Coventry City Council

Agenda

Coventry Health and Well-being Board

Time and Date
2.00 pm on Monday, 16th October, 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. **Chair's Update**

   The Chair, Councillor Caan will report at the meeting on the following:

   - **West Midlands Well-being Board**
   - **Director of Public Sector Reform**
   - **Health and Wellbeing Development Days**

5. **Update on the Better Health, Better Care and Better Value Work Streams (STP)**

   Update from 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

6. **Out of Hospital** (Pages 15 - 34)

   Report of Andrea Green, Coventry and Rugby Clinical Commissioning Group

7. **Health and Well-being Strategy - Multiple Complex Needs Update** (Pages 35 - 38)

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

8. **Better Care Fund Plan** (Pages 39 - 102)

   Report of Pete Fahy, Director of Adult Services

9. **Coventry Safeguarding Children's Board Annual Report 2016/17** (Pages 103 - 158)

   David Peplow, Chair of the Coventry Safeguarding Children's Board has been invited to the meeting for the consideration of the Annual Report

10. **Coventry Safeguarding Adults Board Annual Report 2016/17** (Pages 159 - 184)

    Joan Beck, Chair of the Coventry Safeguarding Adults Board has been invited to the meeting for the consideration of the Annual Report

Information Items

11. **Care Quality Commission Local System Review** (Pages 185 - 190)

    Report of Pete Fahy, Director of Adult Services

12. **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, Deputy Chief Executive (Place), Council House Coventry

Friday, 6 October 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: F Abbott, S Banbury, K Caan (Chair), A Canale-Parola (Deputy Chair), G Daly, B Diamond, G Duggins, L Gaulton, S Gilby, A Green, A Hardy, R Light, D Long, J Mason, C Meyer, G Quinton, M Reeves, E Ruane, 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.

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

This page is intentionally left blank

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.

.

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 October 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.

Report Author(s): Andrea Green

Name and Job Title: Chief Officer Coventry and Rugby CCG

Directorate: NHS Coventry and Rugby CCG

Telephone and E-mail Contact: c/o Samantha.checklin@warwickshirenorthccg.nhs.uk

Enquiries should be directed to the above person.

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.

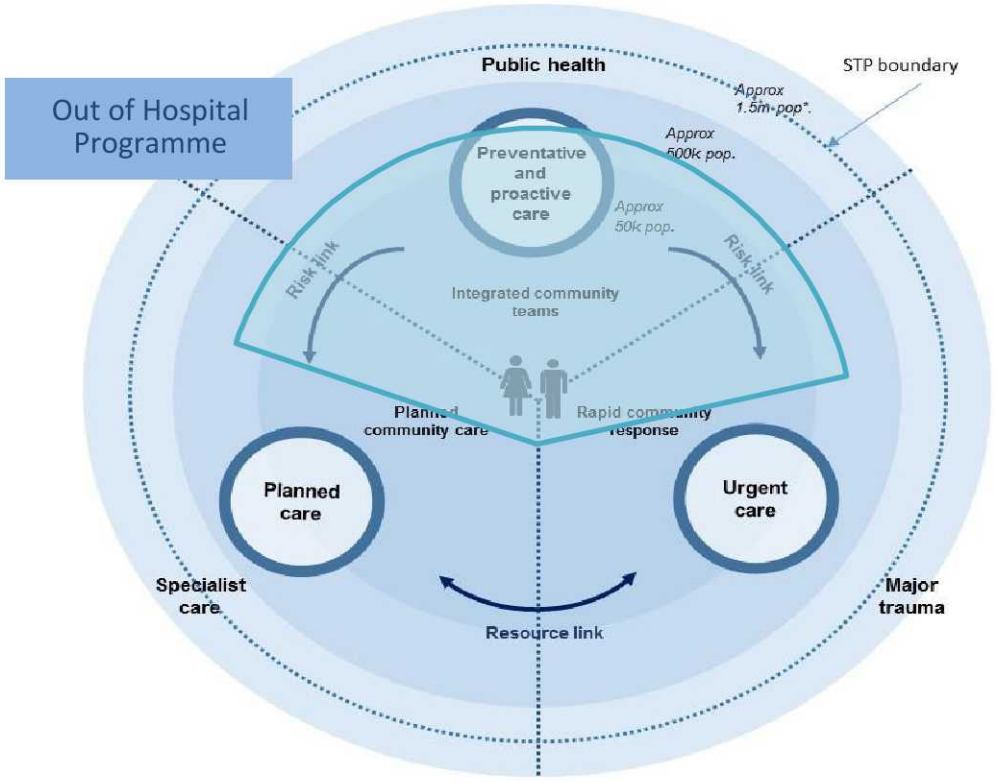


Figure 1 Better Care, Better Health, Better Value

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.

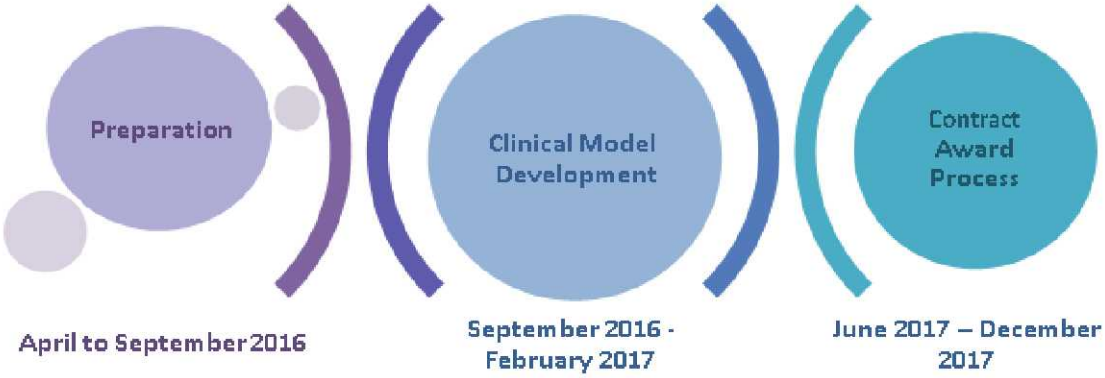
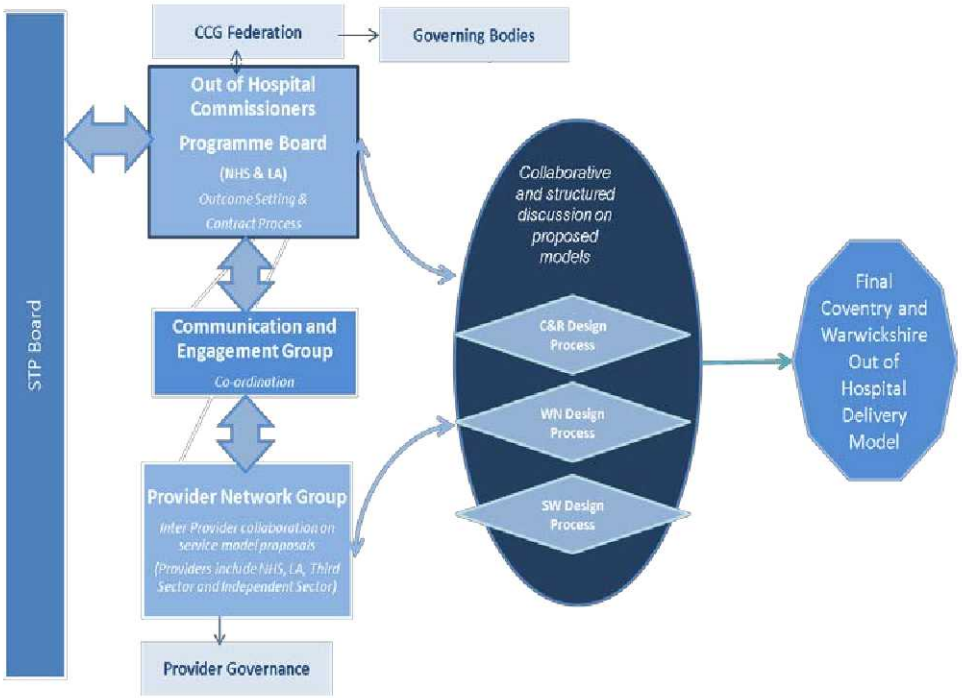


Figure 2 Out of Hospital Processes

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:

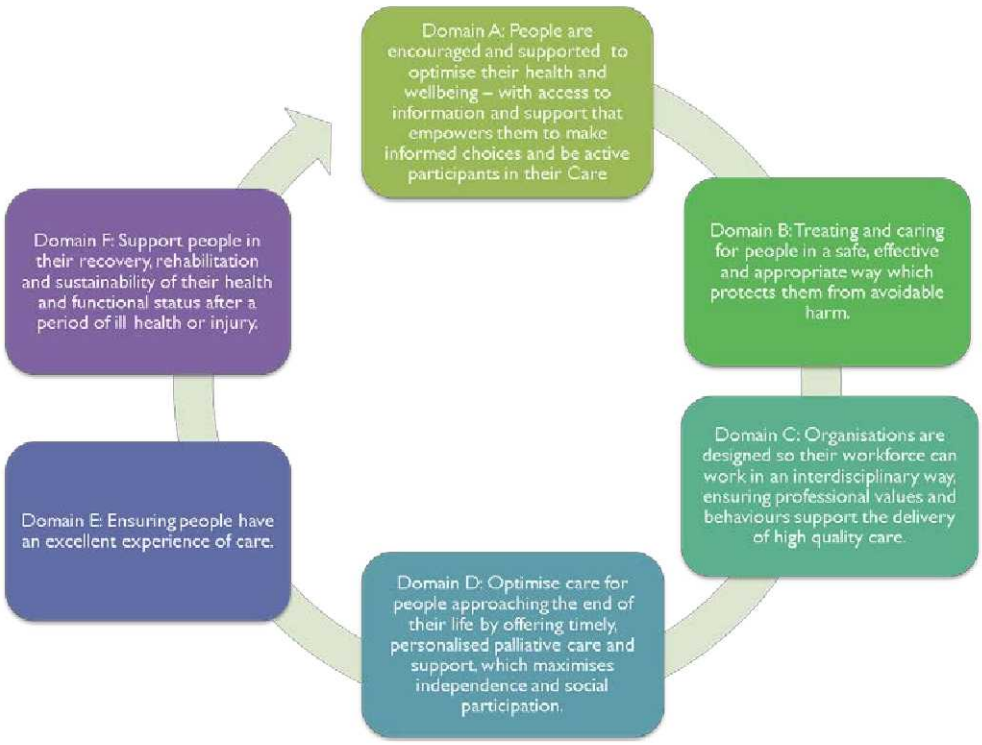


Figure 5– The Outcomes Framework agreed 6 Domains

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:

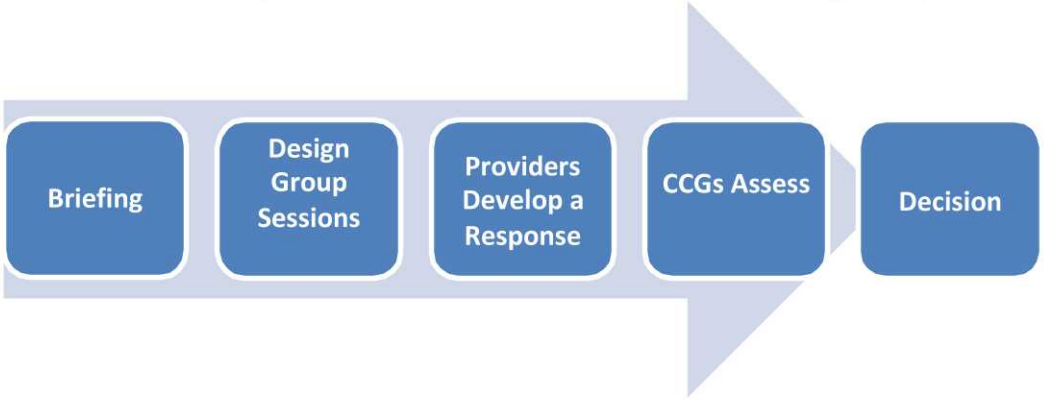


Figure 6 Overview of CLINICAL MODEL OF CARE process

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

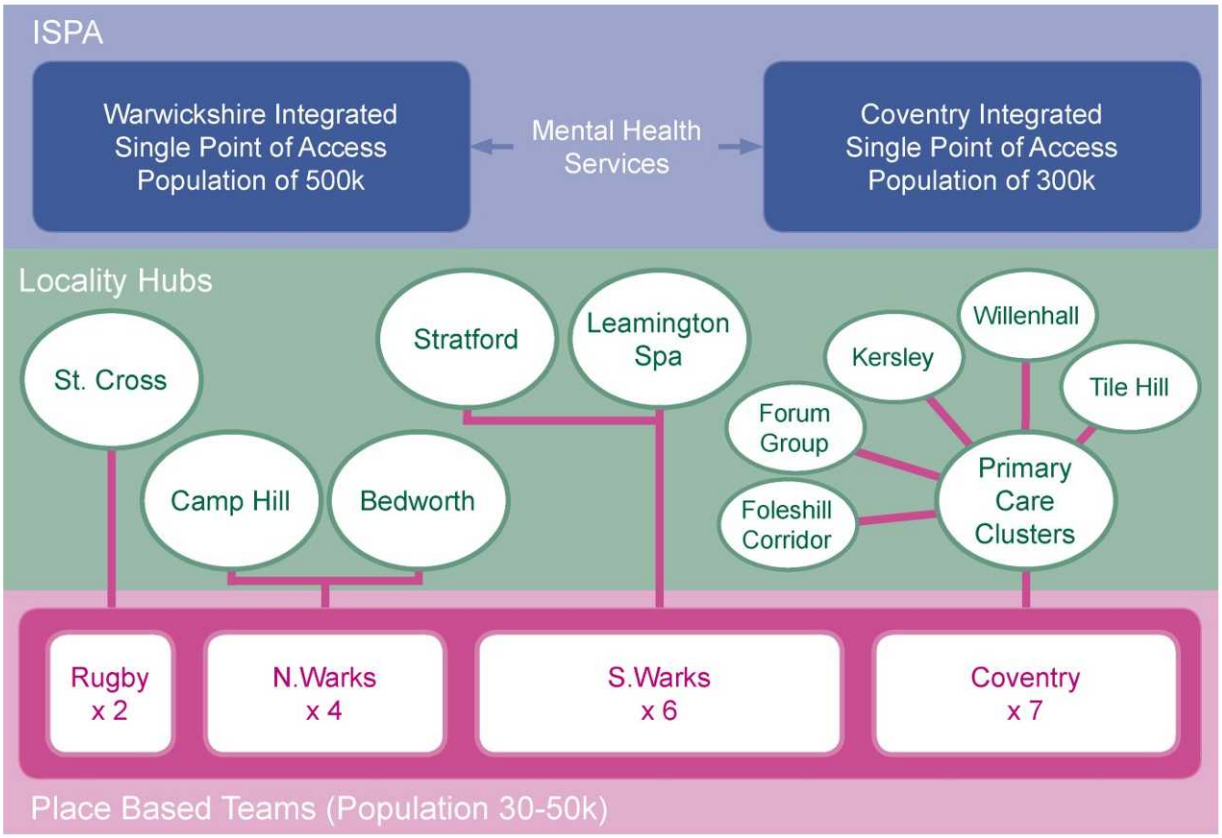


Figure 7: Overview of the proposed single point of access & the proposed locality hubs alignment.

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: 16th October 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).

1.2 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:

- A formal expression of interest has been submitted to MEAM (Make Every Adult Matter) in order to bid to become an official MEAM area.
- The MCN Board's Terms of Reference will be amended to reflect the outcome of the MEAM application if necessary and in any case in order to present an accurate picture of the membership and commitment required to deliver the strategic objectives of the Board.
- PID (Project Initiation Document) is currently being revisited, to ensure it clearly defines the Board's ambition, strategic intent, resource requirement and delivery mechanism.
- In July 2017 a Multiple Complex Needs Operational Group was established in support of the MCN board, with two clear initial objectives:
  - to casework an identified cohort of individuals with MCN
  - to capture, action and track progress of our work with individuals & action transformation activities from the MCN Board
- MCN Project Leads are working on behalf of the board, in consultation with the Operational Group in order to define the first MCN people cohorts to work with. This intervention will enable the MCN Board to gain further traction.
- MCN Board to determine measures of success and intended outcomes.
- Outcome of MEAM bid will 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. There have been 7 key members of the Board who have transitioned roles and responsibilities between January and July

2017. This organisational disruption held up the strategic board's progress, but project work continued in the background, ensuring progress was still made.

3.2 The strategic focus, activity and outcomes of the MCN Board to-date were therefore reviewed by Chief Superintendent Goosen in preparation for the August meeting. 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 needs to clearly see itself as a strategic delivery group in support of the wider project aims and objectives, therefore 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 MCN Operational Delivery Group met for the first time on 20th July 2017. The Multiple Complex Needs Operational Group was established in support of the MCN board, with two clear initial objectives:

- to casework an identified cohort of individuals with MCN
- to capture, action and track progress of our work with individuals & action transformation activities from the MCN Board

3.6 The Board has asked the Operational Group to identify cohorts of individuals with multiple complex needs to become areas of specific focus, inform pathways and transformation of services. Data collection still presents challenges. The Health and Wellbeing Board is asked to note that the cohorts have yet to be defined and agreed by the Board.

3.7 A formal expression of interest has been submitted to MEAM (Make Every Adult Matter) in order to bid to become an official MEAM area. This would result in national co-ordinator support, peer networking and access to national research and strategy, all funded through Big Lottery initiative.

3.8 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.

3.9 On 28th September Coventry MCN team were interviewed by MEAM and the outcome of our application will be known in mid-October.

3.10 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.

3.11 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 the next MCN Board on 12th October 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

Appendices
None

This page is intentionally left blank

Coventry City Council

Briefing Note

To:	**Coventry Health and Well-Being Board**	**16 October 2017**
	Health and Social Care Scrutiny Board (5)	**18 October 2017**
From:	**Pete Fahy, Director of Adult Services**	
Subject:	**Better Care Fund Plan 2017-19**	

1. Background

1.1 The integration of health and care has been a long standing national policy ambition based on the premise that more joined up services will help improve the health and care of local populations and make more efficient use of available resources. Nationally, the primary planning tool being used to deliver improved and sustainable health and care is the Sustainability and Transformation Programme (STP) known locally as 'Better Health, Better Care, Better Value'. This provides a system level framework within which organisations in local health and care economies can plan effectively and deliver a sustainable, transformed and integrated health and care service.

1.2 Prior to, and subsequently alongside the STP the Better Care Fund (BCF) was implemented in 2015 as part of a government drive to integrate health and care. In response to this a BCF plan was developed locally supported by the Health and Wellbeing Board and supported by a section 75 partnership agreement between the City Council with Coventry and Rugby Clinical Commissioning Group (CRCCG). A new plan is now required covering the period from 1 April 2017 to 31 March 2019 including how the Coventry element of the additional £2 billion allocated in the spring budget, as a response to the acknowledged national funding pressures facing Adult Social Care in England, is to be used.

1.3 The planning schedule is such that the planning tools were made available in July 2017 and the plan was required to be submitted by 11 September 2017. Due to these timescales the Health and Well-Being Board on 16 October 2017 was the next available meeting to seek approval of the plan.

1.4 The current BCF brings together ring-fenced budgets from the CRCCG, the Disabled Facilities Grant (DFG) and funding paid directly to Coventry City Council to support adult social care services, as part of the Improved Better Care Fund (IBCF). The total value of the 2017-19 pooled budget is £179.502m made up of £63.897m of local authority resources and £115.605m of CCG resources spread over the 2 year period.

2. Recent changes in requirements

2.1 The Department of Health and the Department for Communities and Local Government originally published a detailed policy framework for the implementation of the BCF for both 2017-18 and 2018-19 in April. However further detailed guidance was subsequently issued

to local areas following a written statement to parliament on Delayed Transfers of Care (DToC) by the Secretary of State for Health on 3 July 2017.

2.2 This guidance has introduced a strong link between the spring Budget announcement of £2bn extra for adult social care budgets, and the expectation that Delayed Transfers of Care (DToCs) should equate to no more than 3.5% of all hospital beds by November 2017 as part of the NHS England (NHSE) Mandate for 2017-18. The parliamentary statement also indicates that the targeted focus on DToC should involve a reduction in delays from both social care and the NHS nationally.

2.3 Within the BCF plan Coventry has submitted a trajectory that would meet the expectations of NHSE if delivered in respect of DToC. However, this trajectory is extremely challenging for Coventry as it is for many other areas. The trajectory submitted is shown in table one below.

Table One: Final Submitted DTOC Trajectories

Coventry	NHS Expected Rate per 100,000 based on Local Area Dashboard (July 4th)	Actual Average Rate per 100,000 18+ over last 12 months (June 16 to May 17)	NHS Expected % Reduction on Average over 12 months	Latest Proposed Rate per 100,000 for Trajectories	Proposed % Reduction on Average over 12 months	Proposed Equated to Days per average month	Proposed equated to Delays per day
Social Care	2	2.6	-23.1%	2.6	0.0%	218.9	7.2
NHS	8.4	17.4	-51.7%	7.8	-55.2%	654.8	21.5
Joint	5.3	3.4	55.9%	3.4	0.0%	285.8	9.4
Total	15.7	23.3	-32.6%	13.8	-40.8%	1159.5	38.1

3. The Better Care Plan 2017-19

3.1 The basis of the pooled funding for the BCF in previous years has been money that has already been committed to health and social care services through a variety of funding streams. The resulting schemes that were identified in the resultant plans were developed in order to target areas of joint activity, investment and resources into improving outcomes for people of Coventry.

3.2 These same intentions underlie the current version of the BCF Plan, which now spans two fiscal years, and a similar set of detailed financial and operational plans have been developed to reflect the current CCG and Social Care priorities within Coventry.

3.3 The iBCF grant announced in the spring budget 2017 has made extra funding available between 2017 and 2020. This has been put in place with the aim of providing additional stability and capacity in local care systems and specifically to 'impact on front line care'.

3.4 More specifically three purposes were assigned to this funding as follows:

- To meet adult social care need,
- To provide support to the NHS (especially through application of the 8 High Impact Changes),
- To sustain the social care provider market.

The use of this additional funding has been agreed by City Council Cabinet in August 2017 and CCG as well as the Health and Well-Being Board at its July meeting.

3.5 The use of this additional funding is also encapsulated in the BCF plan, of which one of the key aims in respect of supporting the NHS is to accelerate the delivery of the 'High Impact Change Model' to support effective hospital discharges and enable the achievement of the NHS mandated target. As well as achieving effective discharge it is also recognised that preventing admission to hospital is as crucial to the effectiveness of the health and care system. To this end activity under the BCF will also focus on a range of projects that seek to improve support to people away from the hospital setting.

3.6 To progress this ambition the BCF contains a number of projects each of which has its own objectives and deliverables that in turn will ensure the delivery of the plans for integration and change in our overall Better Care Plan while supporting the wider ambition of the Better Care, Better Health, Better Value programme (Sustainability and Transformation Plan).

4. Mandatory content and National Conditions

4.1 The BCF policy and guidance states that the plan must set out the local vision and model for the integration of health and social care and include a coordinated and integrated plan of action for delivering this vision, supported by evidence. The narrative should also clearly articulate how the local system will demonstrate its approach to four national conditions:

- Jointly agreed plan
- Social care maintenance
- NHS commissioned out of hospital services
- Managing transfers of care

4.2 Additionally the BCF plan must demonstrate a robust approach to performance and risk management.

5. Governance

5.1 The Joint Adult Commissioning Board (AJCB) will take prime responsibility for the progression of the BCF programme. As the BCF Plan and its associated projects and priorities are to align with the Proactive and Preventative workstream of the STP this group is used as an oversight body for the BCF. The BCF will also link to the local Accident and Emergency Delivery Board to ensure alignment with other system elements.

5.2 The BCF plan was submitted on the NHS deadline of 11 September 2017 with the support of the Chair of the Health and Well-Being Board pending formal sign-off at the next available meeting of the Health and Well-Being Board, 16 October 2017. The plan was also approved by the Director of Adult Services and the CCG's lead officer to enable submission to this deadline. Following this initial submission and initial feedback from NHSE a further revision of the DToC targets was made and the plan was re-submitted on 20 September to reflect this revision.

6. Next Steps

6.1 Following submission a single stage regional assurance process is now underway. This will be followed by moderation and then cross regional calibration. On completion formal letters indicating the results of the assurance process for each individual plan will be issued by NHSE from Friday 6 October onwards. A verbal update will be provided to Health and Well-Being Board and Scrutiny Board 5 on the content of this letter and implications should it be received in advance of the respective meetings.

6.2 There are three assurance categories which are described as “Approved”, “Approved with Conditions” and “Not Approved”. If following moderation a local area plan is not approved or approved with conditions then support will be agreed for that area in consultation with the Better Care Manager, the regional assurance panel and national Better Care Support Team. The nature of this support is so far unclear. There is also a risk that should DToC trajectories not be achieved then NHSE may withhold transfers of funds from CCGs to Local Government. Should this risk materialise it would have a significant impact on the ability of the City Council to provide social care services to support the effective functioning of the health and social care system.

7. Recommendations:

Coventry Health and Well Being Board is recommended to:

(i) Approve the Better Care Plan for 2017-19
(ii) Support the pooling of funds within the S75 agreement to accompany the BCF plan

Scrutiny Board 5 is recommended to:

(i) Support the content of the BCF plan providing comment as appropriate regarding the plan to the Chair of the Health and Well-Being Board and the Cabinet Member for Adult Services.

Appendices

Appendix One: Coventry Better Care Narrative Plan 2017-19

Author: Mike Holden, Programme Delivery Manager, People Directorate

Integration and Better Care Fund

Coventry Narrative Plan 2017/19

Version: Revised Final - 20/09/17

Contents

Approval and sign off

The Coventry Better Care Fund Plan 2017-19 has been reviewed and signed off by each of the representative organisations involved and, through delegated responsibility, by the Coventry Health and Wellbeing Boards.

Coventry and Rugby CCG	Clare Hollingworth
Position	Chief Finance Officer
Date	11th September 2017

Coventry City Council	Peter Fahy
Position	Director of Adult Services
Date	11th September 2017

Coventry Health and Wellbeing Board	Cllr Kamran Caan
Position	Chair of Health and Wellbeing Board
Date	11th September 2017

Introduction/Foreword

The focus across the Coventry Health and Social Care system is on carrying through our strong resolve to significantly improve pathways and interventions by working together to provide a better level of care and to keep people healthy and well. This was initially introduced in our original Better Care Plan and has since been incorporated and enhanced in the current **Coventry and Warwickshire Sustainability and Transformation Plan** (STP).

We recognise that services in Coventry can improve and we are committed to improving patient and service user experience and outcomes by integrating health and social care pathways where this creates system benefits with the intention for health and social care to be more fully integrated by 2020 in line with the 2015 Spending Review and BCF Policy Framework. However we are acutely aware that the integration of the health and social care sectors is a significant challenge at a time when both sectors are under pressure both financially and in terms of increasing demand.

With each commissioning organisation required to pool a minimum level of budget to support and deliver health and social care services, the focus has been on maximising the level of pooling to reflect joint areas of activity whilst focusing additional resources to make improvements to existing services. The total value of the 2017-2019 pooled budget is **£179.502m** made up of **£63.897m** of local authority resources and **£115.605m** of CCG resources spread over the 2 year period as shown in the table below.

Funding levels have been increased in line with nationally set inflation for the minimum contribution as well as other specific changes to the resourcing such as Disabled Facilities Grants (DFGs). Changes to the budgets have been discussed and agreed through the Adult Joint Commissioning Board, and through the Preventative and Proactive workstream of the Sustainability Transformation Programme and, finally, formally approved through the Health and Wellbeing Board. There is a continued commitment in Coventry to maintain the level of the Pool and seek opportunity where possible to expand it further as part of continuing discussions regarding future integration. Further details are outlined in the financial submission template.

The funding agreed will contribute to maintaining existing services that support discharge and social care provision as well as extending opportunities in areas such as targeted prevention, improving whole system flow and promoting independence in the community.

Table 1: Funding Contributions

Better Care Fund (incorporating iBCF)	**2016/17 £m** for reference	**2017/18 £m**	**2018/19 £m**	**Total Plan £m**
Coventry City Council	**20.005**	**30.920**	**32.977**	**63.897**
Coventry & Rugby Clinical Commissioning Group	**35.895**	**57.258**	**58.347**	**115.605**
Total Pooled Budget	**55.900**	**88.178**	**91.324**	**179.502**

This is resourced from:	2016/17 £m for reference	2017/18 £m	2018/19 £m	Total Plan £m
LA Minimum Contribution	**2.851**	**3.133**	**3.415**	**6.548**
LA Additional Contribution	**17.154**	**19.672**	**18.481**	**38.153**
iBCF	**0.000**	**8.115**	**11.081**	**19.196**
CCG Minimum Contribution	**22.338**	**22.738**	**23.170**	**45.908**
CCG Additional Contribution	**13.557**	**34.520**	**35.177**	**69.697**
Total Pooled Budget	**55.900**	**88.178**	**91.324**	**179.502**

The CCG Minimum Contribution is made up of the following elements, in line with the planning requirements.

Table 2: CCG Minimum Contribution

CCG Minimum Contribution	2016/17 £m for reference	2017/18 £m	2018/19 £m	Total Plan £m
Planned Social Care Expenditure	**8.135**	**8.322**	**8.480**	**16.802**
Ringfenced NHS Commissioned OOH Spend	**14.203**	**14.416**	**14.690**	**29.106**
Total Minimum Contribution	**22.338**	**22.738**	**23.180**	**45.908**

Further detail regarding specific funding streams can be found within the Funding Contribution section of the Plan and the Financial planning template.

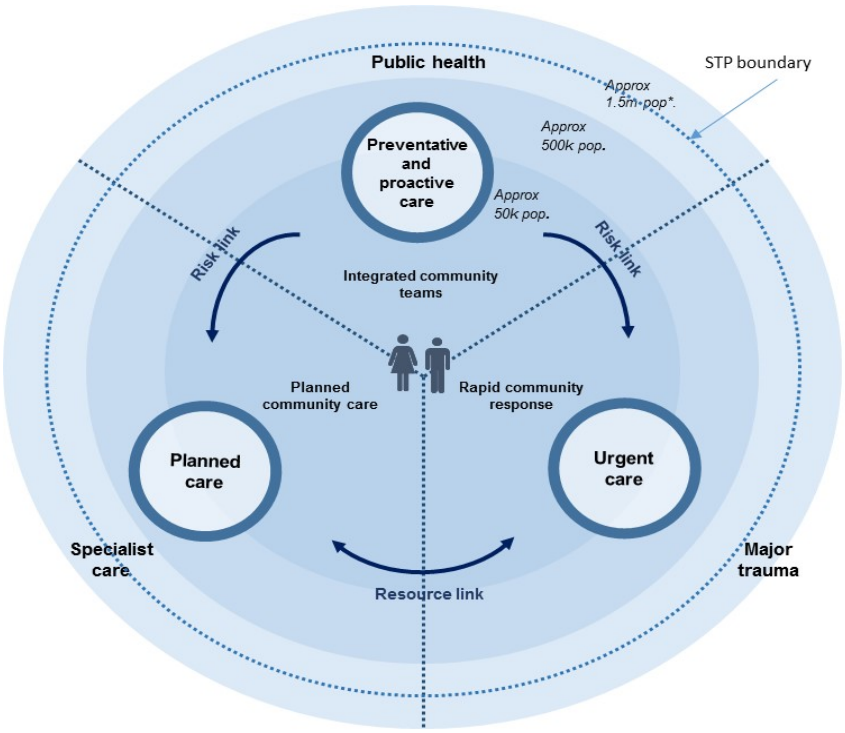
What is the local vision and approach for health and social care integration?

This integrated transformational work across the system health and social care system is summarised within the **Coventry and Warwickshire Sustainability and Transformation Plan** (STP) vision:

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

When designing the future care model, we wanted to move away from current service and organisation boundaries, and reflect a simpler patient focussed view. We aim to design all services within three domains shown in the diagram below: preventative/ proactive care, planned care, and urgent care.

Diagram 1: The Coventry and Warwickshire STP Model



We aim to develop an accountable care system which will have the following key characteristics:

- All services (health, social care, community, mental health) are commissioned for long term outcomes on capitated budgets;
- At the core of the new system, there will be a focus on proactive and preventative care, delivered across approximately 15-18 integrated teams/ communities (covering around 50k population each);
- Services will be commissioned and delivered at the scale most appropriate for clinical and financial sustainability, (e.g. specialised services at a West Midlands level;

- Acute provider will be an active part in managing population demand; and
- Future system will be enabled by integrated IT systems and the use of data.

This reflects a move away from current service and organisation boundaries, towards a simpler patient focussed view which aims to design all services within three domains: preventative/ proactive care, planned care, and urgent care.

Additionally the **Joint Health and Well Being Strategy (2016-19)** for Coventry references the following cross-cutting themes:

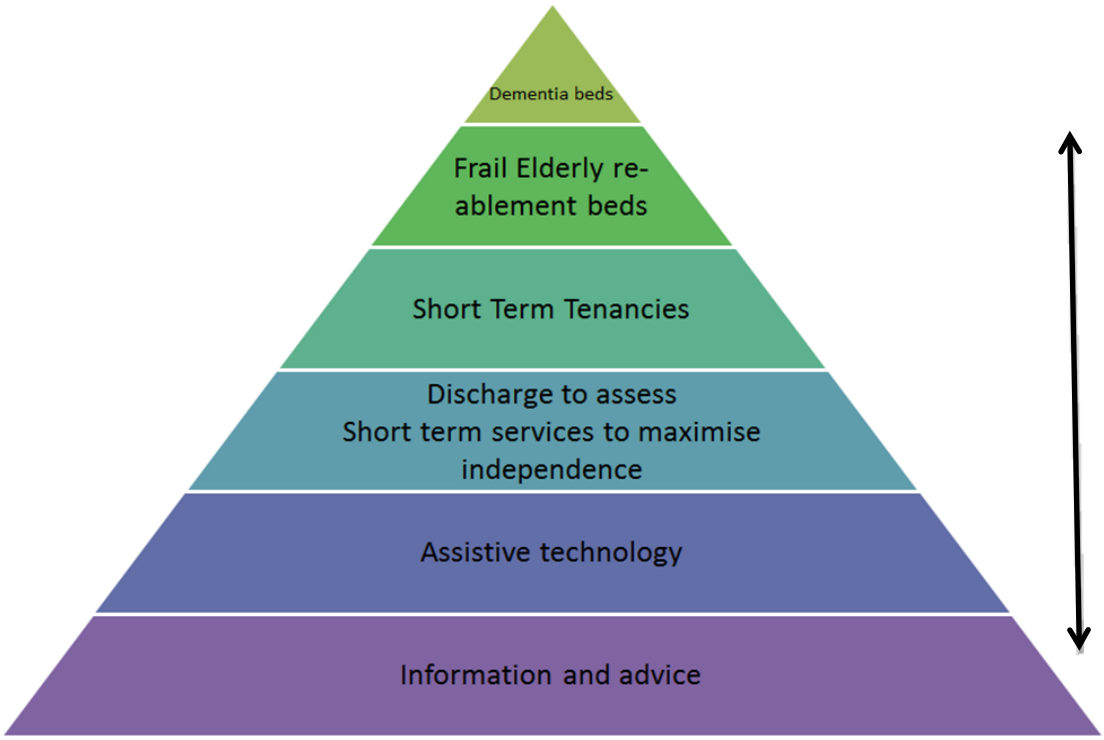
- Reducing Health and Wellbeing Inequalities
- Improving The Health and Well Being for individuals with multiple complex needs
- Developing an integrated health and care system that provides the right help and support to enable people to live their lives well.
- A transformational approach

As such the key aims and objectives of our on-going **Better Care Coventry Programme** compliment and contribute towards the overarching strategic approach to the wider health and care system by having focussed over the last two years on:

- Preventative approaches to healthy living and lifestyle choices that improve health and well-being across the City
- The delivery of personalised care planning organised around the needs of people rather than organisations that keep people out of emergency care
- An integrated health and social care plan, co-ordinated record and information sharing to facilitate effective health and social care delivery
- The delivery of effective hospital discharge, including advanced care planning, which ensures patients are discharged on the date agreed and to an agreed level of short term support, primarily at home
- Effective deployment of resources responsive to population and community need that is equitable, including the delivery of a workforce that is organised to provide integrated care with a commitment to shared ownership and delivery of better outcomes
- Delivery of appropriate and effective support to carers as an integral part of all work undertaken
- Collectively ensuring best use of combined resources so ensuring value for money service provision
- Investment in primary care to enable innovative models of care and develop local areas of expertise that will improve quality and outcomes
- Roll out of a fast change integrated neighbourhood team approach across the city which will support the delivery of our better care schemes

These still remain pertinent to the next iteration of the BCF Planning cycle for 2017-19 as does the current approach to meeting assessed need shown in Diagram 2.

Diagram 2: Promoting Independence - Hierarchy of service provision based on assessed needs



Importantly and more specifically this approach to the BCF programme supports the key themes of the STP, now renamed as 'Better Health, Better Care, Better Value', which is aligned through the three priority areas identified as the key work streams in the model in Diagram 1.

- **Proactive & Preventative Care**
  Which specifically expands on existing activities contained within the 2016/17 Better Care Fund plan. Put simply this means better general physical and mental health for all and helping people to stay healthy and independent. This should result in fewer visits to hospital for those with ongoing conditions, less time in hospital and more rehabilitation.
- **Urgent & Emergency Care** - Which focuses on providing unplanned care quickly.
- **Planned Care** - Which is needed by patients and service users but not always immediately and helping to reduce the necessary visits to hospital before and after hospital treatment.

The key themes are supported by additionally enabling improvements across the system in:

- **Productivity & Efficiency** – By continuing to look at how our back office functions such as finance and IT can be combined or aligned to reduce cost and improve effectiveness.

Delivering our Better Care programme is an important step in the delivery of the local commitment to the integration of health and social care by articulating how we will improve the lives of local residents:

- Increase life expectancy - by tackling specific health conditions for certain age groups, we will be able to improve life expectancy amongst local people.
- Improve the quality of life for people with multiple long-term conditions - by changing the way we provide care to these patients and ensuring consistency of care across the area, we aim to improve patients' health and their quality of life.
- Reduce the amount of time people unnecessarily spend in hospital - by putting care plans in place to support patients with certain health conditions, we will prevent them needing to be admitted to hospital.
- Give more people a positive experience of hospital care - by improving patient experience of hospital care, we hope to increase positive feedback about our hospital services.
- Give more people a positive experience of care outside hospital - by improving the experience our patients have of services in the community, we hope to increase positive feedback about these services. The content and yearly expansion of the BCF reflects the phasing of the 5 year system plan. There are demonstrable links to the STP, Joint Strategic Needs Assessment (JSNA), Joint Health and Well Being Strategy (JHWS), NHS Outcomes Framework, and Public Health Outcomes Framework.
- System shifts away from hospital care are integral to the STP and also underpin our Better Care approach

Additionally the Better Care programme between 2017 and 2019 also supports the key priorities of our **JSNA (2016)** which are:

- Mental Health and Wellbeing
- Long-term conditions
- Physical wellbeing
- Infectious diseases
- Resilience of the health and social care system

More information can be found in the following document links.

Document or information title	**Synopsis and links**
Coventry and Warwickshire Sustainability and Transformation Plan	http://www.coventry.gov.uk/downloads/file/23430/coventry_and_warwickshire_stp
Coventry's Joint Strategic Needs Assessment 2016	http://www.coventry.gov.uk/downloads/file/21652/joint_strategic_needs_assessment_2016
Coventry's Joint Health and Wellbeing Strategy 2016-19	http://www.coventry.gov.uk/info/190/health_and_wellbeing/2864/coventry_health_and_wellbeing_strategy
Coventry & Rugby CCG Strategic Plan 2014-19	http://www.coventryrugbyccg.nhs.uk/About-Us/Publications-and-Policies/Coventry-and-Warwickshire-CCGs-Strategic-Plan
Coventry Carers Strategy: 2016-2019	http://www.coventry.gov.uk/downloads/download/2306/coventrys_carers_strategy
Coventry: A Marmot City	http://www.coventry.gov.uk/info/176/policy/2457/coventry_a_marmot_city

Background and context to the plan – Changes in Demand

Population Growth

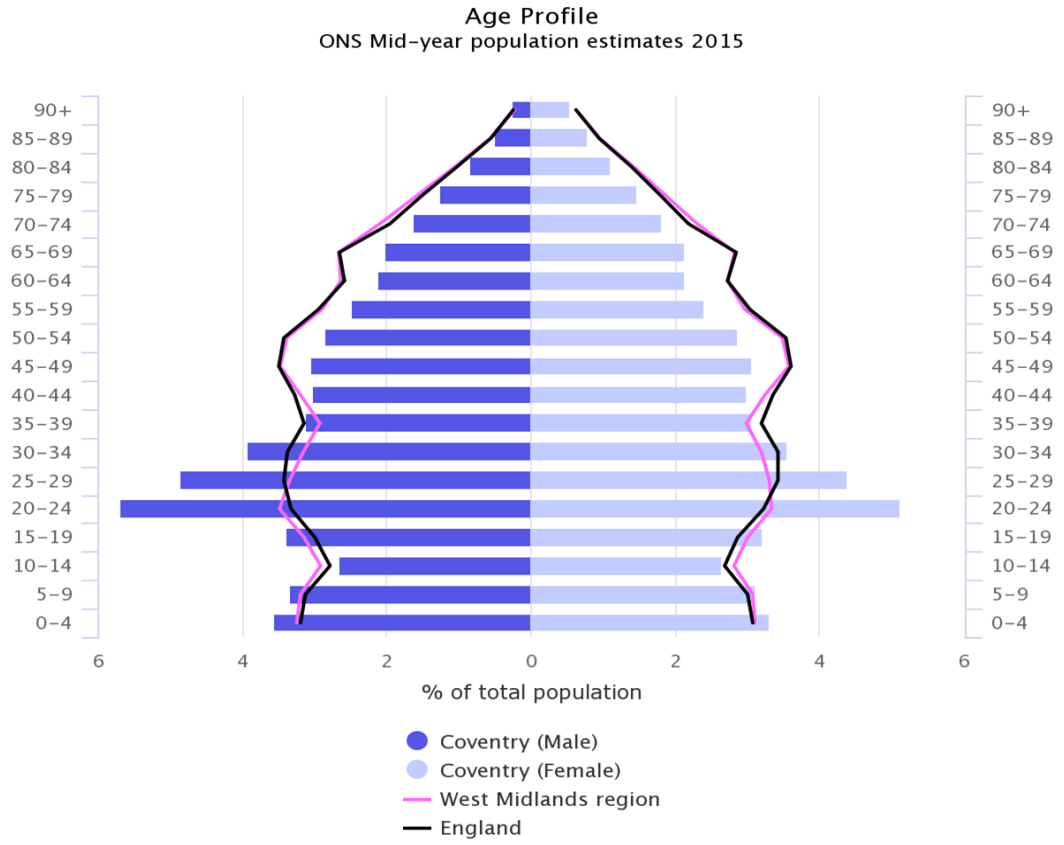
The city of Coventry is the thirteenth largest in the UK. The current estimated population of Coventry (2016) has 345,400 people living in the city which is the 10th largest of all local authorities. This is 8,000 more people than in 2014 when the population was estimated to be 337,400. This is an increase of 2.4%, compared to the England average of 0.9%. Between June 2014 and June 2015 Coventry's population was growing at the 9th fastest rate out of all council areas in Great Britain. Based on current estimates by the year 2025, the overall population is estimated to increase to 376,800. The population of people aged 65 and over is expected to increase to 57,100.

Currently 33.4% of the population comes from ethnic minority communities and this is likely to increase as 46% of school pupils are from backgrounds other than White British. Additionally over 100 different languages are spoken across the city with 8.7% of households contain no people with English as their main language.

Age Profile

The city has a much younger age profile than the national average, with the average age of residents being 33.

Diagram 3: Coventry Age profile



The growth of the city's two Universities has been a factor in recent population growth and has also impacted on the age profile.

An Ageing Population

We expect our older population to increase in the coming years with the proportion of 65+ in the overall population rising to 16% by 2030. The increases in an aging population can be regarded as positive in terms of longevity and improved quality of life but older people become, the more pressure they put on finite health and social care resources.

Table 3: Coventry – Estimated Population Change by Age Band (Source: POPPI & PANSI)

Population aged 18-64, projected to 2030

	2015	% of All	2020	% of All	2025	% of All	2030	% of All
People aged 18-24	47,000	14.0%	45,600	12.8%	46,000	12.2%	51,100	12.9%
People aged 25-34	52,700	15.6%	58,100	16.2%	59,400	15.8%	57,800	14.6%
People aged 35-44	41,200	12.2%	44,100	12.3%	49,100	13.0%	52,700	13.3%
People aged 45-54	40,600	12.1%	40,600	11.4%	39,500	10.5%	41,800	10.6%
People aged 55-64	31,200	9.3%	34,900	9.8%	38,000	10.1%	37,900	9.6%
Total population aged 18-64	**212,700**	63.1%	**223,300**	62.4%	**232,000**	61.6%	**241,300**	61.1%

Population aged 65 and over, projected to 2030

	2015	% of All	2020	% of All	2025	% of All	2030	% of All
People aged 65-69	14,200	4.2%	13,400	3.7%	14,900	4.0%	17,000	4.3%
People aged 70-74	11,800	3.5%	13,000	3.6%	12,400	3.3%	13,800	3.5%
People aged 75-79	9,400	2.8%	10,300	2.9%	11,600	3.1%	11,100	2.8%
People aged 80-84	6,800	2.0%	7,600	2.1%	8,600	2.3%	9,700	2.5%
People aged 85-89	4,400	1.3%	4,800	1.3%	5,500	1.5%	6,400	1.6%
People aged 90 and over	2,900	0.9%	3,400	1.0%	4,100	1.1%	5,100	1.3%
Total population 65 and over	**49,500**	14.7%	**52,500**	14.7%	**57,100**	15.2%	**63,100**	16.0%

People aged under 18	74,700	22.2%	81,800	22.9%	87,700	23.3%	90,800	23.0%
Total population - all ages	**336,900**	100.0%	**357,600**	100.0%	**376,800**	100.0%	**395,200**	100.0%

The phenomenon of an ageing population and increasing urbanisation is impacting on Coventry with the most recent population estimate indicating that nearly 15% of the population is over 65yrs and over 2% are over 85 yrs. As the population ages more people will be living with multiple health conditions that require support because increasing age is an important risk factor for higher mental health needs. There are a number of conditions that older people are more likely to experience, particularly as this group is frequently associated with a wide range of diseases such as cancer, heart and respiratory disease, diabetes, hypertension, dementia etc. Additionally older people are more prone to social isolation, financial difficulty, chronic physical health problems (long term conditions) and loss/bereavement.

Isolation

There is a projected increase of those aged 75 years+ living alone (approx. 10% increase) from 2015 to 2020. However those aged 65-74 years living alone are projected to remain relatively stable (1.4% increase).

Table 4: Increased numbers of people are living alone (estimated 2015-16)

Age range	% males	% females
65-74	20	30
75+	34	61

Loneliness and social isolation are harmful to health and can have an effect on both physical and mental health. Stress hormones, immune function and cardiovascular function are impacted by chronic loneliness and it can also lead to anxiety and depression. Research shows that lacking social connections can be as damaging to our health as smoking 15 cigarettes a day. Those who are socially isolated are 2-5 times more likely to die prematurely than those with stronger social ties.

Deprivation

We also know that a large proportion of our inward migration from new migrants tends to be into the more deprived areas of the city. The levels of deprivation in the city, although improving, will remain relatively high and those living with lower levels of wealth are more likely to develop poor health. Currently 8.5% of the population live in neighbourhoods that are amongst the 10% most deprived in the city. Deprivation is also associated with poorer mental health. The Mental Illness Needs Index (MINI) estimates levels of mental health need relative to England; and includes admissions related to mental health conditions. A number of wards within Coventry have higher scores than the England average indicating a higher prevalence of mental ill health.

Life Expectancy

Coventry's life expectancy at birth is 82.3 years for females and 78.6 years for males. This is lower than the national average, but it is at the level expected given the city's level of deprivation. The life expectancy gap for men is similar to the national figure but for women is significantly higher at 8.7yrs. Improvements in mortality rates have been greater for men than women, with the number of men aged 75 years and older increasing by 149% since mid-1974. By comparison, the number of women in the same age group has increased by 61%. Premature mortality (deaths under the age of 75) is higher in Coventry than the national average from cardiovascular, cancer and respiratory disease.

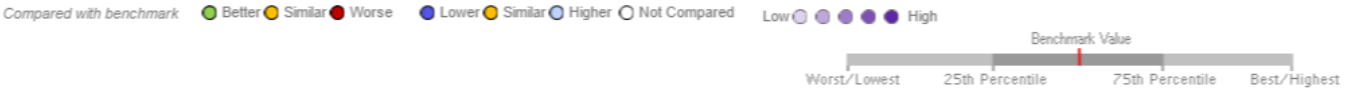
In terms of healthy life expectancy, the figures are 60.6 years for males and 62.7 for females. Whilst this is similar to the combined authority area figures of 61.5 and 62.3 years, it is below the England figures of 63.4 and 64.0 respectively.

Health Inequalities

Health inequalities exist between people of different socio-economic groups and also between genders and ethnicities. However the underlying causes of health inequalities are complex as some of these may be because population groups differ genetically, so that some diseases are more prevalent in certain ethnic groups and also includes altered prevalence and patterns, in different ethnic groups for common conditions such as cardiovascular disease (CVD) and type II diabetes. Others are due to specific lifestyle factors that range from smoking and alcohol consumption to nutrition and exercise.

There may also be wider determinants involved such as poverty, housing, education and access to healthcare. Therefore as a local system we must strive to understand the levels of significance in respect of how disadvantaged or protected groups (under the Equalities Act) fare compared with people overall in being able to access appropriate services or care and the broader health inequalities agenda.

Table 5: Public Heath England profile – Coventry Health Outcomes



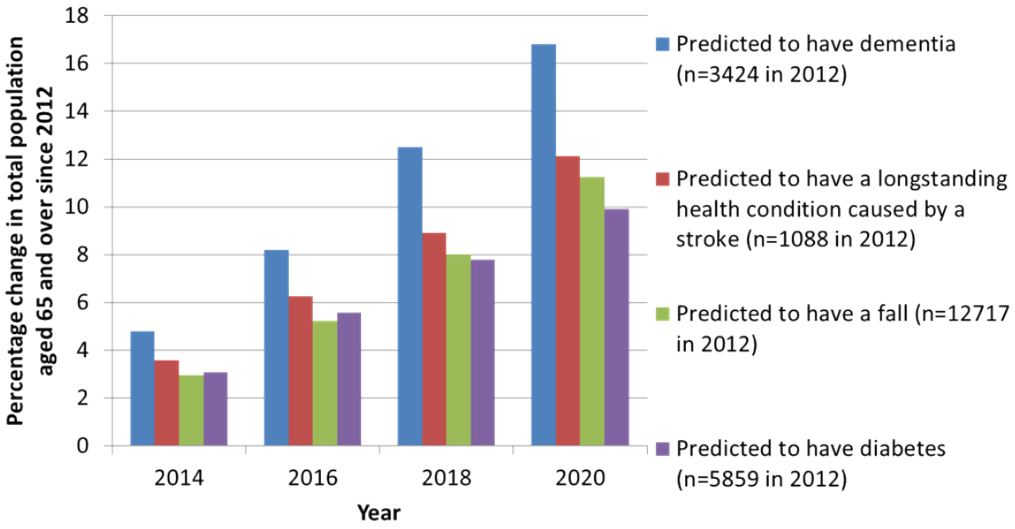
Indicator	Period	Coventry			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Life expectancy at birth (Female)	2013 - 15	–	-	82.3	82.7	83.1	79.4		86.4
Life expectancy at birth (Male)	2013 - 15	–	-	78.4	78.7	79.5	74.3		83.4
Healthy life expectancy at birth (Female)	2013 - 15	–	-	63.8	-	64.1	52.4		71.1
Healthy life expectancy at birth (Male)	2013 - 15	–	-	62.9	-	63.4	54.0		71.1
Inequality in life expectancy at birth (Female)	2013 - 15	–	-	9.6	-	-	-	-	-
Inequality in life expectancy at birth (Male)	2013 - 15	–	-	9.4	-	-	-	-	-
Inequality in healthy life expectancy at birth (Female)	2009 - 13	–	-	18.0	-	-	-	-	-
Inequality in healthy life expectancy at birth (Male)	2009 - 13	–	-	17.1	-	-	-	-	-
Mortality rate from causes considered preventable	2013 - 15	–	1,707	219.6	197.2	184.5	320.5		130.5
Under 75 mortality rate from all cardiovascular diseases	2013 - 15	–	604	87.9	78.9	74.6	137.6		45.4
Under 75 mortality rate from cancer	2013 - 15	–	1,025	149.1	143.6	138.8	194.8		105.8
Under 75 mortality rate from liver disease	2013 - 15	–	158	22.0	20.3	18.0	44.4		10.0
Under 75 mortality rate from respiratory disease	2013 - 15	–	290	43.3	34.7	33.1	68.3		16.5
Health related quality of life for older people	2015/16	–	-	0.723	0.719	0.733	0.642		0.799

Long-term illness

Although life expectancy is increasing, the number of years people are living without a limiting long-term illness is decreasing, particularly in males. It is estimated that 17.7% of the population have a limiting long term health problem or disability with the latest figures suggest that on average males in the city are not quite reaching their 60th birthday without having a limiting long-term illness.

Due to these factors there is likely to be an increase in the number of people that require additional support in order to continue to live independently. The forecast increases in key health conditions are shown in the graph below.

Diagram 4: Changes in key Health Conditions since 2012



An important initiative (See Scheme 1 Targeted Prevention in the Appendix) within the BCF plan will focus on the promotion of improved health outcomes for the citizens of Coventry by reducing the risk factors in the general population and links into the upgrade in preventative work within the STP to deliver long term sustainability. This will involve a variety of interventions to change behaviour, reduce the impact on the health and social care system of preventable diseases and alleviate and/or delay the pressure caused by some long term conditions.

Evidence has shown that interventions that are made earliest in a potentially negative health outcome are the most likely to be effective. Moreover for many health problems in the population a combination of primary, secondary and tertiary interventions are needed.

Other areas impacting on Demand

At least 1 in every 4 people will experience a mental health problem at some point in their life. One in six adults has a mental health problem at any one time.

Additionally the numbers of people with severe physical or learning disabilities living into adulthood will continue to increase as long term survival rates improve.

Should all other factors remain the same it is predicted that one of the greatest increases in demand with mitigating actions will be in non-local authority care homes, with an increase from 1,242 in 2015 to 1,365 people (65+) in 2020. In Coventry we have a long history of supporting people to live independently using alternatives to residential care, and this needs to continue in order to ensure that residential care is not overused.

There will be a continued increase in the provision of unpaid care. Currently 40% of all carers provide support for their parents or parents-in-law and 26% care for their spouse or partner.

It is estimated that about 30% people aged 65 and above living at home and about 50% of people aged 80 and above living at home, or in residential care, will experience a fall at least once a year.

Approximately 1 in 20 older people living in the community experience a fracture or need hospitalisation after a fall (NICE, 2015). When measured between April 2016 and March 2017, falls and frailty accounted for 14.6 % of 75+ years Non Elective Admissions for registered Coventry GP practice patients.

Progress on Better Care projects initiated to date

Integrated Neighbourhood Teams (INT)

Upwards of 50% of unplanned admissions to hospital are in the over 75 age group. This has led to the development of a multi-disciplinary process centred on cross-agency assessment and care planning to support older people with complex needs where they require specialist levels of support in order to return them to their pre-event level of health and well-being. This reduces reliance on statutory services and helps maintain these people at this level or steps them down to a more preventative stage.

During the 2015/16 BCF programme the Integrated Neighbourhood Team was developed, it has since been rebranded as “Your Health at Home” and was launched to the public in June 2016. The focus of the INT is primarily aimed at reducing hospital admissions through the early identification of needs. This work-stream has now successfully moved through the development and implementation phases into an on-going operational service with three clusters of GP practices now referring ‘high risk’ patients into a central Hub. Triage arrangements are working well and referral momentum continues to build with a good spread of GP’s now actively engaged. The service was also nominated for a national community health award.

Joint working agreements and the development of joined up commissioning

A well-established Adult Joint Commissioning Board (AJCB) is in place which meets monthly, chaired by the DASS and attended by CCG directors and senior commissioning and finance staff. This Board steers the delivery of joined up care, receiving reports in relation to key policy, planning and commissioning practice and oversees a programme of integrated commissioning. The Board reports to the Coventry HWBB. Additionally a ‘commissioning collaborative’ group has been established across Coventry and Warwickshire included the two local authorities and three CCGs.

Recent integrated commissioning initiatives include joint re-commissioning of short and long term home support and care home provision for all adults customer groups. There are also jointly commissioned short term reablement services in care homes and housing with care. These joint arrangements are overseen by the AJCB.

The integrated commissioning team also deliver joint quality monitoring initiatives with nurses co-located with the City Council's strategic commissioning staff to form a joint Quality assurance function. Arrangements include a Provider Escalation Panel which reports to the Quality and audit Sub group of Safeguarding Board and which is a multi-disciplinary, multi-agency group including stakeholders from the City Council, Coventry and Rugby Clinical Commissioning Group (CRCCG), Coventry and Warwickshire Partnership Trust (CWPT) and Care Quality Commission (CQC). An annual report on QA is taken to Coventry Safeguarding Adult Board.

Provider relationships for jointly commissioned services including home support and care homes are jointly managed through a number of initiatives including provider forums and workshops. Regular multi-disciplinary meetings take place in relation to home support services to ensure joined up delivery including targeting of therapy resources for short term provision in service users own homes and bedded provision. The Council have been instrumental in facilitating the re-constitution of a Registered Managers network which re-launched in May 2017.

The focus has been on building on the work underway with a renewed focus on market development and completion of trusted social care and CHC assessments. This work will continue into 2017-19 and includes plans to strengthen the on-going Learning Disability and Mental Health commissioning arrangements.

In addition the joint re-commissioning of care home beds is underway and will take place in the coming year and further opportunities for joint commissioning will be considered going forward. This will build on the joint work regarding quality assurance and the successful initiatives such as 'React to Red' which has resulted in a sustained reduction in pressure ulcers. Development of Discharge to Assess services have also been the product of a joint commissioning approach.

Opportunities for people to use these arrangements to provide personalised support will underpin the delivery of these contracts.

Information Sharing

The Coventry and Warwickshire Digital Transformation Board is now providing oversight to the on-going information sharing project within Coventry with the local GP Alliance now fully integrated into the programme of development. This includes the distribution of a letter to all households in the city, explaining that GP's have agreed to share appropriate patient information with partner health and social care organisations and an individual's choices in relation to this.

A workshop has taken place with practitioners and clinicians to gather requirements on system integration and information sharing which will inform the programme for the next 18 months.

There has been significant progress in the development of a data sharing agreement across organisations. Continuing work with the Black Pear software solution provides a suitable

portal for accessing data from the different partner organisations enabling this to be viewed jointly and this development currently covers INT and End of Life care.

Coventry Social Care is now using the NHS number after integration of the social care system with the NHS spine.

'Why not Home Why not today'

The Why not Home, Why not Today' initiative was first trialled at UHCW with patients that were considered suitable with the overall objective being for services to work together in order to both reduce the number of admissions of frail elderly patients over the age of 75 into hospital, and to reduce the time spent in hospital if they are admitted. One of the key activities was to identify and implement the most appropriate packages for these patients and their carers' in order for them to be supported in their own home environment.

The initial overarching project has now ended and the ethos of and learning from this programme has been mainstreamed into the on-going development of the three pathways within the Discharge to Assess model now being implemented in Coventry and the continuing operation of the GP-led Frailty team at UHCW.

GP-led Frailty Team

The historical approach to treating frail elderly patients in Coventry has been a siloed model of working between the different agencies involved in caring for frail patients, mainly from the acute, primary, community, social, and voluntary sectors. The care provided has tended to focus more on the patient's medical conditions and is usually in response to a medical or social crisis.

Analysis has shown that frailty is one of the leading causes of Non Elective admissions for over 75s at UHCW. Further analysis into this patient cohort highlights a number of performance challenges within the system, including:

- Increased length of stay
- Delayed transfers of care
- Prolonged wait in ED
- Higher readmission rates

The GP-led Frailty Team is located at the 'front door' of the hospital in the Emergency Department and has been in operation since October 16 and was initially funded non-recurrently via the Prime Minister's Access Fund (PMAF). This initiative was then joined up with the wider system transformation programme for frailty within the 'Why not home why not today' programme at UHCW.

Research evidence suggests that frail patients benefit from a service model based around ongoing proactive person-centred, co-ordinated care via care and support planning, all of which are hallmarks of the MDT approach adopted by the Frailty Team.

As the GP-led Frailty team is at a relatively early stage of development and not yet running to full capacity, it is not yet possible to provide a full evaluation of its impact and cost

effectiveness. However initial qualitative and quantitative analysis undertaken by the GP Alliance indicates that the Frailty approach has potential to deliver benefits for the health economy in Coventry with the expectation that the Team will have a positive impact on both the clinical management of frail elderly patients, on hospital flow and on ongoing support requirements.

Dementia

A multi-agency approach to supporting people and their carers through the dementia pathway has featured prominently in previous BCF plans and the implementation of the 'Living Well with Dementia' strategy across the city is being overseen by the Dementia Strategy group.

This has led to an number of achievements to date including the implementation of a Dementia navigator service for Coventry and also the recruitment of both Admiral nurses and Dementia 'Locksmiths' that have been working alongside the INT multi-disciplinary teams. The work done to improve the dementia environment of people living in care homes has also demonstrated improved outcomes for this group and Coventry has recently seen the opening of a new specialist dementia housing with care scheme with 33 flats which increases the capacity of the City to provide appropriate support for people with this condition. Briefly, some major improvements delivered include:

- Coventry is a better place to live with dementia with the city being awarded Dementia Friendly Community status by Alzheimer's Society.

- It is quicker and easier to get an assessment and timely diagnosis if you may have dementia. Waiting times for a memory assessment have reduced from over 20 weeks to 3 weeks, against a 12 week target and diagnosis rates for Coventry and Rugby have increased from 48% in 2013 to 60% in 2017.

- Overall there is more support available for people living with dementia and their carers in Coventry.

Long Term Care

Interim capacity was secured in the latter part of 2016 to focus on a range of key areas which included Section 117 and Continuing Health Care cases plus 'out of city' placements. Over ninety long term care cases, involving residential or nursing care, were allocated during the year resulting in a number of the 'out of city' placements being relocated back into Coventry which enabled both additional independence for a number of service users and placement cost savings for both health and social care.

Moreover, the decision has been made to continue this successful approach as part of the standard operating model through the recruitment of one FTE Social Worker and a part-time administrator from March 2017. This will enable further significant work to be done in terms of assessments and further cost savings.

Frailty, Step up and Therapy

A system wide transformation programme was included in last year's BCF that encompassed three core projects:

- Establishment of a step up Community response and crisis reduction capacity
- Establishment of a trusted frailty assessment pathway
- Creation of a Community Therapeutic pull model

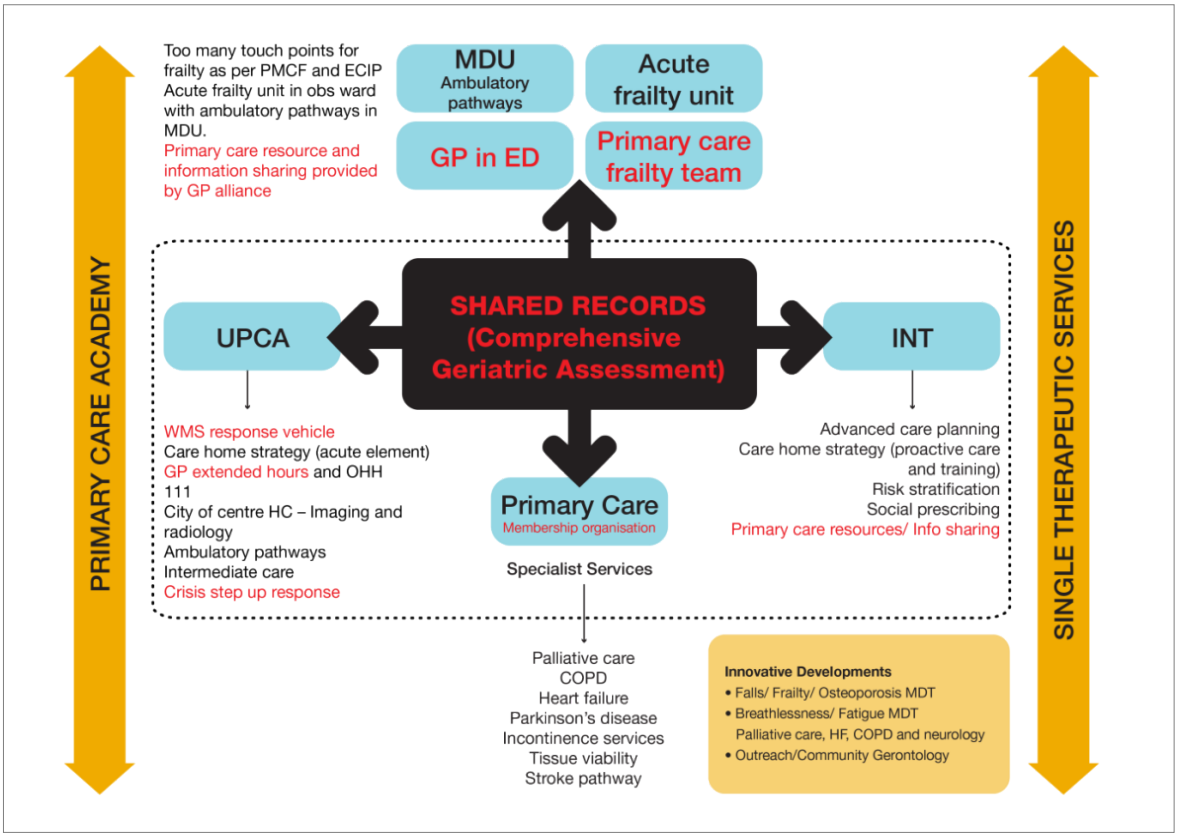
These elements were subsequently incorporated into the Coventry and Warwickshire STP and progress on developments was reported through the Proactive and Preventative Care workstream. This followed a 90 Day Frailty project between June and September 2016 that was instigated by the NHS Emergency Care Improvement Programme Team (ECIP) based at UHCW and which involved partner organisations across the city.

Recent evidence suggests that frail patients benefit from a service model based around ongoing proactive person-centred, co-ordinated care via care and support planning, all of which are hallmarks of the MDT approach which has been adopted by the Frailty Team at UHCW.

According to British Geriatrics Society, the gold standard for the management of frailty in older people is the process of care known as Comprehensive Geriatric Assessment (CGA), involving a holistic, multidimensional, interdisciplinary assessment of an individual by a number of specialists of many disciplines in older people's health.

A patient who receives CGA during an illness is 30 per cent more likely to be alive and living in their own home at six months than a person receiving standard care. The introduction of the CGA is expected to lead to better outcomes for this vulnerable patient group including reduced readmissions, reduced long term care, greater patient satisfaction and lower costs.

Diagram 5: The alignment and interdependencies of system wide initiatives including the GP-led Frailty team.



BCF Performance 2016/17 continuing system issues

Overview

The Health and Social Care system in Coventry is considered to be challenging and is currently in national escalation through NHSE and NHSI. It has also recently been selected as one of the twelve CQC Local System Reviews based on performance across a range of indicators at the health and social care interface.

The local system in Coventry is currently characterised by increasing levels of attendance and longer waiting times at A&E, rising numbers of emergency admissions to the University Hospital combined with continuing high rates of delayed discharge.

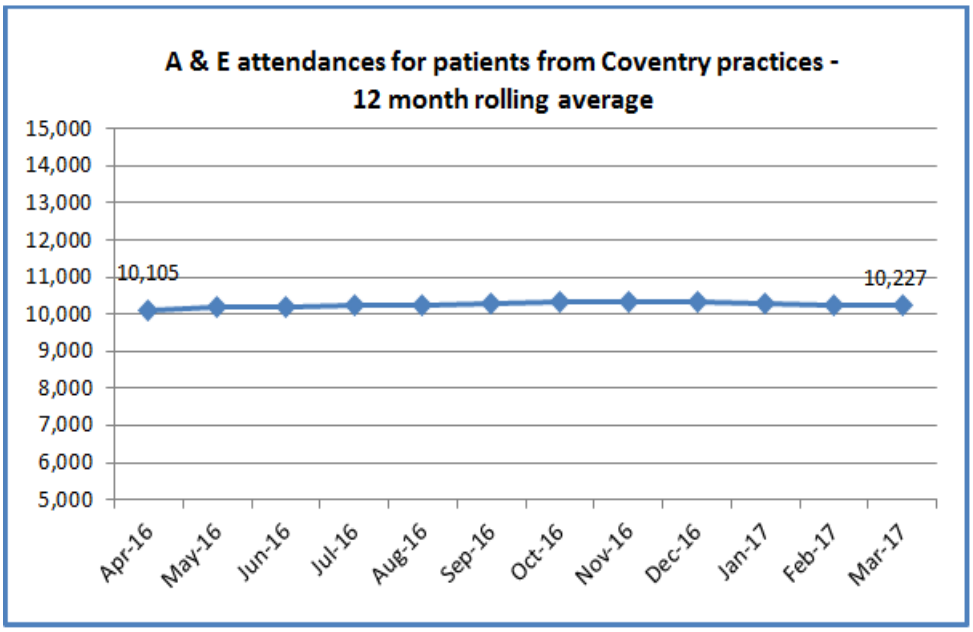
This contributes to increasing health and social care activity overall and diverts capacity from responding proactively and early to prevent deterioration in the community. The need to shift activity to the 'front door' is accepted and understood by partners and activity has been targeted in this direction over the last 12 months, however realising this shift in resources and activity to deliver this remains challenging.

The Coventry and Warwickshire A&E Delivery Board oversees the implementation and monitoring of the A&E Improvement plan, including the DToC plan based on the High Impact Change Model, to address these established issues within the urgent and emergency care system as it has a direct impact on, and is intrinsically linked to the BCF plan and improvement and sustainability of the whole health and social care system. (*See Governance arrangements on Page 41*.)

A&E Attendances

UHCW attendances were lower between January and March than in the same period in 2015/16 and continued to follow last year's trend.

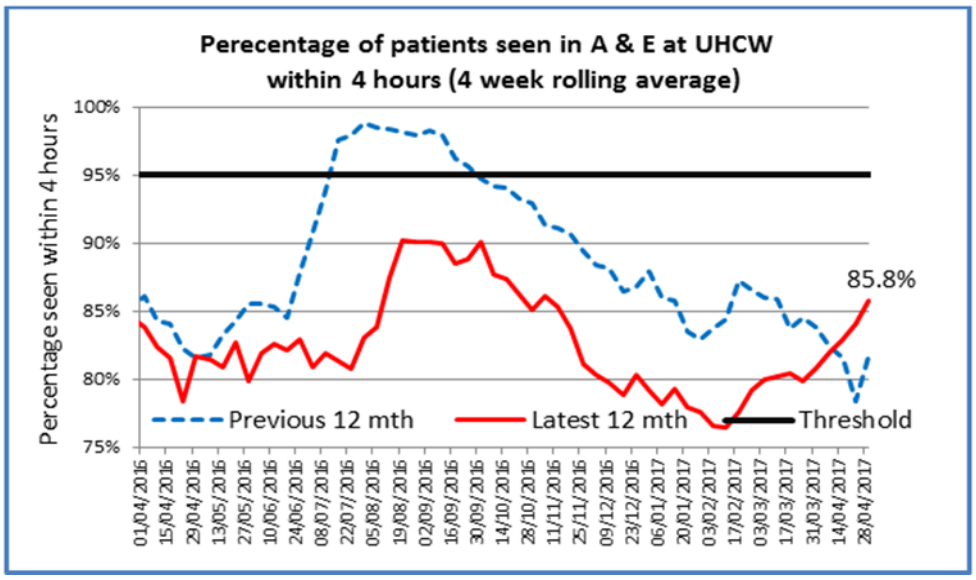
Diagram 6: A&E Attendances 2016-17 (Source – SUS)



A&E Waiting Times

The recent increase in A&E attendances has resulted in additional pressure at the 'front door' at UHCW with the percentage of patients seen within 4 hours in A & E remaining below 95% throughout the last year and reached its lowest point over the last 12 months in February.

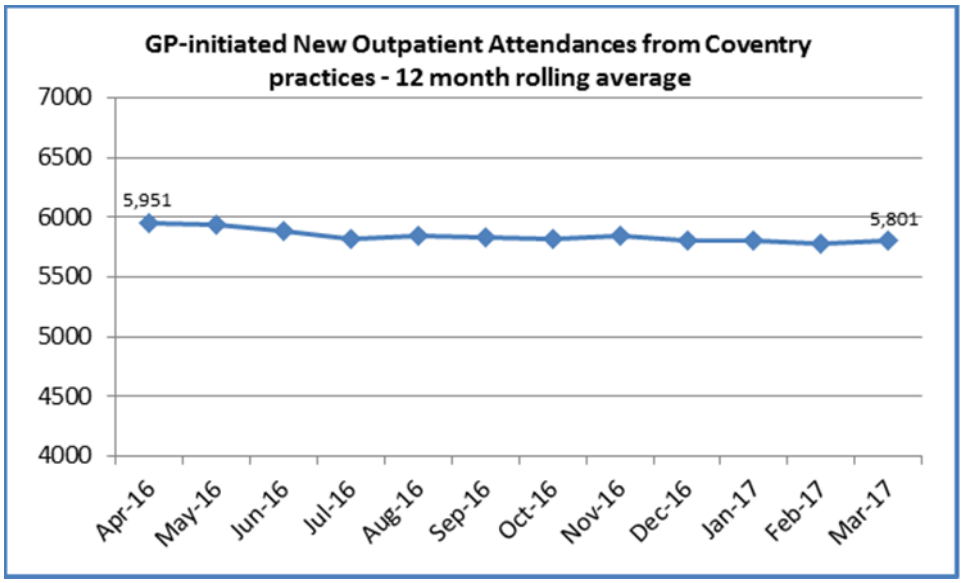
Diagram 7: A&E Waiting Times 2016-17 (Source - UHCW A&E Exception Report)



Outpatient Attendances

Attendances over the course of the last 12 months have seen a 2.5% reduction in the MAT (Moving Annual Total) figure. Over recent years GP-initiated new outpatient attendance rates for Coventry and Rugby patients have been running below national average levels and the latest CRCCG rate is again slightly lower than the England median and 4% lower in 2016/17 than in 2015/16.

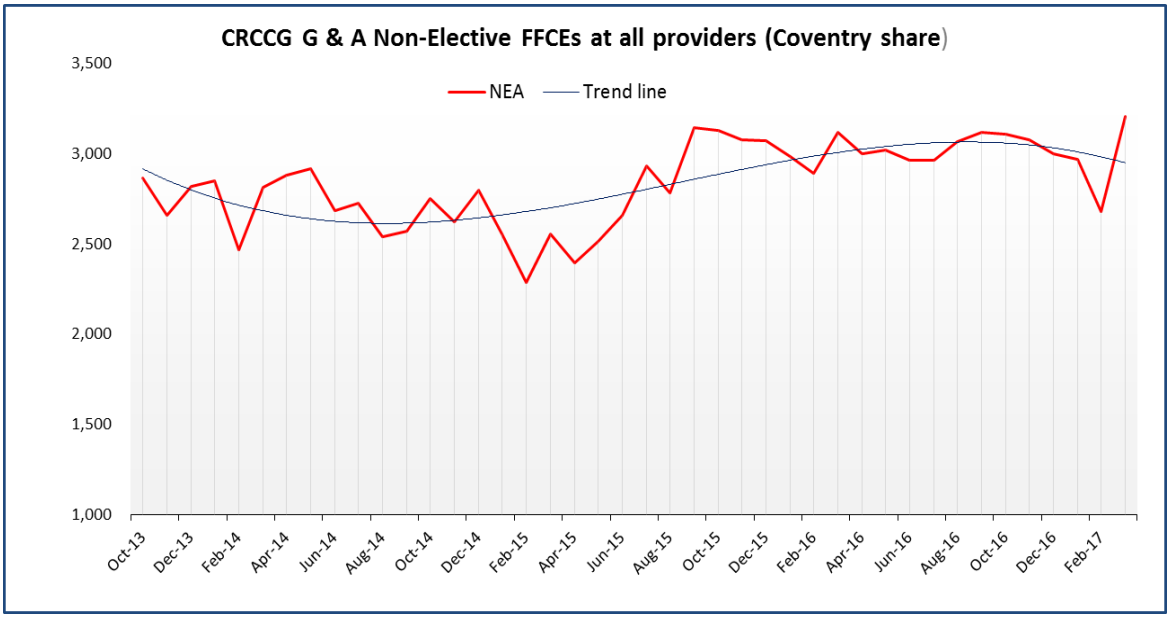
Diagram 8: GP initiated New Outpatient Attendances 2016-17 (Source – SUS)



Non Elective Admissions

The latest reported MAT figure for emergency admissions is 36,179 (12 months total as at the end of March 2017) which is 7.0% higher than the BCF plan target of 33,801 for the financial year. The figures from April to August saw increases against the same months last year, however the six months between September and February produced small decreases against 2015-16 indicating some stabilization in Emergency admissions. The Coventry LA element is calculated as 73.9% of total Coventry and Rugby CCG Non Elective Admissions (as per the BCF template guidance).

Diagram 9: Non Elective Admissions October 2013 to March 2017 (Source – MAR)

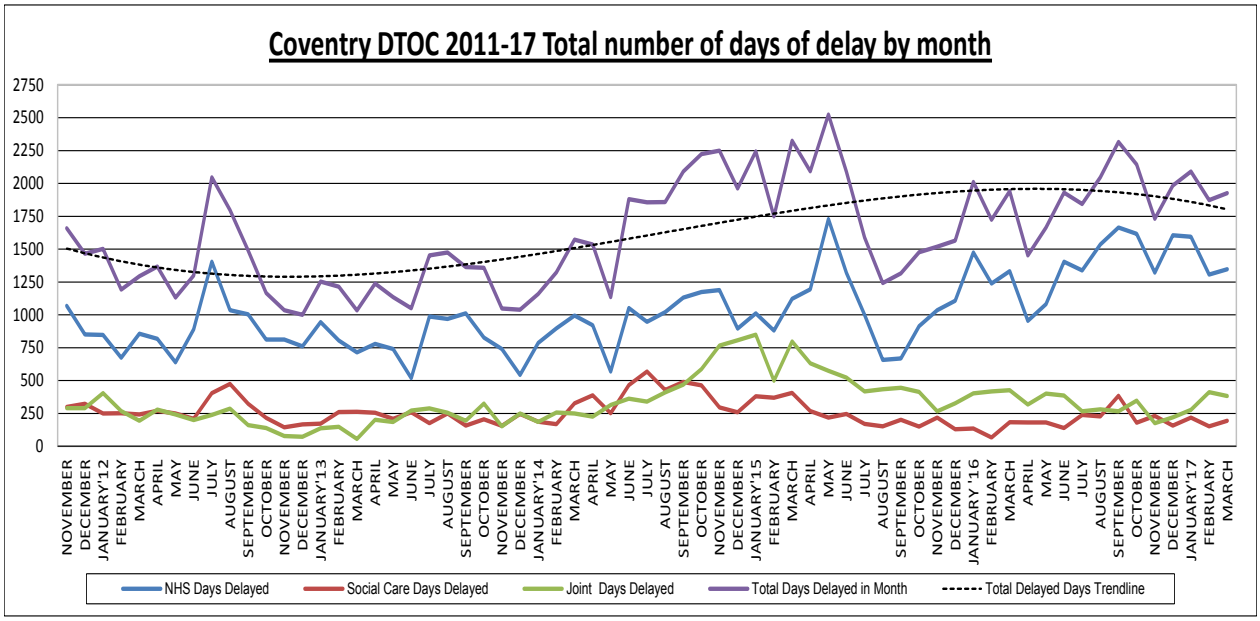


Delayed Transfers of Care

DToC performance has been a significant challenge to the partner organisations in Coventry over recent years. However there was an improvement in year on year performance in 2015/16, following a period of relative stability in the reported days of delay during the year. However the latest MAT figure for total delayed days as at the end of March 2017 (23,000) reflects a rise of 9.1% on the outturn at last year end but a 0.5% reduction on 2014/15. The first quarter of the financial year saw a brief respite in the mainly upward trend in delayed transfers but since August this has resumed. The proportion of days of delays attributable to social care and jointly with health have declined over the last 24 months from a peak in early 2015 as shown in the graph below.

The latest target trajectories for Delayed transfers submitted to NHSE on July 21st are shown on Page 47.

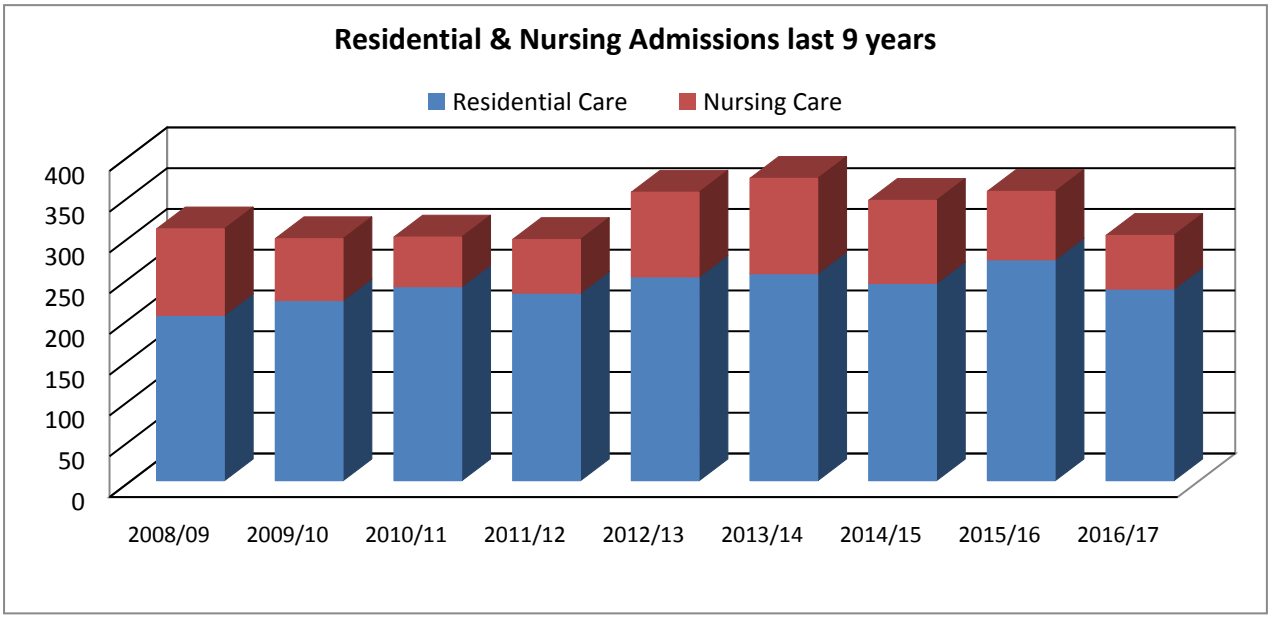
Diagram 10: Delayed Transfers of Care 2011 – 2017 (Source – UNIFY)



Permanent Admissions

Over the period from 2010-11 to March 2016 the numbers of people entering residential and nursing care increased by 13%. However the latest figure reported for the 12 months to the end of March 2017 is 301 which is 15.2% below the year end outturn for 2015-16 and which reflects an increase in activity to prevent permanent admissions and promote alternative community based support.

Diagram 11: Permanent Admissions to Residential & Nursing Care 2008 - 17 (Source - CCC)



Better Care Fund plan 2017-19

Overview

The integration of health and care has been a long standing policy ambition based on the premise that more joined up services will help to improve the health and care of local populations and make more efficient use of available resources.

Whilst the Sustainability and Transformation Programme (STP) is the primary planning tool for health and care, the Better Care Fund is the only mandatory policy to facilitate integration. The Better Care Fund (BCF) is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.

The planning and implementation of the BCF Fund in Coventry over the last couple of years has been successful in providing a practical opportunity for all partners in the local health and social care system to appreciate that they have something to gain by actively working together to collectively focus on what is best for the patient. This cultural shift has also resulted in improved working relationships at various levels across the system between

stakeholders and encouraged the articulation of a common direction of travel with ownership of the transformation activity required to achieve improved integration by 2020.

This is at the same time that the Coventry health and care system faces increasing challenges to improving our residents' health and wellbeing and maintaining the quality of care whilst experiencing a widening gap between available funding and growing demand.

There is now a collective understanding that there needs to be a unity of voice to what will be different in the future and that commissioning will play a crucial role in enabling the integration of provision across health, social care, mental health, community and primary care by supporting sustainability in the provider sector, through providing strategic direction, assuring outcomes and creating capacity.

The regular oversight of BCF activity is now being managed and controlled through the Adults Joint Commissioning Board where programme delivery and performance is reported monthly. Additional system governance is also in place to ensure alignment with broader objectives and plans and this is discussed in more detail on Page 41.

As a local area Coventry has mirrored national improvements in reducing permanent admissions of people aged 65 and over to residential and nursing care homes and by increasing the proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation services (*Page 45*).

BCF Plan 2017-19

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 arise from the 2015 spending review and the 2017 spring budget and taken together comprise the Improved Better Care Fund (iBCF).

This additional funding, which is being made available by the Department for Communities and Local Government direct to councils is intended for three purposes:

i. To meet adult social care need
ii. To provide support to the NHS (especially through application of the 8 High Impact Changes)
iii. To sustain the social care provider market

Plans for use of the grant have been agreed by the City Council with Coventry and Rugby Clinical Commissioning Group (CRCCG), through City Council Cabinet and with the local Health and Well-being Board.

Since the implementation of the Better Care Fund (BCF) in 2015, the City Council has had a BCF plan facilitated by the Health and Wellbeing Board supported by a section 75 partnership agreement with Coventry and Rugby Clinical Commissioning Group (CRCCG).

The basis of the pooled funding for the Better Care Fund in previous years has been money that has already been committed to health and social care services through a variety of funding streams. The schemes that were identified in the resultant plans were developed in order to target investment and resources into transforming the system and improving

outcomes for citizens and the entire care economy. Some of the learning and evidence from projects completed and others still on-going has been incorporated into the discussion and development of new initiatives for 2017-19.

The same intentions underlie the current version of the Better Care Plan, which now spans two fiscal years, and a similar set of detailed financial and operational plans have been developed to reflect the current CCG and Social Care commissioning priorities within Coventry.

There is a growing acknowledgement that a focus on admission prevention is as crucial to the effectiveness of the health and care system as enabling discharge and this is accepted at a strategic level across partner organisations. The iBCF grant announced in the spring budget has made significant extra funding available between 2017 and 2020 and this has been put in place with the aim of providing additional stability and capacity in local care systems and specifically to 'impact on front line care'. This additional funding will also enable the continued sustainability of provision that may otherwise have closed or reduced as a consequence of reduced local government funding.

With this in mind the health and social care partners in Coventry will continue to focus the resources and activities of the Better Care Coventry Programme to deliver on the following aims in line with wider STP aspirations.

- Ensuring that people who require care and support are assessed and provided with the necessary treatment or services in a timely and effective manner which are fundamental to preventing further deterioration as well as helping to ensure that people's individual outcomes are met.
- Focuses on promoting wellness by keeping people well, reducing demand and providing ongoing support to patients and service users.
- Reduce health inequalities across the city by early intervention, changing behaviours and providing the opportunities to improve lives.
- Maximisation of the capacity and strengths that the person and their family bring and what is already available within the community.
- Provide simple access to care and support without duplication and moving towards integrated delivery through multi-disciplinary teams.
- Primary care at the core, with social care, mental health, community services, and acute services out-reach and in-reach, forming a network of care and support.
- Reduced reliance on urgent and emergency care over time, with integrated teams within communities' proactively managing people at higher risk.
- Patients and service users are supported in the most appropriate setting and helped to access their care in a planned way through earlier intervention where appropriate.
- Improving system performance and patient flow prior to admission, whilst in hospital and then at the point of and following discharge.
- Optimising the capacity and processes to facilitate hospital discharge through continuing to support system change that will in turn improve long term performance.
- Maximising the independence of people either after a stay in hospital or when they first come into contact with social care, by investing in community based preventative services that reduce the requirement for health and/or social care in the longer term.

- Supporting the sustainability of social care and mitigating the local market pressures associated with increasing costs and recent funding reductions to local government.
- Commissioners need to work together across the system to develop the capability and capacity around a common vision and make best use of the collective assets available.

Existing BCF schemes carried over

This current BCF Plan will continue to deliver and monitor the impact of schemes that were implemented or already in place during previous years of the programme and with expenditure detailed in the finance template:

- **Acceleration Fund** (Driving Change)
- **Care Act Implementation**
  - Personalised healthcare at home
  - Physical health / wellbeing
- **Carers services**
  - Carer advice and support
  - Respite services
- **Dementia**
  - Residential placements
  - Dom care packages
- **Disabled Facility Grants**
- **Out of Hospital and Nursing Care**
  - Personalised healthcare at home
  - Physical health / wellbeing
- **Short Term Care**
  - Personalised healthcare at home
  - Physical health & wellbeing
  - Residential placements
- **Domiciliary care at home**
- **Urgent Care**
- **Voluntary Sector Review** (Primary prevention & early intervention)

We are also developing and implementing a number of **new key schemes** which are shown in more detail in Appendix 1 and in Table 6 below.

BCF Initiatives 2017- 2019

The aims stated above are reflected in a programme of initiatives focused on:

1. **Targeted Prevention** - this will involve a variety of interventions to change behaviour, reduce the impact on the health and social care system of preventable diseases and alleviate and/or delay the pressure caused by some long term conditions and lifestyle choices.

2. **Improving Whole System Flow** - improving the flow of patients, service users, information and resources within and between health and social care organisations have a crucial role to play in coordinating care around the needs of patients and service users, and driving up service quality and productivity.

3. **Hospital Discharge Support** - moving patients promptly when they are ready to be discharged from hospital, not only frees hospital beds for people that need them, it also benefits the patient themselves as their health should improve further once they are back in their own place of residence.

4. **Community Promoting Independence** – provide a cost effective preventative intervention to people who by virtue of ill health or disability have lost skill in managing daily living activities, to enable them to regain the necessary ability and confidence and reduce their potential dependence upon long term care and support.

5. **Integrated Commissioning and Improved Programme Management** – improve the capacity and ability to deliver change towards 2019/20 through joint working across commissioning organisations within Coventry

6. **Protecting Social Care** - ensuring that the social care market is sustainable and that system capacity is not reduced or put at risk.

Each is based on a case for change and has its own objectives and deliverables that in turn will ensure the delivery of the plans for integration and change in our overall Better Care Plan and also importantly the wider Sustainability and Transformation Plan.

The six work streams are explored more in Table 6 below in terms of how each will deliver against the four national conditions, the three primary purposes of the new iBCF grant and how they link to the various delivery themes within the High Impact Change Model approach to reducing Delayed Transfers.

Table 6: BCF Coventry Programme Planned Workstreams

Coventry Better Care Fund - Provisional Planned Workstreams 2017-2020						
BCF Workstreams 2017-2020		National Conditions	Primary Purpose	Link to High Impact Change Model	Contribution to Metrics	Notes
1	Targeted Prevention	i, ii, iii	Reducing Pressure on NHS & Meeting Social Care Need	Enhancing Health in Care Homes	Non-elective admissions, Delayed Transfers	Including Public Health, Mental Health & Voluntary Sector initiatives
2	Improving Whole System Flow	i, ii, iii, iv	Reducing Pressure on NHS	Systems to monitor flow	Non-elective admissions, Delayed Transfers	CCG develop and lead a circa 18 month project.
3	Discharge Support	i, iii, iv	Supporting Discharge	MDT's, Early Discharge Planning, D2A, Trusted Assessors	Delayed Transfers, Effectiveness of Reablement, Admissions to Residential	Continuation of investment in D2A
4	Community Promoting Independence	i, ii, iii, iv	Meeting Social Care Needs	MDT's, Early Discharge Planning	Effectiveness of Reablement, Admission to Residential	To support people in their own homes by providing short term 'step up' support
5	Integrated Commissioning and Improving Programme Management	i, ii, iii, iv	Capacity to Deliver Workstreams	N/a	N/a but enabling of those above	Support BCF for programme and various joint commissioning projects underway
6	Protecting Social Care	i, ii, iii	Meeting Social Care Needs & Sustaining Provider Market	Discharge to Assess	Non-elective admissions, Delayed Transfers	Sustaining social care and meeting additional demand previously met through council reserves

National Conditions
i Jointly Agreed Plan
ii Social Care Maintenance
iii NHS commissioned 'Out of Hospital' services
iv Implementation of the High Impact Change Model for Managing Transfers of Care

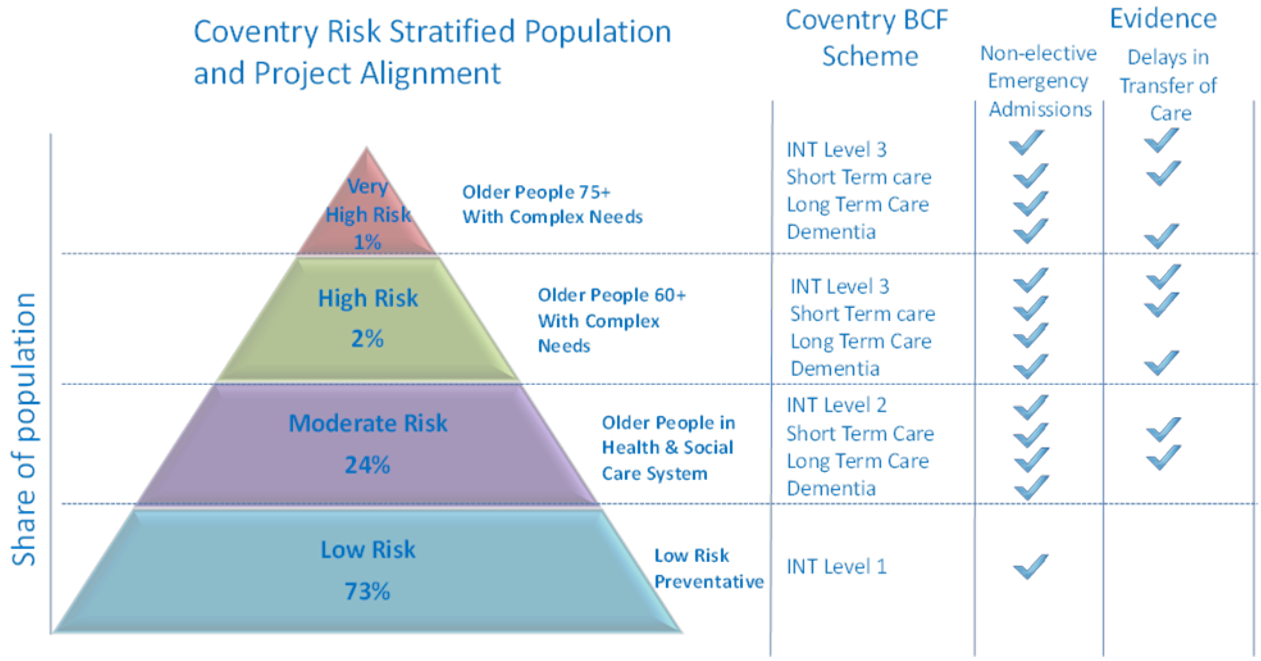
Population health risk and stratification

Identification and case management of patients with current long term conditions and at risk of developing or exacerbating a long term condition is key to delivering the key aims and objectives of our transformational plans, by providing appropriate care in appropriate settings and reducing the reliance on hospital services and ongoing social care support. These should, in turn, reduce A&E attendances, subsequent non elective admissions, reduce discharge delays (through enhanced supported discharge and appropriate reablement packages) and reduce the need for long term care and residential home admissions through better patient centred support and self- management of their conditions.

Patient experience of services should also improve due to better facilitation of their treatment, 'telling their story' only once due to integrated patient records, seamless joined up services between community, social and acute care and less time spent in hospital.

We have previously matched our on-going projects to these high risk cohorts as well as focusing effort on keeping lower risk people out of hospital:

Diagram 12: Risk Stratification Model in Coventry



Coventry has a total population of 345,400 (ONS, 2015) of which around 49,500 (14.3%) are aged over 65. The risk pyramid shows within this age group in Coventry, circa 500 are at very high risk of a non-elective (emergency) admission to hospital, 1000 are at high risk, and 12,000 present a moderate risk and the majority (36,000) a low risk.

The current INT service operating across Coventry focuses on patients identified in the top 3 levels of the pyramid through GP practice risk stratification tools, face to face patient assessments and referrals from hospital, community and social care discharge teams. The INT multi-disciplinary teams assess referrals and review patients to agree how best to manage their health and potential long term conditions to keep them in their own homes and

mitigate the need for hospitalisation. If case managed patients' conditions do exacerbate the patient is referred to out of hospital rapid response and 'step-up' services and only conveyed to hospital if absolutely necessary. Patients can then receive the treatment required in a more appropriate setting and return to their own home more quickly and safely.

Developing the Frailty and Musculoskeletal pathways are key work streams within the Coventry and Warwickshire STP and the progress to date made through existing Better Care projects have been aligned to the wider system footprint during the last year.

Further analysis of the flow of patients through the whole system is planned to fully understand where services can be improved, to deliver better patient outcomes, and the extent of financial efficiencies that can be made. Proposals are being developed and reviewed through the BCF and STP Programmes and iBCF resources have been targeted at this important piece of work however actions and timescales are yet to be confirmed.

National Conditions

National condition 1: jointly agreed plan

The local health and social care system benefits from good working relationships between the council and NHS partners with well established relationships at senior levels which are open and honest and work positively towards collective perspectives and joint approaches to local issues.

Since the implementation of the Better Care Fund (BCF) in 2015, the Council and CCG have a BCF plan facilitated by the Health and Wellbeing Board supported by a section 75 partnership agreement.

The current Coventry BCF plan has been jointly developed and agreed through the following committees with various drafts and summaries of the plan and the financial template shared for comment and amendment:

- Coventry & Rugby Clinical Commissioning Group Executive
- Coventry City Council Cabinet and Full Council
- Coventry Health and Wellbeing Board of which the member organisations are:
    - *Coventry and Rugby Clinical Commissioning Group*
    - *Coventry and Rugby GP Federation*
    - *Coventry and Warwickshire Partnership Trust*
    - *Coventry City Council*
    - *Coventry Healthwatch*
    - *Coventry Safeguarding Children's Board*
    - *Coventry University*
    - *NHS England*
    - *University Hospitals Coventry and Warwickshire*
    - *Voluntary Action Coventry*
    - *Warwick University*
    - *West Midlands Fire Service*
    - *West Midlands Police*

Additionally the plan has been communicated to and discussed with:

- Coventry Adults Joint Commissioning Board
- Coventry and Warwickshire Collaborative Commissioning Group
- Coventry Accident and Emergency (A&E) Delivery Group
- Coventry and Warwickshire A&E board
- Better Care, Better Health, Better Value (formerly STP) board

The plan is also aligned to, and overlaps considerably with the wider Coventry and Warwickshire STP.

National condition 2: social care maintenance

An important element of the wider BCF and the specific iBCF grant provision is to support the sustainability of social care provision. This reflects the recent ongoing pressures on Adult Social Care as a result of reductions in local government funding and the impact this has had on the wider city council resources.

It is also recognised that the City Council has put significant sums from its own reserves or savings delivered elsewhere across its operations into sustaining social care and delivering its statutory responsibilities. For 2015/16 and 2016/17 social care overspend by £5.2m and £3.4m respectively and has delivered savings of approximately £6m since 2015/16.

There are continuing significant market cost pressures associated with the national living wage and also as a result of recent HMRC guidance on sleep-ins.

In recognising these pressures on social care the CRCCG have transferred to the local authority the various sources of funding identified nationally to protect adult social care as outlined in the previous BCF guidance.

The proportionate spend of the BCF pooled budget against each of the local services and new initiatives has been a matter for local determination between Coventry City Council (CCC), and the Coventry and Rugby Clinical Commissioning Group (CRCCG) in consultation with other partners. As such the proposals put forward in the BCF plan represent a combination of additional capacity required to improve the effectiveness of health and social care, sustaining existing capacity and schemes that will further improve the system and contribute to longer term sustainability beyond the current two years for which the BCF Plan applies.

Both CCC and CRCCG are committed to a joint commissioning approach that develops and maintains a modern and responsive market providing care and support for people and their carers when and how they need it and is underpinned by a commitment to:

- Provide high-quality, affordable and personalised care and support
- Promote and improve wellbeing, independence and individual outcomes through person-centred care
- Empower individual decision-making, control and ownership over care and support needs and options
- Shape and enable range of sustainable and flexible care services for the future that provide real choice for the local population

For residential and nursing homes, commissioning work in underway jointly to deliver a more stable and joined up contractual basis for this important element of the market. Although the provider market has remained relatively stable with only one closure of a care home since 2015/16 the number of providers seeking additional resources has increased and is expected to rise further.

This process will continue but is expected to be put under increasing pressure as a result of market forces. The additional resources available through the iBCF will support the City Council in meeting these costs without further impacting on the need to use reserves to support social care as a result of incurring significant overspends

A failure to meet these growing cost pressures within the local market will potentially result in the social care provision becoming unsustainable, resulting in closures and having a direct impact on the capacity within the health and social economy. This in turn could result in more delayed transfers of care and possibly more admissions to hospital if providers were forced to withdraw services at short notice and where no alternatives sources of provision were readily available.

Activity is currently underway to review and update Coventry's Market Position Statement (MPS) within the next 12 months, for which the intention is to develop a combined health and social care picture of the local market. CCC and CRCCG commissioners have recently began working within integrated project teams across core areas of provision; care for older people, community and preventative care, learning disability and autism services, and support for people with mental-ill health. This will enable a growing focus on developing a common insight on demand, provision trends, capacity, market gaps and commissioning intentions that will inform a refreshed MPS.

National condition 3: NHS commissioned out-of-hospital services

A significant amount of 2017/19 BCF investment (**£35.6M or 40.3% in 2017-18**) is aimed at keeping people well and out of hospital.

Agreement of the areas and services to be developed out of hospital has been driven through robust patient data and trend analysis to understand how and why our population use our acute hospital services as opposed to other services available in the City and also through evaluation of the current out of hospital services we have in place. Identification of gaps in services have led to a prioritisation in investment in order to service our population in the most appropriate settings for our frail elderly, who have a significant number of support needs and put the most pressure on our health and social care services.

The BCF plan is committed to investing in out of hospital services to empower our population to not be reliant of health and social care and to seek alternatives to hospital through better awareness of alternatives. Where individuals have more complex needs, proactive case management will ensure a co-ordinated package of support to maximise well-being and avoid exacerbations and hence unnecessary hospital admissions.

A prime focus for 2017/19 will be the implementation of the recently agreed Coventry & Warwickshire clinical model for Out of Hospital Care. A single point of access will provide a single referral route into all adult community services, with signposting into the most appropriate service. Community staffing (health and social care) will be reconfigured around

clusters of GP practices covering a neighbourhood population of circa 30-50k. A single neighbourhood team approach will be encouraged, reducing hand offs between different professionals and enabling the workforce to be deployed more flexibly. The focus of the neighbourhood teams will be to encourage healthy lifestyles, facilitate self-care, promote the use of community assets and provide personalised care to those with more complex and long term needs.

We envisage that we will contract for Out of Hospital Care through a lead provider contract (subject to final Governing Body decision) with a percentage of payment linked initially to achievement of transformation milestones and ultimately to delivery to improved outcomes. There is an OOH commissioning Board in place along with an OOH design board to progress this work across the three Coventry and Warwickshire CCGs and the two local authorities (Coventry and Warwickshire).

During 2016/17, the BCF invested in a GP-led Frailty service to work within the local Acute hospital, case finding at the A&E front door, deflecting patients into alternative community pathways where possible, and working with wards to facilitate earlier discharge and providing proactive follow up to prevent readmissions. Over the next twelve months we will work closely with the GP team to ensure that the benefits of this substantial investment (£1.5m) is maximised.

We will also build on the work started in the winter of 2016 to improve discharge pathways, with health and social care colleagues working together to ensure individuals are assigned to the pathway that is most appropriate to their needs, whether this is early discharge home with a short term support package, intensive reablement to ensure independence is maximised or a short stay in a nursing home where long term care needs can be assessed.

We expect these work programmes in combination to support the achievement of:

- Reduced A&E attendances
- Reduction in Non-Elective admissions (NEAs)*
- Reduction in Readmissions within 30 days
- Reduced Delayed Transfers of Care (DToC)
- Reduced hospital length of stay
- Reduced permanent admissions to residential care

*Our Out of Hospital work programmes are intended to deliver the reduction in NEAs as planned within Coventry and Rugby CCGs 2017/18-18/19 Operational plan (recalibrated). These plans are seen as challenging enough to deliver so no further reductions are being planned specifically for BCF, and no additional financial contingency for non-achievement of this is therefore required.

National Condition 4: Managing Transfers of Care

The health and social care system in Coventry has adopted the 'High Impact Change Model' which identifies eight areas of change that can help local systems to ensure people do not stay in hospital for longer than they need to. There has also been significant work with ECIP (Emergency Care Improvement Partnership) to deliver improvement in this area.

Significant progress has been made in implementing the high impact change model in Coventry and this is overseen by the Coventry and Warwickshire A&E Delivery Board. The iBCF funding is intended to support acceleration in the delivery of the 'High Impact Change Model' across the wider health economy where this is likely to result in benefits for both health and social care and within the Coventry plan there is resource specifically identified to invest in work to improve flow. While also focusing on the achievement of the NHS target that delayed transfers must make up no more than 3.5% of occupied bed days by September 2017.

The current Coventry position in respect of each area of the model is as follows:

- **Early discharge planning**: Preoperative assessments are now in place and social care are notified via a joint assessment form.
- **Systems to monitor patient flow**: Revised discharge pathways are now established that enables patients to be tracked. Additionally a 'red to green' initiative is being implemented to embed a 'no lost days' culture.
- **Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector**: Multi-disciplinary teams are established for people who have been discharged into short-term services which have third sector representation e.g. Heart of England Carers Trust.
- **Home first/discharge to assess**: A focus on returning people 'home first' is in place alongside a range of other provision to be used based on people's needs.
- **Seven-day service**: The hospital social work team is present in UHCW on Saturdays and bank holidays. Other constituent parts of the system are now being put in place to facilitate discharges over the whole weekend.
- **Trusted Assessors**: Trusted assessor arrangements are in place for home support providers and residential homes providing discharge to assess resources.
- **Focus on choice**: The consideration of long term options for individuals are being made outside the hospital setting where people are more aware of the available options and their likely ongoing needs.
- **Enhancing health in care homes**: The CRCCG have employed a care homes nurse to support local residential homes and initiatives such as 'React to Red' are showing benefits through reduced pressure ulcers.

Some of the proposals described above will further the delivery of the model by increasing the 'Discharge to Assess' capacity which is often a barrier to effective discharge. As implementation of the model progresses locally additional iBCF resources will be utilised where appropriate to ensure the model continues to be delivered and that patient/service user benefits are realised.

Discharge to Assess

There has recently been considerable focus by partner organisations within Coventry on improving the process and approach to hospital discharges. This is in the light of the rising level of delayed transfers of care and the variety of discharge pathways that previously existed across the health and care system, as shown in Table 7 below.

Table 7: Previous Coventry Discharge pathways

Pathway A	Pathway B	Pathway C	Pathway D	Pathway E	Pathway F
Voluntary Sector Support at Home	Home with Short Term Package of Care : With or without Therapy	Bedded Unit with Therapy with the aim to return home.	Social Care increase in existing Services	Period of Assessment	Fast Track : less than 8 weeks of life
Support to ensure patient safe and well. No personal care involved. Support may include; shopping, transport home, safe and well-being check. Options are; • 4hrs post discharge. • 7 & 30 days *Provider gate keep access to provision*	Home based support for up to 6 weeks to regain independence which includes goal based enablement: washing, dressing, meal preparation. In addition therapy based support to improve mobility and transfers to regain independence. Telecare: Std packages *Social Care gate keep access to provision*	Bed based support for up to 6 weeks to regain independence which includes goal based enablement: washing, dressing, meal preparation. This pathway is also for patients where safety between calls and overnight needs to be considered. In addition therapy based support to improve mobility and transfers to regain independence. *Social Care gate keep access to provision*	Existing Social Care service users that may need an increase to their existing package or placement to return home *Provider management by Social Care*	Patients that require a period of assessment outside of an acute setting to determine their long term care and support needs. Options are; • Home (POC) • Residential Home (Recovery & Recuperation) • Nursing home • Unstable Fractures • Non Weight Bearing (NOF) • CNRT *Provider management by CCG*	Patients who are in the last 8 weeks of life Options are; • Home (POC) • Residential Home • Nursing Home • Housing with Care *Provider management by CCG*
Case Manager: Ward	**Case Manager**: IDT / React / Social Care	**Case Manager:** IDT / React / Social Care	**Case Manager**: Social Care	**Case Manager:** IDT / Social Care with CCG	**Case Manager:** IDT / Social Care with CCG

The process that was in place was creating a range of issues all of which impacted on the ability to control delayed discharges.

- Duplication of assessment
- Inconsistency
- Communication
- Family expectation
- Culture
- Technology

It has become apparent from the experiences and results provided by early adopters that establishing a 'Discharge to Assess' process improves patient flow through the system, brings a number of benefits for the patient and the family, and removes many barriers that have delayed discharge in the past. Moreover it has allowed the establishment of closer links with community colleagues, and facilitates a timely and safe transfer of care between hospital and home as soon as patients no longer require acute hospital care.

Therefore a redesign and streamlining project has recently been completed that has involved participation, experience and expertise from all the partner organisations within the existing process. This is delivering a number of significant benefits:

- Established robust working relationships across Health & Social Care economy
- Redefined and clarified access criteria for each pathway
- Trialling various documentation
- Robust checks & balances across each organisation
- Opened access routes to all pathways for all organisations
- Working towards trusted assessment
- Working towards reducing referral to discharge time

This means patients no longer have to wait in hospital for assessments, and are impacting on levels of delays by removing steps, handovers and activities within the discharge process which consume valuable resources and do not add value for the patient.

Table 8: Coventry & Rugby Discharge to Assess Model

Pathway 1	Pathway 2	Pathway 3
Home with short term package of Care: With or without Therapy	**Therapy based bedded units** in care homes and HWC with the aim to return home.	**Period of Assessment** to determine long term needs
Home based support for up to 6 weeks to regain independence which includes goal based enablement: washing, dressing, meal preparation. In addition, therapy based support to improve mobility and transfers to regain independence. Telecare: Std packages *Social Care gate keep access to provision*	Bed based support for up to 6 weeks to regain independence which includes goal based enablement: washing, dressing, meal preparation. This pathway is also for patients where safety between calls and overnight needs to be considered. In addition, therapy based support to improve mobility and transfers to regain independence. *Social Care gate keep access to provision*	Patients that require a period of assessment outside of an acute setting to determine their long term care and support needs. Options are; • Home (POC) • Residential Home (Recovery & Recuperation) • Nursing home • Unstable Fractures • Non Weight Bearing (NOF) • CNRT *Provider access and management by CCG*
Case Manager: IDT / React / Social Care	**Case Manager**: IDT/REACT/ Social Care	**Case Manager:** IDT / Social Care with CCG

The implementation of the new process shown in Table 8 above has enabled existing teams to establish clear roles and responsibilities by working more closely to provide an accurate and precise assessment of the person's needs, the recommendation of a discharge pathway and to collate any specialist reports and treatment plans including Therapy.

Once the pathway is confirmed a Case Manager is required to liaise with patient and family/advocate to manage expectations and to update all parties on progress/issues.

Additionally the team is able to receive or carry out a review of the patient on a daily basis and update colleagues if the patient has improved as the pathway may need to change. Finally this provides the appropriate integrated process to ensure that equipment, prescriptions and transport are all ordered and in place to meet the agreed discharge date.

Weekly data is now provided to the Coventry A&E delivery group to demonstrate the utilisation of capacity across the D2A pathway and the numbers of people delayed waiting for pathway capacity.

Delayed transfers of care (DTOC) plan (High Impact Change Model)

Impact Change	Where are we?	What we intend to do next?	When by?	How we will measure success?
Early Discharge Planning	Established - discharge dates within 48 hours of admission, Nugensis system to monitor dates and assist with Red to Green Safer approach across the Trust. Trust wide view on patient status available to Managers to oversee issues by department.	Extend the work of early discharge planning into the community for onward flow through community, LA, Residential Home, and Nursing Homes - facilitated by community Red to Green initiative. Workshops already held.	Sep-17	Reductions in volume of patients identified as MFFD, and reduced DTOC level, reduced patients in hospital over 7 days, and reduced Excess Bed Days resulting from DTOCs. Fewer issues in relation to onward flow from hospital as capacity availability becomes predictable.
Systems to monitor patient flows	Established - Pathways agreed, regular point prevalence surveys to compare demand against capacity, daily report on referrals and discharges across teams and organisations, revised pathway protocols developed via joint workshops across agencies IDT, CCG, CHC, LAs, GPs.	Dashboard to be in use operationally, and monthly reports up to and through local A&E delivery Board to review constraints in the system, for action.	Jul-17	No CHC assessments taking place within the acute hospital (other than fastrack). No patients identified without a management plan in place and agreed within 24 hours of referral to discharge pathway.
Multidisciplinary Discharge Teams	Mature - in place, trusted assessors within the local organisations and between teams, larger RH / NHs accepting trusted assessments outside hospital.	Continue to develop trusted assessor model to cover majority of RH/NHs, work with other areas on cross boundary flow to ensure trusted model can be adopted as widely as possible.	Sep-17	No duplicate assessments taking place. Reduced need for escalation across organisations operationally.
Home First / Discharge to Assess	Mature - People return home with reablement support from integrated team, most people return home or go to supported care in RH/NH before assessment of future care needs. No CHC assessments inside hospital, clear pathways for Discharge to Assess with dedicated capacity, based around demand from point prevalence surveys, and daily weekly monitoring.	Work to embed CHC work being taken back from CSU within the CCG, to ensure onward case management of patients in D2A capacity, and early onward movement.	Aug-17	No CHC assessments taking place within the acute hospital (other than fastrack). No patients in D2A pathways having final option assessment outside timescales set for pathway - i.e. no one in D2A capacity beyond 6 weeks of initial placement. Reductions in average length of stay especially in pathway 2 placements.
Seven Day Services	In place - Health and social care working to 7 day pattern, plans in place to get assessment in hospital from RH/NHs some do this already (larger ones), part of revised contract specification for 2017/18 with homes.	Seamless provision of care regardless of time of day or week - working with all organisations to have common SOPs that are in place 7/7.	Mar-18	Discharges at weekends at least 60% of normal weekday discharges, admissions from RH/NH equalised across the week, matched with discharge back on day identified in EDD.
Trusted Assessors	Established - assessments some by different organisations and resources committed, development of care prescription in liaison with homes, so that payment based on patients needs rather than type of home, reduces time to assess and the needs for separate assessment and negotiation on prices.	Continue to develop trusted assessor model to cover majority of RH/NHs, work with other areas on cross boundary flow to ensure trusted model can be adopted as widely as possible.	Sep-17	No duplicate assessments taking place. Reduced need for escalation across organisations operationally.
Focus on Choice	In place - admissions advice and leaflets in place, choice protocol developed by the Trust, choice occurs outside hospital in the main especially on pathways 2 and 3, rehabilitation support, and potential ongoing care needs.	All patients aware of choice directive and that they do not have the right to remain in an acute setting longer than they need to for clinical reasons, and that onward placement prior to final choice decision is recognised by patients and their families.	Sep-17	Fewer DTOCs related to patients choice issues.
Enhancing Health in Care Homes	Established - new care prescription as part of new contracts with RH/NHs, with clear timescales for responding and reducing the need for separate assessment, dedicated support to residential and nursing homes especially linked to pathways 2 and 3.	Working to ensure that all new contracts for placement and assessment are under the new contract specification. Clinical support to NHs consistent with clear expectations of what this support means in practice, simplifying how primary and community providers interact with RH/NHs.	Aug-17	Less short time admissions from RH/NHs as they feel supported to maintain that patients in the home.

How the previous National Conditions will be maintained.

Previous National Conditions from Better Care Fund 2016-17	Continuing plans to meet condition?	Actions that are being taken to meet the condition, or any other relevant information.
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes	Urgent Care Primary Assessments - These allow for the safe treatment of patients either in their own home, or to be treated and discharged by A&E where the patient might otherwise have required a hospital admission. Some services now actively support the facilitation of weekend discharges. Expanding 7 day working across the system is integral to the Coventry and Warwickshire STP and will be further developed through this programme.
ii) Better data sharing between health and social care, based on the NHS number	Yes	The 'Digital Coventry' Programme is well underway which includes a number of Inter-operability solutions between partner organisations across the city. The Black Pear system to share key patient data, is to be launched in 2017/18 to support INT, frailty and End of Life patient care.
iii) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes	Full coverage of INT in place across Coventry to support complex patients with multi-disciplinary primary care and community teams working together across health and social care. Three discharge to assess pathways have been agreed and implemented which are supported by a multidisciplinary team based at UHCW.
iv) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes	This plan has been shared with, commented on, updated and agreed by providers represented at the A&E Deliver Board and Health and Wellbeing Board as part of the governance and approval process, also feeds into the Sustainability and Transformation Plan. Healthcare provision contracts have been jointly agreed between commissioner and providers for 2017/19, with implications for providers acknowledged. Engagement and buy-in of both commissioners and providers is now embedded across the local economy through the forums already described in this document – Health and Wellbeing Board, A&E Delivery Board, Joint Commissioning Boards.

Overview of funding contributions

Additional funding priorities

All the specific funding allocations as requiring by the planning guidance have been incorporated in the completed Financial Planning template. However the Care Act 2014 introduced significant changes to Social Care legislation in April 2015 including the introduction of a national eligibility threshold; a new duty to carry out assessments for all carers regardless of the level of care provided, and an expanded role in market shaping.

Enhancing the way we work with customers and carers has been at the heart of our response to the Care Act 2014. Work has progressed on reducing waiting lists and completion times for assessments, and there has been a marked improvement in both the number of people waiting and timescales. This has focused on social worker and team leader performance and through-put including setting out clear expectations, in terms of both professional practice and the contacts they have with the people they are working with.

Some services that were previously considered carer support (short breaks and respite) are now being classed as support for the cared for person, as receiver of the service.

Coventry has developed a Multi-Agency Carers Strategy with partner organisations which covers the period 2016-19 and relates to carers of all ages. The Strategy is accompanied by a comprehensive implementation plan which is overseen by the multi-agency Carers Strategy Steering Group. Key improvement priorities within the plan fall under four areas:

- Identification and Recognition
- Realising and Releasing Potential
- A Life alongside Caring
- Supporting Carers to Stay Healthy

We will also be building on and complementing the short term services which enable people to be discharged from hospital, we have developed plans to enhance our service which helps people living in the community who have lost the capacity to carry out tasks of daily living. This focuses on helping people to regain skills and confidence in living independently and reduces their reliance on long term support services and the risk of being admitted to hospital or other care setting. The service will operate using dedicated occupational therapy and social work staff who will support people through the service.

Our approach to the targeting of the increased Disabled Facilities Grant is to focus on improving the environment for people living with dementia following research by the University of Stirling which shows that using effective dementia-friendly design can result in reduced instances of violence and aggression, reduced falls, reduced staff sickness within the care environment, and improved way-finding for people with dementia. The DFG will also be used to support the shared aims of increasing independence within the community and the reduction of hospital admissions.

The spend at Scheme Level is shown in Table 9 below and further break down of this is available in the financial planning template:

Table 9: BCF Scheme Expenditure 2017-19

BCF Coventry Programme Scheme Name	2017/18 £m	2018/19 £m	Total Plan £m
Whole Population Prevention	0.300	0.500	0.800
Improving System Flow	0.200	0.300	0.500
Discharge to Assess Support	1.300	1.300	2.600
Community Promoting Independence	0.300	0.600	0.900
Integrating Commissioning – improving Capacity	0.200	0.200	0.400
Protecting Social Care	13.253	15.761	29.014
Care Act Implementation	0.883	0.900	1.783
Dementia	11.075	11.281	22.356
Disabled Facility Grants	3.901	3.416	7.317
Out of Hospital & Nursing Care	35.636	36.347	71.983
Short Term Care	9.853	9.604	19.457
Acceleration Fund	2.093	2.133	4.226
Urgent Care	6.587	6.712	13.299
Voluntary Sector Review	2.597	2.270	4.867
Total Schemes	88.178	91.324	179.502

Pooled Budget

The grant determination associated with the iBCF requires that the BCF is transferred into one or more pooled funds established under section 75 of the NHS Act 2006. In Coventry previous Section 75 partnership agreements were established to oversee the Better Care Funds expenditure in 2015-16 and 2016-17.

The purpose of these Partnership Agreements was to support the delivery of the Better Care Fund by setting out the governance and practical management arrangements specifically associated with the Better Care Fund pooled budget.

In extending the use of the existing pooled budget, which is created from allocations from Coventry and Rugby Clinical Commissioning Group and the Council, all statutory responsibilities are retained by both partner organisations. Progress on expenditure and budget positions will be reported through each organisation's existing financial reporting arrangements.

The regulations require that one of the partners is nominated as the host of the pooled budget and this body is then responsible for the budget's overall accounts and audit. In Coventry, it is agreed that the Council continues to be host for the Better Care Fund pooled budget.

The Partnership Agreement includes scheme specifications which will provide the detail for each work-stream including aims and outcomes, level of the pooled budget, the specific management arrangements and risk sharing.

Programme Governance

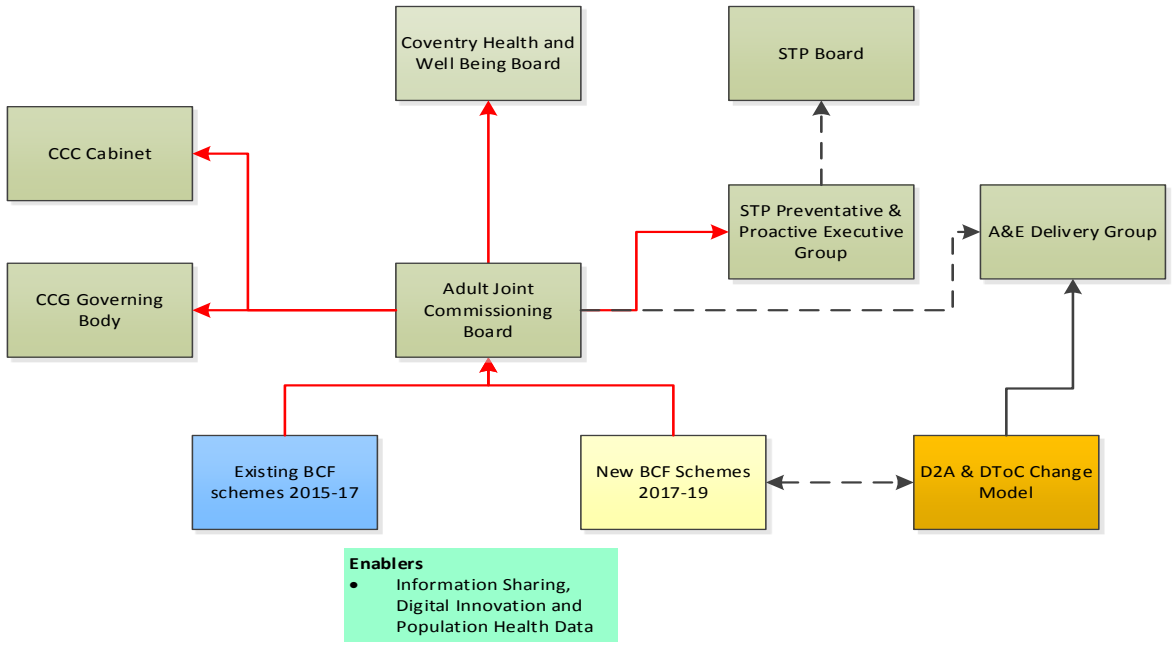
Since the implementation of the Better Care Fund (BCF) in 2015, the BCF plans have been approved through the Health and Wellbeing Board supported by section 75 partnership agreements with Coventry and Rugby Clinical Commissioning Group (CRCCG).

The Adults Joint Commissioning Board (AJCB), held every month, will take prime responsibility for the discussion of the progress on the BCF programme including benefits realisation and metrics plus the approval of specific business cases and new developments. The AJCB will be the operational delivery and decision making body for the BCF programme. Additionally AJCB will have a link to the A&E Delivery Board to ensure alignment with broader objectives and plans.

As the new improved grant and the associated projects and priorities are to align with the Proactive and Preventative workstream of the STP it is proposed that the existing STP P&P Executive Group is used as a regular oversight body rather than establish a separate BCF Board. However both the final BCF Narrative Plan and Financial Template will be ratified at the Coventry Health and Well-Being Board (HWBB) to ensure ultimate local system oversight. Additionally regular briefings will also be made as required to the HWBB as the various aspects of the current BCF plan are finalised, developed and implemented.

The relevant BCF funding decisions are approved by the Council's Cabinet and full Council plus the CCG's Governing Body.

Diagram 13: Coventry BCF Governance Hierarchy (red lines represent formal oversight links, dotted lines show operational alignments)



The governance arrangements put in place are to ensure that there is clear ownership of and system wide understanding of the process for reporting progress and performance on individual projects and the programme as a whole. The frequent cross communication between the BCF and STP programmes and also the activity and developments associated

with the High Impact Change model are essential to ensure an integrated approach to the transformation of the local health and care system.

Further interim arrangements for the quarterly reporting from local authorities to the Department for Communities and Local Government (DCLG) in relation National Condition 4 (Managing Transfers of Care) were issued on May 26th with the Quarter 1 return having subsequently been completed and submitted. The Quarterly reporting to the Secretary of State is also a requirement of iBCF providing central government oversight of the programme at a national level.

A key element of all governance arrangements will be performance against the National Performance Metrics associated with the iBCF. These are the following four indicators:

- Delayed Transfers of Care
- Non-elective admissions (General and Acute)
- Admissions to residential and care homes (ASCOF 2a Part 2); and
- Effectiveness of reablement - (ASCOF 2b Part 1)

We also plan to retain and monitor the local indicator reported in previous years.

- Sequel to Short Term Service (ASCOF 2d)

Performance as a system against each of these are shown in the previous BCF Performance 16/17 section on Pages 20 to 24 and the BCF Dashboard for the last financial year on Page 45.

Assessment of Risk and Risk Management

Governance and Risk log

Our Programme Plan and Programme Risk Register are being refreshed for 2017-19, with both of these being reviewed operationally and strategically at regular intervals as part of the routine work of the Adults Joint Commissioning Board and by the assigned Operational leads for each scheme. Additionally the individual schemes are also subject to delivery plans and risk mitigation and issue resolution. Major issues that impact significantly on the BCF programme as a whole or any aligned transformational programme activity will be escalated through the appropriate governance channels.

The main risks identified which may affect delivery of the BCF programme during 2017-19 are shown on the end of this section on Page 44.

Risk Sharing

The Better Care Fund was launched in 2013 as part of a government drive to integrate health and care. The resources covered by the BCF required the development of a Section 75 agreement which is a partnership agreement whereby NHS organisations and local authorities contribute an agreed level of resource into a single pot (the pooled budget) that is then used to drive the integration and improvement of existing services. In Coventry a total of £52m for 2015/16 and £56m for 2016/17 was pooled between the City Council and

Coventry and Rugby Clinical Commissioning Group (CRCCG) across a series of project areas.

The City Council is currently the host of the section 75 Partnership Agreement and it is agreed that this arrangement continues once the new BCF plan is completed and approved, the timescale for which is currently October 2017. It has been agreed by all partners there will be **no financial risk share agreement in place for 2017/19** within the Better Care Fund. While no specific risk share is in place the partner organisations will work closely together to mitigate against any financial impacts across the health and social care economy.

The risks of failing to reduce emergency admissions and delays to discharge are recognised and understood by all stakeholders. This is especially in the light of the potential review in November of the 2018-19 allocations for social care funding provided in the Spring Budget for areas that are poorly performing in terms of reducing delayed transfers.

However the overall assumed risk is similar to that considered in the two previous BCF plans where no risk share was put in place. As in previous years both the BCF metric and project performance will be regularly monitored and any appropriate resulting financial implications will then be managed as necessary.

These arrangements will be refreshed as part of the Section 75 Pooled Budget Agreement.

Non-financial risk

The impact on patient journeys and experience as a result of pressures on the front door and back door at the University Hospital can impact on the wider health and care system. There are also significant risks other than those directly related to the provision of acute services. For example, a failure to appropriately support carers will result in more people in long term support services. Similarly the failure to support people in the community in a way that enables them to maximise their independence risks the take up of on-going care and support and the potential for much greater lifetime system costs.

Delays to discharges affect patient flow through the hospital, reduce mobility and increase frailty or ill health, which can lead to readmissions and also have a negative impact on A&E waiting times and available bed capacity for patients requiring admission.

The use of long term care reduces capacity for new patients entering social care, and has a knock on effect on future discharges and care planning.

Acknowledged risks exist in trying to treat our population in ‘out of hospital’ locations because bed capacity in hospital may still be filled by other patients potentially requiring admission, at an additional cost to commissioners. As such we will continue to evaluate the impact of out of hospital investment on acute demand to mitigate this and to understand if our service redesign has been successful. As no financial risk contingency is currently in place we will need to address any issues when and if they occur as swiftly as possible.

Risk Log

A BCF Programme Risk Log has been developed to monitor and report progress against each identified risk as shown below in Table 10: Coventry BCF Programme Risk Log

Better Care Fund Programme 2017-19 - Risk Log

At: 04/09/2017

Ref	Name	Risk Description	Programme/Scheme	Category	Open/ Closed	Impact	Likely	Score	Mitigating actions	Mitigated Score
Programme-level Risks										
1	System Capacity	Not enough capacity in the system to deliver change. This may impact on timescales and delivery.	Better Care Programme	Capacity	Open	4	2	8	Identifying necessary resources to meet and deliver the change. System wide view of transformation to be taken. Funding of additional commissioning capacity through iBCF. (See other programmes).	3
2	Reduction in DToC	Failure to achieve reduction in DToC trajectory.	Better Care Programme	Metrics	Open	5	3	15	Implementation of High Impact Model and recovery plan in progress. Amended DToC trajectories agreed at A&E Delivery Board and submitted.	12
3	Reduction in Emergency Admissions	Failure to achieve reduction in non elective admissions.	Better Care Programme	Metrics	Open	5	4	20	Further analysis of reasons for admissions to focus resources on front door. New activity with link to Proactive & Preventative Workstream of STP.	12
4	BCF Budget	BCF Pooled Budget is significantly overspent.	Better Care Programme	Budget	Open	5	1	5	Joint monitoring of expenditure by quarter, potential for contingency allocation in pooled budget yet to be agreed.	4
5	Financial Pressures outside BCF	Financial pressure in the local system outside the BCF diverts resources away from programme.	Better Care Programme	Delivery	Open	3	2	6	Sufficient regular representation from all partners on the programme Board and individual project meetings. Governance and escalation processes in place.	3
6	Lack of commitment to the Plan	Not all Partner organisations accept the funding and work stream arrangements set out within the BCF plans.	Better Care Programme	Stakeholders	Open	3	1	3	A commitment and understanding from all partners to the agreed BCF plan and how this will fit into other system improvement programmes.	2
7	Agreement on Strategy	No agreement across local system on plan priorities or expenditure across system partners.	Better Care Programme	Stakeholders	Open	3	2	6	All Partner organisations contribute to a citywide vision and develop shared plans that will clearly set out how they will improve patient and service user outcomes in the short and medium term.	3
8	National Conditions	The 4 National Conditions are not met in full.	Better Care Programme	National Conditions	Open	2	2	4	Plans for how each will be met are detailed in the BCF Plan and will be monitored on a quarterly basis.	3
9	Provider Failure	Failure of local providers destabalise the market.	Better Care Programme	Provider Failure	Open	4	3	12	Market management and analysis to ensure potential local provider issues are understood and mitigated.	8
10	Strategic differences between health and social care	Funding and strategy differences materialise between health and social care organisations.	Better Care Programme	Stakeholders	Open	3	2	6	(Link to 7) All Partner organisations contribute to a citywide vision and develop shared plans. Extended footprint organisations are signed up to wider STP.	3
11	Section 75	Section 75 not completed/agreed on time.	Better Care Programme	Section 75	Open	5	2	10	Due to the nature of central government planning arrangements the Section 75 cannot be in place in time for the commencement of the pooled budget. Management & mitigation through agreed Governance arrangements	5
12	Changes in regulation or policy	A change in national regulation, policy or direction undermines the BCF/iBCF.	Better Care Programme	Central Government	Open	3	2	6	Lack of certainty following recent election outcome. Management & mitigation through agreed Governance arrangements	6
13	Benefits Realisation	Failure to deliver expected benefits of schemes/programme.	Better Care Programme	Delivery	Open	4	3	12	Recovery Plans being developed. Metrics being developed top track progress and take corrective action.	9
14	Plan fails audit assurance	Failure in programme governance or financial assurance.	Better Care Programme	Audit	Open	2	1	2	Management & mitigation through agreed Governance arrangements	1

National Metrics

A BCF dashboard report has been developed and is used to report progress against plan each month as shown below:

Better Care Coventry

Better Care Coventry Programme Dashboard

Prepared by: Mike Holden
Reporting Month: May 2017

Metrics for Coventry		BCF 14/15 Plan					BCF 15/16 Plan					BCF 16/17 Plan					Performance - Year End 16/17				
		Q1 2014/15 Plan	Q2 2014/15 Plan	Q3 2014/15 Plan	Q4 2014/15 Plan	Total 2014/15 Plan	Q1 2015/16 Plan	Q2 2015/16 Plan	Q3 2015/16 Plan	Q4 2015/16 Plan	Total 2015/16 Plan	Q1 2016/17 Plan	Q2 2016/17 Plan	Q3 2016/17 Plan	Q4 2016/17 Plan	Total 2016/17 Plan	Latest MAT, Month or Actual	% +/- 2015/16 Actual	Against Last Year	% +/- 2016/17 Plan	Against Plan
1. Non-Elective Admissions (General & Acute) All age per 100,000 population	Metric	10221	10333	10333	9845	10082	10039	9277	9677	8686	9324	9753	10050	9873	9699	9786	10598	4.2%	▼	8.3%	▼
	Numerator	8496	8589	8589	8292	33966	8455	7813	8150	7413	31831	8324	8577	8525	8375	33801	36179	4.2%		7.0%	
	Denominator	332492	332492	332492	336894	336894	336894	336894	336894	341389	341389	341389	341389	345400	345400	345400	341389	0.0%		-1.2%	
	Actual	*8480*	*7837*	*8175*	*7399*	*31891*	*7567*	*8862*	*9279*	*8998*	*34706*	*8983*	*9156*	*9182*	*8858*	*36179*					
2. Permanent Admissions of Older People per 100,000 population (ASCOF 2a)	Metric					700.8					586.1	646.8	646.8	639.5	639.5	639.5	608.4	-15.2%	▲	-4.9%	▲
	Numerator					342					290	80	80	80	80	320	301	-15.2%		-5.9%	
	Denominator					48803					49476	49476	49476	50043	50043	50043	49476	0.0%		-1.1%	
	Actual	*86*	*84*	*94*	*80*	*344*	*92*	*109*	*78*	*76*	*355*	*85*	*70*	*86*	*60*	*301*					
3. Older People discharged at home 91 days later per 100,000 population (ASCOF 2b)	Metric					83.5					86.5					80.0	85.2	6.4%	▲	6.4%	▲
	Numerator					284					294					272	109	N/a		N/a	
	Denominator					340					340					340	128	N/a		N/a	
	Actual					*75.0*					*80.0*					*85.2*					
4. Delayed Transfers of All Adults 18+ per 100,000 population (Linked to ASCOF 2c)	Metric	7028	7180	6684	6387	6753	6184	6060	5909	5662	5899	7232	6705	6177	5589	6372	8665	9.1%	▼	36.0%	▼
	Numerator	4550	4648	4327	4188	17713	4055	3974	3875	3758	15662	4800	4450	4100	3750	17100	1917	9.1%		34.5%	
	Denominator	258949	258949	258949	262301	262301	262301	262301	262301	265481	265481	265481	265481	265481	268369	268369	265481	0.0%		-1.1%	
	Actual	*4550*	*5805*	*6435*	*6317*	*23107*	*6705*	*4148*	*4561*	*5677*	*21091*	*5047*	*6205*	*5859*	*5889*	*23000*					
5. Patient/Service User experience (% extremely satisfied)	Metric										80.0					80.0	84.6	4.6%	▲	5.8%	▲
	Numerator										N/a					N/a	33	N/a		N/a	
	Denominator										N/a					N/a	39	N/a		N/a	
	Actual					*N/a*					*80.9*	*80.0*	*87.5*	*90.0*	*85.7*	*84.6*					
6. Local Metric - Sequel to short term service (ASCOF 2d)	Metric					70.0					65					70.0	66.9	2.9%	▼	-4.5%	▼
	Numerator					1016					N/a					N/a	836	N/a		N/a	
	Denominator					1451					N/a					N/a	1250	N/a		N/a	
	Actual		*59.3*			*70.0*		*58.2*	*68.1*	*66.2*	*67.2*	*60.3*	*68.2*	*70.2*	*66.9*	*66.9*					

▲ Above Plan/ LY ▶ Close to Plan/LY ▼ Below Plan/LY

On-going performance, delivery and the tracking of benefits and outcomes and issues is being reported through the production of timely and appropriate programme information and project briefings as part of the regular monthly progress updates to the Adults Joint Commissioning Board as part of the agreed governance arrangements as detailed in Diagram 13. The BCF Dashboard above is also used to monitor and escalate under performance to the A&E Board, which maintains ownership of the DToC and A&E Delivery plans, in order to enable actions as necessary in relation to local activity and process on Non-Elective Admissions and Delayed Transfers of Care.

The rationale for setting trajectories for the national metrics is detailed below:

National Metrics	**Rationale**
1. Non-Elective Admissions (General & Acute) All age per 100,000 population	Our Out of Hospital work programmes are intended to deliver the reduction in NEAs as planned within Coventry and Rugby CCGs 2017/18-18/19 Operational plan (recalibrated). These plans are seen as challenging enough to deliver so no further reductions are being planned specifically for BCF, and no additional financial contingency for non-achievement of this is therefore required.
2. Permanent Admissions of Older People per 100,000 population (ASCOF 2a)	Recent analysis for the West Midlands has shown that permanent admissions in Coventry are made at an older age and for a shorter period than regional comparators. Additionally the Service approval panel was reintroduced in 2015-16 to restore oversight of packages in conjunction with a cultural change which will shift emphasis towards alternatives to residential care. This recent trend in reducing permanent placements in care homes in favour of community based support wherever possible is therefore planned to continue.
3. Older People discharged at home 91 days later per 100,000 population (ASCOF 2b)	This has always been a problematic indicator to complete due to the Information Governance issues that prevent the sharing by UHCW of personal information on patients discharged to enable matching against social care records. This has necessitated the measure to be calculated using the data collated for the national SALT Return. However the underlying local system aim still remains to increase the percentage of service users' still at home 91 days after discharge.
4. Delayed Transfers of All Adults 18+ per 100,000 population (Linked to ASCOF 2c)	The target for the coming year will reflect the programmes of work to improve performance in this key area in conjunction with the DTOC trajectories that have been agreed through the Coventry and Warwickshire A&E Delivery Board comprising health and social care BCF stakeholders. See section on 'National Condition 4: Managing Transfers of Care (Page 29). The aim is therefore to reduce the rate of delayed bed days per 100,000 population in line with final NHSE expectations.

Targets have been agreed by Coventry and Rugby CCG for Non-Elective admissions and DTOC % of beds with Provider Organisations, with the latter converted to represent days of delay (see note below). The planned year end results for the other national and local indicators have been agreed with Coventry City Council.

The following table shows the currently agreed target figures for each national metric.

Table 11: National BCF/iBCF Metric Targets 2017-19

NATIONAL INDICATORS	Planned Activity 2017-18					Planned Activity 2018-19				
	Q1	Q2	Q3	Q4	Total/Target	Q1	Q2	Q3	Q4	Total/Target
Non Elective Admissions	9330	9426	9426	9220	37402	9188	9286	9286	9084	36844
Delayed Transfers of Care - Days Delayed	5857	4788	3684	3433	17762	3470	3508	3508	3432	13918
Admissions to Residential/Nursing (ASCOF 2a)	78	82	75	75	310	75	80	73	72	300
65+ Discharged still at home after 91 days (ASCOF 2b)	N/a	N/a	N/a	N/a	83%	N/a	N/a	N/a	N/a	83%

LOCAL INDICATORS	Planned Activity 2017-18					Planned Activity 2018-19				
	Q1	Q2	Q3	Q4	Total/Target	Q1	Q2	Q3	Q4	Total/Target
% Sequel to Short Term Service (ASCOF 2d)	N/a	N/a	N/a	N/a	73%	N/a	N/a	N/a	N/a	73%

- The Q1 2017-18 DToC activity figure is actual performance as per instruction from the BCF Support Team
- The NEA targets above are not the same as are pre-populated in the Financial Template as all CCGs have had to amend their 17/18 and 18/19 activity plans

Current DToC trajectories

The DToC targets by quarter detailed in Table 11 above reflect the recently revised NHS England DToC trajectories and the current overall recovery target will require a significant improvement in performance.

By planning to reduce the levels of delays attributable to the NHS plus maintaining the average levels of delay for both Joint and Social Care over the 12 months, the total rate of delays per 100,000 18+ population for Coventry will be below the expectation originally set by NHSE.

Table 12: Delayed Transfers of Care Trajectories (revised 19th September 2017)

Coventry	NHS Expected Rate per 100,000 based on Local Area Dashboard (July 4th)	Actual Average Rate per 100,000 18+ over last 12 months (June 16 to May 17)	NHS Expected % Reduction on Average over 12 months	Latest Proposed Rate per 100,000 for Trajectories	Proposed % Reduction on Average over 12 months	Proposed Equated to Days per average month	Proposed equated to Delays per day
Social Care	2	2.6	-23.1%	2.6	0.0%	218.9	7.2
NHS	8.4	17.4	-51.7%	7.8	-55.2%	654.8	21.5
Joint	5.3	3.4	55.9%	3.4	0.0%	285.8	9.4
Total	15.7	23.3	-32.6%	13.8	-40.8%	1159.5	38.1

Note on the reporting of Delayed Transfers

The DToC part of the NHS DTOC metric is 'total days delay reported in a month' rather than 'days per 100,000'. The figure is shown from the NHS Provider's perspective, delays in a particular hospital as a % of Occupied Bed Days (OBD) in that hospital, so if a HWB area is served by 4 hospitals it will receive 4 different performance scores for "DTOC as % of OBD". This is the metric that is increasingly the focus for the local system A&E Delivery Boards (driven by NHSE).

Additionally the OBD performance reported by a single NHS Providers is made up of both local system and out of area residents' delays. Therefore a reduction to 3.5% of OBDs is a matter for all of the Local Authority (LA) areas contributing to the OBD performance and not just Coventry i.e. Warwickshire, Leicestershire and Solihull etc.

However, DToC as included in the ASCOF (and BCF) looks at delays experienced by people who are residents of a single LA area, regardless of where they are delayed. Therefore the Coventry HWBB will only receive one score for "DToC per 100,000 population". This is the figure that LAs focus on because it most effectively reflects what is in 'their' control.

ANNEXE 1 - BCF 2017-19 Planning Work stream Outline Business Cases

Scheme 1

Targeted Prevention

Overview of the scheme and case for change

There is widespread recognition that the current model of social and health care is unsustainable as demand outstrips supply and the gap between the income for health and care services and the costs of these services widens.

This is not down to changes in demographics alone. Although people are living longer this has not been matched by similar improvements in people living longer in good health - so as a result we are spending more years experiencing ill health.

In addition, the burden of ill health is not felt equally – falling to a much greater extent on the most vulnerable and deprived in society. The challenge across health and social care is therefore to improve healthy life expectancy and reduce health inequalities to change the demand for services.

This initiative will focus on the promotion of improving health outcomes for the citizens of Coventry by reducing the risk factors in the population most likely to need both health and social care and links into the upgrade in preventative work within the STP to deliver long term sustainability.

This will involve a variety of interventions to change behaviour, reduce the impact on the health and social care system of preventable diseases and alleviate and/or delay the pressure caused by some long term conditions.

Evidence has shown that interventions that are made earliest in a potentially negative health outcome are the most likely to be effective. Moreover for many health problems in the population a combination of primary, secondary and tertiary interventions are needed.

The BCF supports the key themes of the Better Health, Better Care, Better Value programme and is also aligned in particular to the Proactive & Preventative Care workstream.

Acknowledging both the organisational nature and the significant overlap between existing and anticipated programmes of work, the Proactive and Preventative workstream has adopted the following intervention based model:

- Community Capacity and Resilience – this will change population health outcomes at scale to address how do we keep people healthy and prevent health risks arising. This will be aimed at the general population who are not in direct receipt of services.

- Prevention Framework – this will manage individual health risks by focusing on early intervention to prevent health risks turning into ill-health and where people have health problems to stop those health problems escalating to the point where they require significant, complex and specialist health and care interventions. This will be aimed at those who are ‘at risk’ and will take an early intervention/prevention approach.

- Out of Hospital – better well-being by putting people at the centre of their care through improving quality of live and enhancing people’s ability to have control over their lives by focusing on the whole person. This is aimed particularly for those individuals with long term conditions or with multiple health problems. This work will aim to take a transformational approach that focusses on care and support to allow people to maximise the quality of life and wellbeing rather than delivering specialist interventions.

These principles will be used to progress a number of preventative initiatives as part of the BCF programme specifically targeted at:

a) **Reducing isolation/loneliness** in older people

b) **Making Every Contact Count (MECC)** specifically aimed at points which will have the greatest level of impact on the metrics associated with BCF i.e. at care providers, at admittance, in GP surgeries and at discharge.

c) **Nutrition** linked to MECC above because good nutrition and hydration plays a protective role in various age-related conditions including cardiovascular disease and cognitive decline and can help to protect oral, bone and joint health and wellbeing in later life.

d) Implement a **Warm Homes Initiative** because cold can exacerbate existing long term physical health conditions, especially respiratory and cardio vascular disease, as well as mental health conditions, which result in increased GP and A & E attendances

e) **Improve Mental Health assessment** by increasing Arden Mental Health Acute Team (AMHAT) capacity in A&E in order to signpost and avoid hospital admittance.

These 5 areas are currently being developed to clearly identify the contribution each will be expected to make towards the BCF metrics and the improved performance of the local system as a result the proposed investment before final decisions are made.

Objectives

Objectives of this scheme are:

- Promote and innovate preventative approaches to healthy living and lifestyle choices that improve health and well-being across the City.
- Influencing behaviour and lifestyle changes for the whole population to maximise adoption of preventative activities
- Proactively seeking to intervene early and reduce health risk for individuals.
- Influencing the way services are designed to maximise prevention for those at risk of mental or physical ill health and maintain quality of life.
- To improve nutrition among people at greater risk of re-referral / re-admission to social care and health services.

Deliverables

- A programme of health promotion and interventions targeted at the residents of Coventry
- Support for people to change lifestyle behaviours

Metrics

1. Non-Elective Admissions (General & Acute) All age per 100,000 population
2. Older People discharged at home 91 days later per 100,000 population (ASCOF 2b)
3. Delayed Transfers of Care All Adults 18+, Days of Delay per 100,000 population
4. Permanent Admissions of Older People to Residential & Nursing per 100,000 population (ASCOF 2a)
5. Health related quality of life

Governance

The scheme has governance arrangements in place through Adults Joint Commissioning Board to monitor progress of the project.

Benefits
Benefits for this scheme include: • Improved range of health outcomes • People encouraged to improve their lifestyle behaviours and live healthier lives • Help improve the quality of life for older people • Preventing / delaying re-entry to health and social care system • Reducing isolation and loneliness

Scheme 2
Improving Whole System Flow
Overview of the scheme and case for change
There is an increased emphasis on health and social care organisations working together to tackle the quality and productivity challenges that all systems are facing, and to ensure that care is 'genuinely coordinated around what people need and want'. Improving the flow of patients, service users, information and resources within and between health and social care organisations can have a crucial role to play in coordinating care around the needs of patients and service users, and driving up service quality and productivity. Poor flow is not only a source of significant waste and delay, but it can also be devastating for patients and service users and deeply frustrating for people working in health and social care. Recent flow-related initiatives in Coventry to date have focused on limited sections of the patient or service user journey, usually within hospitals. There is a need to look beyond the hospital and to give attention to every team, service and organisation that patients and service users encounter. Flow is not about the what of clinical or social care decisions, but about the how, where, when and who of care provision. How services are accessed, when and where assessment and treatment is available, and who it is provided by, can have as significant an impact on the quality of care as the actual type of care received. The concept of using flow to improve care has received increasing traction within the health economy, especially in relation to reductions in patient waiting times for emergency and elective care. This is of particular interest given some of the pressures across the health system in Coventry which is currently characterised by increasing levels of attendance and longer waiting times at A&E, rising numbers of emergency admissions to the University Hospital combined with continuing high rates of delayed discharge. This contributes to increasing social care activity overall and diverts capacity from responding proactively and early to prevent deterioration in the community. The need to shift activity to the 'front door' is accepted and understood by partners, however realising the shift in resources and activity to deliver this remains challenging. This is a large transformational change project which has value and importance across the Health and Care system in Coventry and following completion of the business case and specification, which will be led by the Clinical Commissioning Group, there is the need for additional resources to be allocated. This may lead to a formal joint decision to procure and engage the appropriate external expertise or alternatively provide an opportunity for partners to secure the appropriate skills and capacity

internally and so potentially increase the pace of delivery.

Objectives

Objectives of this scheme are:

- Understanding of the whole system.
- Establishing and managing the relationship between flow, quality and cost.
- An optimised system with co-ordinated activities and processes that facilitate effective health and social care delivery.
- Meet demand and speed up flow.
- An integrated health and social care system
- Effective use of resources and technology to support the delivery of integrated care.

Deliverables

- Reduce demand on acute services.
- Reduce the requirement for residential and/or nursing care.
- Reduce the need for long term support from health and/or social care.
- Maximise preventative opportunities

Metrics

1. Non-Elective Admissions (General & Acute) All age per 100,000 population
2. Older People discharged at home 91 days later per 100,000 population (ASCOF 2b)
3. Delayed Transfers of Care All Adults 18+, Days of Delay per 100,000 population
4. Permanent Admissions of Older People per 100,000 population (ASCOF 2a)
5. A&E Attendances
6. A&E 4 Hour waits
7. Referral to Treatment times

Governance

The scheme has governance arrangements in place through Adults Joint Commissioning, A&E Delivery and Urgent Care Boards to monitor progress of the project.

Benefits

Benefits for this scheme include:

- Improved system structure, work processes and culture
- Improved patient flow through the whole health and social care system
- Improved service delivery
- Enhanced quality of patient care
- Optimised resources and capacity

Scheme 3

Discharge Support

Overview of the scheme and case for change

The Discharge to Assess (D2A) pathway aims to help those who might need support on leaving hospital earlier, by arranging a care package to support them at home. The ward-based discharge assessments can be time-intensive and once the patient is medically fit to leave hospital, it can take significant time to get their home support in place.

The aim is to deliver care in a more appropriate setting and improve the experience of patients who no longer need the care of an acute hospital but are able to manage at home with support or in a residential setting.

By moving patients home when they are ready to be discharged from hospital, not only frees hospital beds for patients that need them, it also benefits the patient themselves as often we see patients health improve further once they are back in the comfort of their own home. They are then given appropriate support at home until a full assessment can take place and longer term care package implemented.

Currently a range of 'Short Term Support to Maximise Independence' (reablement) is available within the City as follows:

Pathway 1 - Home Based Support

- 1750 hours per week rising to 1,995 per week
- 100 hours a week specialist dementia "Discharge to assess"

Pathway 2 - Bed Based support

- 48 care home places (residential and dementia residential beds)
- 35 places in housing with care schemes.

In summary the system has: -

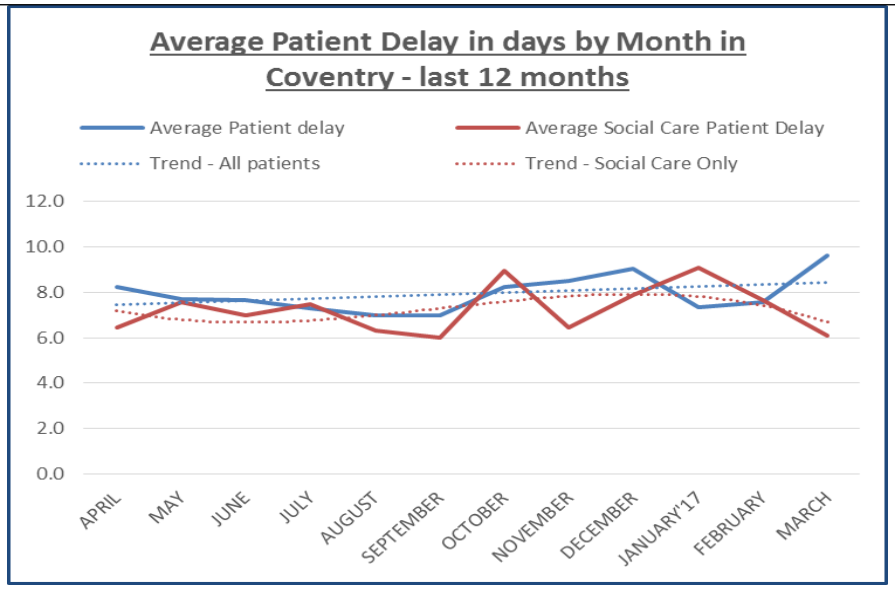
- 83 STSMI bed places
- 1850 home support hours which are block funded

Additional complimentary support services exist through: -

- Coventry & Warwickshire Partnership Trust (CWPT) therapists
- Occupational Therapy (specific to dementia D2A project)
- Dementia locksmiths (specific to dementia D2A project but also working with dementia bedded step down provision)

Improving the DToC performance has been a significant challenge to partner organisations across Coventry and Warwickshire and therefore the wider signatory organisations to the STP submission. In Coventry the most recent year end total for days delayed in 2016/17 exceeded that of 2015/16 by 9%. Following a peak in September there was a short period of reduction in the reported days of delay, however the latest figure for March (1565) reflects consecutive monthly increases since August. The delays attributable to social care and jointly with health have declined since the peak in early 2015 at the same time at the same time as those due the NHS have increased.

As such the average patient delay has been rising over the course of the most recent financial year, as shown in the trend graph below.



Source: Unify

During the 2016-17 financial year Coventry CCG have funded additional bedded capacity on a short term basis to meet the increased pressure on the D2A pathways with a plan to reduce this as more home based support became available.
However the increased demand has not abated and there is a significant risk in decommissioning the currently available bedded D2A capacity given recent discharge data for May 2017 shows utilisation of capacity as follows:

Pathways 1 & 2	Home support	Housing with care	Residential Reablement	Dementia Residential Reablement
Occupancy	100%	91%-100%	90%-100%	90%-100%

Given the extremely high occupancy levels it would seem prudent to maintain the D2A bedded capacity that is currently available as to remove beds from the system and therefore would increase delays.

This represents a commitment to maintain this service over the current BCF planning timeframe of two years but also the life of the iBCF funding settlement and does not include the commissioning of additional capacity.

This workstream will also include an element of contingency planning to cover winter pressures for the next two years.

Objectives

Objectives of this scheme are:

- Maintain D2A bedded and domiciliary based enablement capacity within the community
- Maintain system flow
- Reduce DToC
- Meet winter pressures

Deliverables

- Reduce number and duration of delays to a sustainable level
- Reduce length of stay for complex patients
- Reduction in excess bed day costs

- Work to understand and meet the capacity requirements for winter pressures

Metrics

1. Delayed Transfers of Care All Adults 18+, Days of Delay per 100,000 population
2. DToC % of occupied beds
3. Re-admissions to hospital
4. Older People discharged at home 91 days later per 100,000 population (ASCOF 2b)
5. Sequel to short term service (ASCOF 2d)

Governance

The scheme has governance arrangements in place through Adults Joint Commissioning and A&E Improvement Boards to monitor progress of the project.

Benefits

Benefits for this scheme include:

- Speeds up hospital discharge and reduce delays
- Helps improve outcomes for older people
- Improved discharge planning
- Better patient flow

Scheme 4

Community Promoting Independence

Overview of the scheme and case for change

There is a substantial promoting independence offer available for hospital discharge, however currently limited promoting independence services are available for use within community services, as these are almost completely focussed on 'step down' from hospital.

This forms the rationale for developing an additional Promoting Independence service which is planned to be in place later in 2017 with an aim to support people in their own homes by providing short term 'step up' support.

A business case has been developed to scope an "invest to save" model for community-based support which focuses on "step up" intervention rather than hospital discharge support. This will establish a community-based promoting independence service for older people, people with physical impairment and those with learning disabilities who are ordinarily resident in Coventry.

The service is intended to provide a cost effective preventative intervention to people who by virtue of ill health or disability have lost skill in managing daily living activities, to enable them to regain skill and confidence and reduce their potential dependence upon long term care and support. In doing so, those people in receipt of the service will be less likely to have unnecessary hospital admission or admission to residential care.

Providing an increase in community-based promoting independence capacity, by putting in place the required resources to move these cases through the system, will enable savings and cost avoidance to be achieved.

There is an intention to deliver this service through the Gilbert Richards Centre with the development of Therapy rooms and facilities funded through the Disabled Facilities Grant.

The proposed approach is consistent with the requirement of Local Authorities to provide preventative services and promote wellbeing under the provisions of the Care Act 2014 and is aligned to the Adult Social Care Vision:

To enable people in most need to live independent and fulfilled lives with stronger networks and personalised support.

and

Effective enablement and prevention and wellbeing - We provide support to people in cost effective ways to enable them to reach or regain their maximum potential so that they can do as much as possible for themselves.

Anticipated Demand

The average number of ST Home Support hours per person is 20. Assuming people would receive the service for six weeks, approximately 2,640 commissioned hours per week would cover demand.

There will be approximately a maximum of 150 people in the promoting independence service at any point in time.

Potential Impact

The average number of people starting a long-term support package per week, from the community, without receiving a short-term service prior to this, was 22 per week over the 12 months between February 2016 and February 2017, or circa 1150 in total.

However approximately 50% of people who receive the current Short Term Home Support service do not require long-term support on exit.

Assuming that, as referrals will only be directly from social care staff, and not for people who are being discharged from hospital, it is estimated that between 10% and 50% of people who receive this promoting independence service will not require long-term support on exit.

Cost avoidance will be a combination of reduced numbers of people requiring long-term home support, and also, a reduction in the level of hours provided for those in long-term support.

This would result in potential cost avoidance as follows:

	10% reduction	**20% reduction**	**50% reduction**
Cost avoidance per week	£10k	£21k	£52k
Cost avoidance per year	£543k	£1,086k	£2,715k

Evidence shows that people that do go on to have a long-term package of support following a short-term service also require less hours - resulting in further cost avoidance as follows:

All Age Disability: £50 per week

Older People: £20 per week

	Based on 90% of people receiving a long-term service	**Based on 80% of people receiving a long-term service**
Cost avoidance per year	£28k	£25k

These are estimated figures based on an 'invest to save' model and there are risks associated with this as savings may not be realised and appropriate actions will be developed to mitigate these.

Objectives

Objectives of this scheme are:

- Promote independence
- Prevent or delay the deterioration of wellbeing and the need for more costly and intensive services
- Reduce unnecessary hospital admission or admission to residential care
- Provide the right care, of the right quality, at the right time, as close to home as possible

Deliverables

- Community-based promoting independence model.
- Targeted, timely, goal focused interventions to support the potential for independence.
- Part of the service will be dedicated to people living with dementia or cognitive impairment.
- Reduce the dependence upon long term care and support.

Metrics

1. Older People discharged at home 91 days later per 100,000 population (ASCOF 2b)
2. Sequel to short term service (ASCOF 2d)
3. Permanent Admissions of Older People per 100,000 population (ASCOF 2a)
4. Re-admissions to hospital

Governance

The scheme has governance arrangements in place through Adults Joint Commissioning Board to monitor progress of the project.

Benefits

Benefits for this scheme include:

- Timely and appropriate interventions
- Helps improve outcomes and quality of life for older people
- Promote and enable independence, choice and control
- More care and more support provided in people's own homes/the community
- Cost avoidance, based on a combination of reduced numbers of people requiring long-term home support, and also, a reduction in the level of hours provided for those in long-term support.

Scheme 5

Integrated Commissioning and Improving Programme Management

Overview of the scheme and case for change

This initiative looks at ways in which the capacity and ability to deliver change towards 2019/20 can be improved through a greater emphasis on instigating joint working across commissioning

organisations within Coventry.

This will focus on a collaborative approach to managing demand and market provision through pooling capacity, expertise and knowledge and minimising professional, cultural and organisational barriers.

Promote a culture that considers the individual's health, well-being, safety, independence and choice through shared commissioning intentions.

It is intended to recruit 2.5 FTE posts to work across the council and CCG to support the management of the BCF programme work streams and provide additional capacity to the integration of commissioning functions.

Objectives

Objectives of this scheme are:

- The effective engagement and deployment of combined resources across the system
- Ensuring that the appropriate knowledge, skills and experience are available to deliver the agreed system-wide transformation
- Joint working to manage and develop current and future health and social care provision.
- Optimise the financial commitments across the LA and CCG through the shared commissioning of services so enabling value for money service provision
- Improve the understanding and management of the provider market within the health and social care economy

Deliverables

- Project management and commissioning coordination
- Enhanced contract initiation and management
- Benefits management and realisation: defining, quantifying, measuring and monitoring benefits
- Stakeholder management and communications: ensuring that relationships are developed and maintained jointly
- Better knowledge, skills mix and potential co-location

Metrics

1. Work streams delivered to plan
2. BCF programme issues and risks mitigated
3. Reduced duplication of specifications

Governance

The scheme has governance arrangements in place through Adults Joint Commissioning Board to monitor progress of the project.

Benefits

Benefits for this scheme include:

- More effective management and coordination of limited resources
- Improved knowledge, expertise and capacity

- Enhanced stakeholder engagement
- Better market and contract management
- Economies of scale

Scheme 6

Protecting Social Care

Overview of the scheme and case for change

In April 2017 the Institute for Fiscal Studies reported that overall local authority spending on social care fell by 11% in real terms between 2009/10 and 2015/16. It also found that six in every seven councils had made at least some level of cut to its care spending per adult resident over the same period.

This has resulted in fewer people getting help despite demographic trends suggesting increasing demand as councils have concentrated on the most vulnerable in society leading to growing concerns about rising levels of unmet need, the impact on carers (exacerbated by the welfare reform changes) and the cumulative pressures these will place on the NHS.

Ensuring that people who require Adult Social Care receive it in a timely and effective manner is critical to preventing further deterioration as well as helping to ensure that individual outcomes are met by creating social care capacity in order to meet the needs of the local population.

A significant element in the allocation of the iBCF grant is the recognition of the on-going pressures on Adult Social Care as a result of reductions in local government funding, the impact this has had on wider city council resources and the need to sustain provision.

Investing in Adult Social Care also means ensuring that the social care market is sustainable and that system capacity is not reduced or put at risk by local providers ceasing to operate as a result of financial failure or deciding to withdraw elements of uncommercial provision.

Objectives

Objectives of this scheme are:

- Maintaining capacity across the market to deliver safe, accessible and high quality care services.
- Improve the understanding and management of the provider market within the health and social care economy.
- Ensuring the best use of resources to enable sustainable value for money service provision
- Investment in community based preventative services and place based systems of care in line with STP priorities.
- Monitoring of the performance and finances of the most significant care providers within the local (and national) market

Deliverables

- Contingency planning - management of risks around service interruption and the potential financial failure of providers
- Early identification and avoidance of quality failings
- A care market that remains vibrant and stable

- Improved demand management

Metrics

1. Delayed Transfers of Care All Adults 18+, Days of Delay per 100,000 population(due to awaiting social care)
2. Older People discharged at home 91 days later per 100,000 population (ASCOF 2b)
3. Sequel to short term service (ASCOF 2d)
4. Permanent Admissions of Older People to Residential & Nursing per 100,000 population (ASCOF 2a)
5. Provider failures

Governance

The scheme has governance arrangements in place through Adults Joint Commissioning Board to monitor progress of the project.

Benefits

Benefits for this scheme include:

- Ensure a sustainable social care market
- Sound risk management
- Protection of difficult to replace services for the future as well as present day
- Maximise the independence of service users and reduce the uptake in long term services
- Focus on prevention and early intervention to reduce the Health and Well-Being gap, in line with the Marmot principles

Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 16th October 2017**

From: Eira Hale, Safeguarding Board Business Manager

Title: Coventry Safeguarding Children Board Annual Report

1 Purpose

To present the Local Safeguarding Board (LSCB) Annual Report 2015/16 to the Health and Wellbeing Board. A full copy of the report is attached as an appendix.

2 Recommendations

The Scrutiny Board are asked to note the attached annual report, the progress made and the areas for future development.

3 Information/Background

The LSCB Annual Report covers the period from September 2016 to March 2017. It summarises progress over the last six months and sets out a new direction for the Board for 2017/18. This brings us back in line with the reporting guidelines as set out in Working Together 2015. The report outlines the achievements and challenges of the LSCB and assesses progress on outcomes for children and young people. It evaluates the impact of Coventry's services on outcomes for children and shows how the work of the Board has contributed to improving outcomes.

The report was presented to Scrutiny Board (2) on 14th September 2017.

4 Key Messages

4.1 The Board has grown in the way agencies are able to challenge each other and hold others to account, both at full board and at the sub-group meetings.

4.2 The multi-agency response to child sexual exploitation is a real strength.

4.3 Previous good progress in the way we listen to and respond to the voice of children has continued. Individual organisations are improving their focus on children and within the Board itself, the testimony from children and young people has shaped thinking.

4.4 Work to protect children and young people from the effects of domestic abuse has made less progress and more needs to be done to ensure the effectiveness of our city-wide early help offer.

4.5 The independent chair continues to work closely with the Chairs of the Local Safeguarding Children's Board, Police & Crime Board and Health and Wellbeing Board, through the Strategic Boards Group. This area of work is important to develop and continue. This will ensure that where Boards have a shared interest in a subject area there is clear ownership, as well as a forum for discussing the way forward on interdependencies.

Report Author(s):

Name and Job Title: Eira Hale, Safeguarding Boards Business Manager

Directorate: People

Telephone and E-mail Contact: 024 7629 4704; eira.hale@coventry.gov.uk

Enquiries should be directed to the above person.

Coventry Local Safeguarding Children Board Interim Annual Report

September 2016 to March 2017

Foreword

I am pleased to introduce the Coventry Safeguarding Children Board (CSCB) interim report for September 2016 to March 2017.

The CSCB is required to publish an annual report on the effectiveness of safeguarding in our area including an assessment of local safeguarding arrangements, achievements made and the challenges that remain.

When I took over as Chair on 1 August 2016, I decided to change the period the annual report was dealing with, bringing it in line with a range of other business processes including the financial year. That is the reason why this report covers half a year. Future reports will be for a whole year April to March.

During this period, building on the work done by the previous chair, the Board has grown in the way agencies are able to challenge each other and hold others to account, both at full board and at the sub-group meetings.

Our approach was examined when we invited the Local Government Association to conduct a "diagnostic", a type of peer review. They confirmed that we are moving with high ambition in the right direction. This was a very pleasing outcome that recognised the progress and hard work of the Board.

The changing and reducing financial landscape continues to be challenging for all agencies and so being able to have frank and strong discussions is vital in keeping our safeguarding system as strong as possible.

Progress against our priorities has been variable. Whilst the multi-agency response to child sexual exploitation is a real strength, the work to protect children and young people from the effects of domestic abuse has made less progress. You will see the detail in the report along with a lot of rich and detailed data.

Whilst any lack of progress against priority areas is disappointing, we should not shy away from trying to understand and tackle difficult issues. Child protection and safeguarding in the multi-agency world is complex and so quick fixes are not always available. If we only took easy issues as our priorities we would not really be driving whole system change and service improvement which will lead to better outcomes for the children and young people of Coventry.

From April 2017, outside of the scope of this report, we adjusted our priorities and these will be reported on next time.

I thank the members of the CSCB for their professionalism, challenge and rigour and the business team for all their work during the last six months.

I must conclude by thanking the frontline practitioners for their dedicated work in safeguarding our children and young people.

David Peplow
Independent Chair

Contents

Use this button to return to the contents page

Table of Figures

CONTENTS

Introduction

Introduction

This report outlines the achievements and challenges of Coventry LSCB from September 2016 to March 2017. It evaluates the impact of Coventry's services on outcomes for children and shows how the work of the Board has contributed to improving outcomes. It details the Board's progress in implementing its current priorities.

The objectives of an LSCB are clearly set out within Section 14 of the Children Act 2004:

a) To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and

b) To ensure the effectiveness of what is done by each such person or body for those purposes.

In order to fulfil its statutory functions under Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 as a minimum an LSCB should:

- assess the effectiveness of the help being provided to children and families, including early help;
- assess whether LSCB partners are fulfilling their statutory obligations;
- quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and
- monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

LSCBs do not commission or deliver direct frontline services, though they may provide training. While LSCBs do not have the power to direct other organisations and Board partners retain their own lines of accountability for safeguarding, safeguarding boards do have a role in making clear where improvement is needed.

This annual report provides an assessment of the performance and effectiveness of local services in improving outcomes for children. It details how Coventry LSCB has helped to create better outcomes for children through improving multi-agency processes and co-ordination, assessing the effectiveness of what is being done by agencies and feeding back to them, quality assuring practice and disseminating good practice, developing and providing multi-agency training and ensuring that agencies are fulfilling their statutory responsibilities. The Board challenges partners but also supports them to improve. It listens to the voices of children and directs its work accordingly.

Local background and context

Local background and context

Coventry Children's Services and LSCB were inspected by Ofsted in January 2014 and judged to be inadequate. Since that time an Improvement Board has been established and the Department of Education has monitored progress. A new independent Chair of the LSCB took up post in September 2014 and completed her two year tenure in August 2016. She reported regularly to the Secretary of State and the Improvement Board on progress. Agencies working together to safeguard children in Coventry are working in a challenging context. There is a growing population, a diverse ethnic mix and higher than average levels of poverty.

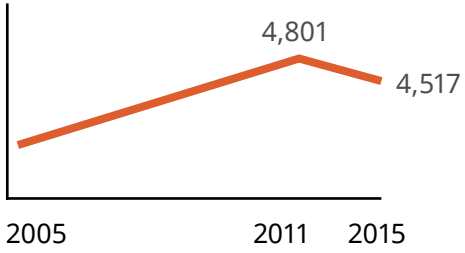
Coventry population[1]

75,100 children and young people in Coventry aged 0-17

22% **of population**

13,900 under 3

Coventry births



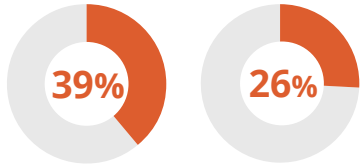
Migration

Net international **3,100** in 2005 to **6,600** in 2015.

If current population growth trends continue, then by **2026** the total population of Coventry will rise by **15%** with the total number of children projected to rise faster than the adult population.[2]

Minority ethnic groups[3]

% of children from minority ethnic backgrounds



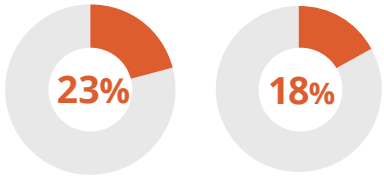
80 languages spoken

In **8.7%** of households no one speaks English as their main language[4]

Deprivation

18.5% of Coventry residents live in neighbourhoods that are among the most deprived 10% of neighbourhoods in England[5]

Children living in relative poverty



17,100 children living in Coventry from households that have an annual income **less than 60%** of the national average.[6]

Lone parents

Coventry also has a higher than average percentage of children living in lone parent households.

Free School Meals

The 2013 School Census indicates that there are higher than average numbers of children in primary schools who are known to be eligible for and are claiming free school meals.

Sources

1. 2015 mid-year population estimates, Office for National Statistics
2. 2014 Sub National Population Projections, Office for National Statistics
3. Mid 2011 Census based population estimates, Office for National Statistics
4. 2011 Census, Office for National Statistics
5. Index of Multiple Deprivation 2015, Department for Communities and Local Government
6. Children in low- income households, Department of Energy and Climate Change

Outcomes for Coventry children

Outcomes for Coventry children

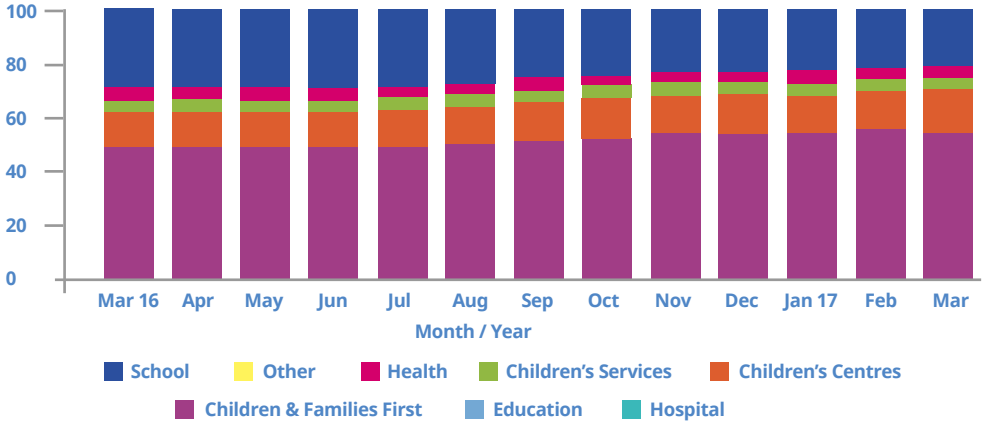
Summary

Outcomes for children in Coventry have continued to improve over the last six months. The good news is that more children are getting help and support earlier, but more needs to be done to ensure that all children get assessed and helped quickly. This is particularly the case for children in need, for whom planning needs to be timelier and more focused on outcomes. The Board has worked to improve the guidance available to partners to improve the quality of referrals and the application of thresholds but there remains some significant difficulty for partners applying these in practice. In terms of Early Help for children and families there is more that could be done to engage a wider range of partners in leading support for families and in understanding the long term impact of interventions. With impetus from the Board, services have worked hard to continuously improve their joint working across all areas and so improve outcomes for children. This section provides more detail of the progress being made.

Early Help

The number of families being supported through the common assessment framework (CAF) continues to rise, in 2016/17 2455 CAFs were completed. Over the year the percentage of early help work shown to be led by partners other than children's social care has decreased. More work is required to understand and overcome the barriers and challenges faced by partners to leading CAF work with families.

Figure 1: Open CAFs by lead agency

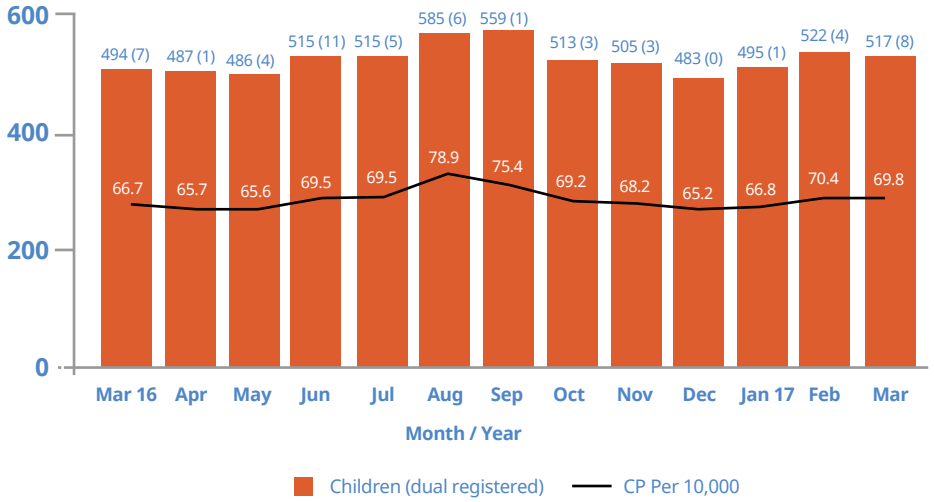


The outcome of CAF work is considered successful if it is completed with all actions completed. Over the year this figure has risen from 68.8% to 70.7%. However, this still does not clearly illustrate whether life has improved for the children involved. The recent audit carried out by the Board suggests that while there is some evidence of positive impact on children and families through early help that there is more work required in understanding the impact of interventions, especially in the long term.

Child Protection

Over the year, the number of children with child protection plans has remained relatively constant. This year there are currently 566 children with a child protection plan. This is still higher than in similar areas. Work has been started to ensure that children get help earlier, avoiding escalation, but there is still more that could be done.

Figure 2: Numbers of children on a child protection plan



Children are mostly still receiving the help they need in a timely way. 86% of initial child protection conferences are held within 15 days and 86.1% of children and family assessments are held within 45 days. This is a weaker position than was reported last year and there are concerns that timeliness is under pressure because threshold standards are not consistently applied. Following the LSCB audit earlier last year threshold guidance has been simplified and reissued across the partnership. Work is also underway to improve the way in which agencies can refer into social care and early help to ensure children and families receive the right help at the right time and in the right way. The number of repeat referrals and the number of children becoming subject to a child protection plan for a second or subsequent time has dropped but remains high. This means that children are still being exposed to significant risk for a second or third time, which calls into question the effectiveness of the intervention already undertaken and the effectiveness of the continuum of need and how families are escalated through it.

Figure 3: Children on a child protection plan by age and category of abuse

Age Group	YTD	%	2015/16 %	2014/15 %	2013/14 %
Unborn	21	4.1	2.6	4.5	4.7
0 to 3	165	31.9	30.0	30.1	33.2
4 to 11	238	46.0	48.5	47.2	44.6
12 to 16	91	17.6	18.1	17.6	16.3
17+	2	0.4	0.8	0.7	1.2
Total	**517**	**100**	**100**	**100**	**100**

Plan category	YTD	%	2015/16 %	2014/15 %	2013/14 %
Emotional	297	57.4	51.5	56.5	51.4
Neglect	179	34.6	41.2	32.4	35.9
Physical	13	2.5	2.4	5.3	7.2
Sexual	28	5.4	4.9	5.8	5.5
Total	**517**	**100**	**100**	**100**	**100**

In Coventry the most prevalent category of abuse is emotional. For the last three years between 51 and 58% of children on child protection plans have been primarily described as suffering from emotional abuse. Neglect is the second most prevalent category, with around 32-41% of children on a plan being subject to neglect. Statistics published by the National Society for the Prevention of Cruelty to Children (NSPCC) show that over the last five years across the whole of England the most prevalent category of abuse is neglect, with an average of 42-45% of children on child protection plans as a result of abuse. Across England in 2015 only 34% of children on child protection plans were subject to emotional abuse. The Board has now made neglect a priority and partners will work together to focus on how neglect is identified and dealt with in Coventry.

Children in need and domestic violence

There are currently 2,154 open Children in Need cases, with 95.4% open less than six months. 53.1% of these do not yet have a plan. This is potentially because they are still in the early stages of assessment. It is important to avoid drift and the Children's Social Care managers monitor these on an on-going basis to prevent case work drifting, but there is concern that there are a number of children who are not having their plans progressed.

The number of domestic violence (DV) contacts has fallen in the last year, from 6,620 to 6,066. The number of contacts that result in no further action has also fallen from 41% to 38.4%. This is a result of changes to the screening process and quality improvements, although there is still work required to ensure that families and children are protected and supported appropriately and that information sharing with other agencies is effective.

Looked after children

Coventry is broadly stable in the number of children who are looked after and is higher than the all England average and statistical neighbours, reflecting levels of deprivation in the city.

The health care offered to looked after children continues to be a focus for partners. 93% of looked after children have a completed health assessment. The Clinical Commissioning Group (CCG) monitors the local performance in relation to initial and review health assessments through a contractual KPI and work continues to improve the consistency of the statutory health assessments and care plans of looked after children. The education of looked after children is also an area of interest for the Board, but there is no new attainment data available in the last six months. The Board will consider progress in this area more fully in the next annual report.

Figure 4: Numbers and rate of looked after children

Year	2013/14	2014/15	2015/16	2016/17
Children looked after at year end				
Coventry	629	587	580	616
All England	453	457	464	-
West Midlands	651	669	660	-
Statutory Neigh.	555	578	554	-
Per 10,000 population				
Coventry	85.9	79.2	78.2	83.1
All England	60.0	64.4	60.3	-
West Midlands	73.0	79.8	73.2	-
Statutory Neigh.	78.0	81.3	76.4	-
Best performing stat. neigh.	Sheffield		46.0	

Early Years

Across Coventry we continue to see an encouraging picture of improvement in the early years of children's lives.

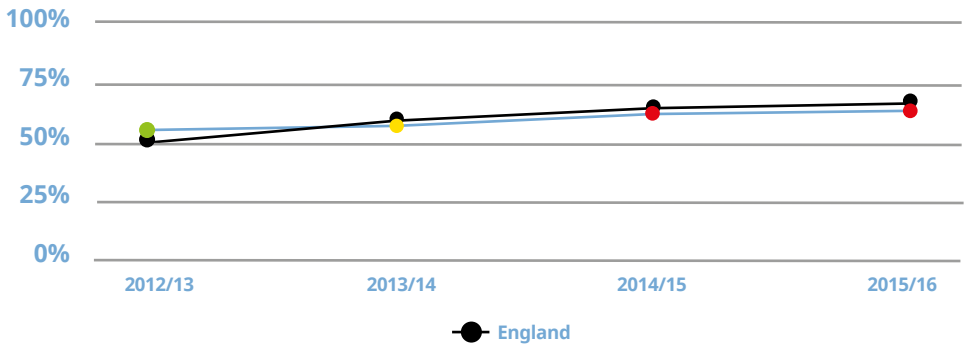
Figure 5: Giving every child the best start in life

	vs West Midlands	vs England
% children achieving good level of development		
% children achieving good level of development FSM		
% mothers smoking status at delivery		
Low birth weight babies		
Breastfeeding initiation		
Child poverty (under 16s)		

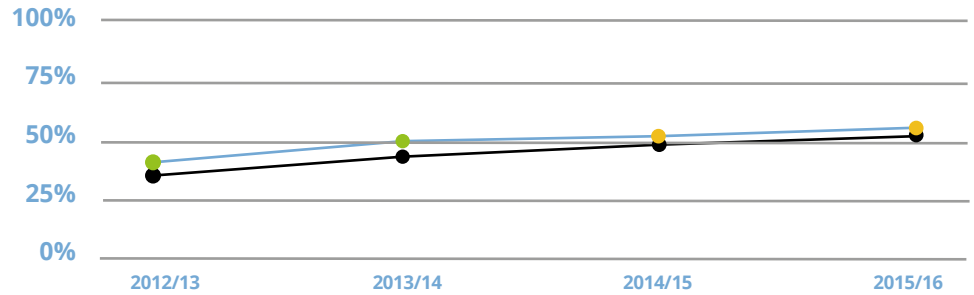
As an indicator for school readiness, the proportion of children achieving a good level of development by the end of reception is used. In Coventry, as with the England average, there has been an increase in the proportion of children achieving a good level of development in the last year, although there is still a large inequality within the city. For those eligible for free school meals, the proportion of children achieving good development is lower than the average for all children. However, for children eligible for free school meals, the proportion achieving good development in Coventry remains higher than the England average.

Figure 6: School readiness

CYP: School Readiness - the percentage of children achieving a good level of development at the end of reception (persons) Coventry



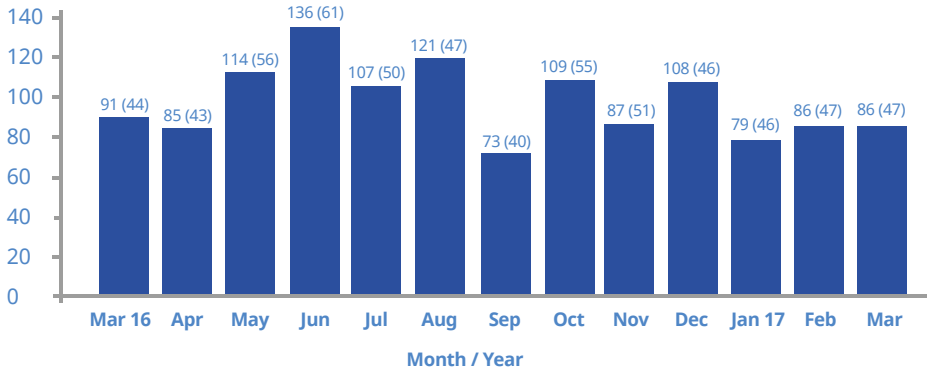
School Readiness: - the percentage of children with free school meal status achieving a good level of development at the end of reception (persons) - Coventry



Missing children

Missing children are concerning because being missing increases their vulnerability to abuse and exploitation. We now have a much better picture of missing children in the city, with higher numbers of missing episodes than in previous years as a result of improved reporting. There is still a high level of repeat missing episodes and concern that children are not being given the opportunity to be seen promptly to discuss the reasons for going missing and to ameliorate any associated risk. Those children who go missing the most and are the most vulnerable are monitored by the Missing Operational Group (MOG), but there is still work to be done to prevent children going missing so frequently and to ensure that the information contained in return home interviews is used effectively.

Figure 7: Number of missing children and episodes



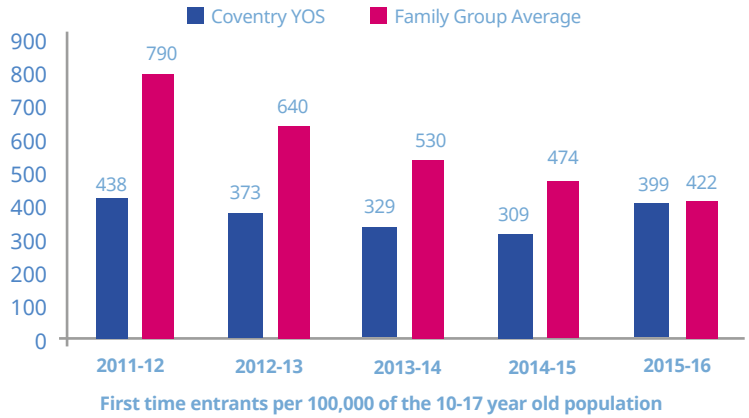
Child Sexual Exploitation (CSE)

Agencies across Coventry have continued to develop the support they are able to offer children who are at risk of, or experiencing, CSE. They have also completed significant pieces of prevention work with suspected perpetrators and with known locations. The CSE Subgroup regularly considers information on CSE across the city, including the numbers of children at risk and the numbers of children, who experience a reduction in their risk levels. Currently 191 children who are experiencing, or at risk of, sexual exploitation are being supported by services and are, therefore, likely to have significantly better outcomes.

Crime and young people

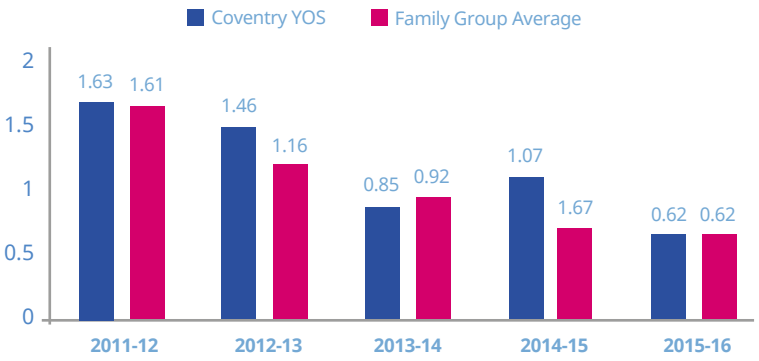
The total of recorded crime where victims are children has risen, but this is in line with the force average within the West Midlands. 26% of crimes against children were for wilful assault which would suggest the majority of offences are committed by a parent or someone in care and control of the child. 20% of crimes against children are recorded as having a positive outcome, which is in line with the force average. The police are now able to report on the number of police protections taken out in the city. The most common reason for police protection powers being used is physical abuse.

Figure 8: First time entrants to the criminal justice system



In recent years there have been a downwards trend in first time offending, with rates consistently below the national average, however first time offending increased in the last year. There is a continued downward trend in terms of youth re-offending, illustrating the effectiveness of youth offending services across the city.

Figure 9: Proven re-offending rates



Educational attainment and attendance

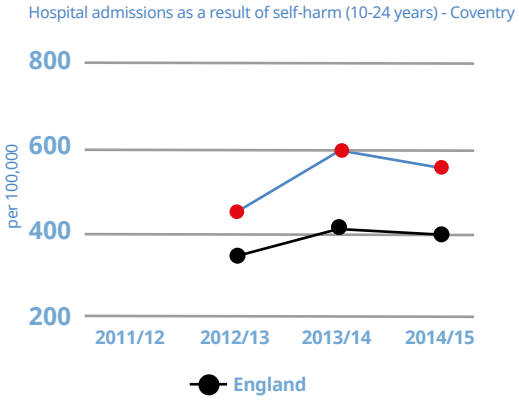
In previous years we have reported a continuing improving picture for reading, writing and maths at key stage 2, in 2015 78% of Coventry children achieved the required standard. In 2016 this dropped to 49%, but this is just three per cent below the England average and in line with a national drop in reported attainment due to changes in the way that attainment is measured. An average of 53% of children in Coventry achieved 5 A* to C grades at GCSE last year. This is higher than the previous three years and closer to the England average than has been seen in recent years.

The educational attainment of children in Coventry remains an area of interest for the Board, but there is no new attainment and attendance information available since the last annual report. The Board will consider progress in this area more fully in the next annual report.

Health

Coventry children are at less risk of serious childhood diseases as a result of a good uptake of immunisations. The majority of immunisation uptakes are at or above the national average. Infant mortality has seen a steady downward trend since 2007 and is now at the average for England. Teenage conception shows a significant downward trend, but remains stubbornly above the England average. The rate for children killed or seriously injured on our roads has significantly fallen in the period up to 2014 (latest available figures) and is now only slightly above the national average. The Board remain concerned about the mental wellbeing of children in Coventry. The rate of hospital admissions as a result of self harm is significantly higher than the national average and, although the rate is lower this year than last year it is still significantly higher than 2012/13. A recent report by the Children's Society (The Good Childhood Report 2016) concluded that children were experiencing increasing happiness with school and a decreasing happiness with friends and appearance. It also concluded that girls were significantly less happy than boys in terms of appearance and life as a whole. These factors are a significant indicator of wellbeing, which when low can mean that a child is more likely to develop mental health issues, of which self harm may be a feature.

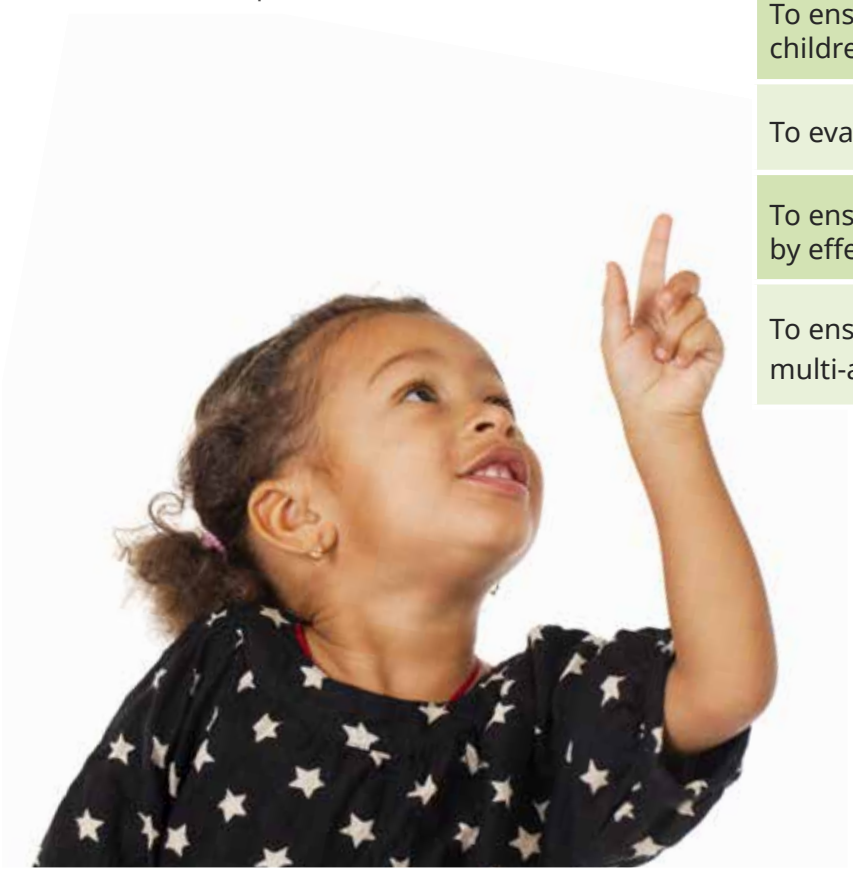
Figure 10: Hospital Admissions as a result of self harm (10-24 years)



Progress against priorities

Progress against priorities

The Board's priorities have been in place since April 2015. Following publication of our previous Annual Report in September 2016, it was agreed that the priorities needed to remain unchanged. The Board priorities for the period covered by this interim report are:



Current priorities:
To listen to and learn from the voice of the child and young person and to ensure that this learning shapes the way in which services safeguard young people in Coventry.
To ensure that the learning from Serious Case Reviews is used to improve outcomes for children and young people and that reviews are carried out efficiently and to timetable.
To evaluate the impact of Early Help arrangements on outcomes for children.
To ensure that missing young people and those at risk of sexual exploitation are protected by effective multi-agency arrangements.
To ensure that children and young people are protected from domestic violence by effective multi-agency arrangements.

The work that is undertaken by the Board is focused sharply on these priorities. Single agencies also contribute. Progress to date is outlined in the tables below.

To listen to and learn from the voice of the child and young person and to ensure that this learning shapes the way in which services safeguard young people in Coventry.
Listening to and learning from the voice of the child has continued to be a high priority for the Board. We have continued with our live testimony from children and young people at our meetings. We have listened to the direct testimony of looked after children and their experience of education support and from a group of disabled children telling us about the difficulties they can face accessing services in Coventry. The Board has recognised the importance of Signs of Safety as a methodology for supporting families because it emphasises the direct input of children. Partners are now working together to deliver appropriate training to support the roll out across the city. Services continue to strengthen their engagement with children and their families. The extensive work that agencies have undertaken to listen to the voice of children includes:
Amplifying the voice of the child has been a core priority for Coventry Children's Services. Continuing previous commitments to supporting the direct input of children into assessments and safety plans through the use of Signs of Safety, over 400 staff have now been trained in this important tool. The Voices of Care Council has influenced some key decisions including the design and location of new residential homes.
The CCG is strengthening patient engagement with children through a number of initiatives, including working on specific projects with local colleges and recruiting young people to participate in specific service development workshops, this will ensure that the voice of the child is heard in commissioning plans.
Public Health have helped children and their families to shape a new Family Health and Lifestyle service, which brings together a range of services including health visiting, schools nursing and the Family Nurse Partnership (FNP) as part of a developing family hub model.
The children's play team at UHCW continues to gather children's views of their hospital experience – using iPad games and a themed feedback wall. Every 24 hours the information is shared with staff for them to respond and make any necessary changes.
West Midlands Police have continued to use the voice of the child, as a victim, to shape their response to CSE. There is now a good practice model for supporting victims of CSE.


What Makes You HAPPY in Hospital?
Sad

To listen to and learn from the voice of the child and young person and to ensure that this learning shapes the way in which services safeguard young people in Coventry.

Within Coventry and Warwickshire Partnership Trust (CWPT) there is a Service User Assembly which gives children and their parents and carers a forum to be involved in the strategic development of services. There are also service user groups within the Family Nurse Partnership (FNP) and Children & Adolescent Mental Health Services (CAMHS).

Through their work managing adult offenders the Reducing Reoffending Partnership, supported by Barnado's has trained all their staff to consider situations through the eyes of a child, influencing the way in which decisions about licence conditions, breaches and prison recalls and releases are made.

The NSPCC facilitates a participation group for children and young people to enable them to explore their experience of working with the NSPCC and other agencies. This is then used to make practice improvements.

Conclusion
Previous good progress on this priority has continued. Individual organisations are improving their focus on children and within the Board itself, the testimony from children and young people has shaped thinking.

To ensure that the learning from Serious Case Reviews (SCRs) is used to improve outcomes for children and young people and that reviews are carried out efficiently and to timetable.

Since September 2016 we have not published any SCRs, although we are in the process of completing two. In the last six months we have focused on embedding the learning from Serious Case Reviews.

Multi-agency and relevant single agency training has been reviewed to incorporate learning from SCRs.

The Board has held a series of sessions focusing on learning from SCRs, with a particular focus on recognising neglect and parental drug and alcohol use.

The Board has also held a series of briefing sessions to frontline practitioners and managers across the partnership which has included learning from SCRs.

Information sharing has improved with GP practices being more fully engaged in the early help, through the common assessment framework, but there is still work to be done to ensure that decisions relating to cases that are stepped down from social care to partners are fully communicated and explained.

Previous work to educate parents about the risks of co-sleeping have contributed to a reduction in sudden infant deaths.

The key recommendations from the child sexual exploitation SCR demonstrated a need for long term support for those at risk of, or experiencing CSE, with particular emphasis on the support available to children when they become adults. The Board is currently working with Coventry Safeguarding Adults Board to deliver this recommendation and considering the potential of working with the voluntary sector.

A standard audit tool has now been developed for all multi-agency audits, which incorporates key lines of enquiry which will test whether learning from SCRs has been embedded in the long term.

Conclusion

We have consistently delivered well in relation to this priority. There is evidence of significant changes to ways of working that have improved outcomes for children and young people. Sound processes are in place for the completion of good quality, timely reviews. In particular, in the last six months we have provided training across the partnership in relation to the completion of individual management reviews (IMR). Arrangements are also in place that assure Board members that recommendations are embedded in practice. However, there is some work still required around sharing information when cases no longer require social care support but do need involvement from other partners and in relation to supporting children who experience or are at risk of CSE as they become adults.

To evaluate the impact of Early Help arrangements on outcomes for children.

Board members have continued to develop their approach to Early Help and how they judge its impact on outcomes for children. The Board completed a multi-agency audit evaluating the impact of Early Help (for more details see **Section 7**). The recommendations made it clear that there was more work to do to ensure partners are able to work together effectively to achieve sustainable improvements for families. The Early Help Board is now co-ordinating the implementation of the recommendations and will report progress regularly to the Effectiveness and Quality Subgroup. The work undertaken by agencies, this year, to ensure early help services are improved includes:

The Acting Early initiative brings midwives, health visitors and children's centre staff together to work in locality specific integrated teams. Through this work there are closer collaborative partnerships between all partners, including early help teams and schools. The programme is currently being evaluated.

Coventry City Council has adopted a 'strengthening families' approach across early help services. This whole family approach that builds protective factors and family resilience ensures that the root cause of families can be addressed, achieving more sustainable change. Ignite, Whitefriars Housing and Coventry City Council continue to work together in the Willenhall areas of the city; engaging with families to prevent rather than respond to crises and supporting families to achieve the outcomes they need to thrive in their homes and communities. This is achieved by building resilience and community support networks.

UHCW has continued to develop the iBumps teenage pregnancy service. It is focused on early intervention to support families through the whole antenatal period with a personalised and co-ordinated support package. Service users provide direct testimony of the positive impact the service has on their confidence as parents.

Conclusion

We have continued with our commitment to early help. Our audit work has demonstrated that there are some positive and lasting outcomes for children and families from our early help offer. However, there still remain some system problems making effective communication between early help and social care much more difficult than it needs to be and these need to be resolved. Continuing work to ensure that all services involved in early help communicate well with each other should result in more children getting the help they need in a timely fashion.

To ensure that missing young people and those at risk of sexual exploitation are protected by effective multi-agency arrangements.

The CSE strategy and plan have been revised in the last six months. This will ensure that our approach to CSE across the city remains focused on the current risks and issues. There continues to be a strong focus on understanding the picture of CSE locally and an increasing focus on prevention.

CSE Champions in each social work area continue to meet regularly with the Horizon Team to understand the intelligence picture around CSE and help practitioners to identify and understand the risks.

The multi-agency Horizon Team continues to work across teams providing support to social workers and other staff working with children who are at risk of or experiencing CSE. The Team is now starting to case hold, and use a relationship based model of working to build an enduring and trusting relationship with a child or group of children, leading to better outcomes for them. This has led to several significant prosecutions. Working with a range of voluntary agencies, Horizon has developed a victim care support package to ensure that the young people who bravely testified in the trial were supported through pre, during and post-trial leading to the retention of all witnesses involved. As a result of all their work the Horizon Team had its achievements acknowledged on a National level as it was awarded Silver in the Guardian Social Work Team of the Year Award. A specialist nurse is now embedded in the team to co-ordinate health assessments for all high/medium risk cases and developing a health framework for service provision for children experiencing, or at risk from, CSE.

Public Health continue to commission the Early Intervention Service – Compass Aspires. The service provides behavioural change interventions to young people identified as at risk from, or experiencing, CSE. It works closely with the Horizon Team and missing young people where there are identified sexual health, domestic abuse and substance misuse concerns.

A sexual violence prevention and an intimate partner violence protection project have recently been commissioned. Both projects involve the delivery of workshops in schools and youth groups. They are designed to address attitudes to women, improve self-esteem, educate about consent, identify acceptable and appropriate behaviour, explore issues of online safety, and raise awareness of CSE and grooming. This project is important in the progression of the prevention strand of our CSE work.

The police have obtained the first Risk of Sexual Harm Order in the West Midlands and continue to apply for these, along with harbouring notices to further reduce the risk of sexual exploitation within the city.

To ensure that missing young people and those at risk of sexual exploitation are protected by effective multi-agency arrangements.

More awareness events have been held over the last six months including (CSE Awareness Day event) a week of targeted activity to coincide with the National Working Group (NWG) CSE awareness raising day on 18 March 2017. People in Coventry were urged to unite against CSE and make a personal pledge to help tackle the abuse.

Information on missing children continues to be regularly reported to the Board. The Council has developed systems to manage and respond to missing children and agencies are now more able to deliver an effective cross agency response. More return home interviews are being completed but there are improvements that need to be made to the way in which information from those interviews is used to inform effective responses.

Coventry City Council has set up a monthly panel to review supported accommodation. This is a multi-agency meeting involving housing providers, substance misuse services, early help workers and community safety officers. The panel discusses young people living in supported accommodation who are considered at risk and identifies strategies for supporting them better and helping them to stay safe.

Conclusion

Progress on this priority continues to be good. Services are focused on supporting victims as well as acting to find and stop would be perpetrators and perpetrators. However, there is still work to do to ensure that learning from previous multi-agency audits and SCRs is embedded in practice. There is evidence that the response to missing children is improving but more work is still needed to understand the patterns and learn how to reduce repeat episodes in a child focused way.

To ensure that children and young people are protected from domestic violence by effective multi-agency arrangements.

We have continued to progress our work in this area, ensuring that the various agencies dealing with domestic violence work well together and the multi-agency arrangements are fit for purpose.

The Board continues to work with the Police & Crime Board to ensure that domestic violence training across the city is well co-ordinated. This helps protect children by ensuring that there is a common understanding across the city and clarity on when to act.

Single agency work relating to this priority includes:

The Reducing Reoffending Partnership runs an accredited perpetrators programme called Building Better Relationships. This involves behaviour change focused group work with perpetrators of domestic violence in Coventry and support to victims.

The NSPCC has commissioned a new domestic abuse service, Steps to Safety. This will work with victims of domestic abuse and their children to ensure that children can express their experience of living with domestic abuse and that the impact of domestic abuse on children is better understood by professionals.

Police, Council and Health partners have reviewed the work together in the domestic violence screening process. This allows information sharing and action to be conducted more easily and improves the quality of subsequent safety planning.

Coventry City Council and adult substance misuse service providers have worked together to deliver hidden harm training to family workers across the city. This helps professionals to identify substance misuse as a hidden issue in other family problems, such as domestic abuse.

Conclusion

There has been some progress on this priority with increased action to support victims but more still needs to be done to reduce the incidence of families affected by domestic abuse.

Statutory responsibilities

Statutory Responsibilities

This annual report is an interim report covering the period September 2016 to March 2017. Our statutory responsibilities in relation to the following were summarised in our September 2016 Annual Report:

- our biennial assessment of all LSCB member agencies and organisations, in relation to their duties under Section 11 Children Act 2004
- an annual self-assessment of educational establishments to review the effectiveness of the arrangements for safeguarding children, in relation to their duties under S157 and S175 Education Act 2002, Keeping Children Safe in Education 2015 and Working Together 2015
- an annual report from the Child Death Overview Panel (CDOP)
- an annual report from the Local Authority Designated Officer (LADO)

An updated report on our work in these areas will be included in our April 2018 Annual Report, as they have not been completed in the period covered by this interim report.

Board development, learning and improvement

Board development, learning and improvement

Board development

The last annual report identified that the Board needed to focus on improving the quality of information recording and information sharing, providing a coherent multi-agency response to safeguard children from neglect and co-ordinating a multi-agency response to understanding the mental health and wellbeing of children in Coventry. These issues were considered at a Board workshop to reconsider the priorities. The workshop also considered what is working well and areas for improvement as evidenced in our learning from single agencies as well as our shared learning from SCRs, multi-agency audits and horizon scanning of regional and national issues. The Board subsequently agreed a new set of priorities and work plan to commence in April 2017. These new priorities are explored in more detail in **Section 10.**

In December we worked with the Local Government Association to complete a peer review of the work of the Board. The headline findings of the reviewers were that:

- Structures, processes and procedures are in place and are underpinned by a genuine willingness for partners to work together, but that the Board needs to evidence this maturity through increased formal constructive challenge and greater direct impact upon the lives of children and young people.
- The structure of the Board and its sub-groups are appropriate, with good formal and informal liaison between the sub-groups.
- The Board is cultivating an increasingly pragmatic approach to its bureaucracy, but also needs to ensure that it is intolerant of any delays that affect the embedding of the actions agreed.
- There are initiatives to improve common understanding of thresholds, early help and neglect issues, but work is not owned across the partnership.
- The Board has demonstrated an ability to ensure good joint working on agreed priorities, particularly Child Sexual Exploitation (CSE)

The peer review recommended that in order to progress the issues outlined in the feedback report, the Board should:

- cultivate a sense of urgency as regards all its improvement actions and be intolerant of delay
- make sure it understands what is happening 'on the ground'
- create a culture of collective challenge from very senior level outwards
- when planning, be specific as to whose responsibility it is to take the next step
- make sure action plans are impact focused upon the child and delivery is audited
- develop the multi-agency audit approach to ensure a sharper focus on practice improvement

- ensure the Learning and Improvement Framework is developed to become a continuous improvement activity that includes Board actions that in turn improve children's lives and frontline practice
- refine its dashboard to focus upon its priorities
- ensure it is satisfied that priorities are realistic and achievable

The Board has considered the peer review report and an action plan has been created in response to the areas for development. This will now need to be incorporated into our work plan for the coming year, however some significant changes have already been made.

Quality assurance and audit

There is now a standard tool for multi-agency audit which outlines key lines of enquiry and ensures that the Board can monitor the extent to which recommendations from previous audits and SCRs are embedded in practice in the long term. An audit toolkit is also being developed which outlines a range of methodologies, other than case file audit, for quality assurance work which will allow for findings to be better tested and triangulated. Practitioner forums have also been introduced into the audit process. This will help the Board to better understand the barriers to some improvement activity becoming fully embedded, so that it can then work to remove those barriers.

Performance information

The Board also held a workshop to review our dashboard of performance measures. Strategic leaders from all our partners attended and worked to create a framework that is more closely aligned with priorities and more focused on assessing outcomes for children. The new performance dashboard will be used from April 2017 and will ensure that the Board can make better informed decisions about where future work is needed.

Learning and development framework

A new learning and development framework has been developed to ensure that the Board is continuously improving. This will be in use from July 2017.

Learning events

As a Board we are committed to promoting our learning in a way that improves service delivery and outcomes for children. Over the last six months we have held a series of events which are summarised below:

LSCB briefings

We have held four briefings in the last six months, reaching over 120 frontline practitioners and their line managers. Through these sessions we have promoted the purpose and work of the board and focused on sharing the learning themes from our SCRs and our multi-agency audit work.

SCR learning and recognising neglect

We have held two training sessions in the last six months, covering recent case reviews with a particular focus on recognising and responding to neglect; this included an opportunity for practitioners to develop their skills and approach to parents while developing a positive working relationship.

Learning and improvement framework

The successful learning events that the Board has held form a substantial part of our Learning and Improvement Framework. This outlines all the ways in which disseminate and embed learning across the partnership and can be found **here**. We are now developing a revised framework to reflect the more mature understanding of learning and improvement by Board members, which will be published in July 2017.

The Board has also continues to develop its communication with professionals across the partnership. A newsletter is published regularly which has a wide readership at strategic and operational levels across the partnership. The Board makes regular use of Twitter and the website to promote its work and share information. In addition there is a standing 'Learning from Success' item at each Board meeting. At a deeper level the Board has also started to focus on key areas through 'Themed Questioning' at Board meetings. Additionally there has been a significant step forward in the sharing of learning from serious case reviews and multi-agency audit work, as detailed elsewhere in this report.

Quality assurance and policy development

Quality assurance and policy development

Quality assurance and audits

In the last six month period the rolling audit programme has included audits on CSE, care leavers' experiences and the impact of early help.

Child Sexual Exploitation (CSE)

This audit reviewed the effectiveness of multi-agency arrangements for supporting children at risk of and experiencing CSE. Examination of cases focused on the extent to which risk is identified early, the quality of risk and needs assessment and the effectiveness of planning and reviews. There was also an assessment of how well agencies worked together, the direct involvement of children and the impact of the support children received. A summary report of the findings can be found on our **website**. Recommendations included: refreshing the multi-agency CSE strategy, refocusing activity on prevention, specifically to ensure that risk reduction strategies are effective, ensuring that responses remain focused on the needs and views of the child at all levels of CSE risk and ensuring that appropriate mechanisms for measuring the effectiveness of support and impact on children's lives is embedded across the partnership.

The CSE strategy has already been revised and the CSE Sub-group is focusing its work for the year on the prevention agenda.

Care leaving experience

The purpose of this audit was to determine the outcomes for children leaving the care of the Local Authority as they become adults. Auditors focused on exploring how well care leavers are safeguarded, whether young people feel they were adequately prepared for independence and were able to influence the support they received, how well agencies worked together and whether improved outcomes for care leavers are achieved as a result of interventions. A summary report of the findings can be found on our **website**. Recommendations included: making better use of health assessments and plans to support care leavers, ensuring that personal advisors are involved at an early stage so that care leavers are able to build good relationships with a consistent professional throughout their care leaving. There was also a recommendation to improve the availability of education, training and employment support to care leavers resident outside of the city.

Impact of early help

The purpose of this audit was to explore how the early help offer within Coventry impacts on the lives of children and families who receive support through the common assessment framework. In particular the audit examined the sustainability of outcomes, the extent to which services were focused on

outcomes, how effectively partners worked together and how well children and families were able to directly influence the support they received. A summary report of the findings can be found on our **website**. Recommendations included: improving communication and understanding of LSCB guidance on applying levels of need to referral decisions, developing post intervention tracking to assess sustainability of support, embedding signs of safety as the preferred model of working and using a family hub model to improve multi-agency communication in the delivery of early help.

The Board has since agreed the adoption of signs of safety as the preferred model of working with families across the city and a roll out programme of training is now underway. A transformation programme to deliver family hub services is also at the consultation stage and will be rolled out throughout 2017.

The results of all audits are reported to Board and appropriate action plans agreed to implement any recommendations. The implementation of these is then monitored by the Effectiveness and Quality Subgroup. Our findings have also been shared with frontline practitioners through our LSCB Briefing Sessions and are published on our website. Updates are also publicised through our newsletter. As a result of this work we now have a clearer understanding of how well we are safeguarding children in Coventry and are putting things in place to share the good practice and learning that emanates from our audit activity.

Policy development

Following last year's comprehensive revision of our policies and procedures we have continued to review them when required, especially in the light of learning from SCRs.

Our policy and procedures can be found **here** and our advice on applying thresholds **here**.

Safeguarding training

Safeguarding training

The LSCB quality assures single agency training, and delivers a programme of specialist multi-agency training and development. It has good information about agency participation in its multi-agency training and it regularly evaluates the impact of such training on practice. It does not yet have good enough information about levels of safeguarding training within the overall safeguarding workforce.

Evaluating impact

Our multi-agency training programme is regularly evaluated to ensure that the impact on practice is understood. The evaluation includes an analysis of end of course and post course feedback specifically linked to impact on practice and evidence of how training has resulted in better outcomes for children.

The courses we have evaluated during 2015-16 include:

- Level 2 Working Together to Safeguard Children

Level 2 Working Together to Safeguard Children

All those who responded reported that the training had increased their confidence in working with other agencies around safeguarding children concerns.

Evidence of better outcomes for children included:

- School - worker helped a family to access support and made a referral to the school nurse to support work around sleeping habits. This resulted in better school attendance. Worker's manager reported that worker had a clearer understanding of the processes around safeguarding children in school.
- Early Years (PVI sector) – worker contributed to a meeting with parents and feels that parents trust her more now and are more open with her. This has resulted in a good open relationship.
- Early Years (Children's Centre) – it helped her around talking to parents about the safety of their child and resulted in a positive outcome and engagement with the setting.

Examples of other outcomes:

- Work based training – worker has put on extra training for other staff
- Early Years (PVI sector) – worker has more awareness of the need to observe children for any safeguarding concerns and to liaise with parents for information
- School – worker continues to work with children with success and positive results. Worker's manager reported that the course had clarified information and allowed the worker to have more informed dialogue.

Evaluation of course impact on practice continues to consistently show that participants become more effective by drawing on what they have been taught in the Board's multi-agency courses.

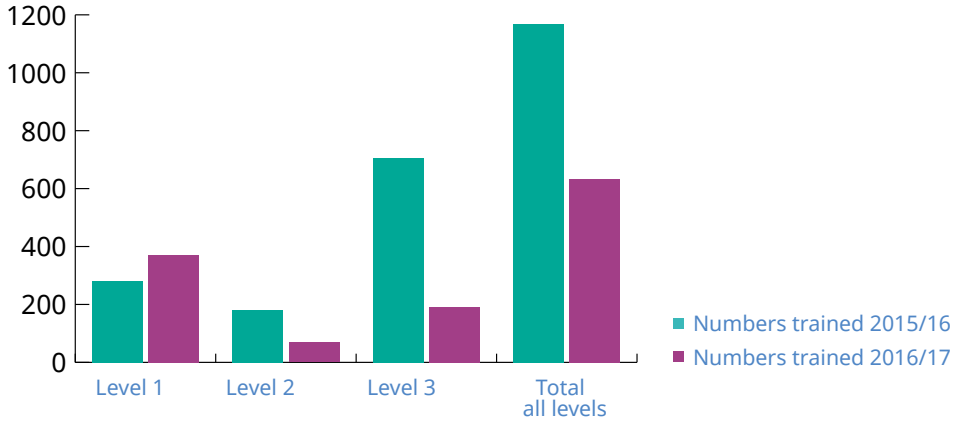
Multi-agency training participation

Agencies provide some in-house single and multi-agency training of their own. Agencies are responsible for advising staff, depending on job role, on which training they should attend. The training year runs from April to March. Two sets of training figures have, therefore, been provided (April 2016 to September 2016 and October 2016 to March 2017) to cover the Annual Report period. From April 2016 recording categories for training attendance have been changed, so it is difficult to make direct comparisons about individual agency participation. The tables and charts below show the overall take up of LSCB provided training. A full breakdown of training participation data can be found in **Appendix 1**.

	Level 1	Level 2	Level 3	Total
Numbers trained 2015-16	280	182	706	1168
Numbers trained 2016-17 (Oct - Mar)*	372	69	191	632
Combined numbers for 2016-17	499	108	668**	1275

* Full reporting for this period can be found on Appendix 1

** Number includes annual conference and SCR learning sessions



In 2015/16 1,170 professionals attended inter-agency training, in 2016/17 1,275 attended training courses. One of the main factors which contributed to the increase in figures this time is an ongoing project with Coventry Muslim Forum around safeguarding responsibilities which includes Level 1 training for Madrasah teachers.

CAF training

The CAF training is delivered by colleagues within the CFF Service, which forms part of the City Council. There are three types of CAF training provided across the LSCB.

Lead professional CAF training

This is offered to professionals who will complete CAF assessments and take the role of Lead Professional/Keyworker. It is delivered by the team of Coventry CAF Co-ordinators who work within the CFF Service.

CAF Awareness Training

This important training is offered to professionals who require an overview of the CAF process and the knowledge needed to attend the Team Around the Family meetings and contribute to the CAF plan. It is delivered by the team of Coventry CAF Co-ordinators who work within CFF.

eCAF Training

eCAF is the electronic recording system for CAF. Training is offered to professionals who have completed Lead Professional or CAF awareness training. It is delivered by a small team of three people and led by the Coventry eCAF Co-ordinator. Drop-in sessions for support and general queries are also run for eCAF. These are held on a weekly basis, led by the Coventry eCAF Co-ordinator and are well attended.

Agency training and development

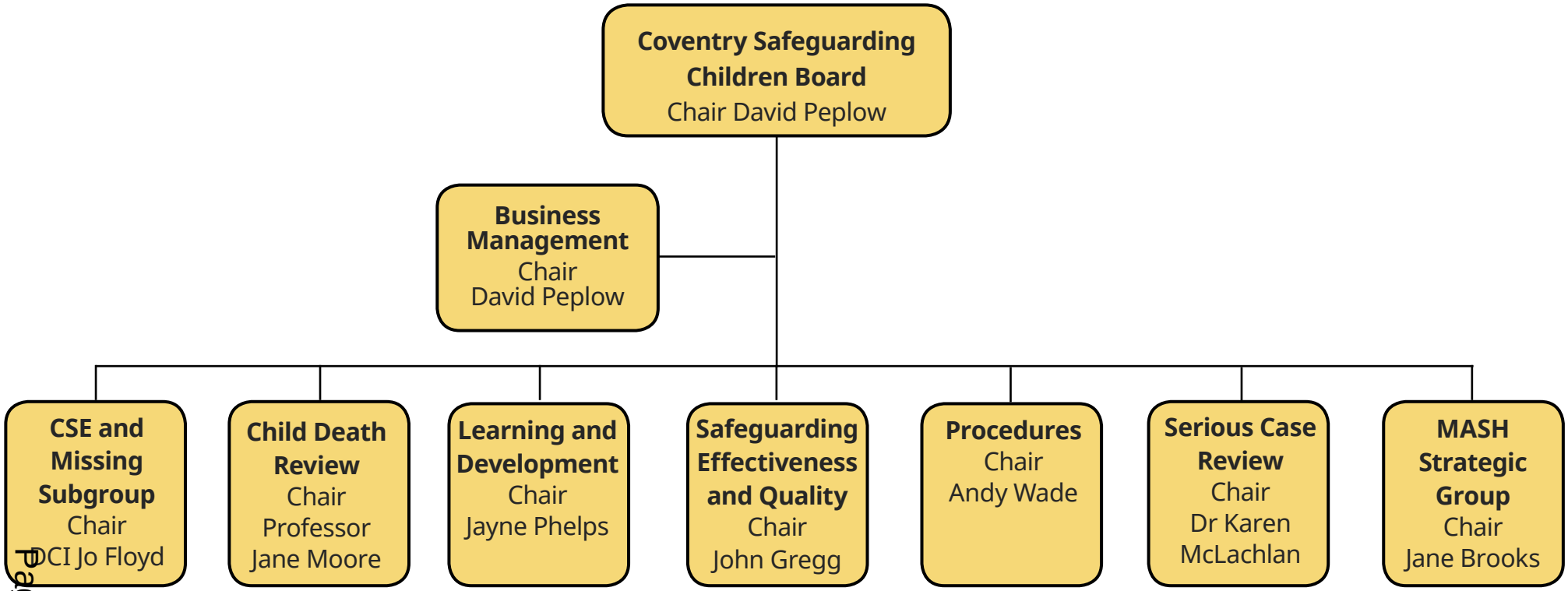
Partner agencies have their own systems and processes in place for ensuring their staff are suitably trained in relation to safeguarding issues and to their role and responsibilities. A full summary of the training and development offered by each statutory agency will be included in our full annual report, due for publication after April 2018.

Governance and Accountability

Governance and Accountability

Board structure and membership

The requirements for LSCB membership are set out in Working Together 2015. The members of the Coventry Board and their attendance at Board are detailed in **Appendix 2**. Attendance is good. The Board structure is detailed below.



The Coventry LSCB sub-groups and panels have work plans which support those of the main Board and will be maintained to operate under the direction of the Coventry LSCB Business Management Group. Each sub-group has a distinct purpose and terms of reference.

Effectiveness and quality

The effectiveness and quality sub-group is responsible for meeting the statutory function in monitoring and evaluating the effectiveness of single agency and inter agency safeguarding processes, assessing the quality of work undertaken and enabling learning to be shared with all relevant agencies.

Child Death Overview Panel (CDOP)

The panel investigates the deaths of children in the area and uses the findings to take action to improve the health and safety of children and prevent other deaths.

Child Sexual Exploitation and Missing

This group ensures an effective response to children and young people who are missing from home or care; children and young people who are at risk of CSE or those who are being abused via Child Sexual Exploitation.

Policy and procedures

This group reviews and revises existing policies and procedures in the light of local and national priorities and changes; drafts new policies and procedures as required; and resolves issues arising in the day to day safeguarding processes.

Serious Case Review

This sub-group is responsible for ensuring the Board meets the statutory functions, in relation to SCRs. This includes making recommendations to the chair as to when a review should be carried out, carrying out reviews and ensuring the learning is shared across all partners, so that improved outcomes for children can be achieved.

Learning and development

The learning and development sub-group monitors the quality of multi and single agency safeguarding training and ensures that there is appropriate training available for, and accessed by, all staff who require it.

Multi-Agency Safeguarding Hub (MASH)

This group is responsible for the strategic management and review of the Coventry MASH and ensures that there are appropriate multi-agency arrangements in place for effective information collation and sharing, in relation to referrals to social care.

The Board also has a virtual communications sub-group. This group includes partners from a wide range of organisations who share learning, agree joint approaches to campaigns and media issues and ensure information is cascaded effectively within partner organisations.

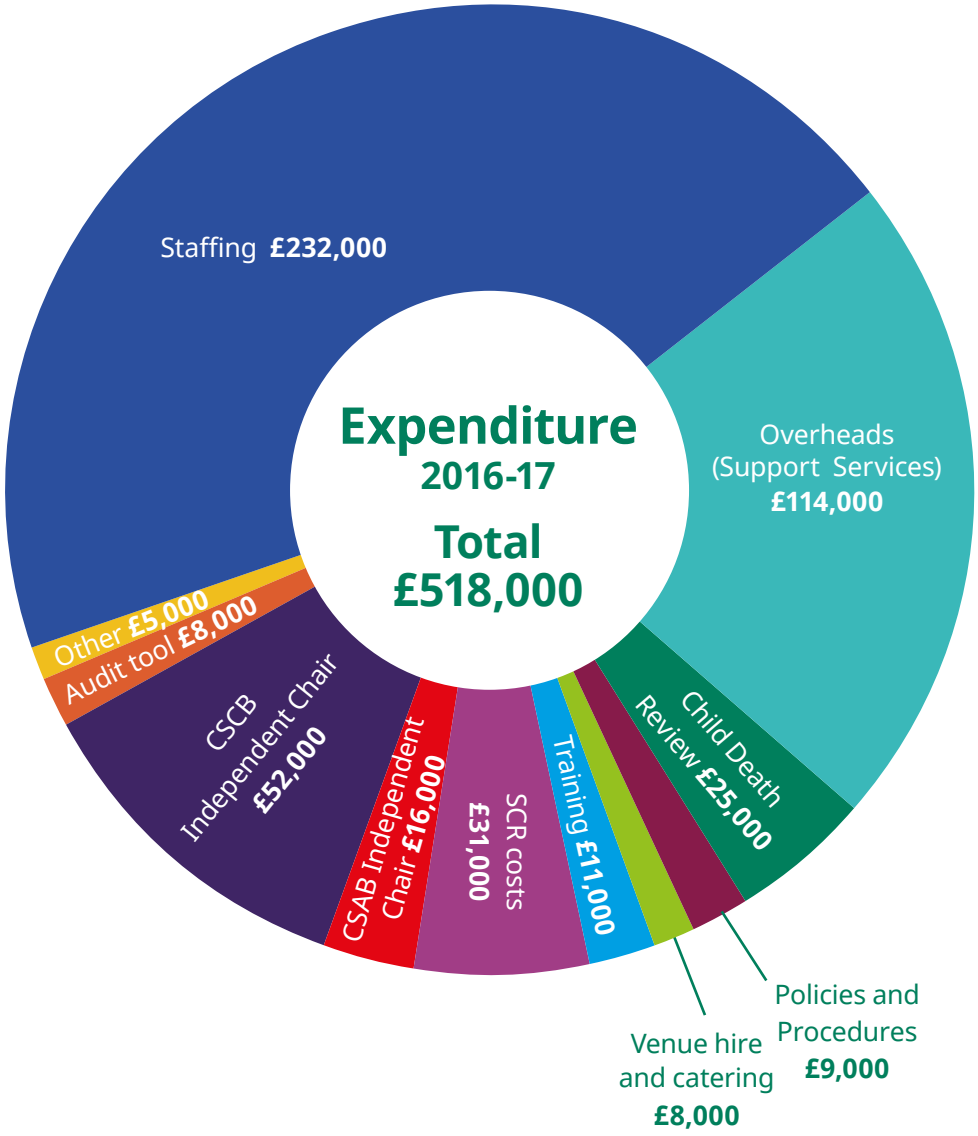
Coventry LSCB does not work in isolation in its aim to improve outcomes for children across the city. The work of other strategic boards also directs and influences the experience of children. There is a governance process between the LSCB, Coventry Safeguarding Adults Board (CSAB), the Police & Crime Board, the Health and Wellbeing Board, the Improvement Board and the Children and Young People Partnership Board to ensure effective working together. Lead officers for each board meet bi-monthly to support this.

They review work plans, priorities and future plans to ensure synergy and manage overlaps, and agree a lead Board where overlaps do occur. This group will also review the effectiveness of the way in which the Boards are able to work together. The chairs of each strategic board meet quarterly to discuss challenges in areas of mutual interest and to review reciprocal membership arrangements. This enables greater collaboration when there is a shared agenda. This has been particularly evident in the joint hosting of the safeguarding and radicalisation awareness event.

Budget

The Board operates a joint budget supporting the work of the Coventry Safeguarding Children's Board and the Coventry Safeguarding Adults Board. In financial year 2016/17 the expenditure budget was £487,000. The actual expenditure was £507,000. Consequently there was an overspend of £20,000. A breakdown of the expenditure can be seen opposite.

Agencies have contributed to the operation of the Board. 78% of funding for the Board is provided by Coventry City Council, 15% by Coventry and Rugby Clinical Commissioning Group, 6% by West Midlands Police and 1% by probation services. There is also a small contribution from CAFCASS. All agencies contribute by hosting meetings, including organising tours of their buildings and facilities and hosting learning events.



Priorities for 2017 / 2018

Priorities for 2017/18

This report outlines clearly the progress that has been made in improving safeguarding in Coventry. Board partners are now committed to a shared set of priorities and there is a genuine willingness for partners to work together. Both multi-agency practice and individual partner audits are robust and there have been significant improvements to the way learning from SCRs is embedded; but there is still work to be done to ensure that all multi-agency processes are good all the time.

To ensure that partners are able to build on this strong foundation of effective partnership working, the Board has agreed a new set of priorities. Reflecting the developing maturity of the board, they are more focused on safeguarding concerns affecting children in Coventry and less focused on the development of the Board itself.

Our plan on a page provides more detail about how we will progress and achieve our priorities and can be found in **Appendix 3**.

Our priorities for 2017/18 will be to ensure that:

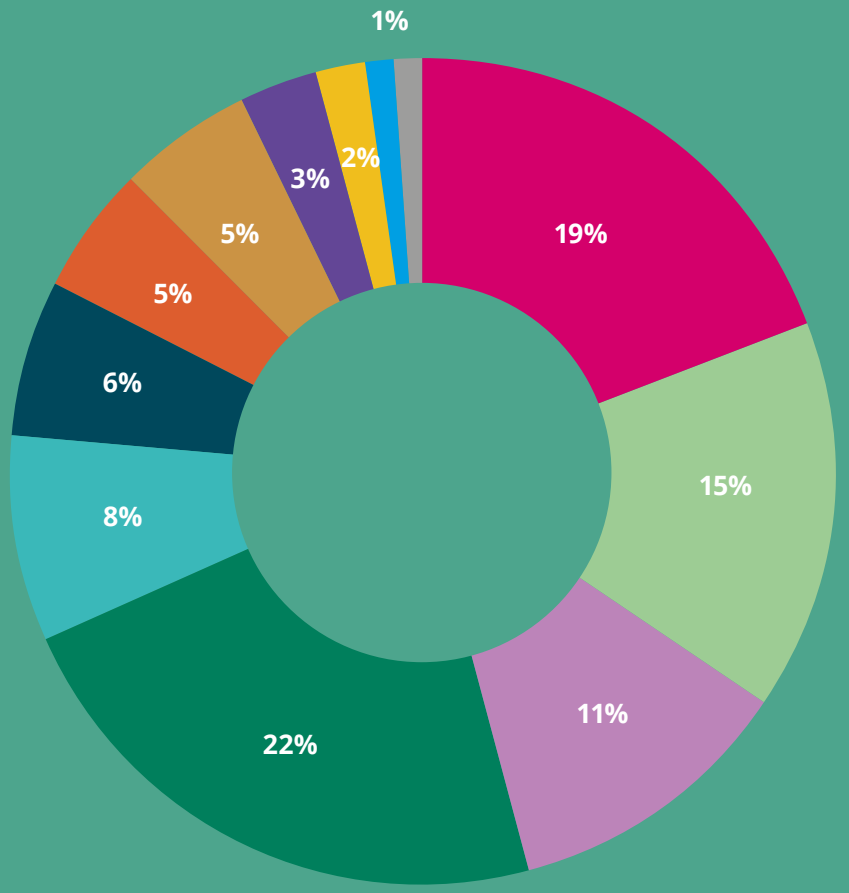
1	Children and young people who are looked after have equal opportunities to other children and young people.
2	Early help services, including mental health support, are available to children and young people and are resulting in positive outcomes.
3	Missing children and young people, and those at risk of Child Sexual Exploitation, are protected by effective multi-agency arrangements.
4	The profile of understanding of emotional abuse and neglect, including domestic abuse, is raised, that abuse is identified as early as possible, and that appropriate interventions are provided to prevent further abuse and harm.
5	The Board to work towards developing the safeguarding partnership and continue to look forward and improve in light of the Wood Report and Children and Social Work Act.

Appendices

Appendix 1: Multi-agency training statistics

Total trained

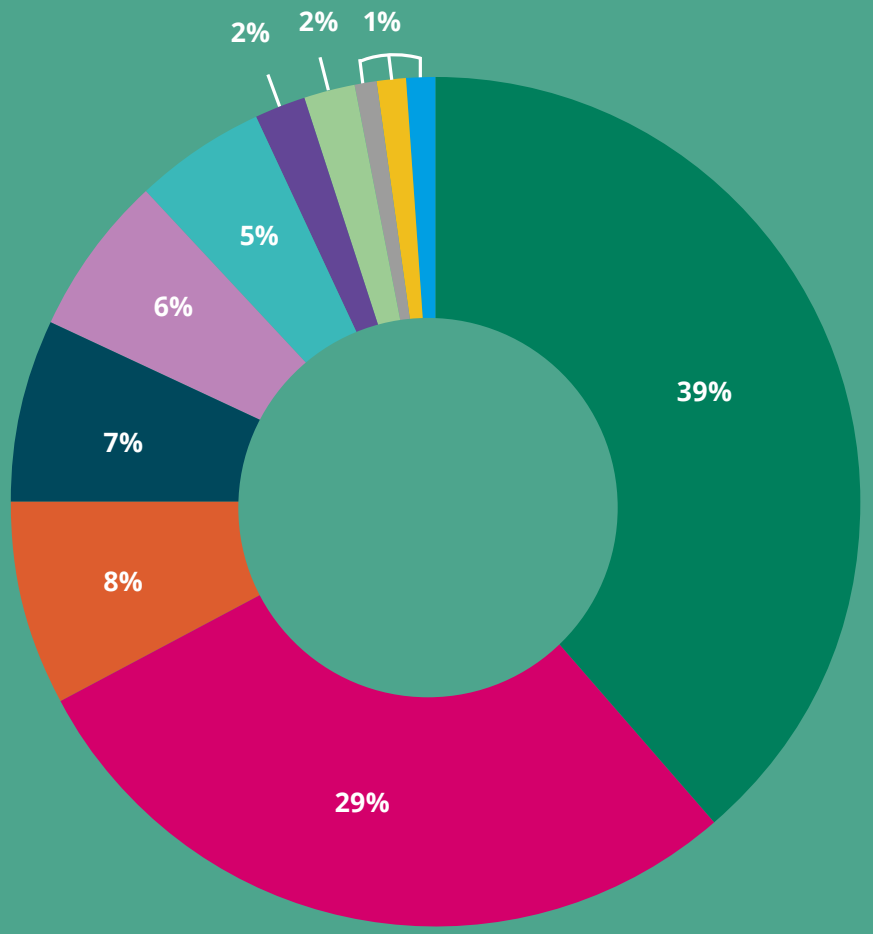
Category	Total trained in 2016/17 Oct to March	%
Early Years Providers	114	19
CWPT	92	15
Primary Schools/Secondary/Academies	70	11
Faith Groups	136	22
Vol/Indie/Private	46	8
Other	36	6
Local Authority (other)	31	5
UHCW	31	5
Children's Centres	21	3
Social Care	14	2
Children & Families First Team	8	1
Private Schools	4	1
Police	3	0
CRC Probation	2	0
Public Health	1	0
FE Colleges	0	0
Youth Services/YOS	0	0
Coventry and Rugby CCG	0	0
National Probation Service	0	0
CAFCASS	0	0
NHS England	0	0
WMAS	0	0
Total	**609**	**100**



* Some Early Years organisations fall within the Local Authority but for these figures they are included in the separate category so that the whole range of Early Years organisations can be counted together. Those which are separate to Local Authority include private and voluntary nurseries, child-minders and crèches.

Level 1

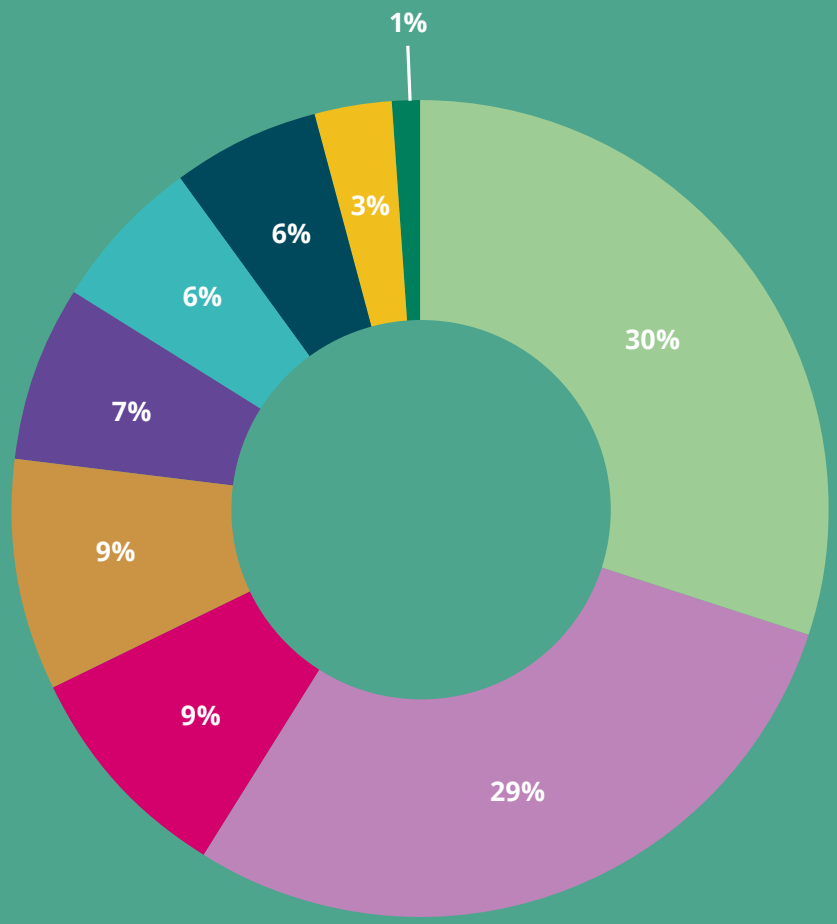
Category	Total trained in 2016/17 Oct to March	%
Faith Groups	135	39
Early Years Providers	103	29
Local Authority (other)	27	8
Other	25	7
Primary Schools/Secondary/Academies	20	6
Vol/Indie/Private	19	5
Children's Centres	7	2
CWPT	6	2
Private Schools	3	1
Social Care	2	1
Children & Families First Team	2	1
FE Colleges	1	0
Youth Services/YOS	0	0
UHCW	0	0
Coventry and Rugby CCG	0	0
WMAS	0	0
NHS England	0	0
Public Health	0	0
National Probation Service	0	0
CRC Probation	0	0
CAFCASS	0	0
Police	0	0
Total	**350**	**100%**



N.B. Some organisations deliver their own in-house training which is equivalent to Level 1 training.

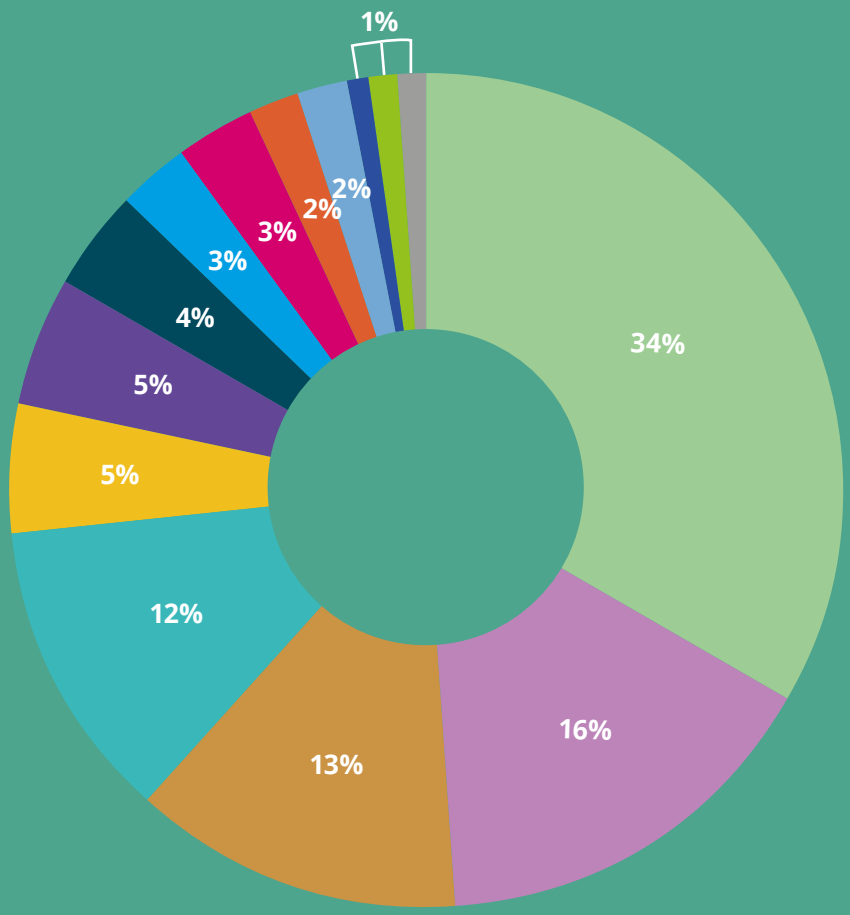
Level 2

Category	Total trained in 2016/17 Oct to March	%
CWPT	21	30
Primary Schools/Secondary/Academies	20	29
Early Years Providers	6	9
UHCW	6	9
Children's Centres	5	7
Vol/Indie/Private	4	6
Other	4	6
Social Care	2	3
Faith Groups	1	1
Private Schools	0	0
Coventry and Rugby CCG	0	0
WMAS	0	0
NHS England	0	0
Children & Families First Team	0	0
Public Health	0	0
Local Authority (other)	0	0
Youth Services/YOS	0	0
National Probation Service	0	0
CRC Probation	0	0
CAFCASS	0	0
Police	0	0
FE Colleges	0	0
Total	**69**	**100%**



Level 3

Category	Total trained in 2016/17 Oct to March	%
CWPT	65	34
Primary Schools/Secondary/Academies	30	16
UHCW	25	13
Vol/Indie/Private	23	12
Social Care	10	5
Children's Centres	9	5
Other	7	4
Children & Families First Team	6	3
Early Years Providers	5	3
Local Authority (other)	4	2
Police	3	2
CRC Probation	2	1
Public Health	1	1
Private Schools	1	1
National Probation Service	0	0
FE Colleges	0	0
Youth Services/YOS	0	0
Coventry and Rugby CCG	0	0
WMAS	0	0
NHS England	0	0
CAFCASS	0	0
Faith Groups	0	0
Total	**191**	**100%**



Appendix 2: Coventry LSCB board membership and attendance

The table below lists the current membership of the LSCB. Correct as of 26 April 2017.

Board Member	Title/Organisation
David Peplow	Independent Chair, Coventry Safeguarding Children Board
Tracey Wrench	Vice Chair, Director of Nursing and Quality, CWPT
Gail Quinton	Executive Director, People Directorate, CCC
Kirston Nelson	Director of Education, CCC
John Gregg	Chair of Effectiveness and Quality Subgroup, Director of Children's Services
Danny Long	Chief Superintendent, Policing, West Midlands Police
Jacqueline Barnes	Interim Director of Nursing, NHS England West Midlands
Andy Wade	Chair of Policies & Procedures Subgroup, Head of Service, West Midlands, National Probation Service
Robert Coles	Head of Safeguarding, West Midlands Ambulance Service
Carmel McCarthy	Director of Housing Operations, Whitefriars Housing
Andrea Simmonds	Partnerships Officer, West Midlands Fire Service
Glynis Washington	Deputy Chief Nursing Officer - Coventry & Rugby CCG
Paul Green	Headteacher, Lyng Hall Secondary School
Kobina Hall	Head of Coventry/Solihull, The Staffordshire & West Midlands Community Rehabilitation Company Limited
Dr James Burden	Safeguarding Lead GP, NHS
Cllr. Ed Ruane	Cabinet Member, Children & Young People, CCC
Vacant	Community Lay Member

Name	Title/Organisation
Cllr. John Blundell	Leader of the Opposition, Member Services
Carmel McCalmont	Associate Director of Nursing (Women & Children's/Safeguarding)/ Head of Midwifery, UHCW
Liz Gaulton	Interim Director of Public Health
Gill Mulhall	Headteacher, Little Heath Primary School
Debbie Newman	Headteacher, Corpus Christi Primary School
Michelle Horn	Primary Care Lead Nurse, Coventry & Rugby CCG
Jayne Phelps	Chair of Learning & Development Subgroup Designated Nurse, CCG
Peter Turgoose	Service Manager, Coventry NSPCC
Julie Newman	Legal Advisor, CLYP & Adults Manager, Legal and Democratic Services
Neil Macdonald	Strategic Lead Quality Assurance and Safeguarding, People Directorate CCC
Dr Jo Gifford	Consultant Community Paediatrician, Interim Designated Doctor, Coventry & Rugby CCG & Named Doctor for CP, CWPT
Debbie Wright	Principal, Further Education
Linda Cane	Service Manager, CAFCASS
Ian Green	Detective Chief Inspector, Specialist Children Team, West Midlands Police, Chair of CSE & Missing Steering Group
Officers to the Board	
Vacant	Business Manager, Safeguard Children & Adults Boards
Mo Ali	Business Support, Safeguarding Children Board (Minuting)
Anne Pluska	Learning & Development Co-ordinator

Board attendance is summarised in the able below. There is an agreement in place for NHS England and West Midlands PPU to attend as required.

Organisation	12/10/16	24/11/16	26/01/17	22/03/17	Meetings attended	Meetings expected at	%
Independent Chair LSCB					4	4	100
Coventry & Rugby CCG					4	4	100
Coventry & Rugby CCG (Designated Doctor)					3	4	75
CWPT					4	4	100
UHCW					4	4	100
GPs					2	4	50
NHS England					3	4	75
Public Health					3	4	75
West Midlands Police - Policing					3	4	75
West Midlands Police - PPU			N/A		3	3	100
Local Authority (Executive Director)					4	4	100
Local Authority (Children's Services)					4	4	100
Local Authority (Safeguarding)					3	4	75
Local Authority (Education and Inclusion)					3	4	75
Local Authority (Early Years)				N/A	3	3	100
Primary Schools					3	4	75
Secondary Schools					3	4	75
Further Education					3	4	75

Organisation	12/10/16	24/11/16	26/01/17	22/03/17	Meetings attended	Meetings expected at	%
Community Lay Member					0	4	0
Councillors (participant observers)					4	4	100
Community Rehabilitation Company					1	4	25
National Probation Service					3	4	75
NSPCC					2	4	50
West Midlands Fire Service					0	4	0
WM Housing					4	4	100
West Midlands Ambulance Services		N/A	N/A	N/A	1	1	100
South Warwickshire Foundation Trust			N/A	N/A	2	2	100
Legal Services					4	4	100
CAFCASS	N/A		N/A	N/A	1	1	100
Officers to the board							
Business Manager, LSCB					4	4	100
Training Co-ordinator					3	4	75
Administration					4	4	100

Appendix 3: Coventry LSCB Plan on a Page

Priority	Why	Metrics	Outcomes
1. The Board to ensure that children and young people who are looked after have equal opportunities to other children and young people.	• To ensure equality of opportunity for all children in Coventry • The full picture for children who are looked after is not clear	• Data set has to be compared with children who are not looked after and OOC looked after children • Number of placement breakdowns • Percentage of moves to permanency • Health assessments • Dental health checks • Quality of health assessments • Educational attainment and NEET • Disproportionality around missing and CSE • Youth justice and criminality figures • Virtual school data	Children who are looked after have equal opportunities to children who are not, and information is used to support and care for children and young people in a way that meets their needs.
2. The Board to ensure that early help services, including mental health support, are available to children and young people and are resulting in positive outcomes.	• To ensure that early help is given both to children and to young people experiencing challenges • To ensure that early help supports families to build strength and to overcome challenges	• Number of children in care, LAC, CP plans, CAFs (including repeat CAFs), re-referrals • Appropriate attendance at health screening • Response to children who demonstrate distress e.g. self-harm • Healthy height and weight • Number of CAMHs referrals • Reduced referrals to social care • Number of early help assessments • Pre and post diagnostic support for children and young people with autism and ADHD • Autism and ADHD diagnosis waiting times • Results from Ignite Project	Children live in nurturing and supportive homes.
3. The Board to ensure that missing children and young people, and those at risk of CSE, are protected by effective multi-agency arrangement.	• Good progress has been made in Coventry, but good practice is not sufficiently embedded to be business as usual • There are further areas for development, particularly in relation to long-term support and police understanding	• Missing children data- number, episodes, frequency and patterns, location • CSE numbers and risk levels, then risk reduction • Content of return home interviews and how these are used to inform practice (e.g. review 2 RHI every month) • Referral source • Use of blame language recorded by professionals reduces	Children are protected from abuse and exploitation and enjoy their childhood.
4. The Board to ensure that the profile of understanding of emotional abuse and neglect, including domestic abuse, is raised and that abuse is identified as early as possible.	• SCRs have identified that children are too frequently left in neglectful situations for long periods of time • Neglected children are at risk of other sources of harm	• Reduction in domestic abuse incidents • Increase referrals for time to talk • Reduced CP plans where the abuse category is neglect or emotional abuse • CAF plans	Children have positive relationships and feel safe at home.
5. The Board to work towards developing the safeguarding partnership and continue to look forward and improve in light of the Wood Report and Children and Social Work Act.	• The context for safeguarding Board arrangements is changing and the Board needs to ensure that CSCB structures are fit for purpose • To ensure that all relevant partners are engaged	• Attendance at Board meetings • Attendance at sub-group meetings • Challenge tracker • Multi-agency training	That safeguarding activity is maintained through the transition process and that regulations outlined in legislation and guidance are complied with. That the Board is responsive and flexible to changes locally and nationally.

This page is intentionally left blank

Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 16th October 2017**

From: Eira Hale, Safeguarding Board Business Manager

Title: Coventry Safeguarding Adults Board Annual Report

1 Purpose of the Note

1.1 To inform the Health and Wellbeing Board of the content of the Annual Report of the Coventry Safeguarding Adults Board 2016/17. A full copy of the report is attached as an appendix.

2 Recommendations

2.1 The Health and Wellbeing Being Board is asked to consider the content of the Coventry Safeguarding Adults Board Annual Report and make any comments to the Independent Chair, which may assist the Safeguarding Board in fulfilling its assurance role of the effectiveness of safeguarding for adults in Coventry.

3 Information/Background

3.1 The Coventry Safeguarding Adults Board is a multi-agency partnership made up of a range of organisations that contribute towards safeguarding in Coventry. Although Coventry has had an Adults Safeguarding Board in place for many years, it is now a statutory requirement under the Care Act.

3.2 The Board is required to publish an annual report and business plan. The report should summarise the key messages from the year and also include a business plan which enables the Board to plan upcoming work. The business plan is included in the annual report.

3.3 The annual report also includes the performance data for the year as an appendix. The Board monitors the performance quarterly at full Board meetings.

3.4 The Safeguarding Adults Board seeks to raise awareness of safeguarding adults, and the annual report is a key way of doing this. The annual report was presented to Scrutiny Board (5) on 13th September 2017.

4 Key Messages

4.1 CSAB has made good progress in ensuring that learning from Safeguarding Adult Reviews (SARs) is embedded into training and practice.

4.2 There has also been good progress in the way in which agencies are able to make safeguarding personal.

4.3 The independent chair continues to work closely with the Chairs of the Local Safeguarding Children's Board, Police & Crime Board and Health and Wellbeing Board, through the Strategic Boards Group. This area of work is important to develop and continue. This will ensure that where Boards have a shared interest in a subject area there is clear ownership, as well as a forum for discussing the way forward on interdependencies.

Report Author(s):
Name and Job Title: Eira Hale, Safeguarding Boards Business Manager
Directorate: People
Telephone and E-mail Contact: 024 7629 4704; eira.hale@coventry.gov.uk
Enquiries should be directed to the above person.

Coventry Safeguarding Adults Board

Annual Report 2016/17

Coventry Safeguarding Adults Board

Board partners

National Probation Service

NHS England

Staffordshire & West Midlands Community Rehabilitation Company PROBATION

Coventry and Warwickshire NHS Partnership NHS Trust

West Midlands Ambulance Service NHS Trust

University Hospitals Coventry and Warwickshire NHS Trust

NHS Coventry and Rugby Clinical Commissioning Group

Coventry City Council

healthwatch Coventry

WEST MIDLANDS FIRE SERVICE

Contents

Message from the Chair

I am pleased to be writing my third introduction as Independent Chair of the Safeguarding Adults Board.

It has been a busy year in which we have embedded the principles of the Care Act in practice and improved the way in which we safeguard people in a personalised way. We continue to learn from reviews of practice and have taken steps to ensure that this learning extends to providers who are contracted to provide services on our behalf. We have renewed our focus on listening to members of the public through a new engagement plan, but recognise that there is more that we can do in this area. Over the next year we will focus on responding to what members of the public tell us about their experiences of safeguarding issues. By doing this, we hope to build awareness of safeguarding in communities and empower communities to be safe places for everyone to live.

Towards the end of this report we have outlined our new strategy for 2017/18. Over the last two years, the Board has matured and developed. We felt the time was right to review our strategy and become more outwardly focused. This will enable us to ensure that adults with care and support needs in Coventry receive the very best safeguarding service from agencies across the city.

We have tried to make this report short and focused, if you would like more information on the Board then please contact the Board's Business Office on 024 7683 2568 or e-mail: CoventrySAB@coventry.gov.uk

Alternatively you can visit our website

I would like to thank Board members and staff for their hard work this year, and look forward to continuing to work together.

Joan Beck
Independent Chair
Coventry Safeguarding Adults Board

About us

Who we are

Coventry Safeguarding Adults Board (CSAB) is a formal body made up of statutory and voluntary members, which oversees how adults are safeguarded in the city. The Care Act 2014 names partners on the Board as the Local Authority, Police and Clinical Commissioning Groups (CCG). We believe that safeguarding is everybody's responsibility, and we have a wide range of members, including: Coventry Warwickshire Partnership Trust, West Midlands Fire Service, West Midlands Ambulance Service, University Hospital Coventry and Warwickshire, Community Rehabilitation Company, National Probation Service – West Midlands, NHS England and Healthwatch.

Although we meet as a Board four times a year, sub-groups and task and finish groups carry on work on the Board's behalf throughout the year.

Who we help

Safeguarding duties apply to an adult who has care and support needs (whether or not the local authority is meeting any of those needs) and:

- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

What we do

We give leadership and guidance to agencies. We also check that arrangements are in place to deal effectively with allegations of abuse and neglect. We aim to enable the professionals who work with adults with care and support needs to act and keep people safe, while ensuring those accused of abuse or neglect, are dealt with appropriately.

How we have made a difference

Our purpose is to promote partner agencies to work together, co-ordinate the work of partner agencies and assess the difference that we make to adults with care and support needs in Coventry. This section presents some highlights of the work agencies have done to deliver Board priorities. We have included some real life stories that demonstrate how our work has improved the lives of adults with care and support needs in Coventry.

The Care Act drives improvement and is embedded in practice
The local authority has developed a quality assurance framework to be introduced in April 2017. The framework focuses on improving and maintaining quality of practice and will demonstrate how the principles of the Care Act 2014 and the Mental Capacity Act 2005 are embedded in practice.
In September 2016 an Adult Safeguarding Champions Forum was held to share lessons learned from Safeguarding Adult Reviews with practitioners in the statutory, voluntary and independent sectors.
Positions of Trust Policy and Best Practice Guidance were approved and published (**to read a copy click here**).
The safeguarding co-ordinator within the local authority works closely with the Local Authority Designated Officer (LADO) on cases where there is the potential for transferable risk between child protection and regulated adult workers.
The Community Rehabilitation Company (CRC) has embedded learning from safeguarding adult reviews by ensuring that a clear adult safeguarding policy is available for all frontline workers to use.
The Clinical Commissioning Group (CCG) has amended contracts to reflect learning from Safeguarding Adult Reviews, to ensure that there are contractual levers to drive quality and maintain safety. The CCG monitors progress at monthly Clinical Quality and Performance Meetings.
University Hospital Coventry & Warwickshire (UHCW) has introduced a newsletter and revised training to inform staff of key adult safeguarding issues, including lessons learned from Safeguarding Adult Reviews.
West Midlands Police have appointed two members of staff to review continuous professional development training (CPD) and ensure that lessons learned from Safeguarding Adult Reviews are appropriately embedded in training.

The Board engages with members of the public, voluntary sector and small providers

We have produced a communication and engagement plan which will continue to shape the way in which we speak with, and listen to, members of the public, voluntary sector and small providers.

Safeguarding awareness within communities and small providers has been raised through work with the Interfaith Forum, Voluntary Action Coventry and the Providers Forum.

Practitioners from across our partners attend Adult Safeguarding Champions Seminars throughout the year – exploring a range of safeguarding issues, including modern slavery, female genital mutilation and making referrals.

University Hospital Coventry & Warwickshire has started to visit families involved in safeguarding enquiries to understand their experience of the process.

When we undertake a Safeguarding Adult Review (SAR) we routinely work closely with families and shape the way we do our work as a result of what they tell us.

We launched our newsletter, aimed at professionals and the public, which is available on our website.

Real life story
Enhanced Care Team

The **Enhanced Care Team** at University Hospital Coventry & Warwickshire has received national recognition from NHS Improvement for its work to support the most vulnerable patients in the hospital who are expressing distress. The team is made up of staff with backgrounds in mental health, learning disability, care of people with dementia and intensive care. Patients and families benefit from having ECT workers who build up a consistent and meaningful relationship with the person they are caring for.

Read more about the project and the outcomes it has achieved.

The Board works effectively with key strategic boards

Our Board chair has continued to meet with the chairs of the Safeguarding Children's Board, Health & Wellbeing Board and the Police and Crime Board. The Annual Report is presented to the Health Wellbeing Board.

We have reported the impact of practice improvements following Safeguarding Adult Reviews to the Scrutiny Committee at Coventry City Council.

We continue to learn from the experience of the Safeguarding Children's Board, adopting parallel processes for audit, performance monitoring, Safeguarding Adult Reviews and checking on the implementation of learning.

We continue to be actively involved in working across the West Midlands region, particularly in the development of policy and procedure and in developing effective partnership working with organisations who have responsibility across multiple safeguarding adult boards.

Our partners who have a region-wide responsibility provide regular updates to the Board about regional issues.

Real life story
Say No To Infection

Say No To Infection is one of the quality improvement campaigns introduced across the care providers in Coventry and Rugby, by Coventry City Council and the Coventry and Rugby Clinical Commissioning Group. The campaign helps care staff understand the principles of minimising the spread of infection. The campaign has a range of supporting information and documents that providers can download and use. Providers who meet the best practice criteria can gain an accreditation to demonstrate their commitment to improving outcomes for residents within their care.

Transforming Care and Making Safeguarding Personal are put into practice

Transforming Care is part of a national programme to improve services for people with a learning disability and/or autism and support them to lead more independent lives in the community. As a national fast track site and exemplar, we consider a progress report at every Board meeting.

The local authority has developed a toolkit to assist the delivery of Making Safeguarding Personal and trained over 20 staff. Key principles include: working with adults to achieve what is important to them; adults are given the opportunity to feedback on their safeguarding experience; and ensuring adults who have substantial difficulty in participating in their safeguarding have a representative or advocate. An evaluation of the project is underway and will be published in the coming months.

Inspired by the work of the local authority, we have challenged all partners to develop a Making Safeguarding Personal action plan for their own organisations.

We have developed our performance dashboard to be more outcome focused, including several measures to monitor how well partners are doing in their efforts to make safeguarding personal.

The work of the Enhanced Care Team at University Hospital Coventry & Warwickshire continues to support patients who express distress in their behaviour and has improved ability to provide person-centred care through seeking guidance from both the learning disability and dementia teams.

The Forget-me-not Care Bundle, introduced to support people with dementia admitted to University Hospital Coventry & Warwickshire, now captures more person-centred information on the 'getting to know me' form.

Performance information drives improvement

When we hold learning events following Safeguarding Adult Reviews, wherever possible, we use direct testimony from people who have direct experience of our services.

After a Safeguarding Adult Review has been published, we check the progress of any required changes in policy or practice at regular intervals. This is reflected by partner agencies who have established processes for checking the progress of change internally and with commissioned providers.

We regularly consider the effectiveness of the Board using our performance dashboard. You can see our report for 2016/17 in **Appendix 1**. We have developed a new, more outcome focused performance dashboard which we have used from April 2017.

We have completed a multi-agency audit, focusing on how effectively information about an individual's care and support needs are shared between partners, as the lead for their care and support changes.

Following learning from a multi-agency audit, University Hospital Coventry & Warwickshire has developed a new discharge policy to ensure that important information about a patient's care and support needs leaves hospital with them.

Coventry City Council has conducted a Making Safeguarding Personal Thematic Review. This has led to a review of the process for gathering feedback on the individual's experience of safeguarding, greater promotion of independent advocacy and establishing a risk enablement panel to support positive risk taking.

The Clinical Commissioning Group has led on improving quality of safeguarding practice across primary care. As a result there is a significant increase in engagement between GP Practices and the safeguarding system, with improved information sharing, risk assessment, multi professional communication and enhanced knowledge.

Real life story
Wave Rave

Wave Rave. Think swimming and then make it fun with music, lights and splashing around rather than ploughing up and down, and that's Wave Rave. It's an after-hours disco with a child DJ. This came about from a combination of community passion alongside Grapevine Coventry and Warwickshire, Coventry Sports Network and Public Health to think about how swimming could be more inclusive in the city. The last Wave Rave saw over 100 people take part, with ages varying from babies to people in their 70s. Wheelchair users have attended with others commenting on how they are surprised how easy it is to use a hoist to facilitate them getting into the pool and having a good time alongside everyone else. The event sees people with a variety of abilities attending but with the community involvement and casual environment, everyone feels comfortable and has a good time. Equal provision is made for those who don't swim (the hope is that they might) provided in the form of socialising around the pool and taking part in eating and socialising together afterwards. The project not only now has backing to create a year-long programme at various swimming pools in the city, but has enabled a successful bid to Sport England to expand our swimming offer more widely.

Click here to find out more.

Safeguarding Adult Reviews

What is a Safeguarding Adult Review?

Safeguarding Adult Reviews (SARs) are opportunities to review practice and improve the way agencies work. Until the Care Act came into place, we referred to them as Serious Case Reviews and used a range of different methods, depending on the case. Within the period of this annual report no Safeguarding Adult Reviews were published.

All of our previous reviews are published on the Safeguarding Adults Board website. You can view these by clicking here.

Last year we developed a toolkit for conducting SARs, introduced by the Care Act. This is still used as a basis for our work and will ensure that there is consistency in practice for all reviews we undertake and that all reviews are conducted to a high standard.

Learning from reviews

When we publish a review we also publish an action plan, which outlines the improvements that need to be made by the partners of the Board. We regularly check progress to implement these improvements and plan audits to measure the impact of changes.

The learning from previous reviews is now well embedded and the Board is assured that significant improvement has been made. In particular, this annual report has described how partners are working to ensure that safeguarding services are delivered in a more person-centred way and that hospital discharge procedures are reviewed and improved.

There is more that we can do to ensure that the learning from previous reviews has been embedded, particularly around ensuring the quality and consistency of safeguarding training. This work is being led by the Workforce Development Sub-group of the Board and will be completed in the coming year. The development of a multi-agency quality assurance programme will also provide us with evidence of the extent to which learning has been embedded into practice.

Looking Forward – 2017/18 Priorities

Boards are required to publish a strategy. We have refreshed our strategy for 2017/18, to reflect our developing maturity as a Board. The outline below is supported by a more detailed business plan that will be owned and delivered by Board members and their organisation, who will be responsible for making the plan a reality.

Through the year, we will add to the business plan, as we respond to things we learn and do.

The Board ensures that complex safeguarding issues, such as self-neglect, modern day slavery, Child Sexual Exploitation and transitions, and domestic violence are understood	**We will...**
	Carry out a multi-agency audit to ensure that all partners are compliant with the requirements of the Care Act 2014 in respect of their safeguarding arrangements
	Develop a series of real life stories to raise awareness of complex safeguarding issues
Why? To ensure that outcomes improve for people with care and support needs because professionals that support them understand these safeguarding risks.	

The Board communicates and engages with members of the public, third sector and small independent providers, including raising awareness of safeguarding	**We will...**
	Publish a communication and engagement plan
	Work with existing carer and service user groups to help people with care and support needs, and their carers, to influence the safeguarding agenda
	Make improvements to our website
Why? To help people be better informed about safeguarding and the route to take to resolve any issues in relation to safeguarding.	

The Board ensures that the Making Safeguarding Personal agenda is championed and improves outcomes for people with care and support needs and carers	We will…
	Agree minimum standards for training in relation to Making Safeguarding Personal
	Ensure that all relevant professionals across the partnership understand and can apply the principles of Making Safeguarding Personal through appropriate workforce development
Why? So that safeguarding is tailored to individual needs and outcomes improve as a result.	

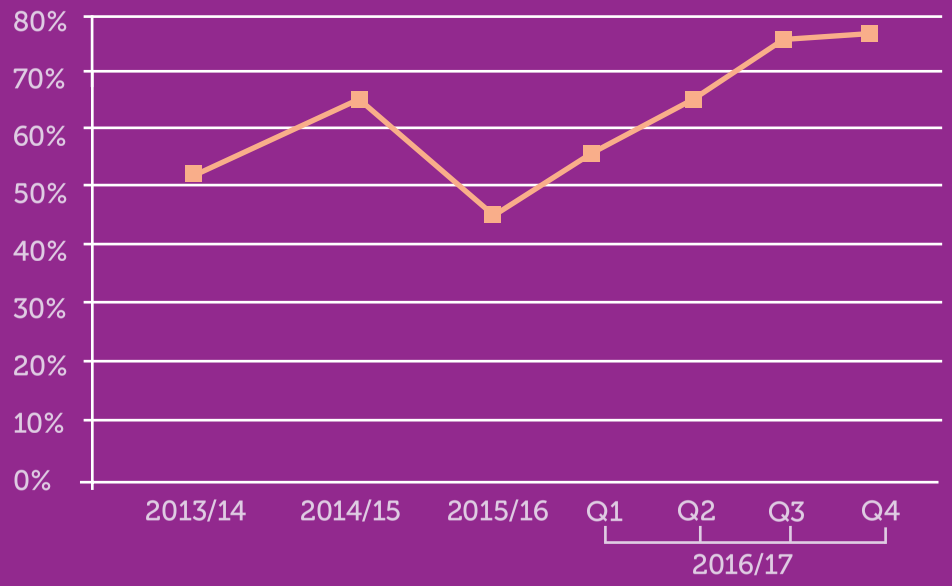
The Board to ensure that the city's learning and development offer is sufficient to ensure the workforce is suitably skilled and equipped to safeguard people with care and support needs in Coventry	We will…
	Create a multi-agency workforce strategy
	Develop a multi-agency training plan
	Agree minimum standards for safeguarding awareness training
	Improve the way in which we quality assure our training
Why? So that the workforce across the city is suitably skilled.	

Appendix 1

Performance Dashboard

Empowerment - Presumption of person-led decisions and informed consent

Percentage of adults with concluded safeguarding enquiries who lack capacity who were supported by an advocate



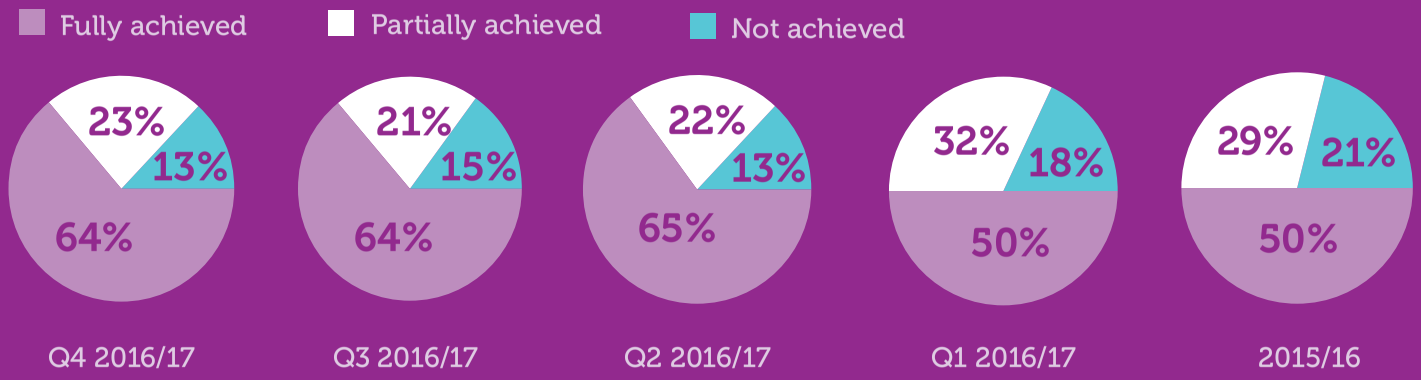
Proportion of people who use services who feel safe (ASCOF 4A)

Coventry				Trend	Comparator 2015/16 Average	West Mids 2015/16 Average	England 2015/16 Average
2014/15	2015/16	2016/17	2016/17 Target				
75.8	70	75	68.6	↑	68.7	70.2	68.8

Proportion of people who use services who say those services have made them feel safe and secure (ASCOF 4B)

Coventry				Trend	Comparator 2015/16 Average	West Mids 2015/16 Average	England 2015/16 Average
2014/15	2015/16	2016/17	2016/17 Target				
85.6	86	88	84.1	↑	84.2	86.9	85.2

Engagement of the adult in the process – outcomes achieved



Safeguarding - MSP Wishes	As at end of month
Number of concluded enquiries (YTD)	965
Number of wishes recorded	663
% of wishes recorded	68.7%

Prevention - It is better to take action before harm occurs

Provision of awareness training by statutory partners

88%

Current **UHCW** staff have been trained to Level 1 in adult safeguarding in the last three years

56%

Current **CCG** staff received basic adult safeguarding awareness training in the last three years

98%

Current **CWPT** staff have been trained to Level 1 in Safeguarding Adults in the last three years

70%

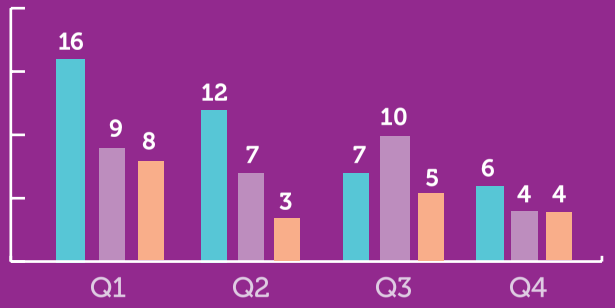
Coventry City Council staff received basic adult safeguarding awareness training in the last two years

Note: We are still developing the recording and reporting of adult safeguarding training. Therefore comparisons cannot be made between agencies.

Current large scale investigations underway

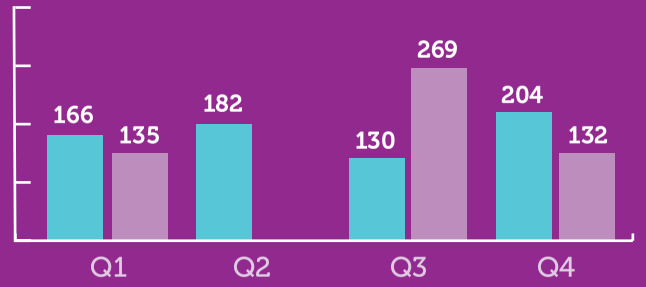
There are no large scale investigations currently underway.

Number of providers in PEP process



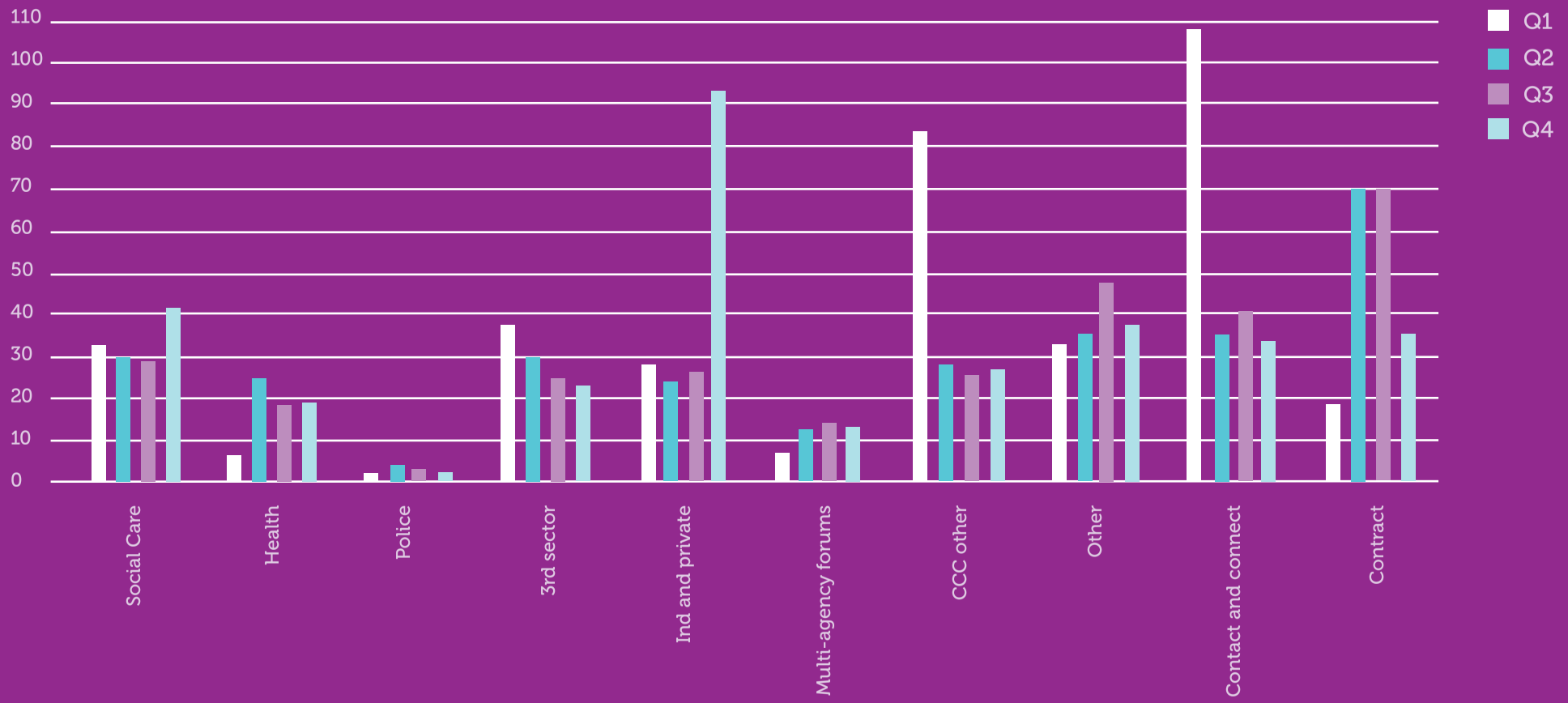
Note: The Provider Escalation Panel is a group of professionals that monitor the quality of care provided through commissioned services.

Number of adults placed out of city



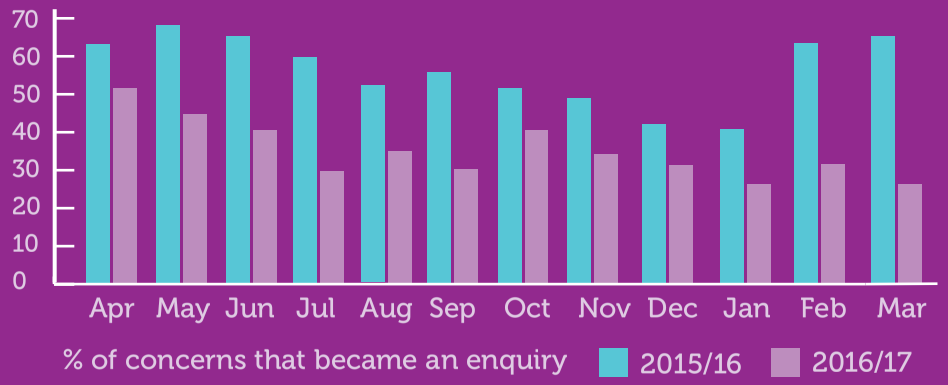
Prevention - It is better to take action before harm occurs

Safe and Well Visits

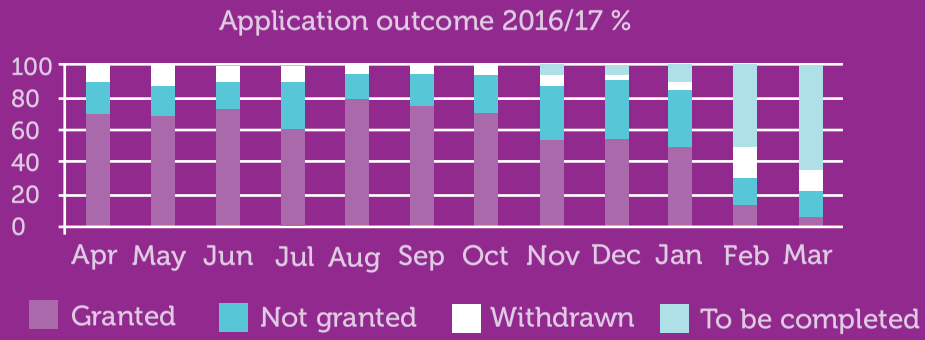


Proportionality - Proportionate and least intrusive response appropriate to the risk presented

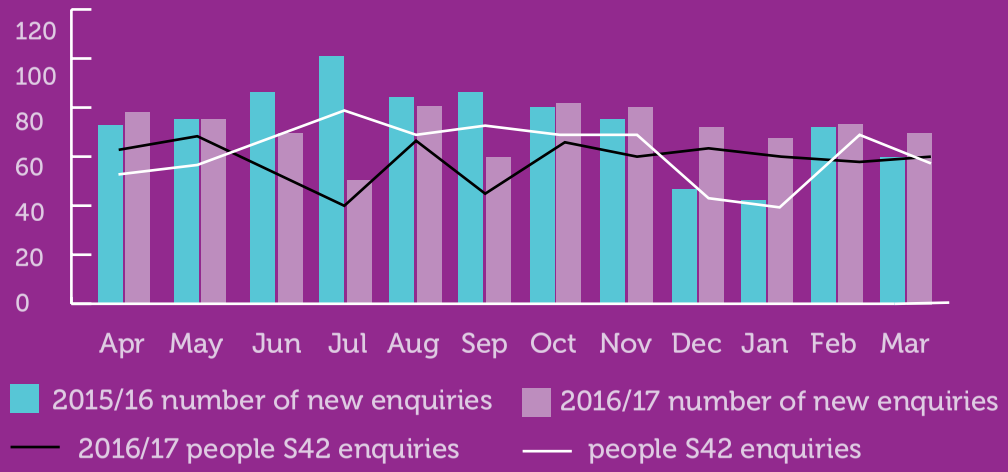
Concerns and enquiries



Deprivation of Liberties (DoLs) requested / granted



Number of people and number of new enquiries



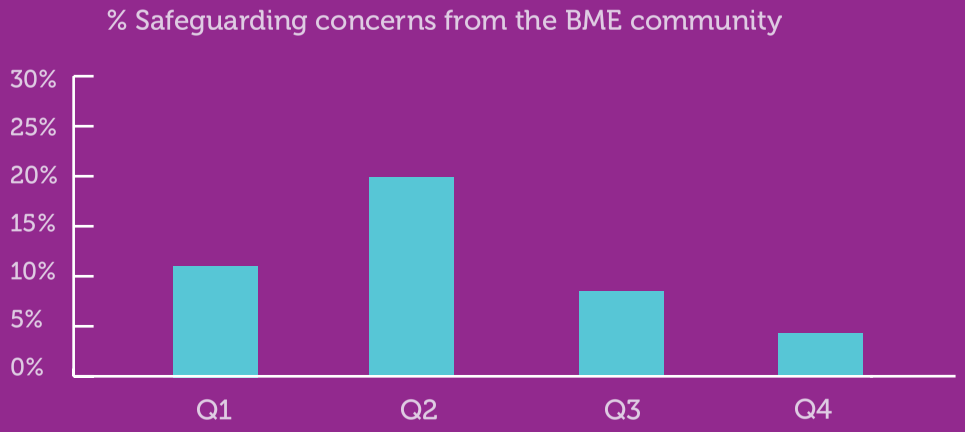
Note: There is a significant continuing rise in the number of new enquiries and in the number of people subject to an enquiry. The number of concerns that become an enquiry is broadly static.

Deprivation of Liberties applications

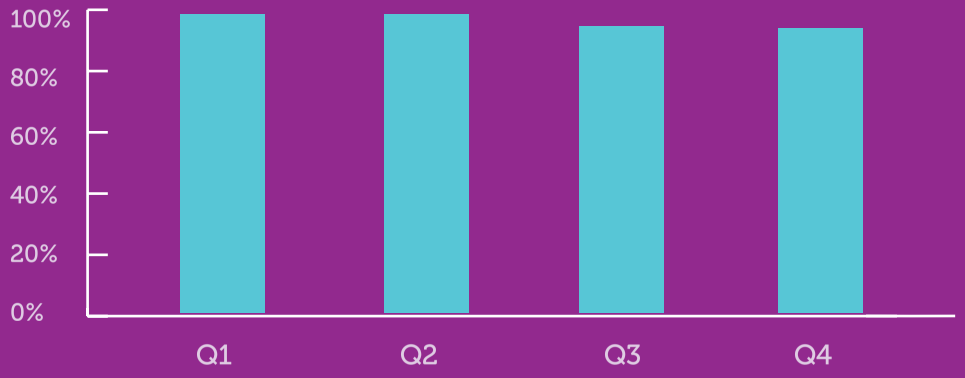
	Applications granted within 3 months of being received		Applications granted after 3-6 months of being received		Applications granted after 6 months of being received		Total
15-16	125	17%	315	42%	310	42%	750
15-16 carried over	32	9%	246	72%	68	19%	344
16-17	514	70%	221	30%	0	0%	735
Total 16-17	**546**	**50.6%**	**467**	**43.3%**	**66**	**6.1%**	**1079**

Proportionality continued

BME concerns reporting



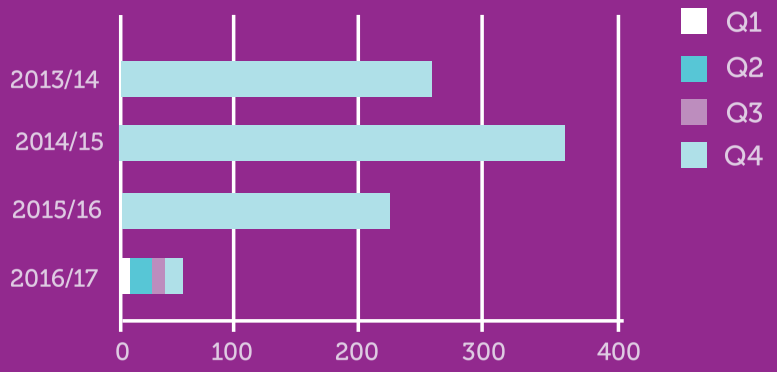
% safeguarding concerns with an initial decision made within 2 days



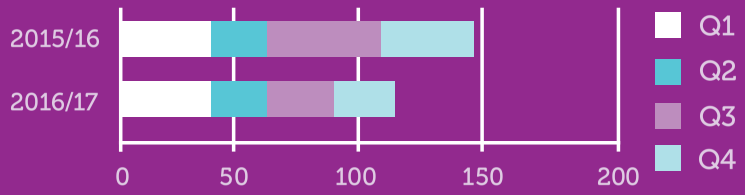
Protection - Support and representation for those in greatest need

Number of pressure ulcers (due to neglect)reported

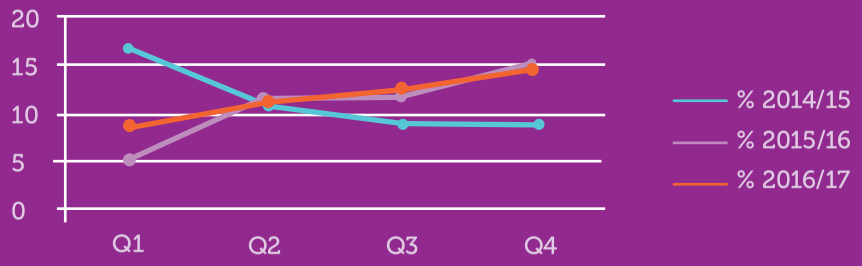
Coventry City Council



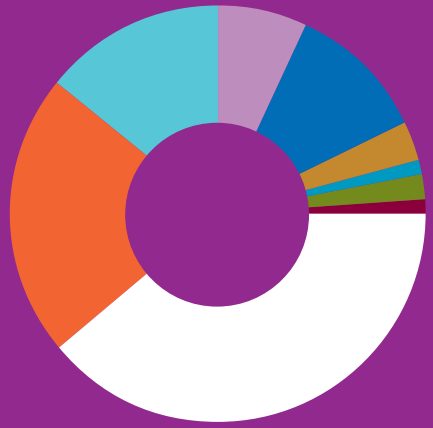
Clinical Commissioning Group



% of repeat safeguarding enquiries



Safeguarding activity by type of abuse

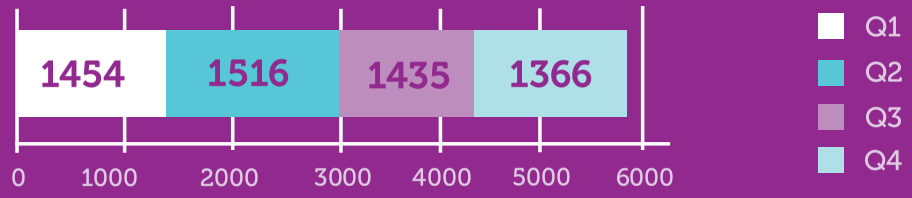


Abuse type	%
Neglect and acts of omission	39
Physical	22
Financial and material	14
Self neglect	7
Emotional/psychological	11
Sexual	3
Organisational	1
Domestic abuse	2
Sexual exploitation	1

Results of action at enquiry conclusion

Concluded where harm/abuse identified	2016/17 YTD	
	Number	%
Risk remains	41	9%
Risk reduced	264	59%
Risk removed	143	32%

Domestic violence incidents reported to Police 2016/17



Note: Total offences reported are 3.4% lower than the previous year

Partnership - Local solutions through services working with their communities

Communities have a part to play in preventing, detecting and reporting neglect and abuse

Source of enquiry

Enquiry Source	No. of concluded enquiries
Residential Care	190
Ambulance Service	117
Hospital Ward Staff	97
Family Member	69
Nursing Home	62
Domiciliary Care	55
Nurse (non-hospital)	49
Extra Care Housing	47
Not Listed	38
Self (Adult at Risk)	32
Social Worker/Care Manager	18
Community Based Professional Allied to Medicine	19
A&E Hospital	17
Anonymous	16
Mental Health Staff - Joint Teams	16
Other Hospital Staff	14
Care Quality Commission	12
Supporting People Accommodation	12
Friend/Neighbour	11
Other Social Care Staff	10
GP	10
Police	9
Education/Training/Work Place Establishment	9
Day Care	8
Advocate	7
Member of the Public	6
Acute PCT	6
Housing	4
Voluntary Organisation	3
Volunteer/Befriender	2
Partner/Ex-Partner	1
Grand Total	**965**

Attendance at Board meetings

Organisation	Meetings attended	Attendance expectation	% attendance
Independent Chair	4	4	100
Coventry & Rugby CCG	4	4	100
CWPT	4	4	100
UHCW	4	4	100
Coventry City Council	4	4	100
Public Health	3	4	75
Health Watch	3	4	75
West Midlands Fire Service	3	4	75
West Midlands Police	2	4	50
Hereward College	2	3	67
GPs	1	1	100
Housing	1	1	100
NHS England	0	4	0
CRC Probation	0	4	0
National Probation Service	0	4	0
West Midlands Ambulance Service	0	1	0

Note: Data covers 1 April 2016 to 31 March 2017

If you think an adult is at risk of abuse call Adult Social Care Direct

024 7683 3003

or e-mail

ascdirect@coventry.gov.uk

Adult Social Care Direct is based at Broadgate House, Broadgate, Coventry, CV1 1FS

10 categories of abuse:

Physical
Domestic violence
Sexual
Psychological
Modern slavery
Financial or material
Neglect & Acts of Omission
Discriminatory
Organisational
Self-neglect

Coventry Safeguarding Adults Board
Tel: 024 7683 2568
www.coventry.gov.uk/csab
E-mail: CoventrySAB@coventry.gov.uk

This page is intentionally left blank

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.

Report Author(s):

Name and Job Title:
Pete Fahy – Director of Adult Services

Directorate:
People

Telephone and E-mail Contact:
024 7683 3555
Peter.Fahy@coventry.gov.uk

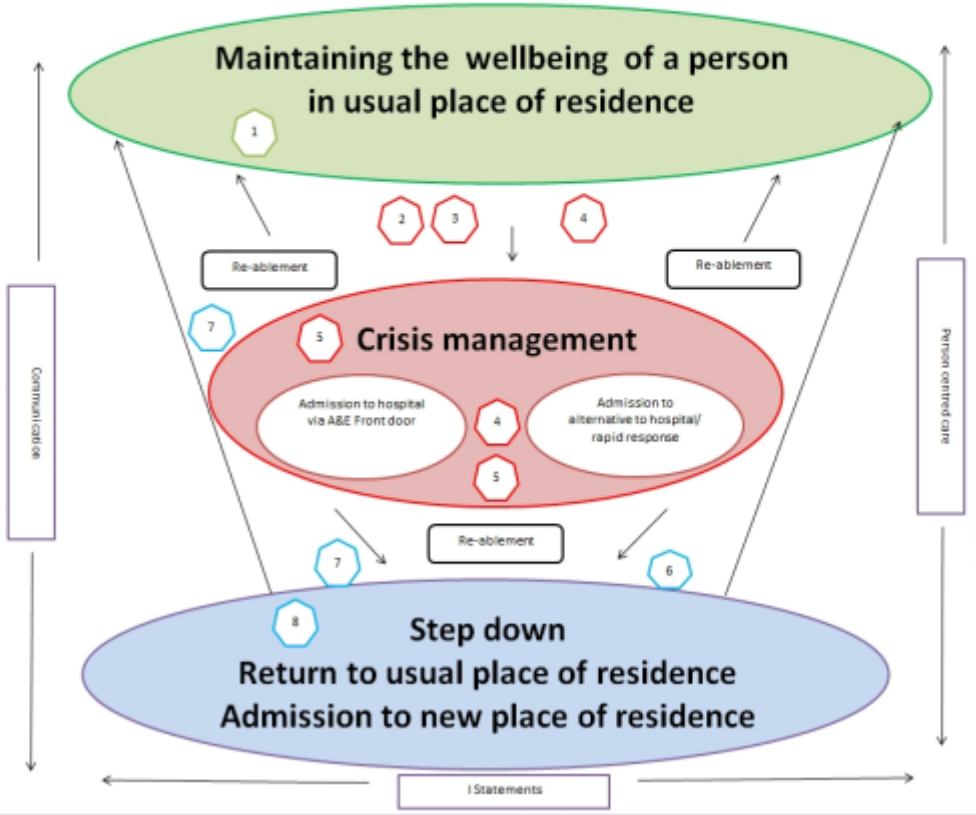
Enquiries should be directed to the above person.

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