care spend.
- For a frail, older person every day spent in a hospital bed means they can lose 5% muscle wastage, which impacts on their level of independence and increases their need for health and care support.
- In November 2021, on average there were 50 patients medically fit to return home who were occupying a hospital bed.
- 56% of all NHS Funds available for the local population are spent on acute hospital services.
- In January 2022, calls to 111 were 115% of the level seen in January 2020. Of these calls, 18% were recommended to attend emergency care.
- Approximately half of patients attending our emergency department are discharged with no follow up treatment.
- Over half of patients (58%) attending the emergency department or urgent treatment centre say they tried to contact or get help from another health service first (42% did not)
- Anxiety disorders and depression are among the top 10 reasons for people seeking urgent care.

Sustainability

The population that we serve as a health and care system is relatively small and isolated. This means we cannot provide the critical mass needed to sustain high, quality, efficient services.

Our unique demographic also provides workforce challenges. We have a lower proportion of working age and young population groups living on the island. Access to the wider mainland workforce is difficult because of our isolated position. This makes it harder to recruit across our health and care system.

Despite making good progress with our finances, we also continue to face significant financial challenges across our health and care system, and we need to continue to use our available resources most effectively to meet the needs of local people.

We have sought to address these challenges by collaborating with partners both on and off the island. Strategic partnerships are now in place with mainland partners for our ambulance services, mental health and learning disability services, community services and our acute (hospital-based) services.

We will need to build on these foundations and continue to develop them over the next three years, as well as working with a wide range of individuals, groups and organisations across the council, other parts of the public, independent, community (including care home and care at home providers), pharmacies and the voluntary sector on the island.

We will also need to work more closely with our residents to help people understand how they can manage their own health and how to access and use services appropriately.

By working together, we can deliver more efficient and effective health and care for our residents.

- The Trust has an operating deficit of £13.8m (2019/20).
- The financial cost of providing services on a smaller scale as is the case on the island is £20.5m.
- On average, 6.8% of roles in adult social care were vacant in 2020/21.
- The number of GPs per weighted population on the island has shown a downward trend since 2015.
- However, the total number of primary care appointments per month recorded since September 2020 have consistently been above the 2019 average (excludes appointments for COVID vaccinations).
- Around 7% of primary care appointments are not attended every week.
- An average of 1,184 primary care appointments are not attended every week (figures from ten-week period to 13th June 2022).
- Since 2018 there has been a 257% increase in referrals made to the Community Equipment Service to provide equipment to enable people to perform essential daily activity and maintain their independence.

What have you told us?

In developing the Island's health and care plan 2022-25 we have sought to not only analyse what our data is telling us, but to also engage with our staff and our local community to listen to and understand your views about what is important for your future health and wellbeing.

We looked again at all the existing public feedback we had received across the health and care system in the last two years and through community organisations like Healthwatch. We then launched a further public survey in January this year and, with the help of our partners, undertook some community conversations about health and care with over 500 people responding.

Everyday care

You told us that:

- Health services do not meet your needs and are not improving.
- Services are not working better together, there is no continuity of care between different organisations and there are gaps in services.
- Services need to communicate better with each other.
- Services need to be more accessible.
- Information and advice needs to be easier to obtain.

Our response:
At the heart of our plans, is a commitment to improve the way we work together. To share information, communicate better with each other and with the community and deliver care in a more seamless way.

Dental services

You told us that:

There is a crisis in terms of access to NHS dental care and a disparity in cost and services provided, that needs addressing urgently.

Our response:
We are working with NHSE who commission dental services on the island, to seek improvements in services and better access for NHS patients.

Seeing a GP

You told us that:

- Seeing a GP was increasingly difficult and there needs to be better, quicker access to GP appointments.
- There needed to be more opportunities for face-to-face appointments.
- It is not easy to contact your GP.
- We are happy to see other skilled professionals in the practice if that means problems are solved more quickly.

Our response:
We are working with our local primary care networks to expand the team of highly skilled health professionals working in local GP practices like mental health and musculoskeletal practitioners. We are providing a variety of options for people to contact their surgery (by phone, online or in person) and working to extend access to appointments outside of normal working hours. Not all symptoms require a face-to-face appointment, but where those are needed, they will be provided.

Community care

You told us that:

- There is a shortage of staff, so care services delivery can be patchy.
- There is a lack of communication between services.
- There is confusion around how to access community services and what is available.

Our response:
Our plan will focus on joined up, high quality community services (including social care, primary care, care homes, care at home, voluntary sector services and pharmacy services), that make it easier for people to find out about and access support to help them care for themselves at home or closer to where they live.

Going into hospital

You told us that:

- You know where to get medical help and what to do in an emergency.
- You would like more control over where and when you have regular hospital appointments, with many of you preferring online/telephone follow ups where appropriate.
- Waiting times for appointments are too long.
- Some of you would choose to be seen at a mainland hospital if it meant seeing a specialist or a shorter waiting time for treatment.
- You would be happy to use in-home technology to monitor your health if that meant you could return from hospital sooner.
- Not everyone has someone at home to provide care when they leave hospital.

Our response:

Through more integrated working with primary care and community care services (including care homes, care at home and pharmacy services) we will ensure that people can access the care they need, including follow up appointments, in the most appropriate environment. For more people this will be in or closer to home rather than in hospital and making use of technology where appropriate. We will continue to build on our mainland partnerships to ensure people have the access to specialist treatment where needed, within the right timescales and in the most appropriate location. We will ensure people have the information available, like www.myplannedcare.nhs.uk, so they can choose to be seen at a mainland hospital if it means seeing a specialist or a shorter waiting time for treatment.

End of life care

You told us that:

- You want to be treated with dignity, compassion, have your choices respected and be kept free from pain as you near the end of your life.
- You want to be able to choose where you die and to be able to have your loved ones with you.

Our response:

Working with our partners at Mountbatten, we will ensure staff across the healthcare system have the best possible understanding of delivering end of life care to Island residents to meet these needs.

Mental health

You told us that:

- There is uncertainty about how to access mental health services to get the support you need
- Mental health support for people of all ages needed to improve further.
- Waiting times for non-acute mental health needs must improve.
- People need to know where and how to get support in a crisis.

Our response:
People living with long-term physical or mental health conditions or learning disabilities will be better supported, with more services working together to help them manage their health and deliver better outcomes for people. People will also know where and when to get support in a crisis.

Technology

You told us that:

- You want professionals to be able to share your health and care information
- People need to know how to access their medical record via the NHS app
- People are not sure what technology is available to them to help them monitor their health at home,
- People understood though, that using technology at home might help prevent unnecessary hospital admissions and attending the hospital for outpatient appointments.

Our response:
Islanders will have better digital access to health and social care services. People will benefit from technology-enabled care, improved access to on and off-island services, and to their personal health record.

COVID-19

You told us that:

- For some of you, COVID-19 has had an impact on your physical and mental health.
- More support was needed to deal with long-COVID.

Our response:

People living with the physical or mental health impacts of the COVID-19 pandemic will receive the support they need to recover.

What are our priorities?

Having analysed our data and listened to the feedback from our staff and the local community, alongside addressing the specific issues raised, we have identified the following four overarching priority areas to ensure we can fulfil our vision of people on the island living healthy, independent lives:

Preventing ill health

Encouraging people and enabling people to make healthy lifestyle choices and changes so that it has a positive impact on their health in the future. At the same time reducing health inequalities (outcome, experience, and access) for those affected.

Partnerships

Working together as on-Island and off-Island partners to strengthen the work we are doing, to provide access to specialists and to deliver seamless care that meets the needs of people in our community now and in the future.

Productivity

Making sure we work together in a more integrated way, communicate better with each other, and use our collective resources, including our own technology, more efficiently and effectively.

Pathways

Finding ways to increase access to care and provide a seamless journey for people who need our support right through our healthcare system and regardless of which organisation they make their initial approach to.

What do we want to achieve?

Over the next three years we have a clear plan to focus on these overarching priorities to deliver the most significant changes in our local population's health and care.

Preventing ill health

We want to encourage and enable people to make the changes they need to make now to have a positive impact on their health in the future and keep themselves as healthy and independent as possible.

Our approach to preventing ill health will focus on:

- Ensuring that ill health prevention and a healthy lifestyle approach is embedded in all health and care pathways in our system, including after a diagnosis.
- Ensuring that as we work as professionals across our health and care system, we use each interaction we have with residents to encourage and enable people to make healthy behavioural and lifestyle choices.
- Delivering screening and immunisation programmes that will help prevent ill health across our population.
- Responding to COVID-19 ever more effectively, delivering vaccination programmes and meeting the needs of patients with COVID-19 and long COVID.

Addressing health inequalities

We will focus on those who are experiencing health inequalities so that we can provide appropriate, targeted support to help improve their health outcomes, experiences, and access to services both now and in the future.

Our approach will focus on:

- Working together on the wider determinants of health including education, climate change, employment, and housing to support social and economic development and tackle inequalities.
- Continuing to collect and review data from our services and safe, non-identifiable data from our population medical records to help us plan where and what services are needed, to consistently improve health outcomes for all in our community

Developing strong partnerships

As Island partners we are committed to improving our population's health, together with improving health and social care services.

We recognise that, because of size and physical isolation, we will need the support of both our island and mainland partners.

Through the health and care plan we will work with our partners to develop improved models of care with more integrated services and innovative workforce solutions to ensure our island health and care system remains sustainable for the future and meets the needs of our community.

Our approach will focus on:

- Exploring opportunities to deliver services on a larger scale with the benefits that brings for our community, through our partnerships both on the island and on the mainland.
- Working together to strengthen the way in which we support frail older people and those with long-term conditions, looking beyond our organisational boundaries as we develop these so that residents can access support more easily.
- Working together as partners to develop robust community services reducing the need for our residents to access acute hospital care.
- Exploring opportunities to develop innovative workforce solutions and utilising our strategic partnerships to attract people to join our workforce on the island and to develop and invest in those already within our workforce.
- Building health and care training and development programmes to provide career progression opportunities and focus on creating a culture that makes the Island a desirable place to work, attract and retain the best talent.
- Considering how digital solutions can bring our partnerships closer together, ensuring we can access the information we need to improve people's health and provide the confidence to the public that their data will be stored safely.
- Developing safe, rapid transfer routes for critically ill or injured patients working closely with our partners and providing training to enhance paramedic skills in critical care on the island.

Improving productivity

As health and care partners across our Integrated Care System we have a responsibility to close the gap between our costs and available funding. It is essential that we use our resources efficiently and, where possible, in new and innovative ways. We have a duty to ensure every pound is spent to the greatest benefit, recognising that when we work together our services are more cost effective.

Our approach will focus on:

- Reducing the need for expensive, temporary staffing costs by exploring alternative workforce models as we transform our services.
- Working together to meet care needs more appropriately and consistently so that people get the help they need in the right place and at the right time.
- Simplifying the way in which people can access care so that people can make the best personal choices and ensuring it is available when required.
- Integrating our urgent and emergency care programmes to ensure our ambulance service is only used to convey people when it is necessary to do so.
- Maximising opportunities to deliver services in alternative ways using digital services where it is appropriate and safe to do so.
- Improving our own technology by ensuring we have the best systems in place for those who need our care and robust, secure infrastructure that enables staff from all our organisations to access one system to record and share health and care information. This will be vital component in improving the way we work together and will also mean people will not have to repeat information to different health and care professionals.
- Being smarter in understanding our waste and costs; making sure our services are delivering best value for money and are used in line with best practice, including developing ways to reduce the number of people who do not attend appointments.

Developing improved care pathways

People have told us they want services to be organised in a way that makes their health and care journey (their care pathway) between our teams as seamless as possible.

Residents on the Isle of Wight who use mental health and learning disabilities are already benefitting from a new, joined-up approach that will mean there is no 'wrong door' when they need support.

We will learn lessons from this as we develop our care pathways.

Our approach will focus on:

- Challenging the effectiveness of existing care pathways and seeking improvements by working together in a more integrated way.
- Developing, as a priority, a joined-up care pathway for frail, older residents to provide physical and mental health care, where possible, at home or closer to home in the community.
- Providing a safe alternative to hospital for people living with frailty through community-based hospital at home solutions.
- Providing timely access to primary care, building community care capacity, and providing access to digital technology to support self-care, where appropriate, to enable people to live safely, and independently.
- Ensuring we have the optimum number of beds available in hospital for those for whom a hospital environment is their most appropriate place of treatment and care.
- Continuing to improve mental health, community services, and services for people with a learning disability and/or autistic people.
- Managing the growth in demand for health and social care among the island's ageing population.

What will this mean for you?

Islanders will spend fewer years of their lives in ill health as health and care services focus on preventing ill health, addressing health inequalities and better management of long-term conditions.

We will work together to address the wider issues that impact people's health, from the earliest age, and educate and support residents to make healthier lifestyle choices and support those in the most vulnerable families at risk of the poorest health.

Older people, many of whom are frail, their families and carers will be better supported by improving and joining up the services they rely on.

People will be supported to live fulfilling lives, regardless of age, sex, disability, ethnicity, or social background. We will help them to access the care they need to live as independently as possible.

People living with long-term physical or mental health conditions or learning disabilities will be better supported, with more joined-up services helping them manage their health and delivering better outcomes.

People who use services, their families and carers will be involved in all aspects of the transformation of health and care services. Their voices will help shape seamless services which are higher quality, more efficient and deliver better outcomes.

Islanders will have better digital access to health and social care services. People will benefit from technology-enabled care, improved access to on and off-island services, and to their personal health record.

People experiencing physical and mental health crisis will have rapid access to a range of high-quality support.

People living with the physical or mental health impacts of the COVID-19 pandemic will receive the support they need to recover.

Anyone who needs to be admitted to hospital or residential care will always receive high quality, compassionate care.

Health, care, community services (including Social Services, independent care and support services, pharmacy services) and voluntary sector partners will work together to provide seamless support to people leaving hospital, making sure that services meet the needs of every individual.

Summary

We continue to face a number of challenges in the health and care of our local community and although, despite the impact of the pandemic, we have made some progress with our plans, we need to continue to address these challenges.

We have shared our three-year plan that will help us to improve the quality and access to services and ensure we can sustain these by using our resources better together.

At the heart of our plan is a commitment to improve the way we work together, to communicate and share information to make sure the care we provide is available at the right time, delivered seamlessly between organisations and in the most suitable location, particularly for our frail, older population.

We are also pledging to do more to prevent ill health by ensuring people understand and can make healthy lifestyle choices from an early age onwards, so they have the best start in life and can maintain a positive approach to health.

Through our plan we are also determined to address inequalities in health and health care provision so that those who are more vulnerable are not disadvantaged and to ensure those with mental health and learning disabilities have access to support in the most appropriate environment.

We will also focus on providing better access to everyday care in the community working with our primary care, community services (including Social Services, independent care and support services, pharmacy services) voluntary and independent sector partners so that people only have to access acute, hospital care when it is appropriate to do so.

As a Local Integrated Health and Care Partnership and Integrated Care System we will work hard to build on the partnerships that we have already created and develop new partnerships with on and off-island partners, to strengthen the work we are doing, to address our workforce challenges and improve services for local people.

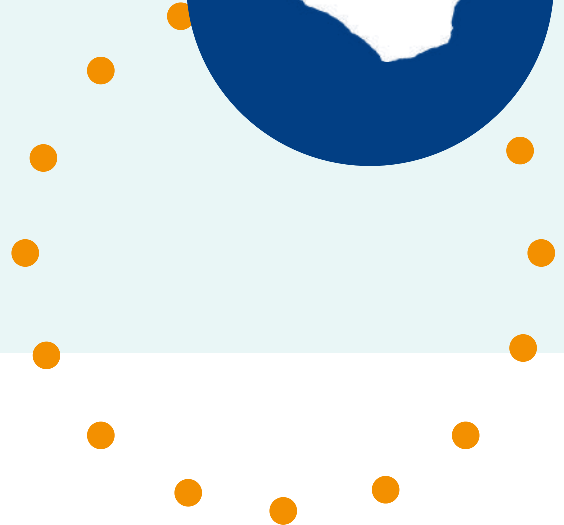
Our plans will include looking at opportunities to work smarter using digital technology to help our staff access shared systems, to enable people to access health and care more easily and to provide options to enable people to manage their own care from home where it is appropriate and safe to do so.

We will work together to utilise our services more efficiently and effectively, reducing waste, investing in our workforce, and developing new ways of working. We will also ensure our services are being used in the right way and work together with our combined resources to meet the needs of our local community.

Our data will be kept under review, including what we continue to learn about the impact of COVID-19, to help inform the way we plan and deliver services to ensure we can produce the best health outcomes for local people and manage the growing demand for health and care services.

Our health and wellbeing as an Island community is the responsibility of us all and the success of our plan is not only dependent on the changes we intend to make to our health and care system but on each and every one of us making the changes needed to look after our own health and wellbeing.

We will continue to be open and transparent and involve local people as we develop our plans further, so that together we can shape a health and care system that can help people live healthy, independent lives.



We would like to thank all of our partners and the wider community that have played a key part in helping to develop this plan.

You can find out more information about the Isle of Wight Health and Care Plan including details of how to get involved at: www.iowhealthandcare.co.uk

To receive a copy of this document in any other format, including large font size, easy read or braille please contact:

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NHS Isle of Wight NHS Trust

ISLE of WIGHT COUNCIL

NHS Hampshire and Isle of Wight

Committee: HEALTH AND WELLBEING BOARD

Date: 28 JULY 2022

Title: BETTER CARE FUND UPDATE Q1 2022/23

Report of: IAN LLOYD, STRATEGIC MANAGER PARTNERSHIPS AND SUPPORT SERVICESCHERYL HARDING-TRESTRAIL, ASSOCIATE DIRECTOR OF COMMISSIONING – URGENT AND EMERGENCY CARE AND COMMUNITY SERVICES, HAMPSHIRE AND ISLE OF WIGHT INTEGRATED CARE BOARD – ISLE OF WIGHT

Sponsors: LAURA GAUDION, DIRECTOR ADULT SOCIAL CARE AND HOUSING NEEDMICHAELA DYER, HAMPSHIRE AND ISLE OF WIGHT INTEGRATED CARE BOARD – ISLE OF WIGHT

Summary

1. The Better Care Fund (BCF) programme supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care and support, and better outcomes for people and carers. The requirements of the BCF are set by NHS England and include requirements for pooled/aligned workstreams and budget within section 75 agreement.

2. The annual planning process for the BCF for 2021/22 and 2022/23 has experienced interrupted cycles due to the ongoing national impact of Covid-19 and restoration progress.

3. In respect of the 2021/22 BCF plan, there has been a national requirement to submit an End of Year template reviewing the delivery performance against plan for 2021/22.

4. The release of information regarding the 2022/23 cycle is now due to be announced in July having previously been indicated by NHS

5. England it would be in the spring 2022 for the delayed timeline requirements.

6. In anticipation of this, and in alignment with the objectives outlined within the BCF plan of 2021/22, work has commenced to review the incorporated BCF workstreams to inform the development of the 2022/23 BCF plan and lay a foundation for further work in 2023 and beyond.

7. In advance of the release of the full guidance documents, BCF information sessions have confirmed that development and management of the BCF will continue to be at Health and Wellbeing Board (HWB) level, i.e. ‘place’, for 2022/23. Use of BCF mandatory funding streams (integrated care board [ICB] minimum contribution, improved Better Care Fund [iBCF] grant and Disabled Facilities Grant [DFG]) must be jointly agreed by ICBs and local authorities to reflect local health and care priorities, with plans signed off by the HWB.

8. The national ICB contribution to the BCF has been increased in line with average NHS revenue growth (by 5.7 per cent for 2022/2023). The relevant funding streams have been adjusted to reflect this growth.

9. This paper provides an update for the Health and Wellbeing Board about the

    a) 2021/2022 Better Care Fund (BCF) End of Year template submission to the National Better Care Fund team, and

    b) proposal for completion of the 2022/23 planning round which, once completed and approved centrally, will be incorporated into the local s.75 agreement.

The Health and Wellbeing Board is therefore asked to receive this update on year end position and plan for 2022-23 for noting and approve the recommendation for the development of the BCF 2022/23 plan in line with national and local requirements with a view to a virtual sign-off by the HWB due to the necessity to align with national submission deadlines, or provide comment and direction on further measures.

Background

10. The current BCF has been in place since April 2017 and is based around the following schemes:
    a) Locality/Community Model (nursing, crisis response and falls etc).
    b) Hospital to Home (Home and Residential Care, Single Point of Access, Personal Assistants etc., Winter Pressures spend)
    c) Carers Support
    d) Community Voluntary Sector (Early Help and Intervention etc)
    e) Support for Providers (Raising Standards)
    f) Promoting Independence (Disabilities Facilities Grant, Equipment inc. Assistive technology, etc.)
    g) Rehabilitation, Reablement and Recovery (Integrated Discharge Team (Single Point of Access Referral Service -SPARRCS), Rehabilitation bedded care, Reablement etc.)
    h) Integrated Mental Health Provision (Woodlands and Mental Health (MH) Grants)
    i) Learning Disabilities (Westminster House)
    j) Continuing Healthcare including Hospital Discharge Scheme (HDS)
    k) Care Act Infrastructure (Maintenance of ASC provision etc.)

11. Since 2018/2019 the BCF has been stable in terms of the workstreams it contains, and the funding attached by both the council and the ICB to those workstreams. The only significant changes have been the:

    a) inclusion of both the Continuing Health Care (CHC) provision and Funded Nursing Care (FNC) following the integration of the Clinical Commissioning Group (CCG) team with the councils Adult Social Care and Housing Needs Department in January 2019

    b) inclusion, and subsequent removal, of additional Hospital Discharge Scheme funding in line with the national directives during 2021/22. However, the NHSE/I letter of the 28 March 2022 outlines the expectation that local systems will continue to make best use of existing resources, to support safe and effective discharges within local priorities. This should build on existing joint arrangements and best practice and be agreed locally.

12. Senior staff from the council and the ICB are engaged in both the development and reporting for the BCF scheme under the current governance process applied. During this financial year the governance process for the BCF will be reviewed and aligned with the

refresh of what has been the IW Integrated Care Partnership (ICP) that may in future be known as the IW Health and Care Partnership Board and the new Integrated Care System (ICS). It will also reflect the cessation of the NHS Hampshire, Southampton and Isle of Wight CCG and NHS Portsmouth CCG with subsequent development into an Integrated Care Board for Hampshire and Isle of Wight, as of 01 July 2022 in accordance with the Health and Care Act 2022.

13. Due to the mitigation work undertaken during Q3/4 regarding Omicron, vaccination roll-out and wider system capacity pressures, the intended review of the BCF schemes timeline of September 2021 to March 2022 was delayed. The process has since commenced in May 2022, during which the current schemes will be reviewed to identify effectiveness and value for money. This will inform decisions around which schemes stop, carry on or are changed moving in to the 2022/23 financial year and development of the 2022/23 BCF plan.

14. The three areas under review are:

    a) **Early Help and Prevention** (including all voluntary sector funded Better Care Fund services) – this piece of work has been completed and a newly commissioned service; 'Living Well, Early Help' provided by Aspire, now in place.

    b) **Rehabilitation, Reablement and Recovery (Regaining Independence)** – a bedded care review was initiated by the Community Transformation Board; a full review of Rehabilitation, Reablement and Recovery, including discharge pathways, Integrated Discharge Team (IDT), Onward Care Intervention Team (OCIT) etc., commenced. This incorporates a review of the Single Point Access Referral Review and Coordination Service (SPARRCS) and Enhanced Professional Service scheme lines and a re-specification within the context of Hospital Discharge Service and Integrated Discharge Team. Work on this is ongoing and forms part of the Community Transformation Programme with additional oversight through the System Resilience Group.

    c) **Refresh of the other Better Care Fund Schemes and associated funding – revised Framework for Isle of Wight delivery of effective integrated services at locality (IW Health and Care Partnership Board (IWHCPB) – formerly the IW Integrated Care Partnership) level by 2022/2023** – Undertaking of a structured review of the Better Care Fund Section 75 agreement framework, scope, metrics/Key Performance Indicators and funding opportunities, based on agreed IW Health and Care Plan (IWHCP) Board over-arching principles and IWHCP refresh. This is intended to potentially reduce the number of individual Schemes (11; see para. 9 above) to reflect the updated models of integrated practice being agreed/consolidated, e.g. with key over-arching schemes such as Discharge and Community Integration, Voluntary Sector Offer, Integrated Mental Health and Learning Disabilities, and Continuing Healthcare. Work on this is ongoing.

15. Subject to updated national guidance for the BCF, the Section 75 Agreement which governs the BCF for 2022/2023 would then be developed in partnership by the council and the ICB and a Deed of Variation to the existing legal agreement would be drawn up to reflect the required changes. The Section 75 Agreement together with the Deed of Variation would provide the clarity around the transfer of the ICB minimum mandated contribution to Adult Social Care and the agreed way in which that will be spent. It is accepted that the contribution would be transferred without deduction or expectation that it will be recharged against ICB service deliverables.

16. The total value of the 2022/2023 BCF is £50,845,464.

17. Mandatory inclusion in the BCF includes:

    a) ICB contribution to Adult Social Care (ASC) (uplifted by 5.7 per cent for 2022/23) to be used for social care and out of hospital spend
    b) ASC Disability Facilities Grant
    c) ASC Improved BCF (iBCF) and Winter Pressures Funding

18. The NHS funded Hospital Discharge Scheme will no longer be available for 2022/23.

19. The remainder is non-mandatory and accounted for £29.5m of the fund. ICB contribution overall is c.£40m and ASC c.£11m. in 2022/23.

20. The IW BCF operates more as an aligned budget than a pooled budget.

National Better Care Fund Planning Requirements

21. For 2021/2022, BCF plans consisted of a narrative plan and a completed BCF planning template including:
    a) planned expenditure from BCF sources
    b) confirmation that national conditions of the fund are met, as well as specific conditions attached to individual funding streams
    c) ambitions and plans for performance against BCF national metrics
    d) any additional contributions to BCF section 75 agreements.

22. The four national conditions for 2020/21, which BCF Plans had to meet to be approved, were:

1	A jointly agreed plan between local health and social care commissioners and signed off by the Health and Wellbeing Board
2	NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution
3	Invest in NHS commissioned out-of-hospital services
4	Plan for improving outcomes for people being discharged from hospital

23. Whilst confirmation is still pending from the central team, it is anticipated that similar requirements for 2022/23 will be in place with the tentative exceptions of:

    a) Revision of National Condition 4 to potentially split into two sub-indicators, one regarding discharge improvement and the other focussed on prevention
    b) Requirement to submit a third document reporting on demand and capacity. This, however, will not be subject to the same level of assurance as the narrative and main planning template. This is in recongition of the short submission timeframe (not yet confirmed but nominally 2 months) but with a view to laying foundations for a more substantial response for 2023/24 onwards.

24. Building on this, it is anticipated that the plan will also need to set out the system's approach to delivery and describe how the approach to integration in the BCF aligns with wider plans in order to:
    a) continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally
    b) support people to remain independent at home

c) jointly improve outcomes for people being discharged from hospital
d) reduce the percentage of hospital inpatients who have been in hospital for more than 14 and 21 days
e) enable a 'Home First' policy

25. Final BCF plans are likely to include stretching ambitions for improving outcomes against the national metrics for the fund. The central team have acknowledged that 'stretching' targets will not necessarily result in an improved metric due to the change in demographic profile, prevalence of conditions and increased complexity. However, supplementary narrative identifying such factors will be required along with the mitigating work undertaken to address.

26. In accordance with the pre-released information from the central BCF team, it is anticipated that the formation of the Plans will continue to be jointly agreed by Integrated Care Boards and local authorities to reflect local health and care priorities, with plans signed off by Health and Wellbeing Boards (HWBs).

National Approval of agreed plans (subject to release of further guidance)

27. The following outlines the assumed process based upon the 2021/22 guidance. Current information provided by the central team supports that a similar process will be in place for 2022/23:

28. The BCF plan will be approved by NHS England following joint NHS and Local Government regional assurance process against a set of national key Lines of Enquiry (KLOEs).

29. Assurance processes will confirm that national conditions are met, ambitions are agreed for all national metrics and that all funding is pooled, with relevant spend agreed.

30. Assurance of final plans will be led by Better Care Managers (BCMs) with input from NHS England and local government representatives. It will be a single stage exercise based on a set of key lines of enquiry (KLoEs). Recommendations for approval will be signed off by NHS regional directors – this will include confirmation that local government representatives were involved in assurance and agree the recommendations.

31. NHS England will approve BCF plans in consultation with Department for Health and Social Care (DHSC) and Department for Levelling Up, Housing and Communities (DLUHC). NHS England, as the accountable body for the ICB minimum contribution to the fund, will write to areas to confirm that the ICB minimum funding can be released. Plans will need to meet all the requirements and national conditions to be approved.

32. Where the local governance schedule does not coincide with the submission deadline, submission is still required with an explanatory note that final approval from the Health and Wellbeing Board is pending. The plan may then proceed through the early stages of the national assurance process but, where otherwise all other conditions are fulfilled, final approval will be held in abeyance until the local Board has granted approval. Only once both approval processes have been completed will the Plan be deemed officially sign off and that the S75 agreement may be put into place. Until that point, all expenditure in line with the BCF intentions will be considered as undertaken 'at risk'.

Strategic Alignment

33. The Isle of Wight BCF Section 75 Agreement (S75) is a large and complex document

dating back to its inception 2013, revised for 2017/2019 with the iBCF, which has been rolled forward in 2019/2020 and 2020/2021 by Deed of Variation. The document sets out the legal basis, governance (BCF S75 Board via Integrated Care Partnership Board (ICP), to Health and Wellbeing Board), Key Performance Indicators and reporting, schemes descriptions/service specifications etc.

34. The BCF Plan and S75 needs to be considered within the context of the refreshed Isle of Wight Health and Care Plan to drive system transformation, financial savings and efficiencies. The S75 agreement will remain in place as the financial and contractual vehicle between the ICB and Local Authority and supports the development of an integrated health and care partnership.

35. The framework for the BCF derives from the government's mandate to the NHS issued under Section 13A of the NHS Act 2006. The BCF provides a mechanism to promote and strengthen integration of health, social care and housing planning and commissioning. And in this context the use of pooled funding arrangements remains consistent with the development of Integrated Care Systems/Partnerships (ICS/ICP).

36. It brings together ring-fenced ICB allocations, and funding paid directly to local government, including IBCF, DFG and winter pressures alongside locally identified budgets into pooled budget arrangements.

37. The BCF Plan aligns with a number of strategic plans including the:

    a) The IOW Health and Wellbeing Strategy – in particular the BCF aligns with the Living Well and Ageing Well domains.
    b) The IOW Health and Care Plan – the BCF aligns with the focus on prevention, integration and care close to home
    c) The ASC Care Closer to Home Strategy (CCtH) -which also aligns to the Councils corporate plan. The BCF provides a vehicle for delivery of CCtH core delivery and enabling pillars including: promoting wellbeing, improving wellbeing and protecting wellbeing as well as integration and partnerships and commissioning for value and impact.
    d) The HIOW Partnership of ICBs Delivery Plan
    e) The System Winter Resilience Plan
    f) The Extra Care Strategy
    g) The Disabled Facilities Grant Plan
    h) NHS Long Term Plan
    i) Local Authority High Impact Change Model

38. The refresh of the BCF schemes is further supported by seven agreed IWHCP Board, priority transformation projects:

    a) Frailty
    b) Dementia
    c) Hospital Discharge and Regaining Independence
    d) Virtual Ward and virtual care pathways
    e) Integrated Care Home Support
    f) Urgent Community response
    g) Population Health Management and Localities

    These scheme each have a Senior Responsible Officer from the Local Delivery System (LDS) and governance and reporting structure to the Community Transformation Board.

Risk

39. There is significant risk to both the IW Council, the ICB, and the wider system if the BCF Plan and submission for 2022/23 is not agreed and subsequently approved by regulators:

No.	Risk	Risk	Mitigation
1	Should the system not agree and fail to submit its plan by the indicated deadline, the system will not receive additional funding earmarked for local systems to support ASC. In particular, the Improved Better Care Fund (iBCF) and Disabled Facilities Grant (DFG) continue to be paid to local authorities on the condition that they are pooled locally into the BCF and spent on specific purposes set out in the grant determinations and conditions. The worst-case scenario could see mandatory funding withheld from the system.	R	• HWB agree to receive an interim position update with opportunity for feedback. • HWB agree to receive a refresh existing financial commitment- recognising these could be subject to change. • Review of services has commenced in advance of guidance release to allow for continued impact of Covid-19 on workforce capacity. • Fortnightly planning meetings in place with representatives from the ICB and IWC. • Where the HWB does not meet prior to submission deadline a virtual HWB sign-off process prior to the final deadline is proposed.
2	Failure to submit presents a significant reputational risk to the ICB, LA, HWB and wider system. In particular, the BCF planning guidance forms part of the core NHS Operational Planning and Contracting Guidance. ICBs are therefore required to have regard to this guidance by section 14Z11 of the NHS Act 2006. With a view to the wider system; having published a single system Health and Care Plan, that includes a single control total, failing to submit the BCF plan will likely result in external scrutiny from National regulators and further scrutiny of system plans and agreements to develop ICP arrangements.	A	
3	Failure to agree financial contributions within the BCF plan may result in the requirement to undertake a significant BCF and S75 refresh placing additional resource strain upon the system.	A	
4	HWB governance arrangements and decision making does not support effective BCF development and delivery. Where there are concerns over the submission, performance or compliance with BCF requirements the Better Care Fund Support team (BCST) and Better Care Manager (BCM) will take action that could range from informal support, advice,	A	• HWB to agree BCF management and decision-making infrastructure as part of the Health and Care Plan implementation. • To engage with the local BCM for guidance prior to final submission. • To have cross-organisational

	and guidance moving through formalized support and formal regional meetings up to formal escalation panels that involve NHS England and LGA. In the event of national escalation, under the NHS Act 2006 NHS England does have the ability to direct the use of ICB funds where an area fails to meet the BCF conditions. The escalation panel may also make recommendation that an area should amend plans that relate to spending of the DFG, Winter pressures or IBCF- however this money is not subject to NHS E powers. However, if there is not agreement and a plan cannot be agreed Departments can recover grant payments or withhold future funding.		contribution and review of the plan prior to submission.
5	Scale of system financial challenge threatens BCF development and delivery	R	• HWB agree the process for investment and disinvestment decisions • Review the current pooled budgets • Ensure that BCF schemes are aligned to sustainability plan priorities
6	Winter pressures money are to be paid to local government via a section 31 grant, to be used to alleviate pressures on the NHS over winter and to ensure it is pooled in to the BCF. No further resources are currently available to the system to support winter resilience.	A	• This is a recurrent approach to Winter pressure funding with well-established planning and delivery mechanisms, which would potentially downgrade this risk to green. However, maintained at a higher escalation level as winter planning and response will also need to factor in any changes arising from shifts in the pandemic.

Financial Impact

40. For 2021/2022 and 2022/2023 Finance leads in the Council and ICB will work jointly with BCF scheme leads to review all funding allocations. The approach and detail will be worked up and agreed through the System Finance Group. This will also provide focus in ensuring any queries in relation to the level of mandated contribution by the ICB are resolved.

41. The total value of the Better Care Fund in 2022/23 is £50,845,464. This value is made up of both mandated and discretionary funding contributions from both the ICB of £39,503,696 and the council £11,341,768. (see para. 12-15 above).

42. From this allocation, services are then agreed in line with the BCF guidance and funding

transferred to either the ICB or council based on who commissions the service. The table below shows the schemes within the BCF and where the money has been transferred to provide the services and contractual payment commitments against each of the identified schemes:

Scheme	BCF FUNDING ALLOCATED TO EACH PARTNER 2022/23		
	ICB £'000	**IWC £'000**	**Total £'000**
1) Locality / Community Model	7,991	69	**8,060**
2) Hospital to Home	69	1,520	**1,589**
3) Carers	-	580	**580**
4) Voluntary Community Sector	-	808	**808**
5) Provider Sector	-	80	**80**
6) Promoting Independence	47	3,236	**3,283**
7) Rehabilitation, Reablement and Recovery	5,329	5,804	**11,133**
8) Regaining Independence - Hospital Discharge Scheme	741	-	**741**
9) Integrated Mental Health Provision	2,589	147	**2,736**
10) Learning Disability Services	-	1,192	**1,192**
11) Continuing Health Care and Funded Nursing Care	15,219	-	**15,219**
12) Care Act and Infrastructure	-	5,425	**5,425**
Total BCF funding shared between ICB/IWC to fund scheme contracts	**31,985**	**18,861**	**50,846**
Percentage of share	**63%**	**37%**	**100%**

43. The BCF template has previously included a summary of the expected income and expenditure that will form the basis of the Section 75 Finances. It outlines the quantum of financial resource included on a scheme-by-scheme basis, including reference to both the mandated CCG contributions, Mandated Local Authority elements and additional local investments and pooled funds. It is anticipated that a similar template will be in place for 2022/23.

44. The ICB has approved the Isle of Wight local financial planning approach and are satisfied that all mandatory contributions have been refreshed and uplifted in line with the National technical guidance.

45. The BCF plan reflects an iterative journey over several years, with some specific agreements

of where funding is assigned dating back as far as 2012.

46. The Section 75 agreement sets out the arrangements for financial risk sharing between the ICB and the Council should the aligned budget over/underspend. The current provisions of the S75 agreement provide that each organisation is responsible for the over/underspend relating to its own functions; therefore, the Better Care Fund does not increase the financial risk to either organisation.

Involvement and Consultation

47. The BCF planning template and associated Section 75 agreement is developed and updated by the ICB and IW Council; processes are in place to ensure that the current submission is reflective of input from both bodies.

48. A engagement process with wider stakeholders is currently being undertaken with service leads. As wider stakeholders have been strongly involved in the development of the refreshed Health and Care Plan and previous BCF planning, feedback will also be drawn from these sources to inform the development of the 2022/23 submission.

49. The oversight of the BCF S75 for the Island is in collaboration between the ICB and council commissioners. This is overseen by both the Managing Director of the ICB-IW and Assistant Director for Commissioning (IWC). Proposals to use the BCF funds must be submitted to both the ICP and then in turn via the HWB for formal sign off and approval. This is in addition to the sovereign organisations' internal governance routes (e.g. ICB board and councils Cabinet). Monitoring of BCF spend is provided via quarterly monitoring reports for S75 aligned budget use.

50. Although required to review and revise the S75 agreement around the agreed priorities, it is not necessary to create a complete re-write of the S75 document every year to form a new agreement. In considering revisions:

    a) It will be reviewed to reflect any specific changes and will maintain the financial risk sharing between the ICB and council should the pooled budget overspend or underspend;
    b) It will clarify the transfer of the ICB minimum mandated contribution to Adult Social Care and the agreed way in which that will be spent;
    c) It will seek to simplify the S75 Agreement to reflect new governance and aspirations based on emerging ICP place principles, priorities, and fit with both NHS Integrated Care Systems and Local Government direction of travel.
    d) It continues to maintain the spirit of the original S75 rather than seeking to start a new agreement that would take considerable time and resource to produce a very large agreement document from scratch with little change to the needs of the agreement.

Decisions, recommendations and any options

51. To note the proposals and:

    a) NOTE the BCF End of Year Template report for 2021/22
    b) APPROVE the development of the BCF 2022/23 plan in line with national and local requirements outlined above with a view to a virtual sign-off by the HWB due to the necessity to align with national submission deadlines (pending).

Appendices

Appendix 1 - BCF End of Year Template 2021/22

MICHAELA DYER
Interim Managing Director, Hampshire and Isle of Wight ICB - IW

LAURA GAUDION
Director of Adult Social Care, IW Council

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Appendix 1

Better Care Fund 2021-22 Year-end Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2021-22, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Hosusing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) To confirm actual income and expenditure in BCF plans at the end of the financial year
3) To provide information from local areas on challenges, achievements and support needs in progressing the
4) To enable the use of this information for national partners to inform future direction and for local areas to

BCF quarterly reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including clinical commissioning groups, local

BCF quarterly reports submitted by local areas are required to be signed off by HWBs as the accountable governance body for the BCF locally and these reports are therefore part of the official suite of HWB

The BCF quarterly reports in aggregated form will be shared with local areas prior to publication in order to support the aforementioned purposes of BCF reporting. In relation to this, the BCF Team will make the aggregated BCF quarterly reporting information in entirety available to local areas in a closed forum on the

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, cont
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercaresupport@nhs.net
3. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2021-22 (link below) continue to be met through the
https://www.england.nhs.uk/publication/better-care-fund-planning-requirements-2021-22/

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met within the quarter and how this is being addressed. Please note that where a National

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: NHS contribution to adult social care is maintained in line with the uplift to CCG
National condition 3: Agreement to invest in NHS commissioned out-of-hospital services
National condition 4: Plan for improving outcomes for people being discharged from hospital

4. Metrics

The BCF plan includes the following metrics: Unplanned hospitalisation for chronic ambulatory care sensitive conditions, Proportion of hospital stays that are 14 days or over, Proportion of hospital stays that are 14 days or over, Proportion of discharges to a person's usual place of residence, Residential Admissions and
This section captures a confidence assessment on achieving the plans for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes that have been achieved.
The BCF Team publish data from the Secondary Uses Service (SUS) dataset for Long length of stay (14 and 21 days) and Dischaege to usual place of residence at a local authority level to assist systems in understanding

The metris worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric plans and the related narrative information and it is advised that:
- In making the confidence assessment on progress, please utilise the available published metric data (which should be typically available for 2 of the 3 months) in conjunction with the interim/proxy metric information for the third month (which is eventually the source of the published data once agreed and validated) to
- In providing the narrative on Challenges and Support needs, and Achievements, most areas have a sufficiently good perspective on these themes by the end of the quarter and the unavailability of published metric data for one of the three months of the quarter is not expected to hinder the ability to provide this useful information. Please also reflect on the metric performance trend when compared to the quarter from

Please note that the metrics themselves will be referenced (and reported as required) as per the standard

5. Income and Expenditure

The Better Care Fund 2021-22 pool constitutes mandatory funding sources and any voluntary additional pooling from LAs (Local Authorities) and CCGs. The mandatory funding sources are the DFG (Disabled Facilities Grant), the improved Better Care Fund (iBCF) grant, and the minimum CCG contribution. A large

Income section:

- Please confirm the total HWB level actual BCF pooled income for 2021-22 by reporting any changes to the planned additional contributions by LAs and CCGs as was reported on the BCF planning template.
- The template will automatically pre populate the planned expenditure in 2021-22 from BCF plans, including additional contributions.
- If the amount of additional pooled funding placed intothe area's section 75 agreement is different to the amount in the plan, you should select 'Yes'. You will then be able to enter a revised figure. Please enter the
- Please provide any comments that may be useful for local context for the reported actual income in 20121-

Expenditure section:

- Please select from the drop down box to indicate whether the actual expenditure in you BCF section 75 is different to the planned amount.
- If you select 'Yes', the boxes to record actual spend, and expanatory comments will unlock.
- You can then enter the total, HWB level, actual BCF expenditure for 2021-22 in the yellow box provided
- Please provide any comments that may be useful for local context for the reported actual expenditure in

6. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2021-22 through a set of survey questions

The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 9 questions.

Part 1 - Delivery of the Better Care Fund

There are a total of 3 questions in this section. Each is set out as a statement, for which you are asked to

- Strongly Agree
- Agree
- Neither Agree Nor Disagree
- Disagree
- Strongly Disagree

The questions are:

1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2021-22
3. The delivery of our BCF plan in 2021-22 had a positive impact on the integration of health and social care

Part 2 - Successes and Challenges

This part of the survey utilises the SCIE (Social Care Institue for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration'

Please highlight:

8. Two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model)
9. Two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model)

For each success and challenge, please select the most relevant enabler from the SCIE logic model and provide a narrative describing the issues, and how you have made progress locally.

SCIE - Integrated care Logic Model

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rurual
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making
5. Integrated workforce: joint approach to training and upskilling of workforce

6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

7. ASC fee rates

This section collects data on average fees paid by the local authority for social care.

Specific guidance on individual questions can be found on the relevant tab.

HM Government

NHS

Better Care Fund 2021-22 Year-end Template

2. Cover

Version 2.0

Please Note:

- *The BCF end of year reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. Narrative sections of the reports will not be published. However as with all information collected and stored by public bodies, all BCF information including any narrative is subject to Freedom of Information requests.*
- *At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.*
- *All information, including that provided on local authority fee rates, will be supplied to BCF partners to inform policy development.*
- *This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.*

			Checklist Complete:
Health and Wellbeing Board:	Isle of Wight		Yes
Completed by:	Cheryl Harding-Trestrail		Yes
E-mail:	cheryl.harding@nhs.net		Yes
Contact number:	07917 306 229		Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No, subject to sign-off		Yes
If no, please indicate when the report is expected to be signed off:	Thu 28/07/2022	<< Please enter using the format, DD/MM/YYYY	Yes
Please indicate who is signing off the report for submission on behalf of the HWB (delegated authority is also accepted):			
Job Title:	Interim Managing Director Isle of Wight System, Hampshire and		Yes
Name:	Michaela Dyer and Laura Gaudion		Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Income and Expenditure actual	Yes
6. Year-End Feedback	Yes
7. ASC fee rates	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Year-end Template

3. National Conditions

Selected Health and Wellbeing Board: Isle of Wight

Confirmation of Nation Conditions			Checklist
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in 2021-22:**	Complete:
1) A Plan has been agreed for the Health and Wellbeing Board area that includes all mandatory funding and this is included in a pooled fund governed under section 75 of the NHS Act 2006? (This should include engagement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes		Yes
2) Planned contribution to social care from the CCG minimum contribution is agreed in line with the BCF policy?	Yes		Yes
3) Agreement to invest in NHS commissioned out of hospital services?	Yes		Yes
4) Plan for improving outcomes for people being discharged from hospital	Yes		Yes

Better Care Fund 2021-22 Year-end Template

4. Metrics

Selected Health and Wellbeing Board: Isle of Wight

National data may like be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2021-22 planning				Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements	Checklist Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	609.4				On track to meet target	A challenging workforce position remain a consistant theme across the health and care system. However, despite this, the schemes implemented during 2020/21 have been successful in addressing unplanned	End of year position at 603.9. Whilst the overall admissions for ambulatory care sensitive conditions have remained reasonably static since financial year 2017/18, a slight increase in the plan for	Yes
Length of Stay	Proportion of inpatients resident for: i) 14 days or more ii) 21 days or more	**14 days or more (Q3)**	**14 days or more (Q4)**	**21 days or more (Q3)**	**21 days or more (Q4)**	Not on track to meet target	Data discrepancy between local monitoring and the centrally held BCF time series remains. E.g. the Performance Information and Decision Support team report for Q3 10.8% and 6.2% then for Q4 10.6% and 6.5%	This metric is one of the key ones being proactively monitored at a system level (System Resilience Group) with partner organisations able to respond to any fluctuations accordingly. The end of year	Yes
		11.0%	11.5%	6.0%	6.2%				
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	82.3%				On track to meet target	Whilst the target as been met one of the greates challenges has been, and continues to be, is that of sourcing home care packages.	End of year position achieved 91.8% as calculated by the local performance team. The central data provided indicated that for 2021/22 the rate was 92.6%. Both of these figures indicate an improvement on 2020/21	Yes
Res Admissions*	Rate of permanent admissions to residential care per 100,000 population (65+)	1,957				On track to meet target	None identified. 2021/22 figures will be finalised on completion of this year's SALT return. As noted above, one of the main rate limiting	Figures provided and derived from the ASC SALT return and is the number of NEW Long-term support needs met by admission to residential and nursing care homes, RATE: per 100,000 population (65+)(ASCOF 2A part	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	78.0%				Not on track to meet target	This measure is an ASCOF measure and derived from the ASC SALT return and is based on QTR 3 of a financial year. Previous years have seen the IOW outturn slightly below the national average:	Performance during Qtrs 1 and 2 of 2021/22 averaged at 78%, meeting the target.	Yes

* In the absense of 2021-22 population estimates (due to the devolution of North Northamptonshire and West Northamptonshire), the denominator for the Residential Admissions metric is based on 2020-21 estimates

Better Care Fund 2021-22 Year-end Template

5. Income and Expenditure actual

Selected Health and Wellbeing Board: Isle of Wight

Income

	2021-22					
Disabled Facilities Grant	£2,272,039					
Improved Better Care Fund	£5,998,410					
CCG Minimum Fund	£12,515,569					
Minimum Sub Total		£20,786,018				
	Planned		Actual			
CCG Additional Funding	£30,841,087		Do you wish to change your additional actual CCG funding?	No		
LA Additional Funding	£2,513,883		Do you wish to change your additional actual LA funding?	No		
Additional Sub Total		£33,354,970				£33,354,970

	Planned 21-22	Actual 21-22
Total BCF Pooled Fund	£54,140,988	£54,140,988

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2021-22	

Expenditure

	2021-22
Plan	£54,140,988

Do you wish to change your actual BCF expenditure?	Yes

Actual	£51,309,075

Checklist

Complete:

Yes
Yes
Yes
Yes
Yes

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2021-22	Local authority overall cost pressure of £51k comprising of hospital social work staffing and internal reablement centres offset by underspends in community equipment and internal homecare teams. CCG overall underspend of £2.9m comprising of Hospital Dicharge funding and CHC.

Yes

Better Care Fund 2021-22 Year-end Template

6. Year-End Feedback

The purpose of this survey is to provide an opportunity for local areas to consider and give feedback on the impact of the BCF. Covid-19 had a significant impact on services and schemes delivered on the ground which may have changed the context. However, national BCF partners would value and appreciate local area feedback to understand views and reflections of the progress and challenges faced during 2021-22
There is a total of 5 questions. These are set out below.

Selected Health and Wellbeing Board: Isle of Wight

Part 1: Delivery of the Better Care Fund
Please use the below form to indicate to what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response	Checklist Complete:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	The BCF remains an underpinning enabler for the delivery of integrated services across the Isle of Wight's Health and Social Care system. At a strategic level, the BCF has received a raised profile over the Q3/4 and continuing into 2022/23. This has enabled wider discussion and improvement integration between organisations. It has also helped shaped initial	Yes
2. Our BCF schemes were implemented as planned in 2021-22	Strongly Agree	The continuation of extant services supported by the BCF into 2021/2022, focusing on inclusive restoration and recovery [I.1; II.1] was a primary action supporting the transition from an emergency pandemic response phase during the height of the pandemic into a restoration and recovery mode. The integrated reablement services [BCF Action IV.2-3] was	Yes
3. The delivery of our BCF plan in 2021-22 had a positive impact on the integration of health and social care in our locality	Agree	The BCF remains a cornerstone of integration within the local health and care system. Transparency of pooled financial and leadership arrangements has built confidence, strengthened relationships and positively impacted on integration and outcomes. The BCF plan, and associated Section 75 Agreement, is used as a fundamental component in the	Yes

Part 2: Successes and Challenges
Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and two Enablers which you have experienced a relatively greater degree of challenge in progressing.
Please provide a brief description alongside.

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2021-22	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes	Checklist Complete:
Success 1	5. Integrated workforce: joint approach to training and upskilling of workforce	BCF funding allocation for a community-bedded Mental Health service was in place since 2017 with two separate funding lines for different elements. The Reablement team worked with inpatients at a site called Woodlands and a wider community caseload. The focus of this team was to work with People With Lived Experience (PWLE) aged 18-65 to support them to "manage their own condition, get a job, make friends, and maintain safe and secure housing of their choice enabling people to achieve their own life goals." The model originally supported, at any one time, 10 inpatients and up to 18 people in the	Yes
Success 2	9. Joint commissioning of health and social care	The Living Well Early Help service was recommissioned in collaboration with the CCG and the new contract started 1st April 2022 for a three plus two-year contract. The new LWEH service pulls together the old Living Well service and combines the following workstreams identified in the BCF review: VCS Living Well and EH Team, Brokerage Scheme, Help Through Crisis, The Volunteering Age UK GNS and Early Help Care Navigators. The new LWEH service provides community resilience and support which brings early help and provision to those in the community before they access statutory services. The service	Yes

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2021-22	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges

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Challenge 1	5. Integrated workforce: joint approach to training and upskilling of workforce	Workforce remains a recurrent theme both within the context of the BCF and wider service delivery. The Isle of Wight, like other more isolated areas, faces a degree of geographical isolation which impacts on recruitment and retention of staff. Services often then are unable to reach optimum delivery of their potential either due to carrying internal vacancies or becoming holders of caseloads where bottlenecks prevent onwards flow. At present, whilst services and pathways may be integrating, workforce is still often viewed at a service rather than system level - often resulting in high turnovers with	Yes
Challenge 2	6. Good quality and sustainable provider market that can meet demand	There is a significant challenge being faced in respect of workforce within the Isle of Wight community services. In additional to local capacity issues experienced prior to the pandemic, the impact of Covid-19 has further reduced capacity across both care homes and home care – a position which is disproportionately felt by those with complex needs and people with dementia who require more specialist support. One of the most significant consequences arising is that we are seeing a higher number of Medically Optimised For Discharge (MOFD) individuals remaining in hospital longer than we, and they,	Yes

Footnotes:

Question 4 and 5 are should be assigned to one of the following categories:
1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

Other

Better Care Fund 2021-22 Year-end Template

7. ASC fee rates

Selected Health and Wellbeing Board: Isle of Wight

The iBCF fee rate collection gives us better and more timely insight into the fee rates paid to external care providers, which is a key part of social care reform.

Given the introduction of the Market Sustainability and Fair Cost of Care Fund in 2022-23, we are exploring where best to collect this data in future, but have chosen to collect 2021-22 data through the iBCF for consistency with previous years.

These questions cover average fees paid by your local authority (gross of client contributions/user charges) to external care providers for your local authority's eligible clients. The averages will likely need to be calculated from records of payments paid to social care providers and the number of client weeks they relate to, unless you already have suitable management information.

We are interested ONLY in the average fees actually received by external care providers for your local authority's eligible supported clients (gross of client contributions/user charges), reflecting what your local authority is able to afford.

In 2020-21, areas were asked to provide actual average rates (excluding whole market support such as the Infection Control Fund but otherwise, including additional funding to cover cost pressures related to management of the COVID-19 pandemic), as well as a 'counterfactual' rate that would have been paid had the pandemic not occurred. This counterfactual calculation was intended to provide data on the long term costs of providing care to inform policymaking. In 2021-22, areas are only asked to provide the actual rate paid to providers (not the counterfactual), subject to than the exclusions set out below.

Specifically the averages SHOULD therefore:

- EXCLUDE/BE NET OF any amounts that you usually include in reported fee rates but are not paid to care providers e.g. your local authority's own staff costs in managing the commissioning of places.
- EXCLUDE/BE NET OF any amounts that are paid from sources other than eligible local authority funding and client contributions/user charges, i.e. you should EXCLUDE third party top-ups, NHS Funded Nursing Care and full cost paying clients.
- EXCLUDE/BE NET OF whole-market COVID-19 support such as Infection Control Fund payments.
- INCLUDE/BE GROSS OF client contributions /user charges.
- INCLUDE fees paid under spot and block contracts, fees paid under a dynamic purchasing system, payments for travel time in home care, any allowances for external provider staff training, fees directly commissioned by your local authority and fees commissioned by your local authority as part of a Managed Personal Budget.
- EXCLUDE care packages which are part funded by Continuing Health Care funding.

If you only have average fees at a more detailed breakdown level than the three service types of home care, 65+ residential and 65+ nursing requested below (e.g. you have the more detailed categories of 65+ residential without dementia, 65+ residential with dementia) **please calculate for each of the three service types an average weighted by the proportion of clients that receive each detailed category:** 1. Take the number of clients receiving the service for each detailed category.
2. Divide the number of clients receiving the service for each detailed category (e.g. age 65+ residential without dementia, age 65+ residential with dementia) by the total number of clients receiving the relevant service (e.g. age 65+ residential).
3. Multiply the resultant proportions from Step 2 by the corresponding fee paid for each detailed category.
4. For each service type, sum the resultant detailed category figures from Step 3.

Please leave any missing data cells as blank e.g. do not attempt to enter '0' or 'N/A'.

Checklist

	For information - your 2020-21 fee as reported in 2020-21 end of year reporting *	Average 2020/21 fee. If you have newer/better data than End of year 2020/21, enter it below and explain why it differs in the comments. Otherwise enter the end of year 2020-21 value	What was your actual average fee rate per actual user for 2021/22?	Implied Uplift: Actual 2021/22 rates compared to 2020/21 rates	Complete:
1. Please provide the average amount that you paid to external providers for home care, calculated on a consistent basis. (£ per contact hour, following the exclusions as in the instructions above)	£19.72	£19.72	£19.68	-0.2%	Yes
2. Please provide the average amount that you paid for external provider care homes without nursing for clients aged 65+, calculated on a consistent basis. (£ per client per week, following the exclusions as in the instructions above)	£619.30	£619.30	£651.63	5.2%	Yes
3. Please provide the average amount that you paid for external provider care homes with nursing for clients aged 65+, calculated on a consistent basis. (£ per client per week, following the exclusions in the instructions above)	£780.98	£780.98	£818.82	4.8%	Yes
4. Please provide additional commentary if your 2020-21 fee is different from that reported in your 2020-21 end of year report. Please do not use more than 250 characters.					Yes

Footnotes:

* ".." in the column C lookup means that no 2020-21 fee was reported by your council in the 2020-21 EoY report

** For column F, please calculate your fee rate as the expenditure during the year divided by the number of actual client weeks during the year. This will pick up any support that you have provided in terms of occupancy guarantees.
(Occupancy guarantees should result in a higher rate per actual user.)

*** Both North Northamptonshire & West Northamptonshire will pull the same last year figures as reported by the former Northamptonshire County Council.