Coventry City Council

Agenda

Health and Social Care Scrutiny Board (5)

Time and Date
2.00 pm on Wednesday, 11th February, 2015

Place
Committee Rooms 2 and 3 - Council House

Public Business

1. **Apologies and Substitutions**

2. **Declarations of Interest**

3. **Minutes**

   (a) To agree the minutes of the meeting held on 7th January, 2015 (Pages 5 - 8)

   (b) Matters Arising

2.10 pm

4. **Winter Pressures in Coventry** (Pages 9 - 34)

   Briefing Notes of the Scrutiny Co-ordinator and the Executive Director of People

   Presentations from Coventry and Rugby Clinical Commissioning Group (CCG) and University Hospitals Coventry and Warwickshire (UHCW)

   The following representatives have been invited to attend for the consideration of this item:

   Councillor Maggie O'Rourke, Chair, Adult Social Care and Health Overview and Scrutiny Committee, Warwickshire County Council
   Sue Davies, Head of Partnerships, Coventry and Rugby CCG
   David Eltringham, Chief Operating Officer, UHCW
   Rebecca Southall, Director of Corporate Affairs, UHCW

3.10 pm

5. **Clinical Management of Large Scale Chronic Diseases** (Pages 35 - 60)

Briefing note and presentation of the Director of Public Health

The following representatives have been invited to the meeting for the consideration of this item:

Dr Surinder Chaggar, GP and Clinical Lead for Integration, Coventry and Rugby Clinical Commissioning Group (CCG)
Dr Colin Gelder, Consultant Respiratory Physician, University Hospitals Coventry and Warwickshire (UHCW)
Michelle Horn, Primary Care Lead Nurse, Coventry and Rugby CCG
Dr Paul O'Hare, Consultant Diabetic Physician, UHCW
Dr Madeleine Wells, GP, Coventry and Rugby CCG and Coventry Local Medical Committee

4.10 pm

6. **Outstanding Issues Report**

Outstanding issues have been picked up in the Work Programme

7. **Work Programme 2014-15** (Pages 61 - 68)

Report of the Scrutiny Co-ordinator

8. **Any other items of Public Business**

Any other items of public business which the Chair decides to take as matters of urgency because of the special circumstances involved

9. **Meeting Evaluation**

Private Business

Nil

Chris West, Executive Director, Resources, Council House Coventry

Tuesday, 3 February 2015

Notes: 1) The person to contact about the agenda and documents for this meeting is Liz Knight, Governance Services, Council House, Coventry, telephone 7683 3073, alternatively information about this meeting can be obtained from the following web link: http://moderngov.coventry.gov.uk

2) Council Members who are not able to attend the meeting should notify Liz Knight as soon as possible and no later than 1.00 p.m. on 11th February, 2015 giving their reasons for absence and the name of the Council Member (if any) who will be attending the meeting as their substitute.

3) Scrutiny Board Members who have an interest in any report to this meeting, but who are not Members of this Scrutiny Board, have been invited to notify

the Chair by 12 noon on the day before the meeting that they wish to speak on a particular item. The Member must indicate to the Chair their reason for wishing to speak and the issue(s) they wish to raise.

Membership: Councillors M Ali, K Caan (By Invitation), J Clifford, A Gingell (By Invitation), P Hetherton, D Howells, J Mutton, J O'Boyle, D Skinner, D Spurgeon, K Taylor and S Thomas (Chair)

Please note: a hearing loop is available in the committee rooms

If you require a British Sign Language interpreter for this meeting OR it you would like this information in another format or language please contact us.

Liz Knight
Telephone: (024) 7683 3073
e-mail: liz.knight@coventry.gov.uk

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Coventry City Council
Minutes of the Meeting of Health and Social Care Scrutiny Board (5) held at 2.00 pm on Wednesday, 7 January 2015

Present:

Members:	Councillor S Thomas (Chair) Councillor J Clifford Councillor P Hetherton Councillor J Mutton Councillor J O'Boyle Councillor D Skinner Councillor K Taylor
Co-Opted Members:	Ms G Allen Mr J Mason
Other Members:	Councillors L Bigham, J Blundell, R Lakha, J Lepoidevin, M Mutton and P Townshend
Other representatives:	Jacqueline Barnes, Coventry and Rugby Clinical Commissioning Group (CCG) Dr Alex Cooper-Bastien, University Hospitals Coventry and Warwickshire (UHCW) Jane Eminson, West Midlands Quality Review Service Jed Francique, Coventry and Warwickshire Partnership Trust (CWPT) Matt Gilks, CCG David Healey, Coventry and Warwickshire MIND Jenni Muskett, Relate Mandy Whateley, CWPT
Employees:	S Brake, People Directorate A Butler, People Directorate V Castree, Resources Directorate G Holmes, Resources Directorate L Knight, Resources Directorate B Lee, Chief Executive's Directorate
Apologies:	Councillors N Akhtar, S Bains and J Innes

Public Business

45. **Declarations of Interest**

There were no disclosable pecuniary interests declared

46. **Minutes**

The minutes of the meeting held on 10th December, 2014 were signed as a true record.

Further to Minute 43 headed 'Work Programme', Matt Gilks, Coventry and Rugby Clinical Commissioning Group, provided a brief update on the latest position concerning the contract to provide the Patient Transport Service at University Hospital Coventry and Warwickshire. The new contract had just been awarded and would commence on 1st April, 2015. An announcement regarding the new contractor would be made in the next few days. Reference was made to the enhanced key performance indicators included in the contract.

Members questioned the representative on the recent provision of the service; whether the new targets were achievable; and enquired about the concerns raised by staff in the Renal unit.

47. **Towards Children and Young People's Emotional Health and Well-being - West Midlands Quality Review Service (WMQRS) Peer Review**

The Scrutiny Board considered a briefing note of the Executive Director for People concerning the findings of the West Midlands Quality Review Service (WMQRS) Peer Review of Child and Adolescent Mental Health Services (CAMHS) and detailing the actions for improvement. A copy of the review report 'Towards Children and Young People's Emotional Health and Well-being' was attached at an appendix. The Board also received a presentation on the review from Coventry and Warwickshire Partnership Trust (CWPT). Members of the Education and Children's Services Scrutiny Board (2) attended the meeting for the consideration of this item.

Jacqueline Barnes and Mark Gilks, Coventry and Rugby Clinical Commissioning Group (CCG), Dr Alex Cooper-Bastien, University Hospitals Coventry and Warwickshire (UHCW), Jane Eminson, WMQRS, Jed Francique, Josie Spencer and Mandy Whateley, CWPT, David Healey, Coventry and Warwickshire MIND and Jenni Muskett, Relate all attended the meeting for the consideration of this item.

The briefing note set out the range of CAMHS services which were commissioned locally in the context of a nationally adopted four tiered framework and referred to the key challenges and risks that had been identified by the commissioners and CWPT. Reference was made to good practice and achievements highlighted in the review report along with the risks and concerns. The immediate actions taken by the commissioners to address the issues were set out and further specific works were highlighted.

The presentation set out the background, scope and process of the review which comprised a two day site visit in July 2014 comprising observation, interviews and review of evidence. Positive key finding for CWPT were highlighted along with the areas identified as requiring attention. The actions being undertaken in the following areas were detailed: service redesign; waiting list management; and self-harm.

The Board questioned all the representatives on a number of issues and responses were provided. Matters raised included:

- If the partner organisations were aware of the issues, why were they not being dealt with
- Clarification about the funding implications for the services
- Whether the review found additional issues that the commissioners and service providers were not aware of
- The reasons behind the increasing demand for services
- The benefits of having the single point of entry to ensure patients receive the right service appropriate to their needs
- Concerns about the problems with record keeping and the vital importance of having documented care plans
- How the service involves the whole family
- The views of the commissioners and the main provider regarding the complexities of the commissioning process
- Details about how the service used telephone calls in light of a concern that this method could be used as oppose to the preferential face to face contact
- How clinicians were being listened to and how their views had been used to help shape the service
- Details about waiting times for children and young people suffering abuse and exploitation
- The measures undertaken to avoid risks to patients including assurances about initial assessments and waiting times for treatment
- A comparison of funding levels for mental health compared to other areas of the health service
- Concerns about the provision of services to support Looked After Children, highlighting the importance of ensuring these children have access to the appropriate support they require
- The support provided to pupils from local schools including the assistance being given to individual schools to ensure they can respond to any child in need
- The provision of training for teachers
- The arrangements for supporting young people aged 16-18 at the Caludon Centre and clarification about the support for patients at the transition stage from childhood to adulthood
- How the partnership can ensure a consistent integrated approach with an equable service for all across the Coventry and Warwickshire locality
- Details about how referrals are made and by whom
- Details about the increasing numbers of patients entering the service and the increasing complexities of individual cases
- The training, advice and support available to GPs to allow them to support their patients with mental health issues rather than making referrals
- The preventative work to support young people using illegal drugs which can have a severe impact on mental health
- The arrangements for dealing with emergency cases
- Are sufficient questions asked when patients' needs are assessed.

RESOLVED that:

(1) The Board noted the action taken to address the findings of the WMQRS peer review and other service pressures identified by commissioners.

(2) The Education and Children's Services Scrutiny Board (2) be requested to consider the following issues for inclusion in their work programme:
(i) The reduction in school based support to children and young people and their families at an early intervention stage.
(ii) Emotional Health and Well-being services for looked after children and other vulnerable groups.

(3) Councillor Ruane, Cabinet Member for Children and Young People be asked to consider the two issues.

48. **Outstanding Issues Report**

The Scrutiny Board noted that all outstanding issues had been included in the Work Programme for the current year.

49. **Work Programme 2014-15**

The Scrutiny Board noted the work programme for 2014-15.

50. **Any other items of Public Business - Current Position at Accident and Emergency, University Hospital Coventry and Warwickshire**

The Board received a verbal update from Jacqueline Barnes, Coventry and Rugby CCG, regarding the current position at Accident and Emergency, UHCW. Twice daily calls were taking place across the health system concerning A and E and patient discharges. Numbers at A and E had not increased significantly; the main problems were being caused by the lack of patient discharges. It was clarified that it had not been necessary to declare a major incident.

(Meeting closed at 4.15 pm)

Coventry City Council

Briefing note

To: **Health and Social Care Scrutiny Board (5)** **Date: 11th February 2015.**

Subject: Winter Pressures

1 Purpose of the Note

1.1 University Hospitals Coventry and Warwickshire NHS Trust (UHCW), Coventry and Rugby Clinical Commissioning Group (CCG) and the Council's Adult Social Care Service have been invited to the meeting to provide the Board with an update on how they are coping with winter pressures and what mitigations are being put in place to alleviate pressure pinch points.

2 Recommendations

2.1 The Board are recommended to note this Briefing Note.

3 Information/Background

3.1 Following national coverage of Winter Pressures, the Board have invited in local partners to discuss the current issues.

3.2 This includes UHCW, who as one of the largest secondary and tertiary care providers in the Midlands plays a pivotal role in the local health economy. Its designation as a Regional Trauma Centre has formalised a developing trend in the development of its services, with patients suffering from severe trauma from a wide area now being sent to the site.

3.3 This winter has seen a number of acute Trusts struggle to cope with the impact of the colder weather, despite it being a milder winter than is often experienced. The weather, along with, increases in general illness, additional falls etc with older patients means they have regularly failed to meet the national 95% target that patients attending A&E are to be seen and treated in 4 hours or less.

3.4 The CCG, which buys the area's health services, have also been invited to provide details of action they are taking to improve the situation in Coventry.

3.5 Adult Social Care will also be present to discuss their role in maintaining flow through the system, particularly in relation to speed of discharge from hospital.

Briefing Note Author:
Victoria Castree
Scrutiny Co-ordinator
Resources Directorate
Tel: 02476 831122

2nd February 2015.

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Coventry City Council

Briefing note

To: Health and Social Care Scrutiny Board (5)

Date: 11 February 2015

Subject: Social care responses to winter pressures during 2014/2015.

1 Purpose of the Note

1.1 To provide a briefing to Scrutiny Board 5 on social care responses to winter pressures during 2014/2015.

2 Information/Background

2.1 The challenges faced by both the NHS and social care with regards to winter pressures have been more acute than previously and have caused significant challenge throughout the Health and Social Care system during the winter of 2014/2015. Social care is an integral part of the system that ensures people receive the right support in the right places at the right times, alongside primary and secondary health and the voluntary sector.

3 Challenges

3.1 The key challenge for the local health and social care system is to accurately predict demand and align resources to meet that increased demand. Predictions around demand are informed by analysing prior year trends and developing plans around those areas that are considered the highest priority. Locally, demand has exceeded expected activity and despite analysing that activity there are no specific trends that have been identified as a result of that analysis.

3.2 Winter pressure monies are allocated across the health and social care system, however social care allocations are a relatively small part of the total allocation. Additional monies have been made available as a result of the national challenges. Most recently a Department of Health grant was announced on 16 January 2015 to support 65 local authorities to implement actions that will reduce delayed transfers of care locally. Coventry City Council received a grant allocation of £325,000.

3.3 A strict requirement of the allocation is that it has to be spent by 31 March 2015. The timescale in which the money can be spent can mean that it can be difficult to source, commission and implement the right sort of support in a timely way.

3.4 Since being awarded the additional grant monies the local response by social care has been to increase equipment services, occupational therapy resources, dementia short term services, work with domiciliary providers to identify extra capacity to support people in their

own homes and to secure additional residential beds. Although equipment, therapy and support in people's own homes are all in line with jointly agreed strategies, the use of residential beds (all-be-it as a last resort) is counter to the preferred approach and is a consequence of money being allocated at short notice with strict criteria and short timescales in which to spend it.

4 Responses to challenges

4.1 Social care services are an integral part of daily telephone conferences to discuss pressures and identify any additional responses required.

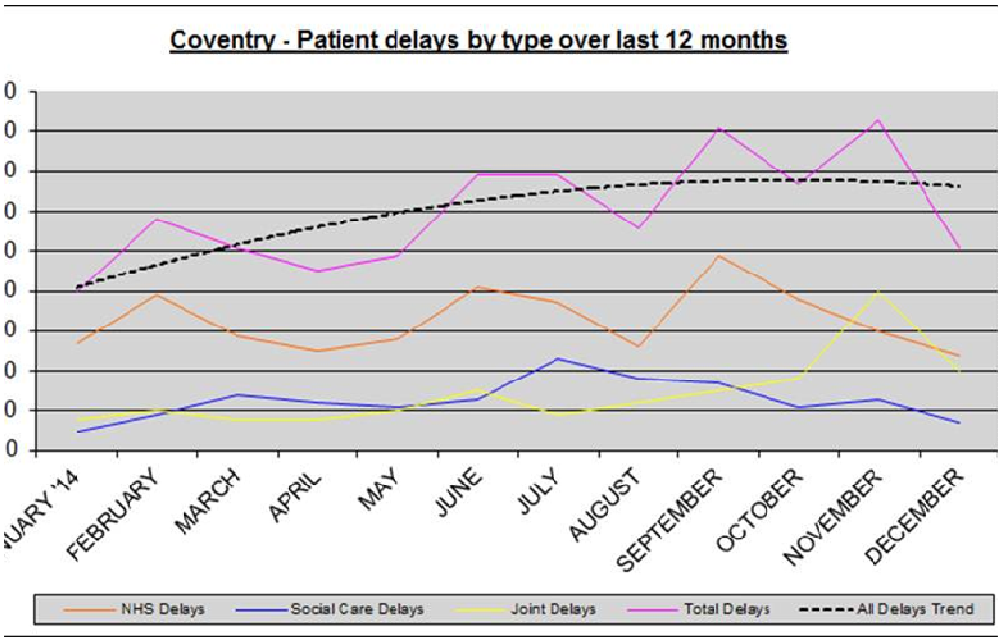
4.2 Social care are active, at a senior level, in both the System Resilience Group (SRG), which develops strategic responses to locally identified problems, and the Urgent Care Group, which drives the operational implementation of plans that are identified as priorities by the SRG.

4.3 Social care services have full involvement in the System Resilience action plan that is currently focussed on addressing challenges around emergency department waiting times, referral to treatment waiting times and patient flow, including delayed transfers of care, through the health and social care system.

4.4 A number of multi-agency approaches have been implemented to try and manage these challenges including an Integrated Neighbourhood Team pilot and involvement in admission avoidance schemes focussed around the walk-in centre, falls avoidance and the use of NHS 111.

4.5 Where social care services are approached to change, or increase, capacity there is a proven ability to do so. The actions taken, referred to in paragraph 3.4, indicate social care responsiveness in these circumstances.

4.6 Whilst delayed transfers of care are cited as one of the main reason for difficulties with flow through acute hospitals, social care only delays are proportionally low with the higher delays being attributed to either joint and health social care delays or NHS only delays. The chart below provides a 12 month trend of delays attributable by type.



4.7 Within the hospital there are very few delays attributed to people requiring assessment by social workers. There are people within the hospital that are determined to be nearing their discharge date that are not yet delayed transfers of care and social care actively support in identifying those people earlier on in their admission to try and reduce any potential for them becoming a delayed transfer of care.

4.8 Through the Department of Health grant funding to local authorities there are a number of schemes that are in the process of being implemented. The majority of the schemes will provide additional reablement support or enable greater levels of 7 day services to be provided. Whilst some monies are identified to fund additional residential and nursing home placements on a short term basis, it is recognised that maintaining and improving people's independence to enable them to return to their own homes remains the priority.

5 Strengths

5.1 There is a proven ability to increase capacity in priority areas in managed ways, however doing so on a short term ad-hoc basis presents different challenges. Between October 2013 and September 2014 the number of long term home support hours commissioned by Coventry City Council was increased by 16.5% at more competitive rates. The table below provides further detail.

Long term home support	**October 2013**	**September 2014**
Enhanced packages (Hrs per week)	1067.75	1163.75
Standard packages (Hrs per week)	10540.75	12358.50
Total	**11608.50**	**13522.25**

5.2 The multi-agency approach to developing plans to address the local challenges is positive. There is recognition by all partner agencies that the current pressures are a shared challenge and there is good evidence of collaborative working as a result of this, both at senior and front line levels.

6 Conclusions

6.1 Winter pressures remain a significant challenge both nationally and locally. Plans to address the local challenges have been jointly developed across partner agencies and show evidence of strong partnership working.

6.2 Not all of the schemes are able to have an immediate impact and require some time to show benefits. The schemes that are being implemented from the Department of Health grant announced on 16 January 2015 focus on providing additional reablement support or enabling greater levels of 7 day services to be provided.

6.3 There is a commitment to evaluate the effectiveness of any locally implemented plans in order to prioritise future funding of the more successful approaches.

Author: David Watts, Assistant Director – Adult Social Care, People Directorate

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University Hospitals Coventry and Warwickshire NHS Trust

Winter Planning Improving and Sustaining Performance

David Eltringham, Chief Operating Officer

11th February 2015

Outline

- The Winter challenge for UHCW
- Our approach to dealing with this
  - Improvement to Emergency Care Pathways
  - Winter specific plans
- Performance and Risks
- Questions

Ambulance

Walk In

Home Care

GP

111

Emergency Department

Assess and Decide

Alternative Care Pathway

Discharge

Admit

Investigate, Treat and Review

Discharge

Simple

Bed

Package

Partnership Trust

Voluntary Sector

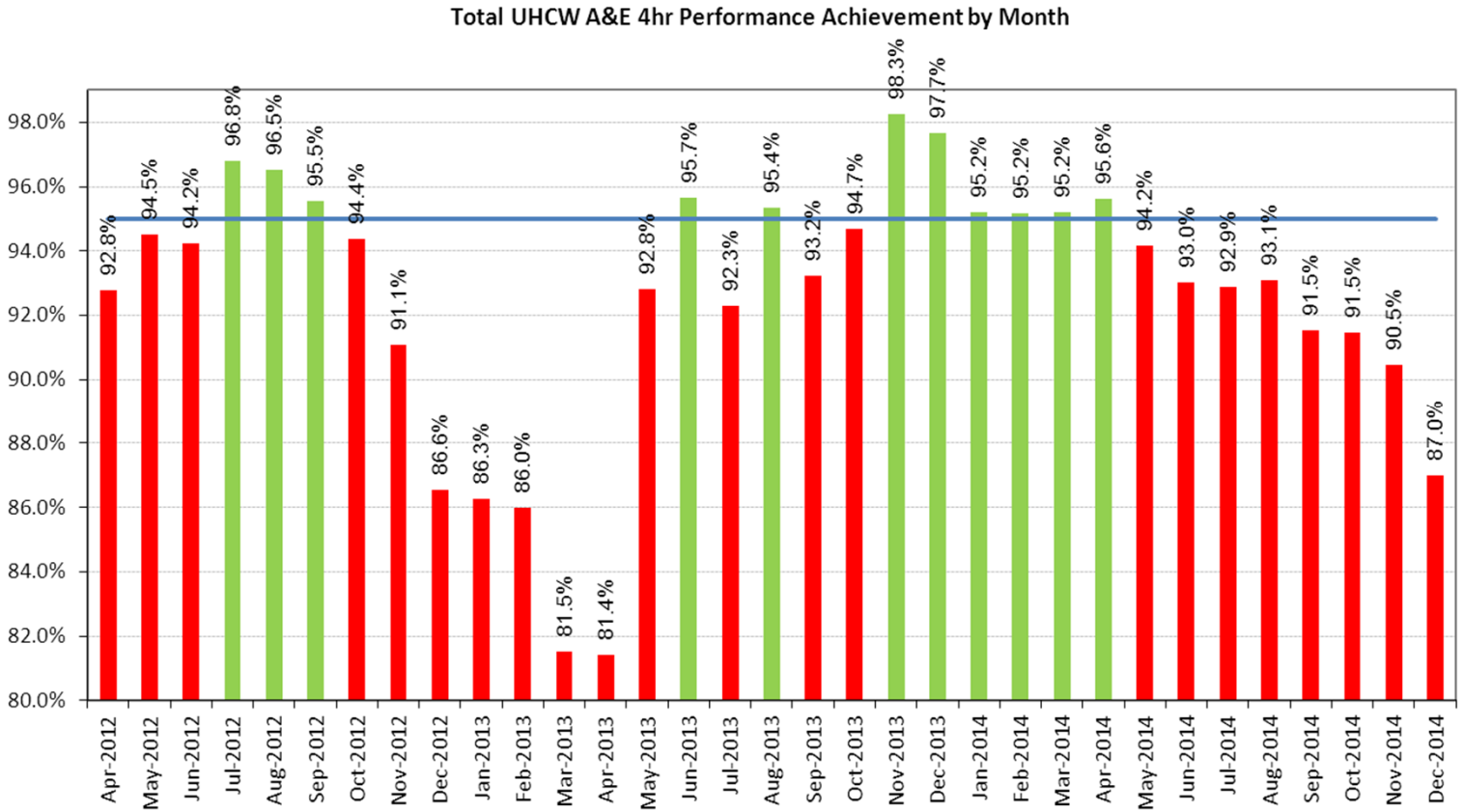
Social Care

Complex

Continued Healthcare

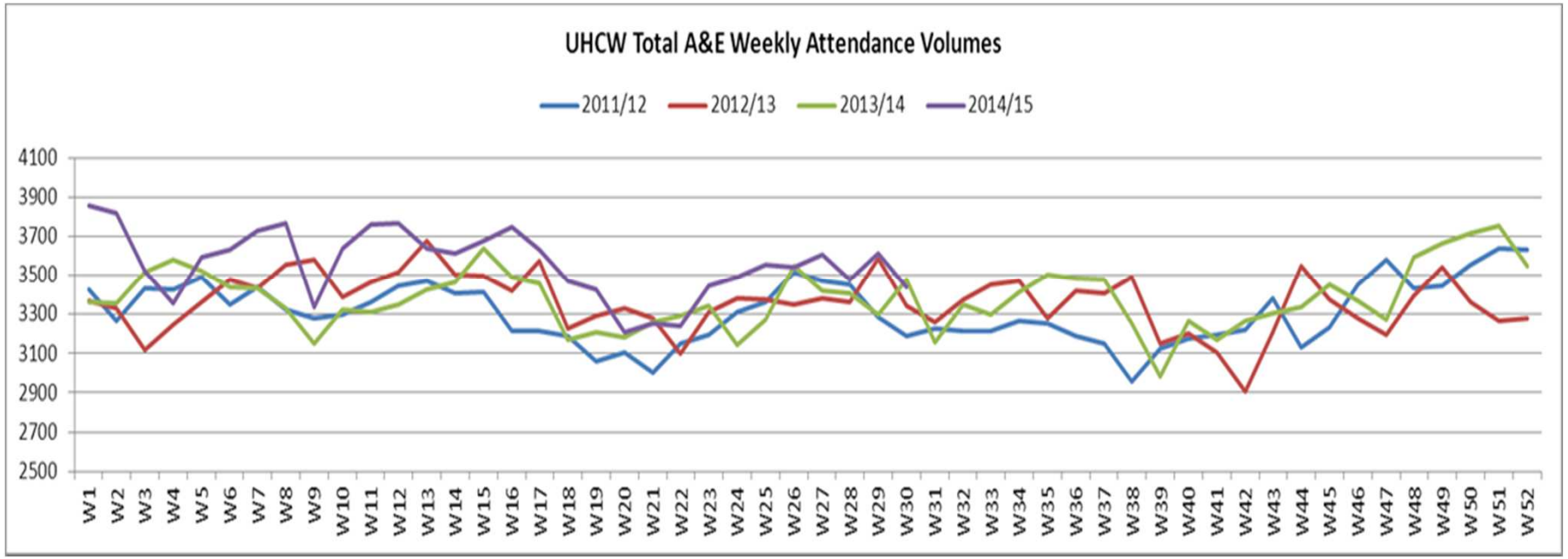
University Hospitals Coventry and Warwickshire NHS Trust

The Winter Challenge



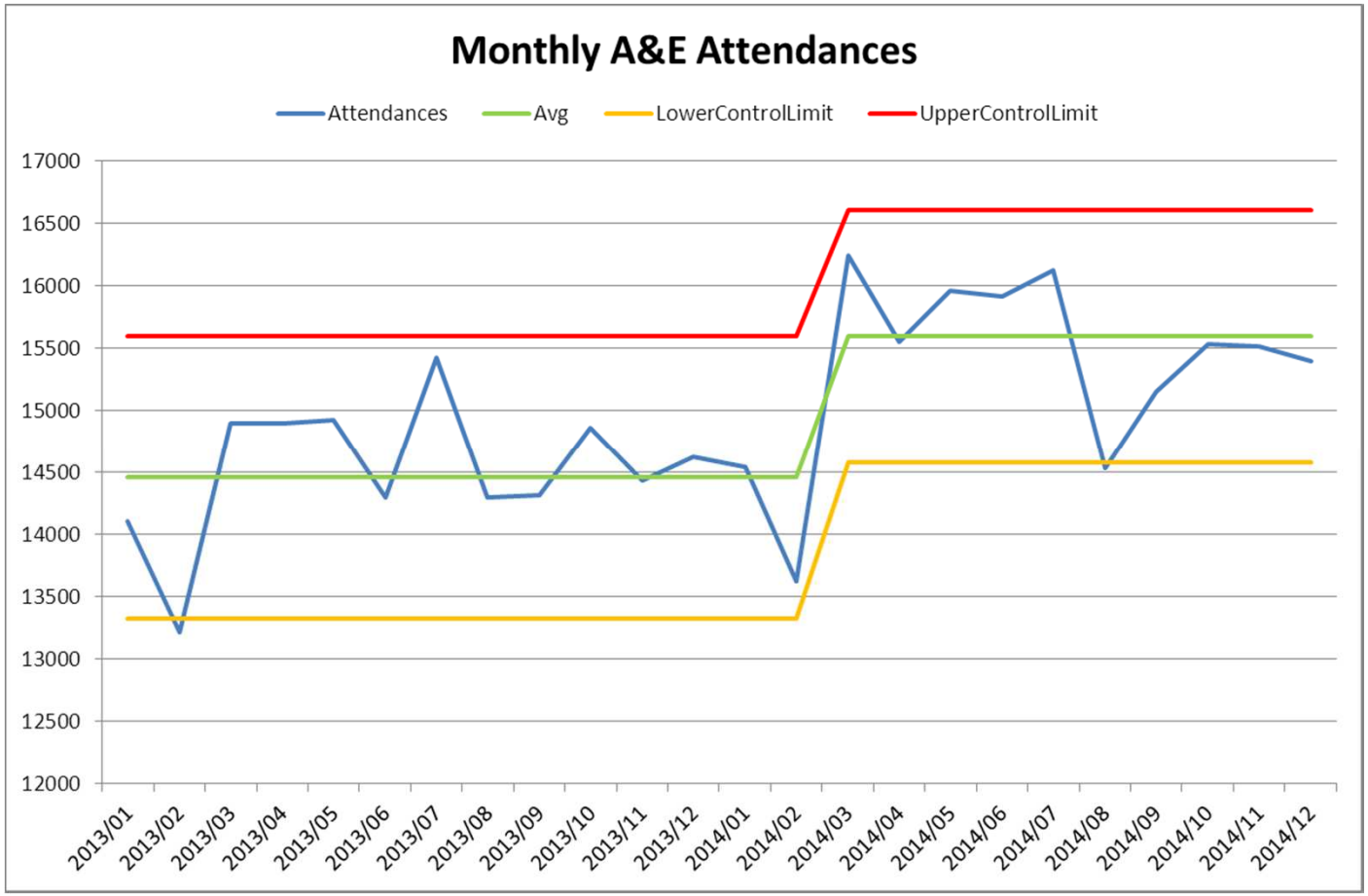
University Hospitals Coventry and Warwickshire NHS Trust

The winter challenge…continued

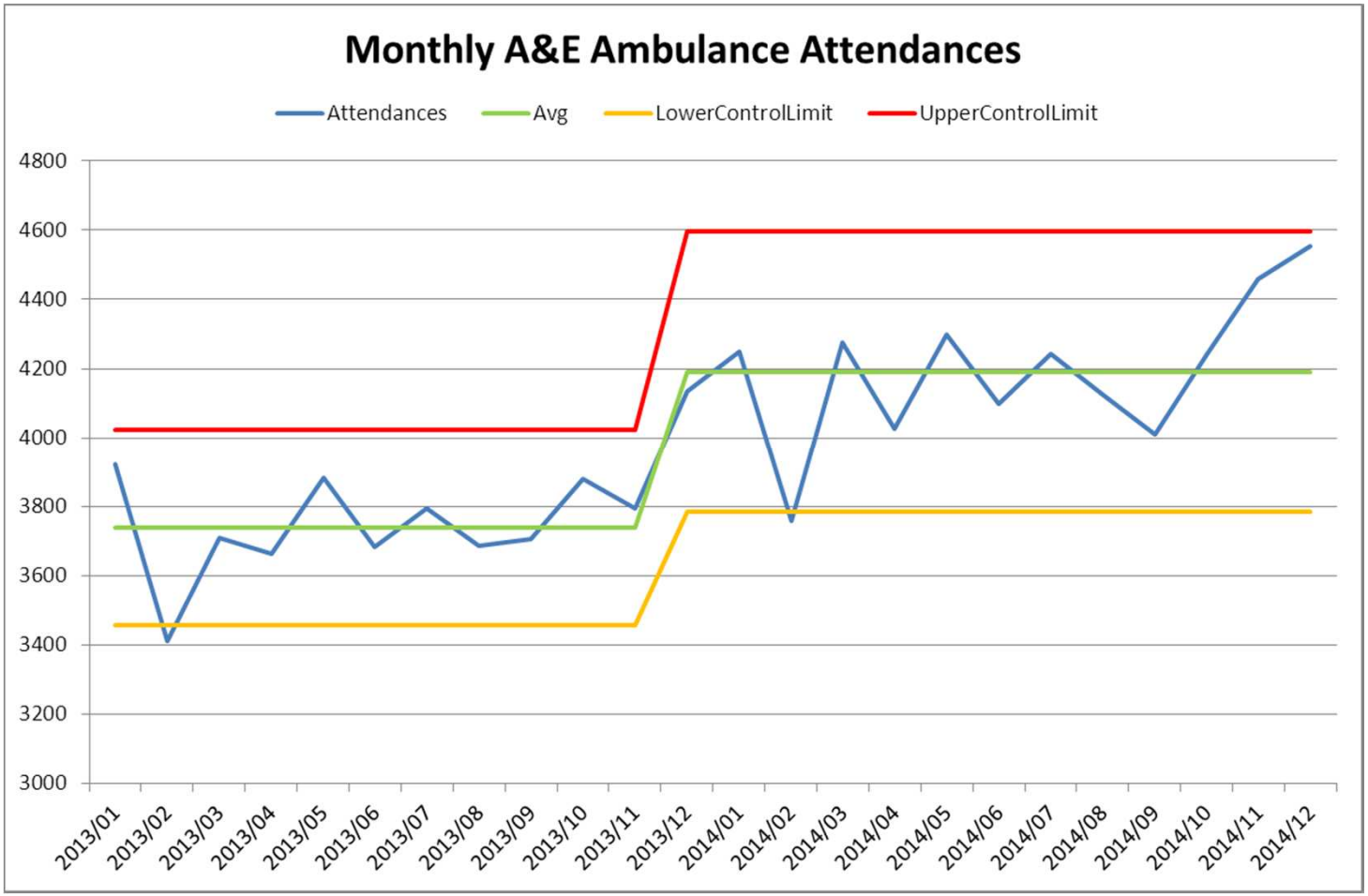


University Hospitals Coventry and Warwickshire NHS Trust

Attendances



Ambulances


Monthly A&E Ambulance Attendances
Attendances
Avg
LowerControlLimit
UpperControlLimit
4800
4600
4400
4200
4000
3800
3600
3400
3200
3000
2013/01
2013/02
2013/03
2013/04
2013/05
2013/06
2013/07
2013/08
2013/09
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2014/01
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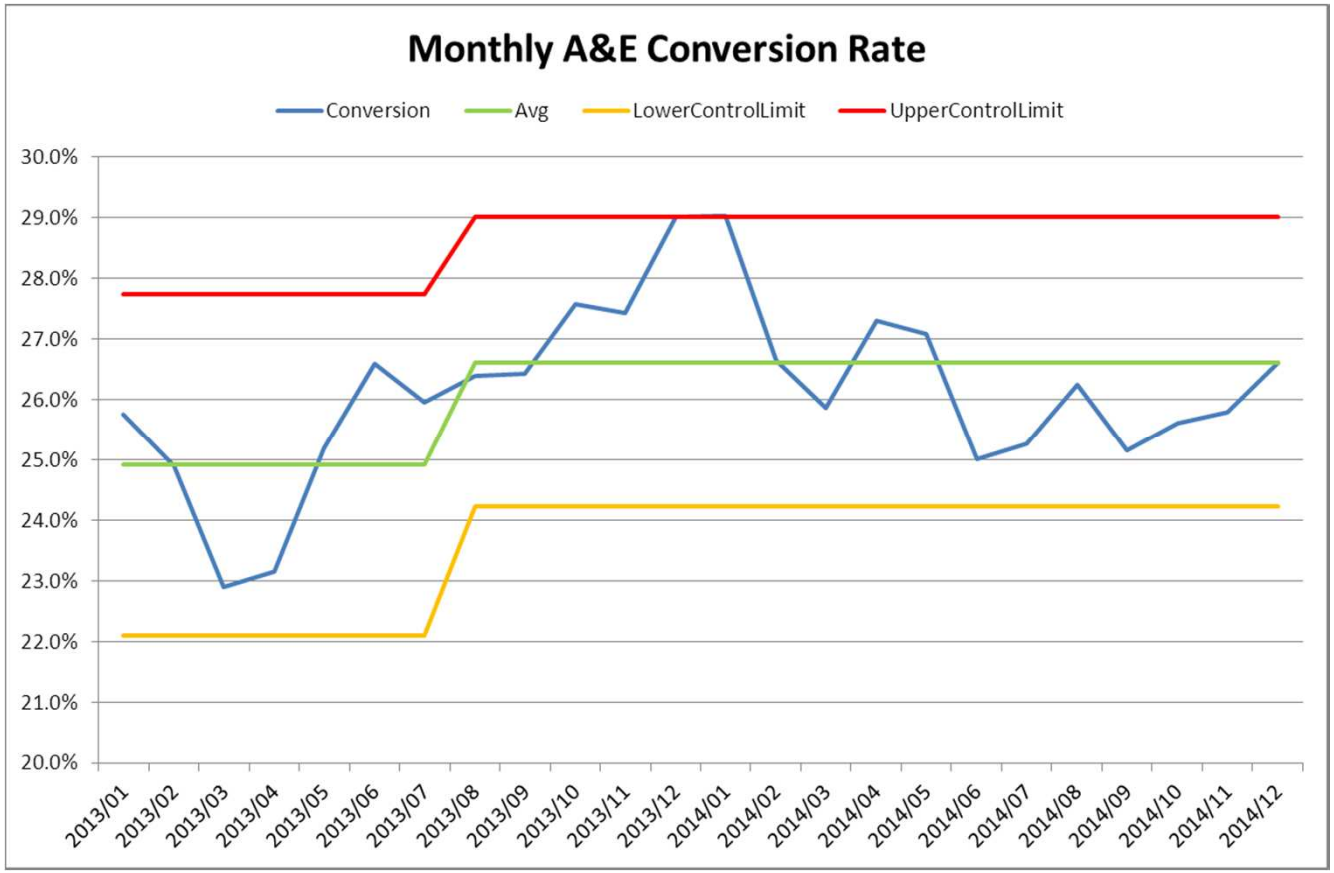
2014/11
2014/12

Admissions


Monthly A&E Conversion Rate
Conversion
Avg
LowerControlLimit
UpperControlLimit
30.0%
29.0%
28.0%
27.0%
26.0%
25.0%
24.0%
23.0%
22.0%
21.0%
20.0%
2013/01
2013/02
2013/03
2013/04
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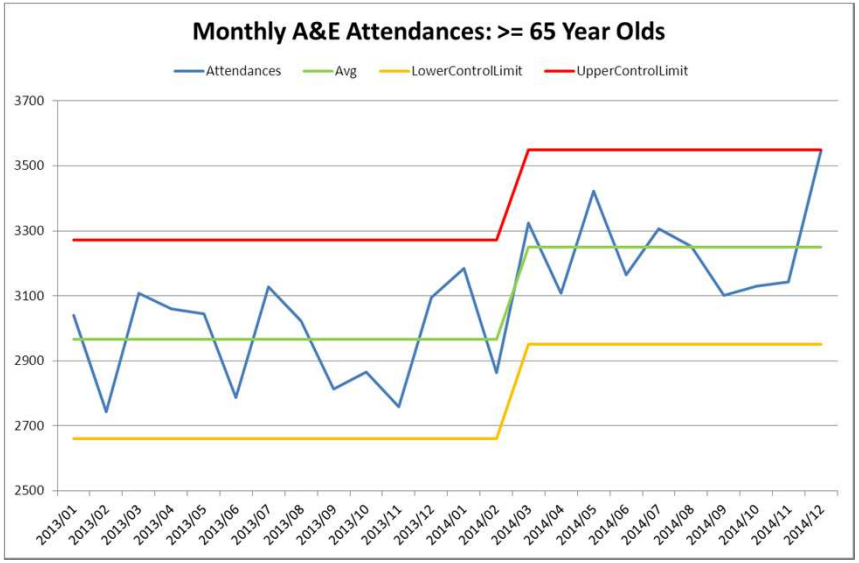
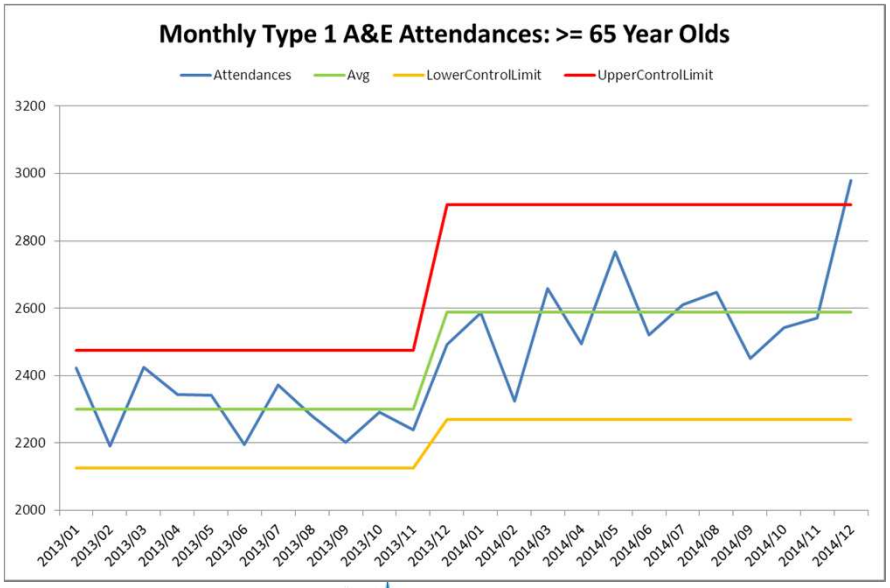
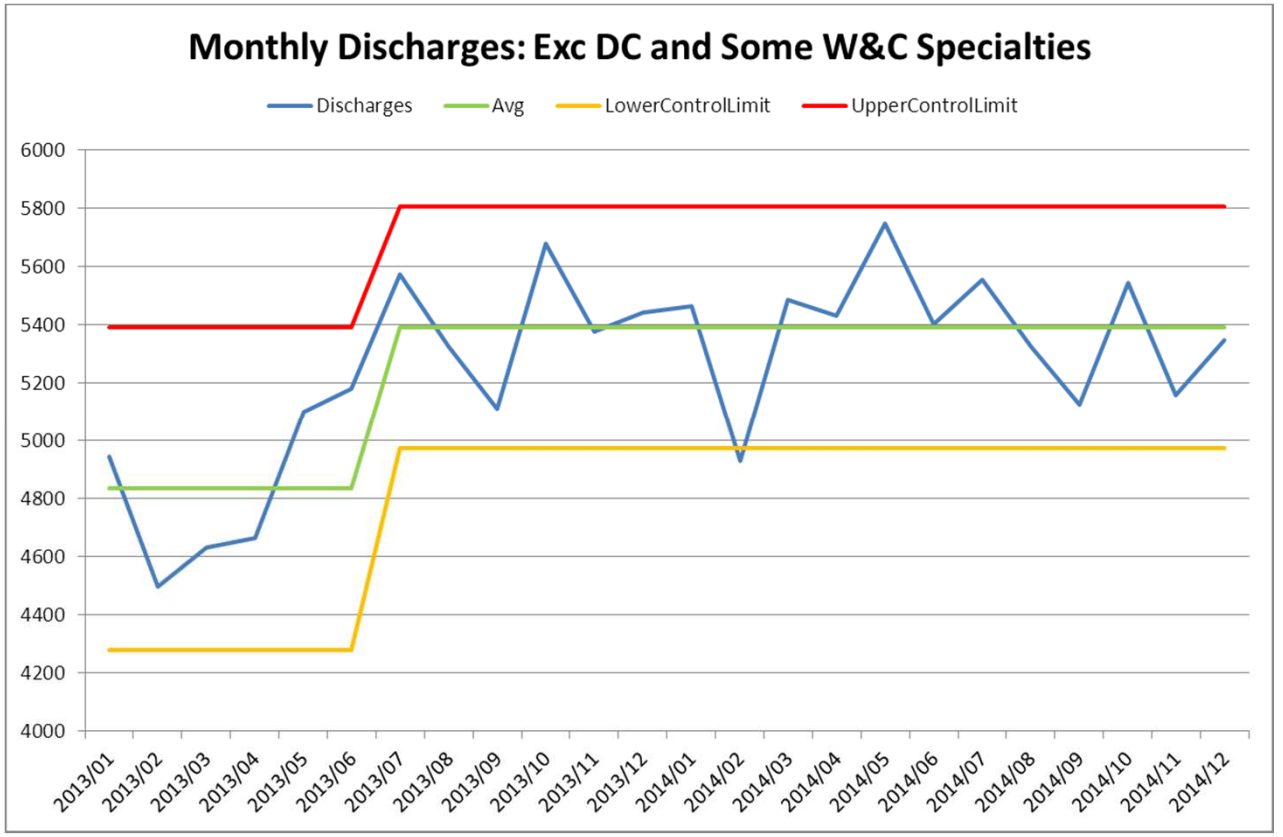
>65 Years – Attendances & Admissions





University Hospitals Coventry and Warwickshire NHS Trust

Discharges


Monthly Discharges: Exc DC and Some W&C Specialties
Discharges
Avg
LowerControlLimit
UpperControlLimit
6000
5800
5600
5400
5200
5000
4800
4600
4400
4200
4000
2013/01
2013/02
2013/03
2013/04
2013/05
2013/06
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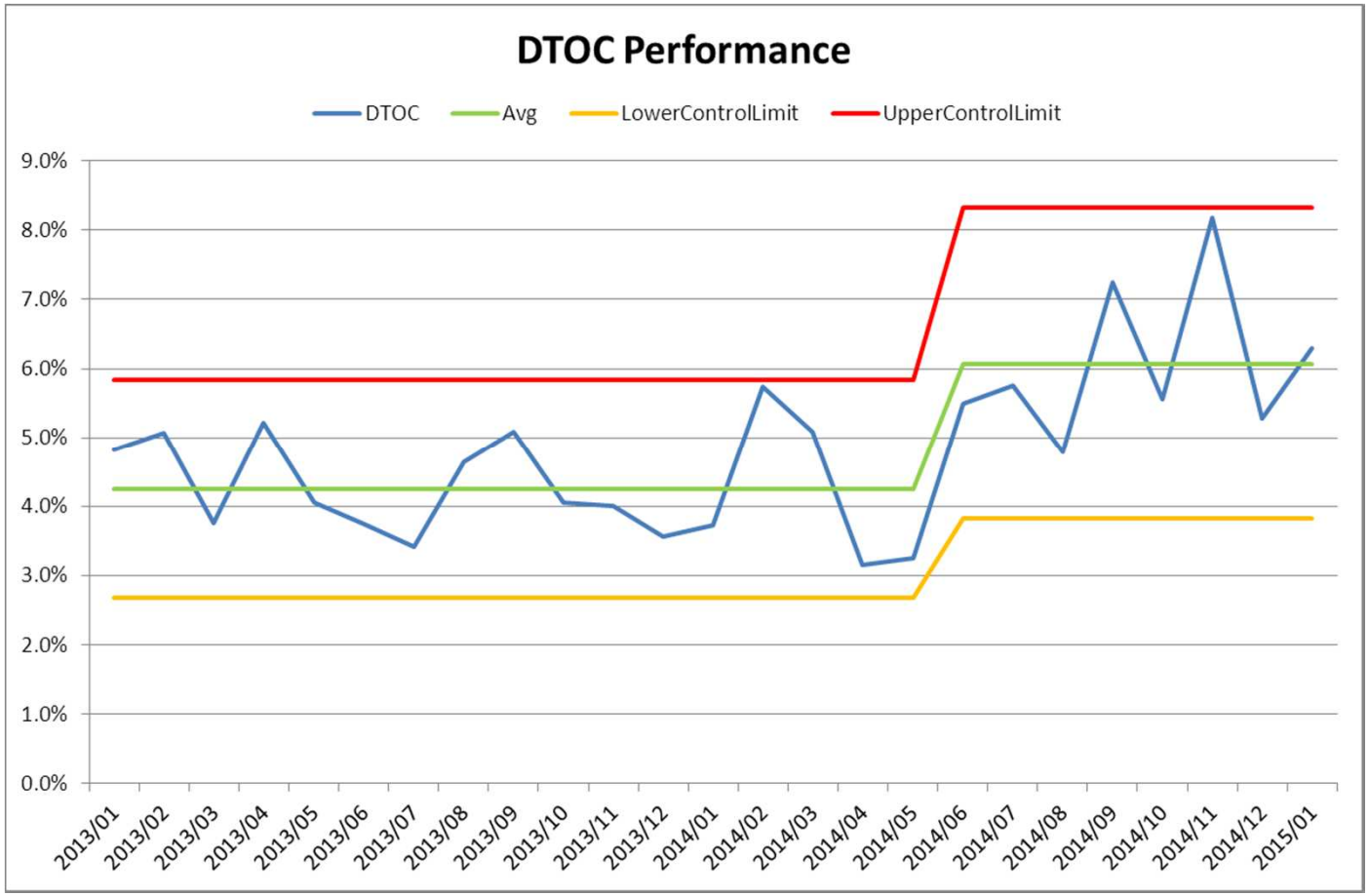
Delayed Transfer of Care



University Hospitals Coventry and Warwickshire NHS Trust

Comparison Data

Measure	Jan 13 – Dec 13	Jan 14 – Dec 14	Total Variance	%	Weekly Variance
A&E Attendances	174300	184106	9806	5.63%	188
Type 1 A&E Attendances	125260	138131	12871	10.28%	247
Admissions from A&E	45213	48384	3171	7.01%	61
Ambulance Conveyances	45269	50342	5073	11.21%	97
Discharges	61526	64525	2999	4.8%	58
Aggregate DTOC (1 mth in arrears)	4.3%	5.3%	1.0%	N/A	N/A
Avg Medical Outliers	108	130	11	20.3%	N/A

RTT Performance

	Admitted Clock Stops (Target 90%)	Non-Admitted Clock Stops (Target 95%)	Open Pathways (Target 92%)
100 : General Surgery	72.67%	94.18%	83.52%
101 : Urology	84.28%	96.36%	86.18%
110 : Trauma & Orthopaedics	73.69%	89.25%	85.12%
120 : Ent	57.58%	93.11%	86.00%
130 : Ophthalmology	72.06%	93.54%	89.45%
140 : Oral Surgery	84.11%	96.11%	92.58%
150 : Neurosurgery	91.36%	92.93%	86.98%
160 : Plastic Surgery	78.95%	91.43%	76.59%
170 : Cardiothoracic Surgery	100.00%	100.00%	87.56%
300 : General Medicine	100.00%	99.69%	94.72%
301 : Gastroenterology	95.53%	89.24%	89.32%
320 : Cardiology	71.83%	98.16%	92.28%
330 : Dermatology	91.78%	96.52%	95.00%
340 : Respiratory Medicine	100.00%	100.00%	98.12%
400 : Neurology	100.00%	98.56%	97.51%
410 : Rheumatology	100.00%	98.50%	97.94%
430 : Geriatric Medicine	0.00%	100.00%	97.40%
502 : Gynaecology	91.22%	98.00%	93.34%
X01 : Other	97.98%	99.37%	96.36%
Total	81.91%	95.67%	89.34%

Our Analysis

- An increase in attendances to ED in March 2014, sustained to this point in time but no longer rising.
- An associated rise in admissions, with the percentage conversion rate broadly holding stable
- An increase in ambulance conveyances and an increase (in recent weeks) of >65 year old attendances/admissions which would imply an increase in frailty dependency, complexity and acuity.
- A steady decline in discharges over time (both simple and complex) although year on year comparisons indicate higher levels of discharge this year than last.
- A significant rise in Delayed Transfers of Care.
- A significant rise in patients outlying their base ward.

Rest of the Country

Rank – Top of bottom – 33%

No 12 hour trolley waits

No major incident declaration

Action – Admission Avoidance

- Reduction of 20% of Type 1 attendance to admission rate (over time)

- Ambulatory Emergency Care
- Hot Clinics
- Making these things user friendly in ED
- Complying with GECR Safety Standards
- Consultant sign off to admissions
- Creation of AMU/FEAU
- Snapshot admission audit

Action – Discharge Management

- Increase the number of people being discharged by 10% and simultaneously reduce DTOC <3.5%

- Single Database (single version of the truth)
- Discharge Hub
- ‘Know how we are doing’
- Focus on all delays, not just DTOC
- Discharge decision making audit

Action – The Outside World

- Creation of System Resilience Group (SRG)
- Focus on delay to discharge reduction
- Reduced DTOC
- Admission avoidance
    - INT
    - Falls
    - Medicare
- Improved discharge flow
- Additional capacity
- Diagnostic piece
- Escalation through NHSE/TDA

Current Performance

As at 27.01.2015

Week to Date – 84.02%

Month to Date – 83.89%

Quarter to Date – 83.89%

Year to Date – 91.47%

Patients fit for Discharge awaiting a package of care – 128

DTOC - 103

Any Questions…

Coventry City Council

Briefing note

To Health and Social Care Scrutiny Board (5) **Date 4th February 2015**

Subject "Clinical Management of Large Scale Chronic Diseases: To review how pathways are being managed in primary care for a range of challenges"

1 Purpose of the Note

1.1 To describe services being delivered in primary care and designed to prevent onset or progression of long-term conditions which are currently being commissioned by Coventry City Council Public Health (CCC PH)

1.2 To describe existing pathways designed to prevent progression of and manage specific long-term conditions (focussing on parts of these pathways which are undertaken in primary care)

1.3 To describe plans to transform existing long-term conditions pathways, focusing on areas were a move towards delivery of care in primary care setting is planned

1.4 To describe plans to provide more integrated, holistic care for patients with multiple long term conditions or frailty, rather than focussing on individual conditions

2 Recommendations

2.1 To note services commissioned by both Coventry City Council Public Health (CCC PH) and Coventry and Rugby Clinical Commissioning Group (CR CCG) and delivered in primary care settings designed to prevent onset or progression of a number of different long term health conditions; especially noting planned changes to treatment pathways

2.2 To make recommendations to relevant commissioning organisations, especially where significant changes to pathways are being suggested

2.3 To note and make recommendations on plans to provide more holistic, integrated care to those with multiple conditions and frailty.

3 Information/Background

3.1 *Introduction*

3.1.1 Long term conditions are defined as diseases which cannot be cured and therefore the treatment focus is on management. Treatment may be aimed at stopping or slowing down disease progression. For some long term conditions focus of treatment is on preventing complications associated with the condition, for example preventing blindness in people

who have diabetes. The overall aim of treating long term conditions is to minimise the impact the condition has and enable the patients to lead a fulfilling life, despite their illness. In England 15 million people are diagnosed with one or more long term conditions and care of people with long term conditions accounts for 70% of the money spent on health and social care in England. Common long term conditions include diabetes, chronic obstructive pulmonary disease (COPD) and cardio-vascular diseases (for example heart disease, heart failure and stroke). Degenerative conditions like dementia are also considered to be long term conditions.

3.1.2 The last number of years has seen significant improvement in prognosis for some long-term conditions, for example early deaths from heart disease have reduced by 40% in the last fifteen years. However, as people are living longer, their risk of developing one or more long term conditions increases. Living longer also increases the likelihood that serious disease complications will develop. Development of long term conditions is also linked to deprivation. People living in deprived areas are more likely to develop long term conditions, more likely to develop them earlier in life and less likely to have well managed conditions. Any strategy to reduce burden of long term conditions needs to consider the wider challenge of reducing inequalities. Finally new technology to diagnose and treat conditions is always developing, while this will increase numbers of people living well with these conditions, it will also increase the costs associated with these conditions.

3.1.3. The way people wish to be treated is changing with many people wanting greater involvement in their own care. This challenges the traditional patient-professional divide and creates an opportunity for people to care for and manage their own conditions.

3.1.4 The NHS Five-Year Forward Plan, describes a number of ways to deal with the increasing prevalence and associated increasing cost of managing long-term conditions, including:

- Greater investment in prevention and public health to curb the sharp increase in the burden of avoidable illnesses; including national action to decrease smoking, obesity and alcohol use
- Sharing of health and social care budgets to reduce existing inefficiencies and increase patient satisfaction
- Breaking down barriers between different parts of the care system, so that a whole-person, patient centred approach can be given to those with multiple conditions and complex needs.
- Support GP practices to provide high-quality long term care and facilitate a shift in investment from hospital to primary and community care, where appropriate.

This report will outline how services are being commissioned to reflect these principles in Coventry. It includes cross-cutting prevention strategies and a range of disease-specific pathways, as well as some innovative work to create holistic care pathways for people with multiple needs. The report has been produced in consultation with Public Health, Clinical Commissioning Group and Acute Care colleagues.

3.2 *Cross-cutting, prevention strategies*

3.2.1 A number of services to prevent conditions developing, to increase early diagnosis, and to prevent disease progression and complications are commissioned. These include a range of services from those designed to support healthy lifestyle choices and commissioned locally by CCC PH to nationally commissioned vaccination programmes for people with long term conditions. A full list of healthy lifestyle services has been created and CCC PH have developed a Single Point of Contact from which to access these services which will

be live from February 2015. The following section highlights some of the prevention services commissioned by both CCC PH and other organisations.

3.2.2 Physical activity can prevent weight gain and aid weight loss, but evidence also shows that physical activity alone can independently improve outcomes for people with a number of different long-term conditions including diabetes and COPD. CCC PH commission a range of services to help people increase their levels of physical activity. We also engage with GP practices to ensure that they are aware of these services and to sign-post their patients to these services, where appropriate. Last year CCC PH held a consultation event with GPs to try and understand some of the barriers to physical activity for patients and how CCC PH could support GPs to support their patients to increase their physical activity. CCC PH also commission a programme of healthy walks around the city – about 1000 individual walks and around 8000 individual attendances. Some of these are targeted at groups with or at greater risk of developing long term conditions.

3.2.3 Obesity is linked to a number of long-term conditions including diabetes, stroke, and coronary heart disease. Being over-weight or obese is also linked to complications for many long term conditions including heart failure and COPD. CCC PH commission a number of services to help people achieve and maintain a healthy weight including Slimming World on prescription which can currently be access via some GP practices in the city. From April 2015 all PH-commissioned weight management services will be delivered via the Health Trainer Service, this includes Slimming World on Prescription which will no longer be available through GPs. This decision was made as not all GP practices are providing referrals, thus limiting accessing to the service. It is believed that Health Trainers will improve access to weight management services and are in a position to target those most at risk of developing long term conditions. While most of the support Health Trainers deliver is around weight management they also deliver support and advice around other lifestyle behaviours like smoking and alcohol. This means that people can be offered more holistic support to help them change their unhealthy behaviours.

3.2.4 Smoking is linked to both the development and progression of a number of long-term conditions including COPD, heart failure and stroke. CCC PH commissions three providers to deliver a stop smoking service in a wide range of locations. These include pharmacies, GP practices, community health centres and non-health venues in the community venues. Services specifically targeting vulnerable populations and populations with high prevalence of smoking (for example people with mental illness) are also commissioned.

3.2.5 The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions or have certain risk factors, will be invited (once every five years) to have a check to assess their risk of these conditions and will be given support and advice to help them reduce or manage that risk. In Coventry GP practices are the main provider of NHS Health Checks. Additionally, NHS Health Checks are being delivered in outreach locations across Coventry to target people who do not attend their GP. There are also plans to increase uptake among men using innovative approaches like partnering with Coventry Sports Foundations and Trusts. Over 65% of Health Checks have been delivered in GP practices based in the most deprived areas of the city.

3.2.6 Living in a cold home is associated with exacerbation of a number of long term conditions including COPD and cardio-vascular diseases. People how live in cold homes also have an increased likelihood of developing flu or pneumonia-both of which are more serious for people with long term conditions. CCC PH has commissioned Groundwork to deliver the Keeping Coventry Warm programme. The programme aims to support vulnerable groups

including those with long term conditions. This results in reduce demand for health and social care provision. The service includes support to manage energy use, switching utility bill supplier and (where the patient meets eligibility criteria) the provision of home improvements such as loft insulation, cavity wall insulation and boiler replacements and repairs.

3.2.7 NHS England commission an adult vaccination schedule for older adults and adults with specific health conditions. This schedule includes annual 'flu vaccination and pneumococcal vaccination for adults over 65 and those diagnosed with long term conditions. Adults with long-term conditions are offered these vaccinations because they are at increased risk of developing serious complications if they do become infected with influenza or pneumococcal. Both vaccinations are provided by GP practices with the local health protection board (led by CCC PH) responsible engaging with practices to ensure good vaccination uptake.

3.3 *Diabetes*

3.3.1 Diabetes is one of the key priorities for CR CCG as defined in the 2014/15-2018/19 Plan on a Page (Appendix I). The rate of diabetes is rising across the population of Coventry, with prevalence rising from 4.7% in 2005 to over 5.5% in 2015 and is predicted to rise to over 6.5% by 2025. This prevalence relates to diagnosed cases only and it is estimated that the true number of cases is about 35% greater. The diabetes service transformation is designed to ensure that services are fit for the increasing numbers of diabetics.

3.3.2 The programme has been formed to take forward a number of key areas to improve services for patients with diabetes, and ensure that CR CCG are commissioning the right services that are best placed to meet the needs of patients and carers. It will ensure only specialist diabetes patients requiring acute hospital care will be seen in hospital, in line with best practice guidance

3.3.3 CR CCG has considered models of care identified as best practice from across the country, and has decided to that only patients who need very specialist care (for example children diagnosed with diabetes and people at risk of foot amputation) will be seen in hospital. The remaining patients will be seen within the newly developed Community Diabetes Service. The Community Diabetic Team will consist of a multi-skilled, multi-function team whose role will be to support primary care (GP Practices) and will be responsible for:

- Advice and support to primary care (by telephone and email)
- Case management of borderline cases to decide if patients need hospital care
- Patient pathway monitoring
- Consultant-led community clinics
- Audit and education (including educational sessions with CR CCG clinical educators)

The team will be consultant-led and include:

- GP with Specialist Interest in Diabetes
- Diabetes Nurse
- Dietician
- Podiatrist
- Consultant diabetes physician

3.3.4 The transformation programme will be commissioned so that the provider will be paid based on patients' outcomes, rather than a traditional commission model where payment is based on activity. In developing the new community clinics, CR CCG is working with

Diabetes UK to ensure patient engagement and have had 4 patient events with over 300 people attending. The new service provider will also lead on developing a self-care approach in partnership with Diabetes UK. This part of the service will focus on developing local communities' assets to provide peer support for diabetics. Another key element is patient education including a number of initiatives to engage with ethnic minority groups whose uptake of diabetes patient education has traditionally been low.

3.4 *Stroke*

3.4.1 The CR CCG Stroke transformation programme is focussing on primary and secondary prevention, and community neuro-rehabilitation. CR CCG is also involved in a wider Coventry and Warwickshire re-design of the acute care pathway across the patch.

3.4.2 Both Coventry and Rugby and wider Coventry and Warwickshire stroke programmes are taking a whole pathway approach so that acute stroke care, bedded stroke rehabilitation, early supported discharge and community stroke rehabilitation can be considered. Both programmes will aim to achieve shorter lengths of stay in each element of the pathway, achieving improved health outcomes, reduced disability as a consequence of stroke, and a reduction in the number of strokes. The programme will also consider the workforce requirements for the new service model, and ensuring that stroke physicians are suitably available on the pathway according to the regional stroke service specification.

3.4.3 Across Coventry and Rugby there are an estimated 1000 cases of undiagnosed Atrial Fibrillation (AF). Individuals with unmanaged AF who go on to have a stroke have significantly worse recovery time and outcomes. Diagnosis and management of AF is the subject of 2014 NICE guidelines and considered an important part of Stroke prevention. This part of the prevention stream of the stroke programme includes working with primary care to detect AF in patients who may currently be asymptomatic. Part of this will be to make AF detection a mandatory part of NHS Health Checks from April 2016. With enhanced AF detection it will also be necessary to redesigning the current anticoagulation service to cope with the increased impact finding undiagnosed cases will have. This work-stream will be informed by the 2014 NICE guidance for AF.

3.5 *Dementia*

3.5.1 Dementia is a major and growing challenge for the UK society and economy due to increasing life expectancy, chronic morbidity and the aging population. With better understanding of prevention, diagnosis, treatment and care for dementia, and an understanding of the local population, there is more scope to improve the quality of life and wellbeing of people with dementia and their carers in Coventry.

3.5.2 In Coventry, there are thought to be approximately 3,600 people living with dementia. According to the Alzheimer's Society, only around 50% of those people have received a formal diagnosis. The National Dementia Strategy highlights the importance of timely diagnosis, in ensuring that people receive appropriate treatment and support.

3.5.3 Following on from a 2012 Needs Assessment undertaken by CCC PH, Coventry's Living Well with Dementia Strategy 2014-2017 was published in 2014. The vision of this strategy incorporates whole scale change to enable people with dementia and their carers to be as independent as possible, for as long as people, and for people with dementia to 'live well' with the condition. The aim is to fully engage people with dementia and their carers in the design and evaluation of services and support. The needs and wishes of people with

dementia and their carers will be at the heart of action planning and delivery of this strategy. The detailed strategy including plans for implementation are included with this briefing note (Appendix II)

3.6 *Heart Failure*

3.6.1 CR CCC has commissioned an integrated heart failure service the main purpose of which is to provide a consistent and systematic approach to the diagnosis and treatment of chronic heart failure throughout Coventry by strengthening the existing specialist provision in the community and by introducing clear clinical leadership and responsibility across the agreed clinical pathways. The primary aims of this service are:

- To improve the quality of life and clinical outcomes for patients with heart failure
- To reduce admissions, lengths of stay & readmissions to hospital

This aim will be achieved by:

- Prompt diagnosis
- Optimal treatment and management in line with best practice guidance
- Provision of individualised management plans for all newly diagnosed and unstable patients
- Facilitating and supporting management in primary care by improving GP understanding of heart failure management and thus the confidence to treat in a practice setting
- Improving patient access to appropriate treatment and high quality personalised care in the community setting, therefore reducing the over-reliance on hospital care
- Developing a shared care approach across primary, secondary and specialist care services for the patients most at risk
- Supporting self-care

3.6.2 The new service due to commence in April 2015 will:

- Stabilise patients with decompensating heart failure to avoid crisis and hospital admission
- Continue intravenous diuretic therapy for patients stepped down from inpatient treatment to reduce length of stay; or day therapy in secondary care to reduce hospital attendances.
- Reduce admission to hospital for patients with an established diagnosis of heart failure who attend A&E with signs of fluid overload where their condition can be safely managed in the community

3.6.3 Success of the integrated heart failure service will require collaboration with other services, in particular general practice, community services and secondary care. This service will support a shift from reactive care (with a focus on crisis management) to a more proactive preventative approach which promotes partnership and multidisciplinary collaboration. Patient education and the promotion of self-management are integral to the service.

3.7 *Chronic Obstructive Pulmonary Disease (COPD)*

3.7.1. A new COPD pathway was approved as part of CR CCG's transformation programme. The transformation included the implementation of a new community COPD service in April 2012. The overall focus of the transformation was:

- Optimal chronic disease management (including assessment for long term oxygen therapy and optimisation prior to pulmonary rehabilitation)
- Exacerbation assessment and management
- Care for advanced disease
- Self-care and well being

- Support and advice for healthcare professionals

3.7.2 The purpose of the transformation was to make a significant improvement in the care provided for people with COPD and improve access to appropriate treatment and high quality personalised care in the community setting, therefore reducing the over-reliance on hospital care. This will be achieved by supporting the shift from reactive care, with a focus on crisis management, to a more proactive preventative approach which promotes partnership and multidisciplinary collaboration. Patient education and self-care are central pillars of this service transformation. Transformation will require integrated working with other services, in particular general practice, community services and secondary care. The service helped keep admissions to hospital for COPD stable whilst admissions have risen by 25% in other medical areas over the last three years.

3.7.3 An innovative element of the new COPD pathway is the RIPPLE Project (Respiratory Innovation: Promoting a Positive Life Experience) a joint research project between University Hospitals Coventry and Warwickshire, Coventry University and its 3rd sector partners – the British Lung Foundation, Age UK, Grapevine, and People Point Coventry. The project is built upon an asset based community development model that focuses on using community organisations to help bring about better wellbeing when coupled with medical care. The project was conceived following observations by Dr Colin Gelder (respiratory consultant) and Coventry's Community Respiratory Service that their COPD patients were not only experienced ill health from their COPD, but also experiencing social exclusion because of the chronic breathlessness and hyperventilation that is characteristic of this disease. RIPPLE aims to increase patients' wellbeing and resilience by plugging them into community assets, this in turn increases their ability to self-manage and leads to improved clinical outcomes. The RIPPLE project is an important example of asset-based working, use of non-medical interventions to improve clinical outcomes and use of a holistic, person-centred approach to healthcare. The RIPPLE Project is currently being evaluated by Coventry University. If the project is considered cost effective, the model could be transferred to other long-term conditions. The service would need to be funded from the reduction in hospital admissions attributed to it.

3.7.4 Key performance indicators to measure effectiveness of the new COPD pathway include:

- Patient satisfaction as measured by questionnaire
- Number of complaints/compliments received
- Number of adverse events
- Clinical patients outcomes
- Quality of life measures
- Patient admission data

3.8 Holistic care pathways

3.8.1 The traditional divide between primary care, community services, and hospitals is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three. Caring for the needs of patients with long term conditions requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. This partnership is even more important when we are dealing with patients with multiple conditions, or older people who have more complex care needs.

3.8.2 A Kings Fund Inquiry into Managing People with Long Term Conditions states that people with several long-term conditions have markedly poorer quality of life, poorer clinical outcomes and longer hospital stays, and are the most costly group of patients that the NHS has to look after. There is little evidence suggesting what high-quality care looks like for people with multiple long-term conditions and complex needs. However, what evidence does exist suggests that people with multiple long-term conditions tend to get poorer treatment than others. The challenges posed by multi-morbidity underline the importance of general practice, but also the need for it to work more collaboratively with other care providers – and vice versa. Problems in the care of people with multiple needs appear to be system-wide rather than specific to general practice. This suggests a need for a collaborative care model comprising multi-disciplinary case management, systematic follow-up, and working that is better integrated – for example between mental and physical health professionals. While GPs or other professionals in general practice might not necessarily take the lead role, they need to work closely with whoever does provide the case management, as well as maintaining clinical responsibility and remaining a locus of care continuity for the patient.

3.8.3 Locally, services to address the needs of patients with multiple-morbidities and complex care requirements are being developed through The Integrated Neighbourhood Team (INT) pilot which is one programme within the Better Care Fund (BCF). BCF is a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services. The INT pilot project is being funded as part of the Coventry Better Care Programme. This is a three-tiered model of care which seeks to ensure that the frail elderly are managed with the most appropriate levels of care from healthcare, social care, community and voluntary sectors. At level 3, a multi-disciplinary team case manages patients with extremely complex needs in order prevent avoidable hospital admissions. The team includes a GP, community matron, social worker, and with other specialists being invited where required. This team puts together a holistic package of care to meet the needs of the individual. At levels 1 and 2 patients with lower need levels will be assessed opportunistically and packages of care developed to help them stay as healthy as possible. This will include support to access both medical and non-medical interventions.

3.8.4 Currently, this new service is being piloted in two GP practices and is focussing mainly on level 3 patients. Plans to reach level 1 and 2 patients and to roll out the service city-wide are being developed. This pilot focusses on older people, but if successfully rolled out in this cohort, could be used as a model to better manage the needs of complex patients of all ages.

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CHIEF EXECUTIVES DIRECTORATE
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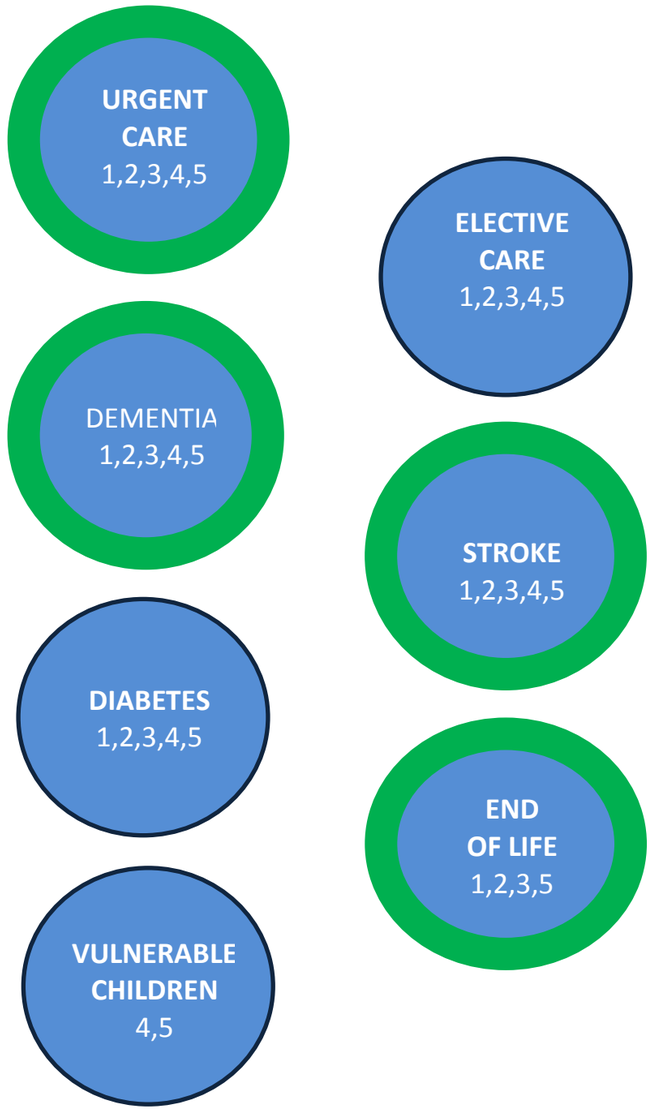
APPENDICES

I. **Coventry and Rugby Clinical Commission Group Plan on a Page**

II. **Coventry Living Well with Dementia Strategy**

NHS Coventry & Rugby Clinical Commissioning Group
Everyone Counts: Planning for Patients 2014/15 -2018/19

NHS
Coventry and Rugby
Clinical Commissioning Group

Vision	Working together to improve the NHS, improving the health and wellbeing of our community, providing the best possible patient experience and ensuring choice, value and high quality care		
Strategic Priorities	Objectives	Transformation Programmes	Success Measures Over Plan Period
1. To ensure best practice in acute hospital care	Actively engage with members and the public to drive commissioning for quality, safety and improvements in acute hospital care including reconfiguration of existing hospital services		X% reduction in avoidable admissions over plan period X% improvement in elective care productivity over plan period X% reduction in out-patient follow ups Progress towards eliminating avoidable hospital deaths Progress in improving experience of hospital care
2.To improve the wellbeing of people with mental health needs	Work with LA partners and other stakeholders to secure improvements for people with mental health needs, in particular, in quality of life for people with dementia and their carers		Improvement in people with mental health conditions having additional years of life. X% reduction in numbers in long term care X% improvement in CAMHS services
3. To improve health of (frail) older people	Work with LA partners and other stakeholders to improve longer term support to older people, focussed on early intervention and maintaining independence and available through a single point of access		X% improvement in experience of acre at end of life X% improvement in people dying in place of choice Focus on older people aged 75+ X% increase in 65+ still at home 91 days after discharge
4. To improve healthy living and lifestyle choices	Work with LA partners, public and other stakeholders to enable people to take more responsibility for their own and others physical and mental health		Increased coverage and effectiveness of patient self management resources X% reduction in smoking in pregnancy X% improvement in safeguarding events Improvement in people with physical health conditions having additional years of life
5. To achieve high quality safe GP practices	Work with CCG members and Area Team colleagues to drive primary care quality and safety and expand expertise. Enable locality focussed working and the development of integrated teams		X% improvement in primary stroke prevention X% increase in number of patients diagnosed with dementia X% improvement in GP patient survey responses X% improvement in diabetes support
Values	Quality and Safety Promoting Integration Securing Best Value Patient Involvement Innovation Access	PRIMARY CARE AT SCALE BUILDING COMMUNITY RESILIENCE AND OWNERSHIP COMMISSIONING INTEGRATED OUT OF HOSPITAL SERVICES ACCESS TO HIGHEST QUALITY CARE IMPROVEMENT IN ELECTIVE PRODUCTIVITY MARKET MANAGEMENT	NHS Constitution Pledges BETTER CARE FUND PLANS
	INFORMATION/RECORD SHARING PROGRAMME		

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Coventry's Living Well with Dementia Strategy 2014-2017

WEST MIDLANDS FIRE SERVICE

Coventry and Warwickshire NHS Partnership Trust

University Hospitals Coventry and Warwickshire NHS Trust

NHS Coventry and Rugby Clinical Commissioning Group

Coventry City Council

Warwickshire County Council

Alzheimer's Society Leading the fight against dementia

Voluntary Action Coventry

Foreword

I am pleased to introduce Coventry's first Dementia Strategy. This Strategy sets out the priorities that local people with dementia and their carers have told us are important to them. The Strategy explains how we are locally responding to these priorities, along with the priorities set out in the National Dementia Strategy and the Prime Minister's Challenge on Dementia.

I recognise that people fear dementia- it has replaced cancer as the disease people fear the most. As cancer treatments improve, the prospect of a slow descent into dementia frightens people more than any other fate. In Coventry, we are working together to enable whole-scale change, to ensure that people with dementia and their carers know where to go for information, advice and support, and are enabled to 'live well' with dementia.

This Strategy begins to address the stigma and challenges that people with dementia and their carers face, from accessing an accurate diagnosis, to accessing support when their needs change. I encourage people with dementia and their carers to be involved as we move towards our ambition for Coventry to become a truly dementia friendly community.

I hope that you will refer to this Strategy and keep up to date with our progress via Coventry and Warwickshire's Living Well with Dementia Portal: www.livingwellwithdementia.org

Councillor Alison Gingell
Cabinet Member for
Health and Social Care

Introduction

Dementia is a major and growing challenge for the UK society and economy due to increasing life expectancy, chronic morbidity and the aging population. With better understanding of prevention, diagnosis, treatment and care for dementia, and an understanding of the local population, there is more scope to improve the quality of life and wellbeing of people with dementia and their carers in Coventry.

There are thought to be around 3,600 people living with dementia in Coventry, and by 2016, this is set to rise to approximately 3,900 (Dementia Partnerships 2013). Dementia can affect anyone irrespective of their gender, ethnicity and spirituality.

People with dementia typically experience a progressive decline in their memory, reasoning, communication skills and the ability to carry out daily activities. Alongside this, individuals may also experience behavioural and emotional symptoms.

Most people with dementia in Coventry live at home, with support from friends and family members. Caring for someone with dementia can increase the risk of depression and physical illness. We recognise that caring for someone with dementia, alongside the feeling of losing a loved one can be a physically and emotionally demanding experience. We aim to support carers to continue to care and to have a life of their own alongside their caring role. This Strategy should be read in conjunction with Coventry's Multi-Agency Carers' Strategy and Coventry's Health and Wellbeing Strategy.

The National Dementia Strategy

'Living Well with Dementia: A National Dementia Strategy' was published by the Department of Health in 2009. The overall vision is for people with dementia and their family members and carers to be supported to live well with the disease. It was proposed that this would be achieved by changing attitudes towards dementia, people receiving a timely diagnosis and good quality interventions, such as use of assistive technology. The Strategy identified 17 key objectives to realise these improvements.

The Prime Minister's Challenge on Dementia

Published in March 2012, the Prime Minister's Challenge on Dementia sets out an ambitious programme of work to deliver major improvements in dementia care and research by 2015, building on the achievements of the existing National Dementia Strategy. The Prime Minister identified the national cost of dementia to be £55 billion. The identified work programme includes increasing resources for research into dementia, and creating 'Dementia Friends' and 'Dementia Friendly Communities,' to better equipped society to help people with dementia to 'live well.'

Coventry Living Well with Dementia Strategy

In Coventry, there are thought to be approximately 3,600 people living with dementia. According to the Alzheimer's Society (2013), only around 50% of those people have received a formal diagnosis. The National Dementia Strategy highlights the importance of timely diagnosis, in ensuring that people receive appropriate treatment and support.

In response to the 'Living well with Dementia: A National Dementia Strategy' and the 'Prime Minister's Challenge on Dementia,' statutory and third sector organisations have worked in partnership with people with dementia and carers, to develop Coventry's 'Living Well with Dementia Strategy.'

The strategy outlines a set of outcomes for people with dementia and their carers. Partner agencies have adopted these outcomes and have committed to using them as a foundation for future commissioning intentions and on-going work with people with dementia and their carers. This will ensure that the delivery of the National Dementia Strategy and the Prime Minister's Challenge on Dementia is firmly rooted in the expectations and aspirations of local people and will support the aim for people in Coventry to live well with dementia.

In addition, an annual multi-agency action plan will be formulated. This will support the progression of the strategy and improvement across the work of joint partners. The action plan will be agreed by the Health and Wellbeing Board.

In Coventry, there are thought to be approximately 3,600 people living with dementia. According to the Alzheimer's Society (2013), only around 50% of those people have received a formal diagnosis.

Developing the strategy

Coventry's Public Health Department undertook a 'Dementia Needs Assessment' in 2012, identifying current and future prevalence of dementia, current service provision for people with dementia, and possible gaps. This piece of work has informed the production of this strategy.

The Strategy was developed through a series of engagement exercises with key stakeholders, including people with dementia and their family members and carers, staff from partner organisations, and third sector partners. The engagement exercises consisted of surveys, questionnaires, and workshops. People were supported to consider how things could be, how Coventry as a whole could be more dementia-friendly, and current examples of good practice and gaps in service provision.

Qualitative analysis of the feedback received through the events and sessions was undertaken, to produce a set of outcomes. Work was then undertaken within the partner agencies, through Coventry's Dementia Strategy Board, to determine what achieving these outcomes would look like, and to identify priority action points.

Coventry's vision

A lot of work has already been undertaken to improve opportunities for people with dementia and their carers, for example;

- A Department of Health funded initiative to improve the environment of care for people with dementia within three care homes and two day care centres
- Development of the HOPE (Helping to Overcome Problems) programme for carers of people with dementia, through Coventry University
- Carers' training for carers of people with dementia
- Development of Dementia Advisors at the Alzheimer's Society

We wish to build on this good practice to further improve the lives of people with dementia and their carers.

Our vision incorporates whole scale change to enable people with dementia and their carers to be as independent as possible, for as long as people, and for people with dementia to 'live well' with the condition. We aim to fully engage people with dementia and their carers in the design and evaluation of services and support. The needs and wishes of people with dementia and their carers will be at the heart of action planning and delivery of this Strategy.

We are committed to Coventry becoming a dementia friendly community, which in essence means reducing stigma and people with dementia having equal access to community resources, including local businesses and services. This involves the general population of Coventry having an understanding of dementia and continuing to support family members living with the condition. More information about dementia friendly communities can be found on the Alzheimer's Society website: **www.alzheimers.org.uk**

We are committed to making person-centred dementia care a reality, and ensuring that commissioned support and services are designed in conjunction with people with dementia and their carers, assuring that they are fit for purpose.

This Strategy begins to address the stigma and challenges that people with dementia and their carers face, but there is still work to do. Our long-term vision is for the people of Coventry not to fear dementia, but to recognise that people with dementia can be empowered to continue to live the life they wish, and for people to think person first, rather than dementia.

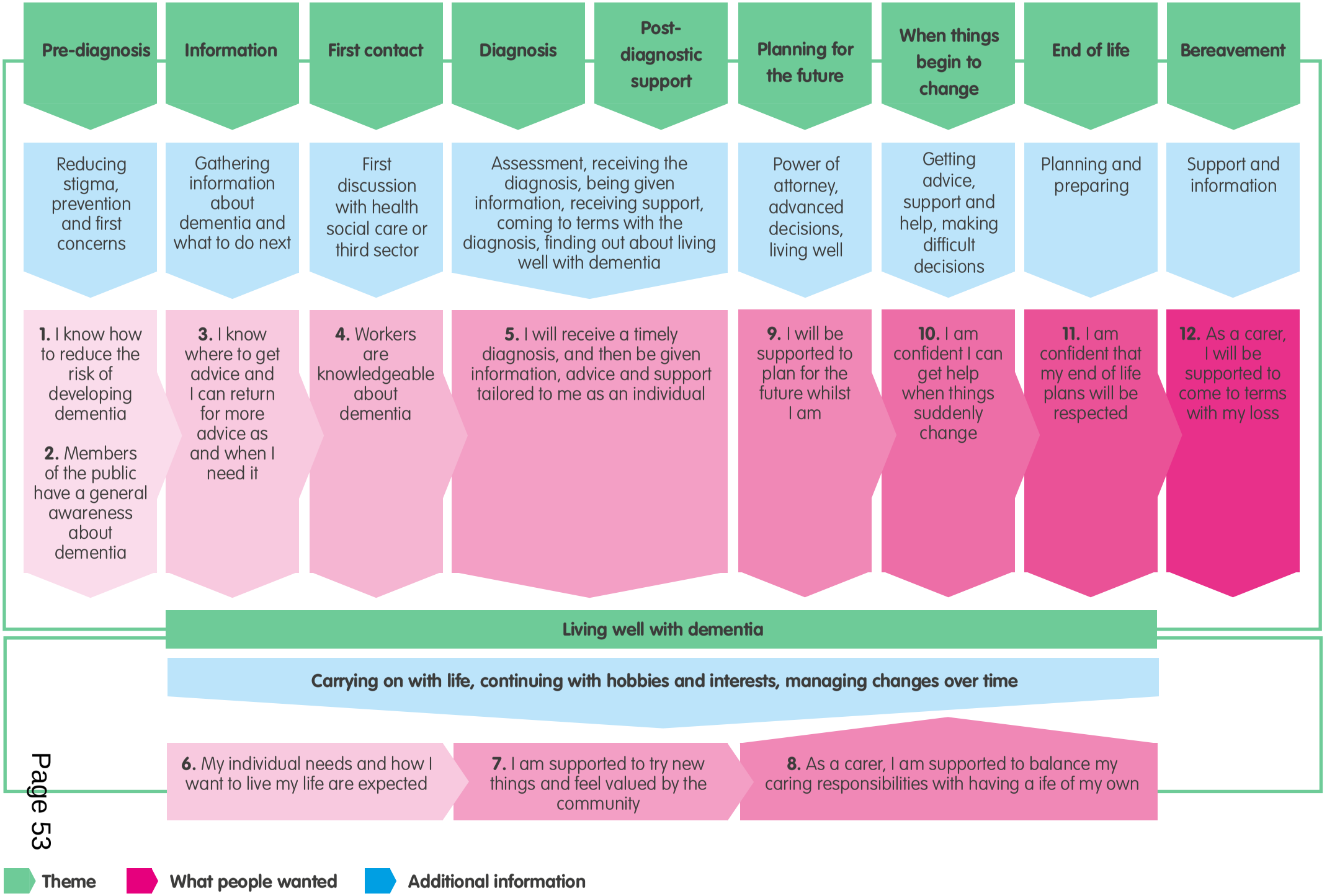
Links to other areas of work

This Strategy links closely with a number of other programmes of work, including Coventry's Carers' Strategy, Coventry's Health and Wellbeing Strategy, Age Friendly Cities, Autism Friendly Communities, and safe places. Wherever possible, areas of work will be joined together to eliminate duplication and ensure better outcomes for people Coventry residents. We also aim to work closely with partners in Warwickshire, including Warwickshire County Council, North Warwickshire CCG, and South Warwickshire CCG.

Structure of the strategy

The outcomes in the strategy are organised alongside the stages of the dementia journey, from prevention through to bereavement (see following table).

Photograph courtesy of Coventry Telegraph


Pre-diagnosis
Information
First contact
Diagnosis
Post-diagnostic support
Planning for the future
When things begin to change
End of life
Bereavement
Reducing stigma, prevention and first concerns
Gathering information about dementia and what to do next
First discussion with health social care or third sector
Assessment, receiving the diagnosis, being given information, receiving support, coming to terms with the diagnosis, finding out about living well with dementia
Power of attorney, advanced decisions, living well
Getting advice, support and help, making difficult decisions
Planning and preparing
Support and information
1. I know how to reduce the risk of developing dementia
2. Members of the public have a general awareness about dementia
3. I know where to get advice and I can return for more advice as and when I need it
4. Workers are knowledgeable about dementia
5. I will receive a timely diagnosis, and then be given information, advice and support tailored to me as an individual
9. I will be supported to plan for the future whilst I am
10. I am confident I can get help when things suddenly change
11. I am confident that my end of life plans will be respected
12. As a carer, I will be supported to come to terms with my loss
Living well with dementia
Carrying on with life, continuing with hobbies and interests, managing changes over time
6. My individual needs and how I want to live my life are expected
7. I am supported to try new things and feel valued by the community
8. As a carer, I am supported to balance my caring responsibilities with having a ife of my own
Theme
What people wanted
Additional information

Outcome	Indicative Outcome Measures and Priorities
1. I know how to reduce the risk of developing dementia	• A programme of awareness and education to be developed, accessible for all Coventry GPs and healthcare professionals. This will include information on the benefits of a healthy lifestyle in reducing the risk of developing dementia, and the benefits of a timely diagnosis • Reach 500 members of the public with prevention messages, through Dementia Friends sessions • All primary and secondary schools having access to 'dementia awareness' sessions that include information about preventing the onset of dementia. These sessions will also highlight support available for young carers • All generic public health schemes, such as Active for Health, being 'dementia friendly'
2. Members of the public have a general awareness about dementia	• 500 more Dementia Friends in Coventry • Living Well with Dementia Portal materials available in all GP surgeries and libraries in Coventry * Coventry being awarded 'Dementia Friendly Community' status
3. I know where to get advice and I can return for more advice as and when I need it	• Number of people accessing Coventry and Warwickshire's Dementia portal www.warwickshire.gov.uk/livingwellwithdementia Coventry hits increasing by 25%. • A consistent signposting approach to information and advice services throughout the journey with dementia. • 100% of people diagnosed offered a referral to Coventry Alzheimer's Society. • A single point of entry, through the 'Front Door' for people with dementia and their carers to access social care information and support

Outcome	Indicative Outcome Measures and Priorities
4. Workers are knowledgeable about dementia	• A consistent multi-agency Dementia Workforce Development Framework for all workforce staff that may come into contact with people with dementia and their carers • Awareness and assessment training for 200 health and social care staff members • A consistent specification and quality framework for dementia care providers in the city, specifying the level of training required for staff. To be introduced to all dementia care homes, by 2017 • E-learning programmes to be promoted amongst all staff that may come into contact with people with dementia and their carers
5. I will receive a timely diagnosis, and then be given information, advice and support tailored to me as an individual	• Eight week target for Memory Assessment Clinic assessments • Health and social care utilising the Dementia Needs Assessment (2012) and Dementia Prevalence Calculator www.dementiaprevalencecalculator.org.uk/ to identify future projections of need • A review of post-diagnostic support to be undertaken, involving a consultation with at least 200 members of the public. A revised 'menu' of post-diagnostic support to be developed following the consultation. Post-diagnostic support will be tailored to the individual's needs, and a variety of options will be made available. • 100% of people diagnosed offered a referral to Coventry Alzheimer's Society • A 'Buddy' pilot to be undertaken, whereby people newly diagnosed with dementia are offered a chance to link with another person living with dementia in Coventry. This will be reviewed and scaled up if successful

Outcome	Indicative Outcome Measures and Priorities
6. My individual needs and how I want to live my life are respected	• People with dementia and their carers are encouraged to be as independent as possible for as long as possible • Reduce care home placements by 8%, in line with Better Care Fund programme of work • Coventry being awarded 'Dementia Friendly Community' status- everyday community services should be dementia friendly • Personal budgets and direct payments being offered to eligible people with dementia and their carers (critical and substantial needs as defined under the FACS eligibility criteria) • Health and social care staff have a working knowledge of the Mental Capacity Act • Telecare offer to be redesigned, and 3,000 new Telecare users in 3 years
7. I am supported to try new things and feel valued by the community	• 500 more Dementia Friends in Coventry • Coventry being awarded 'Dementia Friendl Community' status • People being encouraged and supported through one to one or peer support groups to participate in every day community activities • If 'Buddy' pilot is successful, people with dementia will have the opportunity to volunteer their time for this programme
8. As a carer, I am supported to balance my caring responsibilities with having a life of my own	• Carers' Assessments being offered to eligible carers • A carer's educational and employment needs being taken into account during their own assessment and the assessment of the person they care for • Carers having access to education about dementia and wider wellbeing, including formal education and information support via peer support groups • The post-diagnostic support consultation will be held in conjunction with a carers' consultation, to inform the review of carers' services. The needs of carers of people with dementia will be considered explicitly as part of this review

Outcome	Indicative Outcome Measures and Priorities
9. I will be supported to plan for the future whilst I am able	• 100% of people with dementia and their carers are directed to sensitive legal advice regarding Lasting Powers of Attorney and Advanced Directives • Health and social care staff have a working knowledge of the Mental Capacity Act • Post-diagnostic support enables and encourages people with dementia and their carers to plan for the future both in terms of legal aspects but also in getting their financial and family support in place before things deteriorate
10. I am confident that I can get help when things suddenly change	• 100% of Carers are signposted to emergency planning support and education opportunities, such as online training, when the diagnosis is given • People with dementia and their carers are encouraged to plan for the future • Single point of entry for CWPT services. Details given to 100% of people diagnosed • Single point of entry for social care information and support. Details given to 100% of people diagnosed • Planned emotional and practical support, including short breaks for carers, for all eligible carers who have received a Carer's Assessment • Commissioning of high quality services and support to meet the needs of people with dementia and their carers. 100% of dementia care homes being subject to the revised dementia specification by 2017 • A pilot of short-term services to maximise independence for people with dementia to be undertaken during 2014/15. This service will aim to reach 50 people, enabling them to regain their skills and be as independent as possible. This pilot will be scaled up if successful.

Outcome	Indicative Outcome Measures and Priorities
11. I am confident that my end of life plans will be respected	• People with dementia are encouraged to make plans for the future • Health and social care staff have a working knowledge of dementia end of life care • 100% of people living with dementia in care homes to be offered the opportunity to develop an end of life care plan
12. As a carer, I will be supported to come to terms with my loss	• Carers signposted to online and community sources of support, for example, Grouple • To be considered as part of the carers' services review • 100% of carers receiving a Carer's Assessment to be signposted to training which enables them to understand changes during the dementia journey, and to plan for the future

References

Dementia Partnerships (2013) Dementia Prevalence Calculator [online] available from http://www.dementiaprevalencecalculator.org.uk/ [2 August 2013]

Department of Health (2009) Living Well with Dementia: A national strategy, HMSO: London

Department of Health (2012) Prime Minister's Challenge on Dementia, HMSO: London

Public Health Coventry (2012) Dementia Needs Assessment, Public Health Coventry: Coventry

Thanks

We would like to thank the following people for giving up their time to support the development of this strategy:

People who took the time to engage in consultation exercises to inform the development of the Strategy

Members of Coventry's Dementia Strategy Board

Ken Howard

Action plan

A yearly Action Plan will be developed, to enable the implementation of the themes of this strategy. Organisations will pledge their yearly commitments to improve dementia care in Coventry.

Governance and review

Coventry's Dementia Strategy Board is the responsible Board for overseeing the implementation of Coventry's Dementia Strategy. This Board is accountable to Coventry's Adult Commissioning Board, which in turn is accountable to Coventry's Health and Wellbeing Board. This strategy and its achievements will be reviewed by December 2017.

We are committed to Coventry becoming a dementia friendly community, which in essence means reducing stigma and people with dementia having equal access to community resources, including local businesses and services.

If you need this information in another format (including easy read) or language please contact us

Telephone: 02476832473
email: dementia@coventry.gov.uk

14-0300-CB

11th February 2015

Health and Social Care Scrutiny Board (5)
Work Programme 2014/15

For more details on items, please see pages 2 onwards

30 July 2014
- Coventry and Warwickshire Partnership Trust (CWPT) Quality Account
- West Midlands Ambulance Services (WMAS) Quality Account
- Patient Transport Services
- Follow up to Peer Review of Adult Social Care

10 September 2014
- Coventry Safeguarding Adults Board Annual Report
- Adult Social Care Local Account
- Patient discharge/winter pressures from UHCW
- UHCW Quality Account

15 October 2014
- Public Health – progress since joining the Council
- Learning Disabilities Strategy
- Increased Community Support through Telecare
- Winterbourne

19 November 2014
- Director of Public Health Annual Report
- Sexual Health Services – proposed re-commissioning
- Overview of the Care Act and Coventry's Preparations for when this becomes Legislation
- ABCS Implementation
- Adult Social Care Complaints and Representations Annual Report 2013-14

10 December 2014
- Mrs D – Progress following SCR
- Winterbourne View
- Update on the Care Quality Commission Wave 1 Pilot Inspection

7 January 2015
- Towards Children and Young People's Emotional Health and Well-being

11 February 2015
- Winter Pressures
- Clinical management of large scale chronic diseases

18 March 2015
- Review of the Health and Wellbeing Board
- Impact of different Models of Primary Care delivery
- Deprivation of Liberty Implications

22 April 2015
- Coventry and Warwickshire Partnership Trust – progress following CQC Inspection

Date to be determined
- Social Isolation
- NHS Targets
- Community Mental Health Services
- Increase in smoking in during pregnancy
- Update on Sexual Health Services

Implementation of the Director of Public Health Annual Report recommendations regarding primary care
Patient Transport
Clinical Training
Care Act

Health and Social Care Scrutiny Board (5) Work Programme 2014/15

Meeting Date	Work programme item	Lead officer	Brief Summary of the issue	Source
30 July 2014	Coventry and Warwickshire Partnership Trust (CWPT) Quality Account	Tracy Wrench (Director of Nursing)	NHS Provider Trusts are required to produce annual statements of quality and outcomes. The Board has a role in providing a short commentary on progress.	Annual Report
	West Midlands Ambulance Services (WMAS) Quality Account	Anthony Marsh, CEX	The Board has asked to receive a short presentation from WMAS on its Quality Account 2014/15, with commentary on measures being taken to address improvements to targets not achieved. They are also interested to have information about the "make ready" process, its impact on the service and patient care in terms of efficiency, effectiveness and financial considerations.	Annual Report and informal Scrutiny meeting 02/07/14
	Patient Transport Services	Steve Allen/ Clare Hollingworth CCG	Review of progress since the Board discussed at its 5 March 2014 meeting the delayed plans to re-commission Patient Transport Services in Coventry and Warwickshire following concerns raised by Healthwatch. West Midlands Ambulance Service to be invited to attend.	SB5 05/03/14
	Follow up to Peer Review of Adult Social Care	Mark Godfrey	Review of progress on the recommendations arising from the Peer Challenge of Adult Social Care that took place in March 2013, including a focus on personalisation, client centred care and managing the adult social care budget. NB The Peer Challenge report specifically recommended that some increased scrutiny on adult social care such as commissioning, transformation and budget plans, and progress on personalisation would now seem timely and that the Board consider further which adult social care matters should be the subject of scrutiny in its programme for 2014/15.	Recommendations from Peer Challenge
10 September 2014	Coventry Safeguarding Adults Board Annual Report	Brian Walsh / Sara Roach/ Isabel Merrifield	This multi-agency Board is responsible for co-ordinating arrangements to safeguard vulnerable adults in the City. The Annual Report sets out progress over the 2013/14 municipal year and provides members with some data to monitor activity. Representatives of the Safeguarding Board to be invited.	Annual Report

Health and Social Care Scrutiny Board (5) Work Programme 2014/15

Meeting Date	Work programme item	Lead officer	Brief Summary of the issue	Source
	Adult Social Care Local Account	Brian Walsh / Mark Godfrey/ Pete Fahy/ David Watts/ Gemma Tate	This is the annual report of the Council related to services provided to Adult Social Care clients. The report summarises performance, provides commentaries from key partners and representatives of users and sets strategic service objectives for the future.	Annual agenda item
	Patient discharge/winter pressures from UHCW	Rebecca Southall (UHCW) / CCG/ ASC	To include review of effectiveness of 2013/14 winter arrangements and preparations for 2014/15. To include CCG, provider organisations and social care.	Annual item
	UHCW Quality Account	Andy Hardy (Chief Executive)	NHS Provider Trusts are required to produce annual statements of quality and outcomes. The Board has a role in providing a short commentary on progress.	Annual Report c/f from 30/07/14
15 October 2014	Public Health – progress since joining the Council	Dr Jane Moore / Ruth Tennant	Public Health transferred from the NHS to the Council in April 2012. A report has been prepared highlighting progress and achievements since the transfer and the Board would like to review this.	Informal work planning meeting 18/06/14
	Learning Disabilities Strategy	Mark Godfrey/ David Watts/ Lavern Newell	To contribute to the planned review of the strategy	c/f from 2013/14
	Increased Community Support through Telecare	Pete Fahy/ Michelle McGinty	To review the delivery of the high level strategy agreed with health partners, with recommendations to be made to CM (Health and Adult Services) on how the delivery of the strategy is progressed. The Board is interested to hear about the impact with regard to the Aylesford and its proposed cessation; and to understand any changes to the impacts identified.	CM(Health and Adult Services) 17/06/14 Cabinet 17/06/14

Health and Social Care Scrutiny Board (5) Work Programme 2014/15

Meeting Date	Work programme item	Lead officer	Brief Summary of the issue	Source
	Winterbourne	Pete Fahy/ Jon Reading	To consider the report prior to its sign-off by the Health and Well Being Board in November 2014	
19 November 2014	Director of Public Health Annual Report	Dr Jane Moore / Ruth Tennant/ Tanya Richardson	The DPH has a statutory opportunity to issue Annual Reports which provide a commentary of local public health profiles and priorities. (Depending on focus of the report, this could be considered by Scrutiny Co-ordination Committee instead)	Annual agenda item
	Sexual Health Services – proposed re-commissioning	Dr Jane Moore / Nadia Inglis	The Council's Public Health service is re-commissioning sexual health services for the City in partnership with colleagues in Warwickshire. This will provide an opportunity for the Board to review progress once the new contract has been awarded, including how recommendations made at its 2 April 2014 meeting have been followed up.	SB5 02/04/14
	Overview of the Care Act and Coventry's Preparations for when this becomes Legislation	Mark Godfrey/ Emma Bates	Progress report to be submitted to a future meeting of the Board in six months including information on the financial implications. To include information on the Safeguarding Boards preparedness. (Steve Mangan and Mark Godfrey to attend)	SB5 30/04/14 and 30/07/14
	ABCS Implementation	Pete Fahy	The People Directorate is undertaking a significant programme of transformation affecting local people, the organisation, partners and resources. The Board would like to review progress with implementation and understand the impacts, particularly in relation to the way we have worked with partners.	Informal work planning meeting 18/06/14
	Adult Social Care Complaints and Representations Annual Report 2013-14	John Teahan	To review levels of complaints, the way they are managed and how they are used to learn lessons and deliver improvements.	

Health and Social Care Scrutiny Board (5) Work Programme 2014/15

Meeting Date	Work programme item	Lead officer	Brief Summary of the issue	Source
10 December 2014	Mrs D – Progress following SCR	Brian Walsh / Simon Brake	To review progress against the action plan put in place following the Serious Case Review into the death of a vulnerable adult Mrs D, considered by the Board on 18 December 2013.	SB5 18/12/13
	Winterbourne View	Pete Fahy/ Jon Reading	To consider the report prior to its sign-off by the Health and Well Being Board in November 2014 (This items was originally scheduled for October but deferred)	
	Update on the Care Quality Commission Wave 1 Pilot Inspection	Josie Spencer	To provide an update to the Board on progress on the improvements implemented following the Care Quality Commission Inspection.	SB5 April 14
7 January 2015	Towards Children and Young People's Emotional Health and Well-being	Jacqueline Barnes	To consider the report by the West Midlands Quality Review Service into Child and Adolescent Mental Health Service in Coventry and Warwickshire. A number of partner organisations have been invited to the meeting to discuss this report.	
11 February 2015	Winter Pressures	UHCW/CCG/ Social Care	Winter pressures has made headlines throughout January. This is an opportunity to look at how Coventry is coping with winter pressures. UHCW, the CCG and Adult Social Care representatives have been invited to the meeting.	
	Clinical management of large scale chronic diseases	Valerie De-Souza	To review how pathways are being managed in primary care for a range of challenges including diabetes	
18 March 2015	Review of the Health and Wellbeing Board		The Board would like to review the effectiveness of the working of the HWBB organisationally and corporately.	SB5 30/07/14
	Impact of different Models of Primary Care delivery	Sue Price (Local Area Team) / Ruth Tennant/ CCG	Review of what good primary care looks like and whether different models of provision produce better outcomes. Invite 2 or 3 GP practices and patient panel representatives and Healthwatch in relation to patient engagement. (Needs to link with any Health and Well-being Board work)	c/f from 2013/14
	Deprivation of Liberty Implications	David Watts		Forward Plan Jan 15

Health and Social Care Scrutiny Board (5) Work Programme 2014/15

Meeting Date	Work programme item	Lead officer	Brief Summary of the issue	Source
	Tobacco Control Strategy (to be agreed by the Chair)	Berni Lee	To seek approval for the Tobacco Control Strategy – a Cabinet report will be going on 14th April.	Forward Plan
22 April 2015	Coventry and Warwickshire Partnership Trust – progress following CQC Inspection	CWPT	To review progress against the action plan put in place following the Care Quality Commission's review of the Trust, particularly in relation to the enforcement notice and issues relating to Quinton Ward.	SB5 30/04/14
Date to be determined	Social Isolation		The Board would like to understand the extent of social isolation in the city and particularly how this is addressed when people are being supported to live in their own homes. This may involve discussions with representatives of the third sector.	Informal work planning meeting 18/06/14
	NHS Targets		Performance against NHS targets has been raised as a national concern this year, particularly in relation to waiting times for cancer. The Board would like to understand the extent to which targets are being met locally.	Informal work planning meeting 18/06/14
	Community Mental Health Services	Josie Spencer	To provide information to the Board on the services provided through the shared budget of the Better Care Fund in relation to community mental health services and integrated team working.	SB5 10/9/14
	Increase in smoking in during pregnancy			
	Update on Sexual Health Services		To provide an update on sexual health services following the re-commissioning of services for the City in partnership with colleagues in Warwickshire. Suggested that this item is held summer 2015.	SB5 19/11/14

Health and Social Care Scrutiny Board (5) Work Programme 2014/15

Meeting Date	Work programme item	Lead officer	Brief Summary of the issue	Source
	Implementation of the Director of Public Health Annual Report recommendations regarding primary care	Dr Jane Moore	The Board would like an update of the implantation of the recommendations contained within the DofPH annual report 2014.	SB5 19/11/14
	Patient Transport		To look at the patient transport service and how well it is serving Coventry residents visiting UHCW.	SB5 19/11/14
	Clinical Training		An item linked to the education sector, including the vocational nature of courses. Consideration to be given to the recruitment and retention of staff.	SB5 10/12/14
	Care Act	Mark Godfrey	To look at the Care Act and understand the possible implications for the Council and Residents.	