Coventry City Council

Agenda

Coventry Health and Well-being Board

Time and Date
2.00 pm on Monday, 4th September, 2017

Place
Committee Room 3 - Council House

Public Business

1. **Welcome and Apologies for Absence**

2. **Declarations of Interest**

3. **Minutes of Previous Meeting** (Pages 5 - 14)

   (a) To agree the minutes of the meeting held on 10th July, 2017

   (b) Matters Arising

Development Items

4. **West Midlands Well-being Board**

   The Chair Councillor Caan will report at the meeting

5. **Health and Well-being Strategy - Multiple Complex Needs Update** (Pages 15 - 16)

   Report from Chief Superintendent Sharon Goosen, West Midlands Police and Interim Chair of the Multiple Complex Needs Board

6. **Update on the Better Health, Better Care and Better Value Work Streams (STP)** (Pages 17 - 22)

Report of Brenda Howard, Programme Director who will report at the meeting on:

(a) Proactive and Preventative Care

(b) Urgent and Emergency Care

(c) Planned Care

(d) Maternity and Paediatrics

(e) Productivity and Efficiency

7. **Out of Hospital** (Pages 23 - 42)

Report of Andrea Green, Coventry and Rugby Clinical Commissioning Group

Information Item

8. **Care Quality Commission Local System Review** (Pages 43 - 48)

Report of Pete Fahy, Director of Adult Services

9. **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

Private Business

Nil

Martin Yardley, Executive Director, Place, Council House Coventry

Friday, 25 August 2017

Note: The person to contact about the agenda and documents for this meeting is Liz Knight Tel: 024 7683 3073 Email: liz.knight@coventry.gov.uk

Membership: Cllr F Abbott, S Banbury, Cllr K Caan (Chair), A Canale-Parola (Deputy Chair), G Daly, B Diamond, Cllr G Duggins, L Gaulton, S Gilby, A Green, A Hardy, R Light, D Long, J Mason, C Meyer, G Quinton, M Reeves, Cllr E Ruane, Cllr K Taylor and D Williams

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.

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Coventry City Council
Minutes of the Meeting of Coventry Health and Well-being Board held at 2.00 pm on Monday, 10 July 2017

Present:

Board Members:
Councillor Abbott
Councillor Caan (Chair)
Councillor Taylor
Rob Allison, Voluntary Action Coventry
Sarah Baxter, Coventry University
Dr Adrian Canale-Parola, Coventry and Rugby CCG (Deputy Chair)
Ben Diamond, West Midlands Fire Service
Andrea Green, Coventry and Rugby CCG
Ruth Light, Coventry Healthwatch
John Mason, Coventry Healthwatch
Gail Quinton, Deputy Chief Executive (People)
Justine Richards, Coventry and Warwickshire Partnership Trust
Rebecca Southall, University Hospitals Coventry and Warwickshire

Other Representatives:
Councillor Gannon
Brenda Howard, University Hospitals Coventry and Warwickshire

Employees (by Directorate):

Place: L Knight
People: P Fahy
J Fowles
R Nawaz

Apologies:
Councillor Duggins
Guy Daly, Coventry University
Liz Gaulton, Acting Director of Public Health
Simon Gilby, Coventry and Warwickshire Partnership Trust
Sharon Goosen, West Midlands Police
Andy Hardy, University Hospitals Coventry and Warwickshire
Danny Long, West Midlands Police
David Williams, NHS Area Team

Public Business

1. **Declarations of Interest**

There were no declarations of interest.

2. **Minutes of Previous Meeting**

The minutes of the meeting held on 10th April, 2017 were signed as a true record. Further to Minute 118 headed 'Any other items of public business – Social Care

Summit' it was reported that the Social Care Summit organised by Coventry and Warwick Universities had taken place on 26th June.

There were no other matters arising.

3. **Appointment of Deputy Chair of the Health and Wellbeing Board**

RESOLVED that Dr Adrian Canale-Parola be appointed as Deputy Chair of the Health and Wellbeing Board for 2017/18.

4. **Progress Update on Coventry's Marmot City Strategy 2016-2019**

The Board considered a report and received a presentation by Ben Diamond, West Midlands Fire Service and Co-Chair of the Marmot Steering Group which provided a progress update on the Coventry Health and Wellbeing Strategy priority 'Working together as a Marmot City to reduce health and wellbeing inequalities'.

The report set out the background to Coventry's position as a Marmot City from 2013 to 2015 and the involvement in the initial Marmot Programme to reduce health inequalities. In 2016 Sir Michael Marmot and his team committed to working with Coventry for a further three years to progress the health inequalities work. Partners were continuing to work together on a number of projects initiated in the first two years. In addition the Marmot City priorities now were to tackle inequalities disproportionately affecting young people and ensuring all Coventry people, including vulnerable residents, could benefit from good growth which would bring jobs, housing and other benefits to the city.

The Board were informed that there remained a strong commitment to the Marmot programme from all the partners on the Steering Group. The Marmot Action Plan set out ways in which partners and stakeholders would work to achieve the key priorities. Progress against the programme indicators included:

- 92% of children and young people reporting an increased awareness of the risks of sexual violence and support services available following the delivery of the sexual violence prevention programme.
- Employment and training support to over 500 young people not in education, training and employment as part of the Ambition Coventry programme.
- All key policy decisions taken by the City Council now consider the potential implications on inequalities across the city
- Voluntary Action Coventry and the West Midlands Fire Service had both signed up to the Workplace Wellbeing Charter.

Progress against the Action Plan and indicators was set out in an appendix attached to the report under the following two headings: young people and good growth. Indicators were split into programme indicators (output focused) and overarching indicators (outcome focused). The Marmot Steering Group met on a quarterly basis to receive updates from partners, discuss progress and identify areas for development and partnership working.

The presentation informed of the continuing national recognition of the work in Coventry and gave detailed information on the supporting young people and good

growth priorities highlighting achievements to date against targets. Comparisons of outcomes from 2015/16 to 2016/17 for both priorities clearly demonstrated positive progress. The presentation concluded with a summary of the next steps for the current year.

Members raised a number of issues arising from the presentation including:

- Clarification regarding some of the indicator statistics in the report
- Further information about the reasons for the positive increase in the number of new young clients accessing the CRASAC Counselling Service
- A request for further updates on progress with the indicators in due course
- What Members could do to support organisations to sign up to the Workplace Wellbeing Charter and the need to market the Charter to employers
- The suggestion that contact be made with the Welfare Reform Group and the Group supporting the Feeding Coventry Initiative to provide access for good guidance concerning health inequalities
- An acknowledgement of the links to the Better Health, Better Care, Better Value programme
- The role of the Voluntary Sector in supporting young people into work
- A suggestion that contact be made with individual trade unions to gain their support for the Workplace Wellbeing Charter

Ben Diamond indicated that he would make contact with the links suggested by Members.

RESOLVED that:

(1) The progress made to date against the Marmot Action Plan be endorsed.

(2) Further progress updates from the Marmot Steering Group be submitted to future meetings of the Board every six months.

5. **Coventry and Warwickshire Sustainability and Transformation Plan Update**

The Board considered a report of Professor Andy Hardy, University Hospitals Coventry and Warwickshire (UHCW) and received a presentation from Brenda Howard, UHCW which provided an update on the Better Health, Better Care, Better Value programme and work streams.

The report highlighted that the Sustainability and Transformation Plan had recently been renamed 'Better Health, Better Care, Better Value' reflecting the triple challenges facing health and social care as set out in the 'Five Year Forward View' report.

On 25th May, 2017 Board Members met NHS England and NHS Improvement for a quarter one review of progress. The meeting was positive with the strength of the collaboration being commended. The well-defined governance and executive leadership structures were acknowledged. A copy of the formal response received was set out at an appendix to the report.

The Board had agreed its support structure to enable the transformational and enabling work streams to deliver their priorities and objectives. Recruitment was underway and the aim was, as far as possible, to attract internal partner organisation applicants as secondments. It was intended to establish a 'System Leadership Academy' enabling participants to experience working in the different organisations within the system.

A second appendix set out the reinforced governance arrangements for the programme. The Design Authority had been reframed with greater representation from local clinical leaders and a Programme Delivery Group had been established. The Board were informed that it had recently been decided that mental health services should be designated as a transformational work stream and arrangements were now progressing to establish this. In addition it had also been decided to establish a cancer work stream as part of the approach to planned care.

The report provided detailed information on progress, including individual priorities, with the following transformation work streams: maternity and paediatrics; urgent and emergency care; mental health; proactive and preventative; productivity and efficiency; planned care and cancer.

The report also referred to the enabling work streams. Work force challenges would be an issue for all work streams and the workforce group had established three key areas of focus: career pathways, leadership, and new roles and new ways of working.

In relation to Estates, the Estates Group provided a report to the Board outlining its key priorities relating to a premises stocktake, resources required to deliver the future model and the efficiency delivery of infrastructure functions. The group was progressing discussions on a Health and Wellbeing Campus model for George Elliot Hospital and a workshop for partners across the system was planned for 11th July. An updated briefing on the Estates Strategy was tabled at the meeting which included background information on the Naylor Report and referred to local plans and key priorities
The report also highlighted the communication and engagement sessions which had taken place since the last report to the Health and Wellbeing Board.

The presentation highlighted the programme governance, structure and work streams; reviewed progress with the regulators; referred to the estates strategy; and concluded with the next steps.

Members raised a number of issues in response to the presentation including:

- Clarification about the estate premises under consideration and whether it included buildings owned by other organisations
- The complexities associated with the mental health work stream community capacity and resilience
- Examples of how voluntary organisations can support and help people suffering from mental health issues and the importance of using these community assets
- The importance of including patients and the public in the structures and ensuring their views are taken into account as work progresses on the work streams

- The importance of using Elected Members who can engage with local residents helping to get the right messages out
- An acknowledgement of the need for organisations to continue to work together putting patients at heart of any new system.

RESOLVED that the contents of the report and presentation be noted.

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6. **Proactive and Preventative Work Stream - Public Health Preventative Framework**

The Board received a presentation from Gail Quinton, Deputy Chief Executive (People) on the Proactive and Preventative work stream of the Better Health, Better Care, Better Value programme. Jane Fowles, Public Health Consultant, also attended for the consideration of this item.

The presentation set out the benefits of a targeted proactive and preventative approach. It was important for this to be undertaken at the current time as there was a greater level of need, conditions for success were stronger and the work stream enabled partners to build on the work already underway. The presentation set out the foundation already in place and highlighted the partnership principles to drive change.

Prevention was to be being integrated into all aspects of the health and care model with agreed prevention priorities being smoking prevention; obesity; falls prevention; and the Thrive Mental Health Commission report. Reference was made to the work programme in a three stage model:

- 80% - community based self-help for the general population
- 10% - at risk or early intervention
- 10% - specialist care

Additional information including the links to the partner organisations and the features for each of these stages were provided.

The presentation concluded with attention being drawn to the need for partner organisations to adopt the model and partnership principles and to provide a clear statement of commitment to be a public organisation which prioritises prevention and supports people to help themselves.

Jane Fowles detailed the support to be provided by Public Health to the Proactive and Preventative programme and the Chair, Councillor Caan expressed support for the Public Health initiatives including fitness in the parks and the recent event in Broadgate. Dr Canale–Parola, Deputy Chair highlighted the importance of the role of the community.

RESOLVED that the progress with the Proactive and Preventative work stream be noted.

7. **Redesign and Improvement of Stroke Services**

The Board received a report from Andrea Green, Coventry and Rugby Clinical Commissioning Group (CCG) on the proposals for the redesign and improvement of stroke services.

The report referred to the establishment of a project in April, 2014 by Coventry and Warwickshire CCGs to improve local stroke services for those who have had a stroke or a transient ischemic attack (mini stroke). In due course the proposals were expanded to include improvements to acute services, specialist rehabilitation and primary prevention of strokes. Reference was made to the project governance structure including the Project Stakeholder Board and an expert Patient and Public Advisory Group.

The report set out the case for change as follows:
Access to Service is time critical both to saving lives and reducing disability
Local gaps in timelines for people who stroke
Local TIA (mini stroke) service variation
Workforce gaps – Stroke Specialist Consultants
Unwarranted variation and inequality in stroke specialist rehabilitation services.

The Board were informed of the engagement with patients, carers and key stakeholders. A pre-consultation engagement programme was undertaken in the initial stage of the project to understand the views of key stakeholders and local people about the potential scenarios for a new stroke pathway in order to shape the future of stroke services in Coventry and Warwickshire. The aims of the discussions were to ensure everyone had a clear understanding of the services delivered currently, the evidence base and rationale for change and what scenarios were being discussed. Four possible scenarios for the future of acute stroke care were put forward. Key themes received from the early engagement with stroke survivors, carers and the public were related to transport issues, communication difficulties, compassion and dignity, staffing and discharge support. Following engagement, the following proposals were developed:

- Having one specialist stroke team based at UHCW, made up of experts in stroke services. They will treat people in the important first few days after a stroke
- A community support service for people who are recovering at home
- Closure of the specialist stroke services at Warwick Hospital and George Eliot Hospital
- The provision of hospital beds for people who need to be in hospital while they recover at Leamington Hospital and George Eliot Hospital.

Following treatment at Hyper Acute and the Acute Stroke Unit on the UHCW site, patients would be referred to one of five settings to meet their rehabilitation or ongoing needs:

- Home with Early Supported Discharge Service
- Cared for in a nurse led stroke ‘bedded’ rehabilitation service at a local hospital
- Home with the Stroke Community Rehabilitation Service
- Home with a package of care
- Nursing or residential care for those with more complex needs.

Attention was drawn to the support from the West Midlands Clinical Senate of national experts on Stroke Care for the model.

It was anticipated that improvements would be a reduced number of people who stroke; a reduction in deaths from stroke; a reduced disability from those who suffer a stroke; and improved cognitive function for people after a stroke.

Further information was provided on the four week public and patient engagement on the proposals. Appendices to the report detailed the consultation questionnaire and the four engagement events to be held during July. NHS England would then need to complete their assurance process before any consultation commenced.

Members raised a number of questions in response to the report, matters raised included:

- The anticipated average length of stay at Leamington or George Eliot hospitals
- The importance of providing the public with a consistent message being clear on the benefits of the proposals during the engagement and consultation stages
- The requirement to tighten up on communications ensuring the message was all about better patient outcomes as oppose to saving money
- The importance of all the partners supporting the redesigned and improved stroke services.

RESOLVED that, having reviewed the proposals to improve stroke services, it be noted that the CCGs are:
a) Completing a further phase of engagement as the scenarios for improvement have now been translated from the feedback from patients, the public and clinicians into proposals attached at Appendix A
b) Have commissioned another integrated impact assessment of the proposals
c) About to enter the final stage of assurance with NHS England.

8. **Improved Better Care Fund**

The Board considered a report of the Deputy Chief Executive (People) which sought approval for the use of additional Better Care Fund resource to support three intended purposes. The report was also to be considered by Cabinet on 1st August and Council at their meeting on 5th September.

The report indicated that whilst the Sustainability and Transformation Programme (STP) was the primary planning tool for health and care, the Better Care Fund was the only mandatory policy to facilitate integration of health and care. The programme spanned both the NHS and local government and sought to join up health and care services so that people could manage their own health and wellbeing, and live independently in their communities for as long as possible.

In March 2017 a new policy framework for the Better Care Fund covering the period 2017 to 2019 was issued at the same time as significant additional funding being made available to Councils in order to protect adult social care. These sums came from the 2015 spending review and the 2017 spring budget and taken together comprised the Improved Better Care Fund. The additional funding element over and above the budget for Coventry was £18.6m as follows: 2017/18 - £7.1m, 2018/19 - £4.4m and 2019/10 - £7.1m (although the 2019/20 figure was

outside the scope of the current planning). This additional funding was provided direct to Councils for the following three purposes:

- To meet adult social care need
- To provide support to the NHS – especially through the application of 8 high impact changes
- To sustain the social care provider market

The Board were informed that plans for the use of the grant needed to be approved by the City Council, Coventry and Rugby CCG and the Health and Wellbeing Board. Resources could then start to be spent through a pooled budget arrangement.

The Board noted that a new Better Care Plan was being developed for the period up to 31st March, 2019 with a supporting section 75 partnership agreement identifying how the additional resources were to be used.

An appendix to the report set out the programme plan which contained a series of project areas which would deliver against the three purposes of the funding.

Members raised a number of issues including transparency of the funding and proposals; the positive aspects of receiving additional resource; and clarification about the current reasons for delayed discharges from hospital.

RESOLVED that:

(1) The programme plan for the resources made available through the improved Better Care Fund against the areas identified be supported.

(2) A further report on the Better Care Fund plan be submitted to a future meeting once the planning tools have been provided and completed.

9. **Coventry Drug and Alcohol Strategy 2017 - 2020**

The Board considered a report of Liz Gaulton, Acting Director of Public Health on the Coventry Drug and Alcohol Strategy 2017-2020, a copy of which was set out at an appendix to the report. An update was provided on the progress to address alcohol and drug misuse against the previous strategies was detailed in a further appendix.

The report indicated that Coventry's vision was to reduce the harms caused by alcohol and drug misuse making Coventry a healthier, wealthier and happier place to live, where less alcohol and fewer drugs were consumed and where professionals were confident and well-equipped to challenge behaviour and support change. This linked to all three of the priorities in the 2016-2019 Health and Wellbeing Strategy. Reference was made to the finding in the 2016 Coventry Drug and Alcohol Needs Assessment which indicated that drug use was falling and that Coventry had a considerably larger alcohol abstinent population than many other areas although there were still sections of the population drinking at harmful levels with approximately 14,000 people in the city being high risk drinkers.

The development of the new Drug and Alcohol Strategy coincided with the re-commissioning of drug and alcohol recovery services in the city. As drug and alcohol misuse was a cross-cutting issue, it required a multi-agency response. The strategy involved partners and covered a wide range of issues such as multiple complex needs, prevention, early intervention, education, training, employment, housing, finance, crime, recovery and support.

The strategy had been developed by, and was being implemented by, a wide range of partners including the City Council, Coventry and Rugby CCG, West Midlands Police, Probation, Youth Offending Service, drug and alcohol treatment providers and the Coventry Recovery Community. It was a three year citywide strategy for both drug and alcohol use covering both young people and adults.

The three strategic priorities were to:
(i) Prevent people from taking drugs or drinking harmful levels of alcohol and intervene early to minimise harm
(ii) Support those with drug and/or alcohol problems and those with multiple complex needs
(iii) Promote sustainable recovery and enable people to live healthy, safe and meaningful lives.
The report highlighted the main actions to be undertaken in the first twelve months.

The strategy was to be reviewed on a quarterly basis by the Drug and Alcohol Strategy Steering Group and would have an action plan detailing the specific actions. The Steering Group reported to this Board and to the Police and Crime Board.

RESOLVED that:

(1) The report summarising actions to date on the current Coventry Drug Strategy and Coventry Alcohol Strategy be noted.

(2) The Coventry Drug and Alcohol Strategy 2017-2020 be endorsed.

10. **Forward Plan Agenda Items and Health and Wellbeing Board Development Day**

The Chair, Councillor Caan informed the Board that arrangements were being put in place for a half day development session prior to the Board's next formal meeting on 4th September, 2017.

11. **Re-inspection of Services for Children in Need of Help and Protection, Children Looked After and Care Leavers**

The Board considered a report of John Gregg, Director of Children's Services which informed of the re-inspection of services for children in need of help and protection, children looked after and care leavers specifically in relation to partners by Ofsted between 6th and 30th March, 2017. A copy of the Inspection Report was set out at an appendix to the report.

The report indicated that the Ofsted re-inspection of services report published on 13th June, 2017 judged overall Children's Services in Coventry 'requires improvement to be good'. Services were no longer inadequate which marked a key point in the improvement journey and demonstrated the improvements made. The Ofsted judgements were:
Children who need help and protection – requires improvement
Children looked after and achieving permanence – requires improvement
- Adoption performance – requires improvement
- Experience and progress of care leavers – good
Leadership, management and governance – requires improvement.

The Department for Education removed Children's Services from intervention on 13th June, 2017 and the service was no longer subject to an improvement notice.

The inspection report identified nine recommendations, two of which specifically related two partners:
Recommendation 2 – Ensure that the Local Safeguarding Children Board supports partners to understand and consistently apply appropriate thresholds to levels of need at every stage of the child's journey, including the early help pathway.
Recommendation 3 – Ensure that the introduction of risk management methodology across the authority includes partners and the authority at all stages.

The report highlighted the areas of partnership strength detailed in the Ofsted report.

A Children's Services Improvement Plan had been developed in response to the Ofsted recommendations and areas for development. Information was provided on the areas for partners which included a risk averse approach across partners.

RESOLVED that, having considered the recommendations highlighted in the inspection report, the agreed approach of multi-agency engagement and support to improve outcomes for children be endorsed.

12. **Any other items of public business**

There were no additional items of public business.

(Meeting closed at 3.55 pm)

Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 4th September 2017**

From: Chief Superintendent Sharon Goosen

Title: Multiple Complex Needs Update

1 Purpose

1.1 This highlight report details the decisions taken at the Multiple Complex Needs (MCN) Board on 4th August 2017 under a new and interim Chair, Chief Superintendent Sharon Goosen (in the absence of Chief Superintendent Long). The Health and Wellbeing Board are invited to note and agree 'next steps'.

2 Recommendations

2.1 The Health and Well-being Board is asked to note:

- Terms of Reference are amended to reflect the membership and commitment required to deliver the strategic objectives of the Board.
- PID document to be reworked into a clear strategy document that sets out the Board's ambition, strategic intent, resource requirement and delivery mechanism.
- Operational Delivery Group must clearly define the MCN cohort to enable the Board to gain traction.
- MCN Board to determine measures of success and intended outcomes.
- Outcome of MEAM bid to inform next steps.

3 Information/Background

3.1 The MCN Board convened on 4th August 2017. The Health and Wellbeing Board is asked to note that the Board last met on 24th January 2017. The MCN Operational Delivery Group met for the first time on 20th July 2017.

3.2 The strategic focus, activity and outcomes of the Board to-date were therefore reviewed by Chief Superintendent Goosen. Chief Superintendent Goosen reviewed the Terms of Reference with those in attendance and amendments are to be made to reflect the membership and commitment required to deliver the strategic objectives of the Board.

3.3 MCN Board is not a project so the PID document is to be reworked into a clear strategy document that sets out the Board's ambition, strategic intent, delivery mechanism and measures of success.

3.4 The current PID (strategy) determines an individual with MCN is likely to be experiencing two of more factors such as, but not exclusively:

- homelessness;
- offending behaviour;
- mental ill health;
- substance misuse; and
- worklessness.

3.5 The Board has established an Operational Group to identify a cohort of individuals with multiple complex needs to inform pathways and transformation of services. Data collection presents challenges. The Health and Wellbeing Board is asked to note that the cohort has yet to be defined by the Board – *see Section 4.*

3.6 Discussion centred on operational delivery. A Making Every Adult Matter (MEAM) bid was submitted prior to the Board meeting on 4th August**.** The bid proposes a focus on female offenders, namely those involved in on and off-street prostitution. In light of the above, this is not yet confirmed or agreed by the Board.

3.7 On 10th August, the Board was notified that Coventry's submission has reached the next stage and been shortlisted for interview with MEAM in September. This programme of work should be considered as just one of the work-stream's under the Board. The MEAM coalition currently works with 27 areas across England that are designing and delivering better co-ordinated services for people with multiple needs. Coventry's cohort must be clearly defined and agreed to underpin this programme of work. If the bid is unsuccessful, the MCN Board must determine the commitment and resource availability to proceed without the co-ordinator support.

3.8 Mitchell Lee (WMFS) updated on the MCN work being undertaken by the West Midlands Combined Authority (WMCA). The Public Service Reform MCN work focuses on preventative work/early intervention within 'adverse child experiences (ACEs).' Their work to-date centres on pupil referral units and a pathfinder programme, supported by a multi-agency team, to reduce demand on services.

3.9 The Health and Wellbeing Board is asked to note the decision, taken previously by the MCN Board, not to pursue ACEs, as the Board considered this area to be covered within other programmes of work, namely Ignite and Troubled Families. The Health and Wellbeing Board need to be satisfied that those programmes of work are appropriately aligned.

4 Options Considered and Recommended Proposal

4.1 Chief Superintendent Goosen has therefore commissioned work to clearly define the area of focus and cohort. A paper is to be presented to the Chair at an extraordinary MCN Board set for 14th September 2017.

4.2 The Health and Wellbeing Board is asked to note the requirement for sign-off of the agreed cohort and resourcing commitment at the earliest opportunity thereafter

Report Author(s)

Name and Job Title:
Chief Superintendent Sharon Goosen, West Midlands Police

Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 4th September 2017**

From: Brenda Howard, Programme Director

Title: Update on the Better Health, Better Care and Better Value Work Streams

1 Purpose

The purpose of this report is to provide Coventry Health and Wellbeing Board with an update on the Better Health, Better Care, Better Value programme and work streams, highlighting any key points as necessary.

2 Recommendations

The board is asked to note this report and its contents

3 Background

The Chief Executive and Accountable Officers of the Health and Local Authority Organisations within the Coventry & Warwickshire Sustainability & Transformation Partnership (STP) footprint meet twice monthly as a Board. The Board enjoys the support of both Coventry and Warwickshire Healthwatch as attendees.

The programme was recently renamed “Better Health, Better Care, Better Value” which reflects the triple challenges facing health and social care, as originally described in the “Five Year Forward View” report. This also expresses more clearly our shared ambition for the outcomes we aspire towards.

We have established a joint vision which all members have signed up to:

“To work together to deliver high quality care which supports our communities to live well, stay independent and enjoy life”

Whilst members of the Board will represent their organisations, it is recognised and accepted by members that strategic decision making for the purpose of developing a system-wide plan for Health & Social Care will require an approach,

whereby overall system benefit is the primary consideration.

4 Progress since the last update

On 13th September, Board members will meet NHS England and NHS Improvement for a quarter two stocktake on progress. The quarter one meeting was positive with the strength of the collaborative was commended. The formal feedback from that meeting has previously been received by the health and well-being board.

Following board agreement to the programme support structure, recruitment has taken place during August and is almost complete. We were successful in attracting applicants from across partner organisations. This workstream support is essential to enable the transformational and enabling workstreams to deliver their priorities and objectives. Subject to notice periods, the support team are expected to be in place from October.

As part of our ambition to develop a cadre of staff who have the knowledge and skills to work across the health and care system seamlessly, we will establish a "System Leadership Academy" enabling participants to experience working in different organisations within our system.

The board has recently completed a developmental OD process led by Health Education England in partnership with Deloittes. This concluded with a workshop in early July. This provided feedback to support the board in its future progress. For a trial period the board will alternate its meetings between a closed chief officer session and the regular full board. The full board will continue to meet monthly and will receive routine updates from the workstreams coordinated through the Programme Delivery Group. In addition, a reference group is to be established which will include local authority lead members for adult social care and health and well-being boards , along with nominated health non-executive directors. This group will meet on an informal basis with board members on a 4-6 week basis.

The board continues to work with a well-respected facilitator (John Bewick) who is known to several partners locally in carrying forward the outcome of the OD analysis.

Transformation Work streams

4.1 Maternity and Paediatrics

In February 2016, Better Births set out the Five Year Forward View for NHS maternity services in England. Better Births recognised that its vision could only be delivered through transformation that is locally led, with support at national and regional levels. A Maternity System Transformation Group is now in place with four key work streams:

- Implementing 'better births'
- Improving maternal safety and wellbeing;
- Reviewing and implementing the West Midlands Neonatal Review

- Implementing ‘saving lives care bundle’.

An Action plan will be agreed by October.

4.2 **Urgent and Emergency Care**

The work stream has undertaken a stocktake to assess progress against implementation of the national A&E plan. An assessment of current capacity constraints has also taken place. Patient mapping exercise is now being undertaken to identify patient flows to emergency and urgent care centres.

4.3 **Mental Health**

A high level care model has now been devised which considers the different approaches required to meet the needs of those experiencing challenges with their mental health, including mental ill health – differentiating between episodic and severe and enduring illnesses. Workstreams have been established which cover:

- Community capacity and resilience;
- Primary care;
- Specialist care;
- Acute and crisis care.

A programme brief, blueprint and road map are now being developed for agreement at the Clinical Design Authority.

4.4 **Proactive and Preventative (P&P)**

A targeted proactive and preventative approach is the foundation for a wider system approach and has the potential to improve overall health and well-being

- Maintain quality of life for longer
- Reduce demand on services longer term
- Reduce costs and deliver return on investment

The P & P work stream enables us to scale up and build upon work already underway with an improved understanding of place-based need via the JSNA with a universal focus on self-help, early intervention.

Prevention is integrated into all aspects of the health and care model with agreed prevention priorities:

-
- Smoking prevention
- Obesity
- Falls prevention
- Thrive Mental Health Commission Report

The work stream has now agreed the out of hospital (OOH) model via the Clinical Design Authority and is moving into the procurement phase.

4.5 **Productivity and Efficiency**

The initial focus of this workstream will be based upon assessments by individual organisations against the opportunities identified in the Carter report. Whilst the Carter report relates solely to NHS organisations this workstream will also take consider opportunities for collaboration across the whole health and care system.

4.6 **Planned Care**

Musculo–skeletal pathway: a workshop took place on 26th May to look at effective hospital discharge and reduction in patient follow up management. Three workstreams have been confirmed: primary care pathway; implementing the principles of the early discharge model; and reducing demand for patient follow up through virtual fracture clinic and group follow ups.

4.7 **Cancer has three confirmed priorities:**

- Prevention
- Screening;
- Early diagnosis

Low Priority Procedures: consultant connect is currently being piloted in Coventry and Warwickshire South. Consultant connect aims to reduce acute referrals by providing advice, guidance and support to GP's regarding patients they are considering referral to surgery.

Reducing patient follow ups appointments: the first pilot is being undertaken in ophthalmology and will commence in July in Coventry and Warwickshire North.

4. Enabling work streams

4.1 Workforce

Workforce challenges will be an issue for all work streams. The workforce group has established three key areas of focus:

i. Career pathways
ii. Leadership and OD
iii. New roles and new ways of working

The group is now completing an outline workforce strategy.

4.2 Estates

The estates group provided a recent report to the board outlining its key priorities relating to a premises stocktake, resources required to deliver the future model and the efficiency delivery of infrastructure functions. Further work is required to better understand the issues such as backlog maintenance.

The group is progressing discussions on a Health and Wellbeing Campus model for George Elliot Hospital and hosted a workshop on 11th July for partners across the system to consider this further. Ideas and potential partnerships from the event will form part of a wider partnership program grouped under the following headings:

- commercial
- education
- housing/social care
- health

Working groups are being formed around each of the above areas which will bring together key partners and scope potential projects.

4.3 Information management and technology (IM&T)

The IM&T group has signed off a data sharing agreement between all partners. All residents of Coventry and Warwickshire have received a leaflet to their homes explaining how data will be shared and giving them the option to opt out via their GP at any time.

4.4 Communications and engagement

Communications leads across the STP footprint continue to meet routinely to share and discuss items of common interest. The support team for Better Health Better Care Better value includes support for communications and engagement.

4.5 Primary care development

The primary care development work continues to progress. As reported at the last meeting, the General Practice Forward View was published in April.

A clear direction for primary care is set, with strong emphasis on practices coming together to work at scale with the common currency of populations of 30,000 – 50,000. The intention is to deliver a “new version of what general practice can be”.

This year’s Shared Planning Guidance included a requirement for every CCG to develop a General Practice Forward View Plan. All three plans have now been rated ‘Green’ (assured) by NHS England.

6. Options Considered and Recommended Proposal

The board is asked to note this report and its contents

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Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 04"' September 2017**

From: Andrea Green, Chief Officer - Coventry and Rugby CCG

Title: Out of Hospital

1 Purpose

This report is to provide an update on the Out of Hospital transformation programme which aims to achieve truly integrated community services based on the changing population needs, by using an outcome based commissioning approach.

The work programme is underpinned by extensive public, patient and stakeholder engagement and seeks to address the structural, cultural and professional barriers to delivering person centred care.

2 Recommendations

Members are asked to receive the report for information.

3 Information/Background

The three CCGs in Coventry and Warwickshire commenced a programme of work (known as the Out of Hospital (OoH) Programme) during 2015 with the aim of improving the integration of community services to deliver a more personal-centered offer. The programme represents a significant component of our CCG strategy and in 2016 was bought into the Coventry and Warwickshire Better Care, Better Health, Better Value Plan as part of the Proactive and Preventative Care workstream.

The early work during 2015/16 was the preparation phase, where Commissioners worked with patients, the public, clinicians and key stakeholders including Local Authority representatives, to shape and define a set of outcomes and objectives that a future clinical model of care would need to deliver.

At the heart of the OoH Programme is the ambition to meet the changing needs of patients, making better use of technology, capitalising on new treatments, and to unleash system efficiencies more widely. To that end, commissioners agreed a number of objectives for the OoH Hospital Programme,

- To reduce the health and wellbeing inequalities;
- To address the care and quality gap by ensuring more services use evidence based best practice;
- Identify those in most need and co-ordinate their care more effectively, by commissioning and ensuring interdisciplinary working;
- To work within tight financial parameters by developing and delivering services around the needs of patients and carers, and reduce duplication and waste of resources.

In April 2017 CCG Governing Bodies formally adopted the Clinical Model presented to Commissioners by Providers. The OoH Programme Board then undertook a process to identify the type of contract(s) and way of awarding the contract(s) that will facilitate collaboration and deliver the outcomes that are important to our local population.

Delivering the transformation required to make our system truly integrated will require sustained effort over a number of years by Commissioners and Providers. The contract in itself, is not the solution, the change will be driven by effective collaboration; cultural shifts within the workforce; and, a more effective relationship with the people receiving the service.

The clinical model and outcomes commissioned will be consistent across Coventry and Warwickshire but the underpinning contracts will be based on geographies that people identify with as 'places' i.e. Coventry. The rationale of this approach is that the lead providers will be able to tailor the operational delivery of the clinical model to the place and allow them to redistribute their resource (human and financial) in a way that reflects the different health needs of each population; different service provision and different historical levels of resourcing. Contracts at place level will provide the CCGs and their populations with a higher degree of transparency than a single contract when reviewing how the lead provider is redistributing resource, and how effective it is in delivering the outcomes.

4 Options Considered and future governance of the programme

In July 2017, the Governing Body of NHS Coventry and Rugby CCG, considered a range of commissioning and contracting options and made the decision to make a direct award to CWPT for Coventry residents, and South Warwickshire Foundation Trust for Warwickshire residents. The CCG Contracting teams are now working as part of the Programme Board through the next stage of contract development with the Provider, with a view to operating the new type of contract from April 2018.

The 3 CCGs and Coventry City Council and Warwickshire County Council commissioners will use the Collaborative Commissioning Board established across Coventry and Warwickshire as the future governance arrangement for the programme.

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Appendix 1 Overview of the programme and process

Background

The Coventry and Warwickshire Better Care, Better Health, Better Value Plan

In December 2015, the National Health Service (NHS) was asked to take a new approach to help ensure that health and care services are built on the evidence about the needs of local populations. Every health and care system in England was tasked to produce a five-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable. The aim is to deliver a vision of better health, better patient care and improved NHS efficiency.

Health and Social Care leaders within Coventry and Warwickshire agreed that the already established Out Of Hospital transformation Programme (OOH) was critical for both the sustainability and development of the local health and care system and therefore agreed that it should form part of the overall plan.

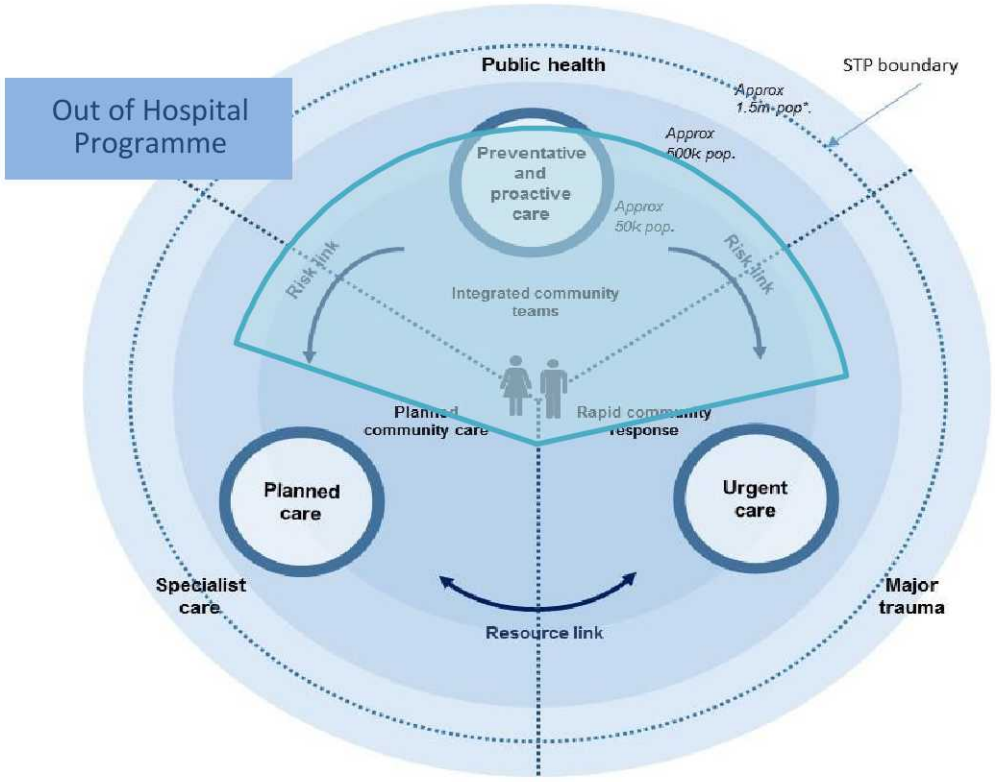


Figure 1 Better Care, Better Health, Better Value

The Coventry and Warwickshire OOH Programme is part of the Sustainability and Transformation Plan and sits within the larger Proactive and Preventative Care Programme. This is illustrated in the diagram above.

Process

The OOH hospital programme has had three distinct but related steps as the diagram below demonstrates.

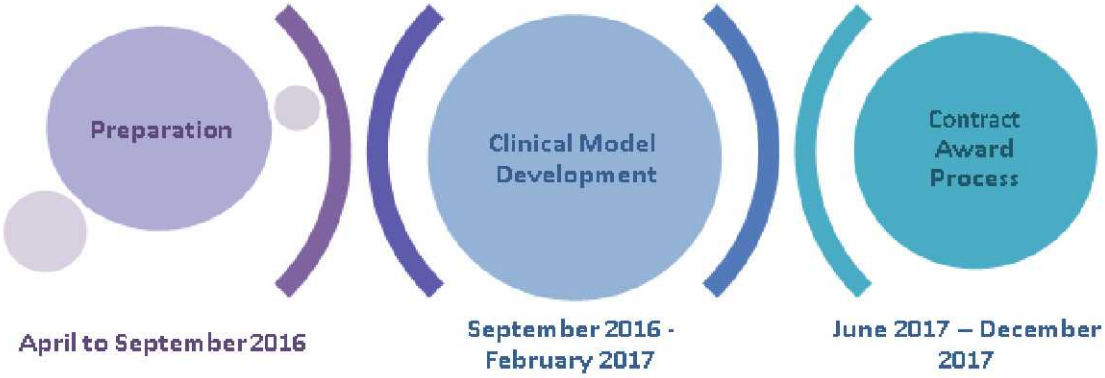
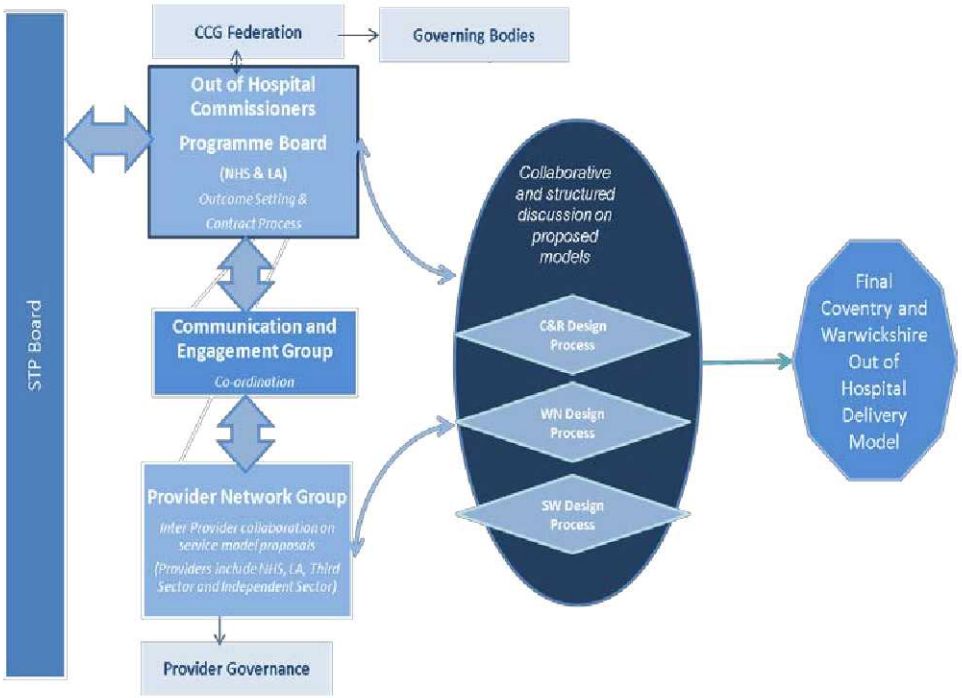


Figure 2 Out of Hospital Processes

The CCG governing bodies' took a decision on making a direct award of a contract in July 2017, and are currently progressing the contract award process, phase 3 above.

Governance Structure

The OOH Commissioners' Programme Board has overseen this process to date and its membership has included senior representatives from the CCGs and commissioning partners from Warwickshire County Council and Coventry City Council, collectively the "Commissioners".



Throughout the process the commissioners have ensured that this programme is a priority; with senior directors responsible for the programme in each CCG and local authorities.

Leads met regularly and progress calls were scheduled for every week. Meetings and workshops were organised to include wider representation as required to ensure a holistic and informed approach to decision making. The commissioners have worked very closely to ensure the most advantageous outcome for their localities whilst ensuring a whole system approach.

As commissioners commence the contract process they will focus the governance arrangements, designed to ensure that as commissioners they continue to work together, with accountability routed through the Coventry and Warwickshire Collaborative Commissioning Board (CWCC Board).

Future Governance Structure (Collaborative Commissioning Arrangements)

The commissioners across Coventry and Warwickshire support a collaborative working arrangement between the three CCGs and the two Local Authorities via the recently established CWCC Board. The details of the working arrangement are being finalised and will be captured in a formal agreement; this will detail how the working arrangements between commissioners will function including budgetary commitments and give potential early insight into delivery risks which can then be monitored and / or mitigated.

The CWCC Board will be responsible for the next phase of development and on-going management of the contract. To support the Board, a dedicated Virtual Commissioning Team is being formed, with the most appropriate staff, from the five commissioning organisations, with the required breadth of skills to manage all the relevant contracts, performance, quality, transitions and the management responsibility of the relevant commissioning budgets. They will have the expertise to develop whole system commissioning which reflects the diverse population needs and changing demands.

The Case for Change

Delivering the Triple Aim

The NHS was founded on a commitment to universal healthcare, irrespective of age, health, race, social status or ability to pay. Whilst “our values haven’t changed, our world has” and so the NHS needs to adapt to new trends which are emerging in both health and social care. These trends are presenting new challenges in society that have led to three gaps in the provision of healthcare across the country. Closing these emerging gaps is known as the ‘Triple Aim’.

The Triple Aim is the term used to describe the three emerging gaps in the provision of healthcare across England which are being driven by a range of factors including changing population, trends in society and our economic situation, workforce challenges, sustainability of health and care organisations, and the ways in which organisations work.

Figure 4 – The Triple Aim

The reasons for the need to close such gaps are:

- **The health and wellbeing gap:** if prevention does not become more widespread, then recent progress in healthy life expectancies will stop, health inequalities will widen, and the ability to pay for beneficial new treatments will be put aside by the need to spend billions of pounds on avoidable illness.
- **The care and quality gap:** unless there is change to the way in which care is delivered; make better use technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in health outcomes will persist.
- **The funding and efficiency gap**: if the systems fail to innovate how they deliver care and do more for patients within our existing tight financial parameters, the result will be worse services, fewer staff, and restrictions on new treatments.

Responding to Local Issues

The Commissioners serve diverse populations and the diversity will continue to grow. Commissioners recognise the need to commission services for local populations that are flexible and can respond to the diversity and the changing needs of the population, with more services, where appropriate, provided closer to the patients' homes. Commissioners remain committed to tackling the challenges that come with diverse populations including an ageing population and to improving the quality of life for those with long term conditions.

It is acknowledged that significant change is needed to deliver the Commissioners' vision of integrated care in the context of the following issues:

- The population of Coventry and Warwickshire is expected to continue to grow between now and 2021, with the greatest percentage growth to be seen in Coventry (15%), closely followed by Rugby Borough (11.1%) and Stratford upon Avon District (9.5%);
- In Warwickshire, the population is ageing and more people are living for longer with long term medical conditions. The county currently has approximately 13,356 people aged over 85, and by 2021 this group is expected to grow by 42%;

- Overall there is a mix of urban and rural populations; Warwickshire's rural population is generally older than in the urban areas. The proportion of people aged 65 or over in rural areas is 21%, whilst in urban areas it is 17%;
- In Coventry, there is a high ethnically diverse population, with 33% of the city's residents coming from minority ethnic communities compared to 20% for England as a whole;
- The combination of a growing and ageing population means increasing pressure on health and social care services;
- It is estimated that more people are likely to suffer from long term physical and mental health problems such as heart disease, high blood pressure and dementia;
- People living with multiple health conditions will become the norm, if people continue on the present trajectory. This trend brings with it poorer quality of life, higher hospital admissions and increased mortality.

There are a number of wider current service issues in parts of the system including pressure on emergency departments, high occupancy in hospital beds, delayed transfers of care, and pressure on limited resources in community and primary care services which makes the need to pursue a whole system approach to the development and implementation of OOH services.

Some of the pressures can be significantly improved though better organised, better integrated and better targeted care. From the evidence, the key factors that will improve care include:

- Preventing ill health and improving the quality of life for people with long term conditions;
- Effective management and early intervention to reduce the impact of long term conditions including diabetes, heart disease, stroke, heart attack and lung disease is key to improving the physical and mental health and wellbeing;
- Identifying people at risk of ill health or hospital admission or who are 'frail';
- Identifying risk factors for people with increasing frailty, avoidable harm and avoidable hospital admissions, can improve their health and social outcomes;
- Coordinating the care of people with complex problems and supporting them to live in the community where possible;
- Coordinating the care of people with complex problems via joined up hospital and community services can avoid sometimes lengthy hospital admissions and increase the chance of ongoing independent living. Integrated care is key to achieving better co-ordinated care for individuals and their carers / families;
- Setting specific outcomes targets by which to measure and manage performance is a key step in achieving effective transformation of joined-up, patient centred care;
- The outcomes framework describes evidence based outcome measures, the achievement /delivery of which would improve the quality of life of people;
- Using Joint Strategic Needs Assessments (JSNAs): The purpose of a JSNA is to bring together information to inform how cross-sector partners and local communities can best work together to prevent ill health and improve services.

Outcome Based Commissioning

Commissioning Approach

At the heart of the OOH Programme is the ambition to meet the changing needs of patients, making better use of technology, capitalising on new treatments, and to unleash system efficiencies more widely. To that end, commissioners agreed a number of objectives for the OOH Hospital Programme, in line with the Triple Aim:

- To reduce the health and wellbeing inequalities;
- To address the care and quality gap by ensuring more services use evidence based best practice;
- Identify those in most need and co-ordinate their care more effectively, by commissioning and ensuring interdisciplinary working;
- To work within tight financial parameters by developing and delivering services around the needs of patients and carers, and reduce duplication and waste of resources.

The Commissioners recognised that in order for change to occur at the front line they need to change their commissioning approach to support provider organisations and their staff make the changes that need to be made without the constraints of the existing contracting and payment mechanisms. Health and Social Care commissioners therefore came together to develop a unified commissioning approach to the OOH contract.

The Commissioners agreed that giving providers a budget to cover the health care needs of a defined population given specific health outcomes for the population that they are responsible for would be the most effective commissioning approach. In essence, outcome based commissioning. This will enable the provider to balance the risks they are expected to take on with the level of control and influence they have on outcomes.

In order to implement outcomes based commissioning, the Commissioners had to develop a set of outcomes. These were done in collaboration with providers, stakeholders' clinicians, patients, carers, and the public to achieve a clear and informed understanding of the requirements for OOH services. Each outcome sits within a domain, and providers will be managed against the delivery of the outcomes associated with each of the following domains:

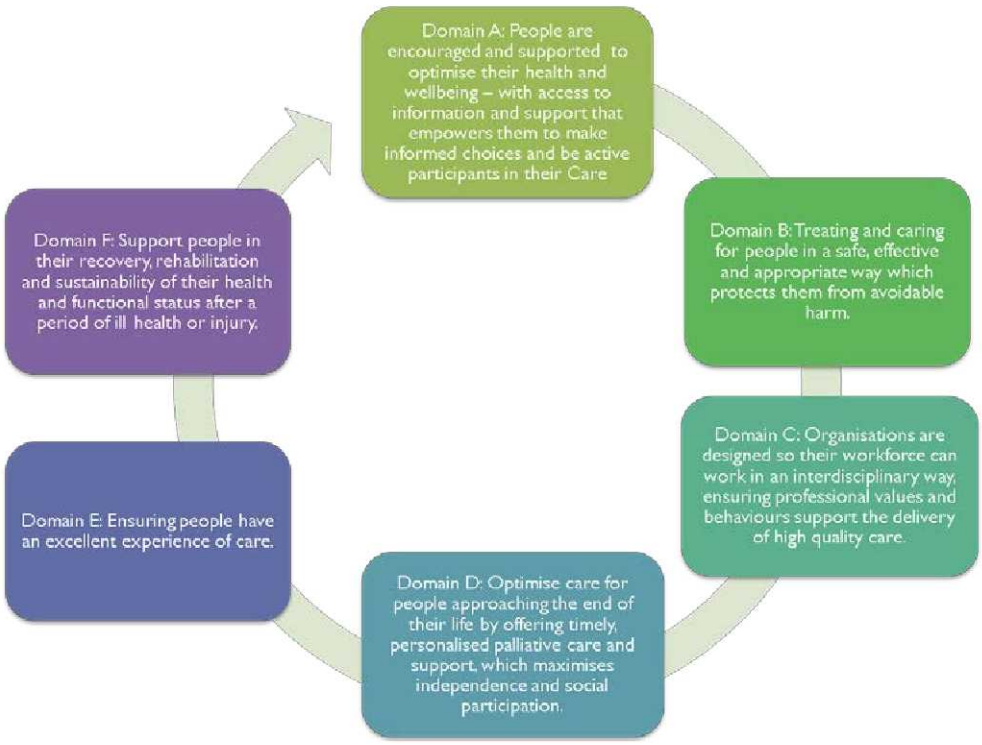


Figure 5– The Outcomes Framework agreed 6 Domains

By taking this approach the Commissioners were seeking to identify a clinical modedl of care that delivered the following principles:

- A population health and care model focused on proactive and preventative care tailored around the needs of the individual;
- Empowering patients and local people to support each other and themselves in their health and care;
- Multi-disciplinary health care professionals working within a system that has accountability for the delivery of health and care services for their population;
- Contracting and payment systems that incentivise and enable the delivery of services for the population health.

Maintaining independence and preventing unnecessary admission into hospital will be one of the fundamental goals of delivering effective care out of hospital. This will not only be more convenient for patients, but will reduce the current unnecessary pressure on hospitals.

Delivering this programme is the first of many steps in transforming our system and our initial focus will be on those individuals who have the most need. Those with:

- Long Term Conditions;
- Young adults with complex disabilities;
- People with high complex needs including physical and / or mental health illness;
- People approaching the end of their life last 12 months;
- High users of health and social care services;
- People at risk of requiring health and social care services;
- People who are housebound.

By adopting this approach the Commissioners will be addressing the following Triple Aims:

Addressing the Health and Wellbeing Gap through:

- Supporting people to care for their own health and well-being by promoting independence, empowering them to care for themselves;
- Ensuring health and care resources are shared to improve outcomes for communities;
- Streamline service delivery, simplifying care model and supporting people to get to the right support to meet their needs;
- Investment in the workforces and empower them to focus on well-designed, personalised high-quality care regardless of which organisation they work for.

Addressing the Care and Quality Gap by:

- Enabling better and more sustainable primary care services;
- Ensuring community services are proactive, responsive and integrated;
- Breaking down boundaries between organisations to maximise the people, buildings and financial resources across the whole footprint;
- Reducing health inequalities by providing consistent, high quality access across the community.

Addressing the Funding and Efficiency Gap by:

- Using existing resources more effectively, by integrating contracts and encouraging the health and care system to work together;
- Encouraging Investment in technology, organisational development and cultural change to ensure more people are cared for in their own home, to proactively plan care for people rather than reacting to unplanned crises;
- Using staff with a wide range of skills, teaming up specialist and generalists to deliver more care in the community.

Financial Arrangements and Principles

The Commissioners continue to face significant financial challenges and expect this level of challenge to continue for the foreseeable future. It is recognised that some of the efficiency savings have already been achieved and the financial challenges ahead will require a more transformational approach. In order to realise the benefits of outcome based commissioning then the payment mechanisms utilised by the Commissioners need to change.

The expectation is that the lead providers will need to interface with other providers, the local authorities, GPs and primary care (this list is not exclusive) to deliver the clinical model and the agreed outcomes.

To move from the present contractual model to the proposed outcomes based model it has been necessary to define the scope of services, the current spend and the interdependencies. If the proposed clinical model of care and the Outcomes Framework are to be delivered then the right scope of services is pivotal in developing and delivering future care models.

The clinical model of care scope included in the OOH service for Coventry and Warwickshire has been refined as part of the process. The discussions with providers included any service changes in progress, pilots in process and services which would impact on the delivery which are not included in the actual scope of services and the financial envelope.

Substantial work has been completed by the Commissioners to date to ensure the accuracy of the financial envelope and the corresponding scope of services.

Whilst the intention is to ensure that the appropriate range of services is in scope, for a number of services where challenges have been identified, to overcome these, the commissioners may consider a phased approach to their inclusion within the contract(s).

In recent years, it has been possible to address this funding challenge by means of realising process efficiencies in areas such as; prescribing and reduction in outpatient activity. Going forwards, savings must come from more effective service models.

The opportunity to implement innovative models of care and more effective contractual arrangements with provider organisations now provides the infrastructure by which the commissioners can take this step and meet in part the financial challenge in a new way.

Overview of financial arrangements in the contract

In addition to creating integrated person-centred care; another objective is to ensure that the Providers deliver improved outcomes as set out in the Outcomes Framework for people, within the agreed financial envelope. It is expected that the totality of the spend within the whole system per head of population will reduce over time; the onus will be on the Providers to manage down demand by taking proactive steps to ensure care is developed in the most appropriate settings and reflects the patients' needs.

It is anticipated that all the required service development will be completed during the first two years of the contract and agreed milestones will be delivered.

The payment mechanism for OOH services will have two components:

- **Fixed element -** a regular payment for the delivery of services paid to the providers.
- **Performance - related element - a regular payment based on the delivery** of specified outcome / performance indicators paid to the provider. In year one this will be linked to the achievement of agreed transformation milestones and by Year 3 will be linked to delivery of improved outcomes. This component will also need to cover nationally prescribed clinical quality (CQUIN) initiatives.

Current expenditure on Out of Hospital Services in scope

The commissioners' current expenditure on the in-scope services is £57m. A breakdown of this by service is provided in the tables below:

In Scope Services (CCGs)	Value 17/18 £m
South Warwickshire	21,715,000
Coventry	21,700,479
Rugby	5,313,621
Warwickshire North	8,698,920
Total in scope	**57,428,020**

Table 1: Value of Scope of Services

The opportunity to implement a wider scope of services will be subject to an agreed programme of work being completed and agreed in year 1 and 2 and to appropriate contract variations being agreed.

Process for setting the Base Annual Contract Value

The basis for the calculation of the Base Annual Contract Value (BACV) will be set at the level of the previous year's BACV.

Performance Incentive Payment

As described previously, one of the key drivers is to improve the integration of services and to incentivise enhanced performance through payment for performance. As such, the commissioners have decided to allocate a percentage of the overall payment as a performance based incentive payment. The outcome / performance indicators and anticipated performance levels along with the methodology for assessing and making the Performance Incentive Payment will form part of the contract.

The Performance Incentive Payment is the contract value set to be awarded if all outcome / performance indicators are met. A proportion of the Performance Incentive Payment will be paid where only some of the outcome / performance indicators are met.

The Performance Incentive Payment will be linked to the Outcomes Framework on the basis of an agreed formula.

All other changes to the contract value that may be required from time to time will be subject to negotiation and supported where relevant by a business case.

An Overview of the Adopted Clinical Model

In April 2017 commissioners made the decision to adopt the CLINICAL MODEL OF CARE that had been developed by providers to deliver the Outcomes Framework and scope of services.

The process undertaken to develop the clinical model consisted of the following steps:

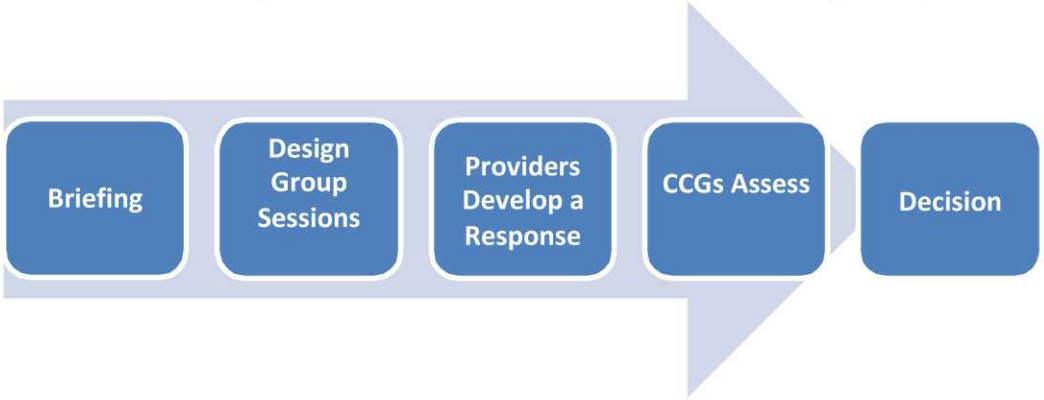


Figure 6 Overview of CLINICAL MODEL OF CARE process

This process took place over a period of 3 months and involved clinical and managerial teams from both commissioners and providers. Patients and wider stakeholder groups were engaged via public events and two large engagement sessions were held.

The Model Vision and Objectives

The vision and objective of the clinical model is to deliver OOH services in Coventry and Warwickshire that will improve care, integrate teams, deliver a sustainable future for services, and reduce demand on acute health and mental health services:

- The providers stated that their "vision is to reconfigure both the provision of services and the culture of care to enable our population to live safe, happy and healthy lives at home for as long as possible";
- A key focus of the development of the model was on the holistic needs of local people to improve the patient and carer experience;
- Providers explored how they could organise their collective resources across the health and social care systems more effectively, to empower people to take control of their own health and wellbeing, thus creating a more efficient system;
- Providers have committed to deliver the outcomes that matter to people in the communities that they live in and as part of the process inputted in the draft outcomes.

Key Characteristics of the Model

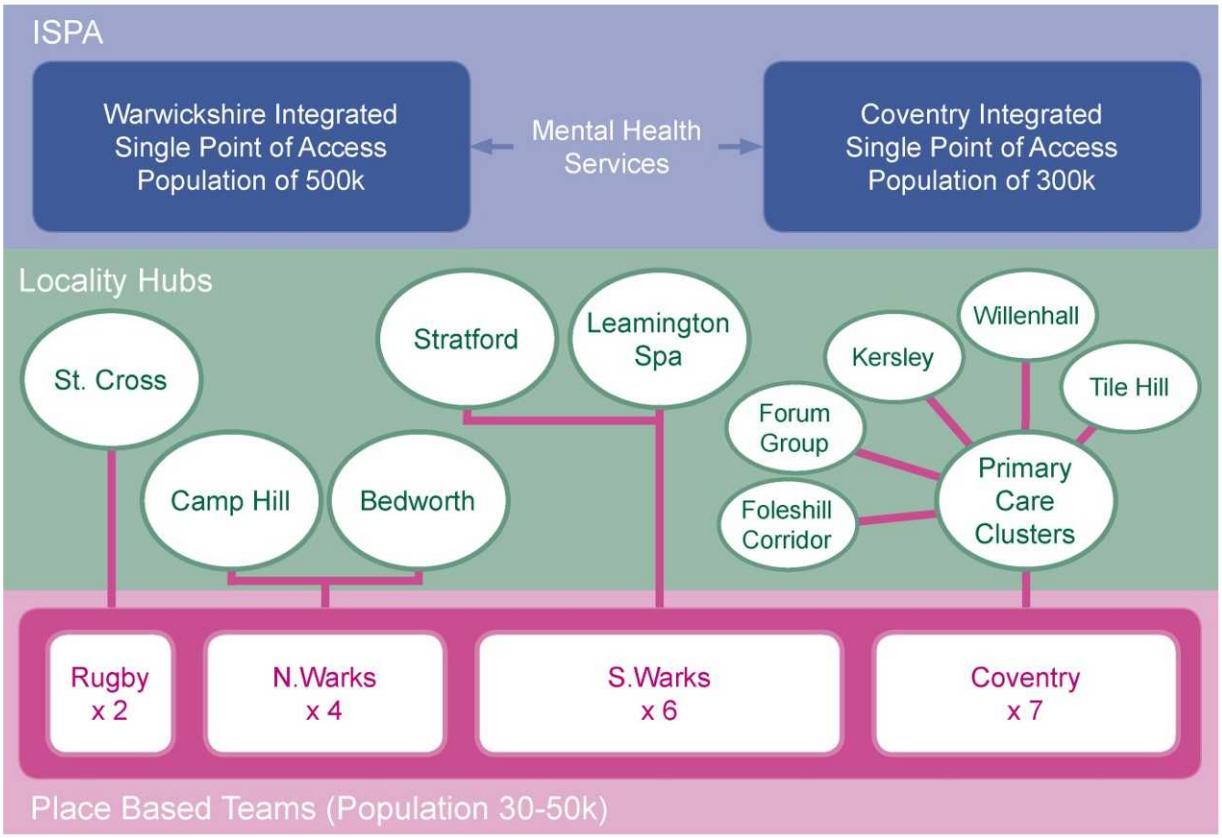


Figure 7: Overview of the proposed single point of access & the proposed locality hubs alignment.

The Intergrated Single Point of Access (ISPA) will be the point of central co-ordination for people across the system and will have an emphasis of improving the outcomes for patients; to achieve these providers will continue to work together to ensure a systematic approach across Coventry and Warwickshire. The ISPA will:

- Be the front door for referrals into the OOH service;
- Co-ordinate care responses to OOH service referrals at a system level;
- Co-ordinate urgent responses to OOH service referrals within a defined timescale allocating teams from across the system, including the Place Based Teams;
- Manage telehealth services available to people including health coaching as part of the prevention agenda;
- Provide educational and continued professional development opportunities to clinicians and other patient facing members of staff;
- Provide data management and analysis, as well as providing a central repository for information (population health system);
- Co-ordinate and disseminate longer term public health information and plans;
- Signpost patients, carers and clinicians to the most appropriate OOH resource;
- Provide links back to acute care where appropriate.

The Locality Hubs are designed to be linked into planned care. Working with larger groups of people than the Place Based Teams, they provide a hub for professionals who the MDT may wish to access, but for whom it is not realistic to have one per team:

- The Locality Hubs will be used as the operational delivery mechanism for training and development;
- Training will then be delivered at the Locality Hub level, to give economies of scale, and will ensure that their local clinical teams understand the range of services available to them, and that they are appropriately using the clinical pathways that will be developed;
- Working at a greater population level will allow services currently delivered in secondary care to be delivered in the community, because of the economies of scale. This is particularly true of specialisms where the PBT would be too small a population group to offer services.

The Place Based Teams (PBTs) are the on-the-ground delivery mechanism for the OOH service. Although exact locations will be determined as part of the ongoing design work, it is anticipated that there will be one team for every 30,000-50,000 people. Other key factors include:

- All staff delivering physical healthcare interventions trained to identify and support individuals improve their own mental health;
- The Multi Disciplinary Team (MDT) will liaise closely with patients, relatives and carers to give them more control over the co-ordination of their own care;
- Within the MDT there will be a deep and evolving knowledge of local services, including those outside of traditional healthcare settings. This will be formalised in the Directory of Services, which is kept up to date with any changes;
- Care co-ordinators will ensure that the MDT generates and delivers a multi-agency care packages tailored to individuals on a case by case basis;
- Care Navigators will also play an important role at the PBTs. They will be responsible for raising awareness of the variety of health and wellbeing options available to access, and navigating people (patients and carers) and professionals within the localities to the right type of care for them;
- Care Navigators will be a key point of patient facing contact within the teams and hence they will have a positive impact on patient experience.

Reasons for Adopting the Model

Overall the assessors recognised the significant amount of work undertaken by the providers and acknowledged the need going forward for a huge shift in organisations' cultures. The submission made clear links on how the proposed model could deliver the commissioners' Outcomes Framework and in doing so gave commissioners confidence that the model was capable of delivering the commissioners objectives and the potential for seamless care.

Commissioning Options Assessment

In developing this process, the commissioners have been mindful of the competition guidance, procurement regulations and consultation requirements.

Legal Context

In 2015, the public procurement regime changed with the introduction of the Public Contracts Regulations 2015 (the "PCR 2015"). The new Light Touch Regime (LTR) is a specific set of rules for certain service contracts that tend to be of lower interest to cross-border competition. The list of services to which the LTR applies is set out in Schedule 3 to the PCR 2015, and includes certain health and social services. The Commissioners will apply the LTR to this contract award.

The advantage of procuring using the LTR is that there are fewer mandatory process requirements with which commissioners will need to comply and follow in order to legitimately award a contract compliant with the PCR 2015. The key express mandatory requirements of which the commissioners will need to be aware, and satisfy, are:

- PCR 2015 Subject to any exemption, advertise the contract in the Official Journal of the European Union (OJEU), using a contract notice or prior information notice ("PIN"):
  - Publish a contract award notice ("CAN") following each individual procurement or, if preferred, group such notices on a quarterly basis;
  - Determine and follow an award procedure sufficient to comply with transparency and equal treatment of providers;
  - Apply "relevant considerations" to the decision to award – flexibility to decide on what these are, including "accessibility" and "flexibility".

In the context of the Light Touch Regime, Commissioners will need to undertake the following steps, regardless of their decision:

- OJEU notice;
- Execution of commissioning contracts in accordance with NHS England standard forms and guidance; and
- Execution of a Memorandum of Understanding (MoU).

LTR rules are flexible on the types of award criteria that may be used, but make clear that certain considerations can be taken into account, including:

- The need to ensure quality, continuity, accessibility, affordability availability and comprehensiveness of the services;
- The specific needs of different categories of users, including disadvantaged and vulnerable groups;
- The involvement and empowerment of people;
- To share down-side risk rather than additional payments.

The applicable National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 requirements are to:

- Act in a transparent and proportionate way;
- Treat providers equally and in a non-discriminatory way;
- Procure services from one or more providers that are most capable of securing patient needs, and improving quality and efficiency of services;
- Consider whether integration and patient choice will improve quality of, and efficiency in, provision of services.

Overview of the process

The options assessment process was designed to ensure openness and transparency and to enable the commissioners to have a common approach, whilst balancing the needs of their localities and the whole system. The options review was carried out between late April and May 2017.

The assessment options process was designed to enable the commissioners to run a robust and transparent process which provides assurance to the Governing Bodies and NHS England.

Throughout this process the objectives have been to ensure that whatever process route and contract mechanism becomes the preferred option the assessment incorporates a full exploration of the benefits and risks of the options to ensure at each stage they are fit for purpose, viable, robust and capable of producing the best sustainable solution for the future services with the whole Coventry and Warwickshire footprint.

To ensure a transparent, robust and comprehensive appraisal of all the options available to the CCGs the following process steps were developed.

Steps	Description	Due
1	Identification and Alignment of the options for the procurement routes & contracting mechanisms	April 17
2	Finalise the scope for the future services	May 17
3	Determine preferred contracting mechanism(s) • Assess & Evaluation of preferred options, • Impact Review of Contract Model	June 17
4	Determine the preferred process option(s)	June 17
5	Commissioner approval of preferred Contract Model option and process	July 17

The processes outlined were supported by an assessment plan, a summary of the contract mechanisms and procurement options and the assessment guidance which was developed by the programme leads.

South Warwickshire created one assessment panel and Warwickshire North and Coventry and Rugby a second, these assessment panels formed a consensus of their preferred option(s) and their recommendations as set out in the assessment report June 2017.

The process was designed to support a fair and open assessment process of the contract mechanisms taking into consideration the driving factors and the needs of the local health economy.

The assessment panels undertook an extensive discussion of the options before reaching their conclusions. These discussions considered the impact of the options and the potential risks in the context of their locality areas.

In carrying out the discussions the commissioners considered the potential impacts summarised below:

- The risk of destabilisation and its impact on patient care in all or parts of the health and social care economy;
- Existing service development gaps management to minimise risk to patients;
- How changes in providers could impacts directly on patients;
- Risk that the incentives developed may not robust or significant enough to drive the process and changes;
- That the model may fail to address the key issues including the unwarranted variations;
- The benefits the contracts are expected to achieve for care quality and sustainability and how will they be achieved;
- The benefits that can be achieved for patients and the local health economy.

Commissioners were clear that whichever process they decided on it must include ensuring transparency and equal treatment of providers.

Procurement Route Outcome

The commissioners determined the process route which best met their objectives and the needs of the population they serve, by which they will award the contract(s) for the providers for the future OOH services.

As the OOH service is deemed a complex service where the commissioners and the local authorities are seeking service development, improvements and integrated working it has been crucial to work with providers to develop a CLINICAL MODEL OF CARE across a range of services and organisations. Having agreed the model, the commissioners then considered their procurement options as listed below:

- Do Nothing – maintain the current arrangement with a collaborative overlay [apply procurement rules to a competitive process via:]
- Procurement process;
- Procurement – Competitive dialogue;
- Direct Award.

The commissioners having weighted up all the options and the likely impacts have decided to recommend a Direct Award of the OOH contract to the incumbent providers in line with the requirements of the LTR.

The regulations support the commissioners in directly contracting with service providers without an extensive competitive process; however, the commissioners in making this recommendation have considered the options, reached their conclusions and evidenced their rationale that the incumbent providers are deemed the most capable of delivering the clinical model.

Contract Mechanism Outcome

The contract mechanisms options considered are listed below:

- Do Nothing – collaboration agreement;
- Alliance;
- Lead Provider.

The potential contract mechanism which emerged was Lead Provider utilising the Standard NHS Contract. Within the CLINICAL MODEL OF CARE submission it is clear that SWFT and CWPT see themselves as a collaborative working together to achieve the aims of the proposed model and it is the intention of both parties that this collaboration is continued and strengthened. It is not the subject of this process to determine as yet whether the collaboration arrangement is continued as a formal or informal agreement. A formal arrangement could be where parties enter into an agreement to work cooperatively to ensure a whole system approach to delivering outcome indicators.

The commissioners, after serious deliberation weighting the benefits and risks, concluded that Lead Provider contracts were the most appropriate mechanism to realise the commissioners' requirements for the future OOH services and the wider health and care economy.

A lead provider is described as an arrangement where commissioners have a single contract with the Lead Provider.

The Lead Provider can then organise other providers along the pathway and be responsible for subcontracting delivery of their services, but cannot decommission "material" subcontracted providers without approval of the Commissioners. For Coventry and Warwickshire, it is the intention to recommend CWPT and SWFT as lead providers.

Conclusion

The commissioners needed to determine the process route by which they would secure provider(s) for out of hospital services. Having explored all the options, the Governing Bodies' determined that the lead provider option is the one most likely to enable the delivery of the contract model and ensure transformation of services is delivered within or sooner than the expected timeframe, and made a decision to make a direct award to CWPT for Coventry and SWFT for Warwickshire.

Next Steps

Indicative timeline

The following milestone table is an indicative high-level timeline in which to conduct a process. This timetable remains high-level until the recommendations to proceed with the options is finalised. Once agreed a detailed project plan, timetable and dates for all necessary meetings with be implemented.

	Milestones	DATES
1	Issue OJEU	19 /20 July 17
2	Commence Contract discussions with providers	July 17
3	Contract Signature	November 17
4	Contract commencement	April 18

Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 4 September 2017**

From: Pete Fahy – Director of Adult Services

Title: Care Quality Commission Local System Review

1 Purpose

This briefing note provides information regarding the forthcoming Care Quality Commission (CQC) review of the Health and Social Care System in Coventry.

2 Recommendations

Coventry Health and Well-Being Board is recommended to:

1. Provide their full support and ownership of the review process through members participating in the review as required, supporting the review within their organisations, and advocating for this review as being an opportunity for system improvement

2. Support the preparation underway and endorse the Coventry Accident and Emergency Delivery Board as being the body for co-ordination and preparation for the review

3 Information/Background

Following the spring budget announcement of additional funding for adult social care, the Department of Health (DoH) has asked CQC to undertake a programme of targeted reviews in local authority areas. These reviews were to be exercised under the Secretary of State's Section 48 powers.

It was subsequently announced that there would be 20 reviews of Health and Social Care Systems where there are challenges particularly in relation to delayed transfers of care. Coventry has been selected as one of the first 12 areas to be reviewed.

The performance metrics used to identify the areas subject to review are contained within the DoH Local Area Dashboard. This dashboard creates a weighted average across 6 measures to identify the highest ranked and most challenged local systems in supporting patient flow. It appears that the 12 systems selected have been identified as 12 of the ‘most challenged’ areas by national rank according to these measures.

3.1 **Focus of the review**

The review will be wide ranging and take a 'whole system approach'. Each review undertaken by CQC will focus on how people move between health and social care, including delayed transfers of care, with a particular focus on people over 65 years old.

The review will seek to answer the following question:

How well do people move through the health and social care system, with a particular focus on the interface between the two, and what improvements could be made?

A number of 'pressure points' have been identified by CQC as significant in the interface between health and social care. Understanding the interface at each of these pressure points will be a key focus of the review. These pressure points are shown in Appendix One.

In understanding these interfaces, a number of Key Lines of Enquiry (KLOE) will be explored which are as follows:

Safe	How are people using services supported to move safely across health and social care to prevent avoidable harm?
Effective	How effective are health and social care services in maintaining and improving health and wellbeing and independence?
Caring	Do people experience a compassionate, high quality and seamless service across the system which leaves them feeling supported and involved in maximising their wellbeing?
Responsive	To what extent are services across the interface between health and social care responsive to people's individual needs?
Well led	Is there a shared clear vision and credible strategy which is understood across the health and social care interface to deliver high quality care and support?
	What impact is the governance of the health and social care interface having on quality care across the system?
	To what extent is the system working together to develop its health and social care workforce to meet the needs of its population?
	Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population?
Resource Governance	How do system partners assure themselves that resources are being used to achieve sustainable high quality care and promoting people's independence?

It is the intention that the review findings will highlight what is working well and where there are opportunities for improving how the system works for people using services.

On completion of the review the findings will be reported to the Health and Well-Being Board with the expectation that a joint action plan is agreed to progress any recommendations made. There will be a support offer from CQC to assist with the delivery of the action plan.

The review of each area will be a publicly available document and once all 12 reviews are completed the CQC will publish a national report of their key findings and recommendations.

3.2 Review ownership

CQC have asked the local authority to co-ordinate the review and ensure the input of partners. The reason for this is that the local authority is responsible for the health and well-being board and the health and well-being is considered to be where the review, its outcomes and resulting action plan, is owned by the system.

3.3 Timing of the review

Information provided by CQC indicates a timescale for the review being 12-14 weeks including an on-site week. This timescale is included in Appendix Two.

The Coventry on-site week is scheduled for week commencing 22 January 2018. This date will be confirmed approximately six weeks in advance at which point the submission of a 'Local System Overview Information Request (SOIR) will be required. This SOIR provides background information to the CQC on the local system, who uses it, how services integrate and how effectiveness is monitored.

CQC will also conduct a 'relational audit' to understand the effectiveness of local relationships. This audit will be sent to key system contacts with the expectation that it is shared with other colleagues within organisations to provide a rounded picture.

In addition, and in advance of the on-site week CQC will want to meet with senior leaders and attend local events. This is usually three weeks prior to the on-site week but due to the Christmas and New Year period this has brought forward and will be week commencing 18 December 2017. This means that the start of the review period will be two weeks in advance of this, 4 December 2017.

3.4 Preparing for the Review

In preparation for the review the following is underway:

1. Work has commenced on scoping content for the 'Local Overview Information Request'
2. Key health partners have been briefed and have agreed that the Coventry Accident and Emergency Delivery Board will be the focal point for system wide co-ordination of the review
3. Information sharing is in place between Directors of Adult Services for Coventry, Stoke on Trent and Birmingham as the three the West Midlands authorities subject to review. The Birmingham review is scheduled for the same timescale as Coventry whereas Stoke on Trent is currently underway with the on-site week being week commencing 4 September 2017
4. A meeting is being arranged with CQC in advance of the review to aid better understanding of what is required in order to support preparations

4 Options Considered and Recommended Proposal

Participation with the review is not optional and therefore options in this regard are not appropriate. Recommendations to HWBB are made in section 2 above.

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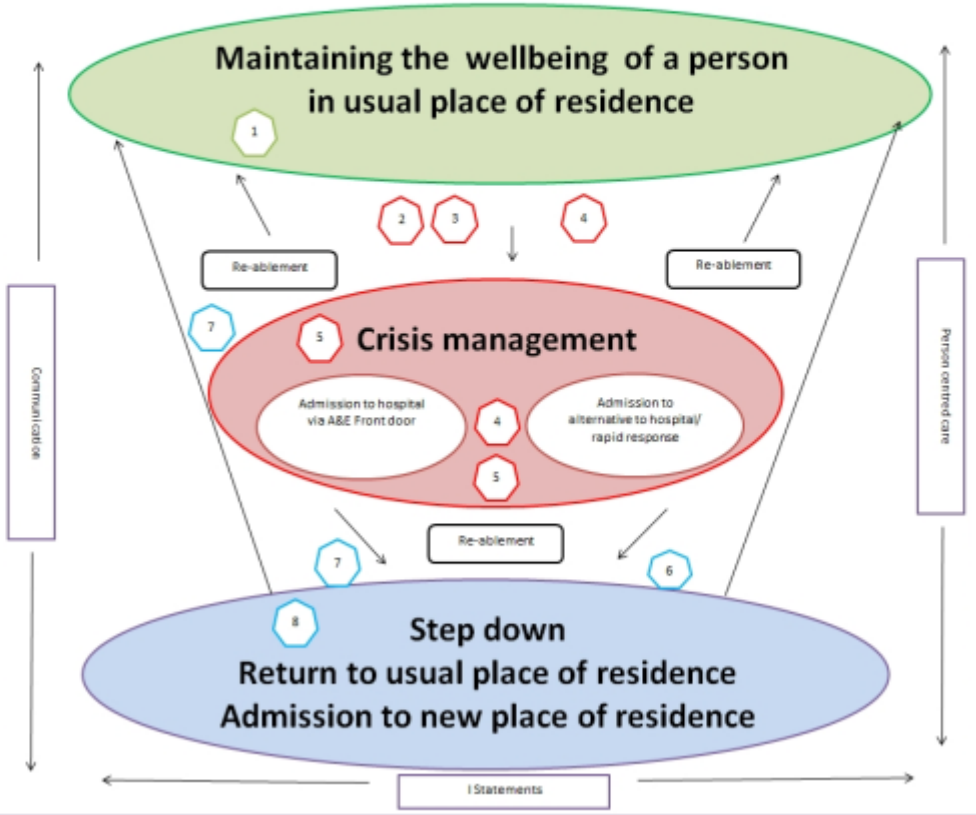
Appendices

Appendix One: **Pressure Points**
Appendix Two: **System Review end-to-end**

Pressure points

1. Maintenance of peoples health and well being in their usual place of residence
2. Multiple confusing points to navigate in the system
3. Varied access to GP/ Urgent Care centres/ Community care/ social care
4. Varied access to alternative to hospital admission
5. Ambulance interface
6. Discharge planning delays and varied access to ongoing health and social care
7. Varied access to re-ablement
8. Transfer from re-ablement



System review end to end