Local Government Association

NHS England

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Coventry City Council**
Clinical Commissioning Groups	**Coventry & Rugby CCG**
Boundary Differences	**CRCCG also developing a plan with Warwickshire County Council for Rugby population.**
Date agreed at Health and Well-Being Board:	**27 January 2014**
Date submitted:	**14 February 2014**
Minimum required value of ITF pooled budget: 2014/15	**£1,293k**
2015/16	**£23,877k**
Total agreed value of pooled budget: 2014/15	**£2,953k**
2015/16	**£44,593k**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Coventry & Rugby CCG

By	Steve Allen
Position	Accountable Officer
Date	13 February 2014

Signed on behalf of the Council	Coventry City Council
By	Brian Walsh
Position	Executive Director, People
Date	13 February 2014

Signed on behalf of the Health and Wellbeing Board	Coventry Health & Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Alison Gingell
Date	13 February 2014

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

The development of this plan has been overseen by the Coventry Transformation Leaders Group which is led by the chair of the Coventry Health and Well-Being Board. The Transformation Leaders Group includes the Chief Executive Officer (CEO) of University Hospital Coventry and Warwickshire NHS Trust (UHCW) and the CEO of Coventry and Warwickshire Partnership Trust (CWPT). These are the two main NHS providers in the City and they are fundamental to the programme's aims of reducing acute demand and supporting people in the community.

This plan has been developed alongside the 5 year system which is currently in development and the Clinical Commissioning Group (CCG) 2 year plan as the Better Care Fund (BCF) is central to the delivery of a clinically and financially sustainable care system. The strategic direction set out in this plan has also been widely discussed with providers through: -

a) On-going dialogue between commissioners and providers;
b) Urgent Care Working Group
c) Coventry and Warwickshire Integrated System Board that brings together leaders of the health and social care system.
d) Workshop sessions to develop plans for integration to support the delivery of a sustainable and high quality care system.

As the specific initiatives outlined in this plan are developed in greater detail there will be further focused discussions with relevant providers.

Proposals contained in this plan have been discussed with Coventry Healthwatch and as a member of the Health and Well-Being Board Healthwatch is signed up to the proposals and direction of travel.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

This submission draws and builds on engagement that has previously taken place to support the development of the Joint Strategic Needs Assessment (JSNA) and the Health and Wellbeing Strategy (HWBS). Both of these key documents have informed our vision for integration and underpin the 5 year system plan and the BCF. Specific patient and public user engagement will occur relating to implementation of the specific schemes.

The fundamentals of the plan correlate with a range of feedback we have had from patients, service users and the public which include themes of:

a) Frustration of the lack of cohesiveness between health and social care;
b) Requirement to be able to access support at the time it is required as opposed to usual office hours;
c) People do not want to go to hospital when they could be treated/supported in another appropriate setting
d) People do not aspire to be long term users of social care or health services where this could be avoided
e) The delivery of best practice, high quality and safe care in acute hospital and GP practices

We will continue to engage patient and service user groups as we develop schemes in greater detail through using established engagement networks wherever possible including Partnership Boards and Patient and Public Engagement forum.

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
'A Bolder Community Services'	The City Councils programme, developed and undertaken with partner involvement, to meet financial challenges and focus support around key principles of maximising independence, support people to do more for themselves and supporting the most vulnerable. http://www.coventry.gov.uk/abcs
Health and Wellbeing Strategy (first)	Identification of key strategic issues that partner organisations will work on together to improve health outcomes in Coventry. http://www.coventry.gov.uk/download/downloads/id/9120/

Coventry Joint Strategic Needs Assessment 2012-13	Description of the key issues that affect the health and well-being of local people. http://www.coventry.gov.uk/download/downloads/id/6541/joint_strategic_needs_assessment_2012
CRCCG Plan on a page	Sets out key priorities, programmes and success measures for 2014/15 – 2018/19 (document attached)

2) VISION AND SCHEMES

a) Vision for health and care services
Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Our vision is that:

'Through integrated and improved working people will receive personalised support that enables them to be as independent as possible for as long as possible'

Over the next five years we expect to implement changes that deliver:

- Availability of key services across the health and social care system, 24 hours a day, and routine services available 7 days a week, to ensure less reliance on urgent and long term health and care services. Initially we will focus on those services that reduce avoidable hospital admissions.
- A proactive approach to identifying those at risk of needing an increased level of care to ensure appropriate support is in place before a crisis situation occurs.
- The right care delivered at the right time through the creation of integrated locality team working.
- Comprehensive and accessible urgent and emergency care services, through multi-disciplinary health and social care teams, including community based and domiciliary services.
- An integrated dementia service with a transparent and seamless dementia pathway from pre-diagnosis to end of life, for people with dementia and their carers.
- Preventative approaches to healthy living and lifestyle choices that improve health across the City and reduce long term demand on health and social care
- Comprehensive and integrated children's services, ensuring improved outcomes and safeguarding and multi-agency working across the whole city, including health, social care, criminal justice, community safety, education, and youth services. An improvement board will oversee changes in year one/two of this plan including the establishment of a MASH in 2014. This work will become integral to the five year system plan 2016/2019.

The difference we expect this to make to patient and service user outcomes are:

- Earlier detection of long term conditions to support the delivery of better long term health outcomes
- Support to ensure that citizens are empowered to manage their own condition/s
- People are able to access a full range of support, this being social care or emergency services close to home when it is needed. This will provide better outcomes through reducing the need for non-acute services delivered in acute settings.
- Effective discharge for those requiring acute hospital care to reduce longer term

dependency.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

The aims and objectives are built around the principles of the Better Care Fund and complement the work undertaken across partners on the City Council's 'A Bolder People Services' programme which seeks to transform City Council activity so that people are supported to be as independent as possible and resources are focussed on supporting the most vulnerable.

Specifically the Coventry aims and objectives arising from the Better Care Fund are:

- The delivery of personalised care planning organised around people's needs rather than organisations.
- An integrated health and social care plan, co-ordinated record and information sharing to facilitate effective health and social care delivery
- Effective deployment of resources responsive to population and community need that is equitable
- The delivery of effective hospital discharge and the diversion of activity away from hospital to ensure that citizens are only in hospital when they require an acute episode of care through advanced care planning
- The delivery of a workforce that is organised to facilitate integrated care with a commitment to shared ownership and the delivery of better outcomes.
- The delivery of an effective IT strategy across Health and Social Care to enable effective care planning through shared record system.
- Investment in primary care to enable innovative models of care and develop local areas of expertise that will improve quality and outcomes.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The BCF is central to the delivery of the 5 year system plan. In the 5 year system plan we articulate how we will:-

a) Radically change our approach to wellbeing and self-management;
b) Take a systematic approach to transfer activity that should be undertaken by primary care back to primary care. This will include relocating elements of the workforce that currently sit within acute services to the community;
c) Remove the boundaries between practice staff and those working in the community to deliver team based care to individuals who need the support of care professionals to manage their care;
d) Reconfiguration of site based services in order to deliver safe and effective services within the constraints on the money that we have available.

The content and yearly expansion of the BCF reflects the phasing of the 5 year system plan. There are demonstrable links to the JSNA, JHWS, NHS Outcomes Framework, and Public Health Outcomes Framework.

The schemes we are looking to initially progress through the Better Care Fund are as follows:

Scheme One: Short Term Support to Maximise Independence

Providing integrated support to individuals in a timely and effective manner can both reduce the need for long term support from health and/or social care and reduce demand on acute services through preventing hospital attendance/admission for conditions that could have been avoided through more timely and integrated community based support.

Key to the delivery of this will be the development of integrated teams comprising of health, social care and allied professions and the effective use of new technologies to support the delivery of integrated care. This area will be further progressed through a 'Hothouse Event' (March 2014) which will include professionals and practitioners from local NHS providers, primary care, social care and commissioners.

A number of key groups will benefit from this integrated approach to short term support including:

- Carers - through targeted support enabling them to continue caring as the needs of the cared for fluctuate.

- People aged 75+ - we will develop our approach to targeting support at older people (particularly 75+) in order to prevent the requirement for more intensive support from

social care or health services. Developing community resilience through asset based working will support this.

Integration will result in:

- Personalised support to deliver better outcomes through an integrated locality approach.
- Reduced system costs through reducing acute demand and requirement for on-going community based health and social care support.
- Improved citizen experience as people will know who the care co-ordinator is and will have timely reviews.
- Commissioning efficiencies through market management and assessment and management efficiencies through effective co-ordination with other professionals.
- Improved quality, diversity, and sustainability of provision.
- More responsive support and expansion of seven day availability.

Scheme Two: Long term care and support (including joint packages & NHS Continuing Health Care - NHS CHC)

Currently health and social care operate independently in relation to NHS CHC and jointly funded packages in terms of assessment, reviews and commissioning activity. Whilst key issues are around market capacity and value for money, there are also increased opportunities through integration in relation to personalisation (e.g. direct payment users), quality and choice within the market, all of which impact on the individual's experience of service provision. These opportunities exist across a range of activity including adults with learning disabilities, older people, carers and adults with mental ill health.

Integration will result in:

- Improved citizen experience as people will know who they are dealing with, will have timely reviews, and will be able to ensure that any changes in providers are linked to care needs rather than changes to funder. People will also be offered a personal health budget.
- Commissioning efficiencies through market management, assessment and management efficiencies through the removal of disputes over the funding stream.
- Financial risk being controlled.
- Improved quality, diversity, and sustainability of provision.

There will be two specific workstreams initially prioritised within this theme – services for people with learning disabilities and longer term support to older people, as part of an integrated care approach in localities.

<u>Learning Disabilities & Mental Health</u>
Work will include:

- Development of a clear resourced delivery plan, focussed on personalised community provision.
- A new pathway for young people to adulthood, with the needs of children seen within the context of their longer term care into adolescence and adulthood.
- Joint work to identify current health and social care costs and commitments from the LA, CCG and specialist commissioning to understand and tackle change to the

current balance of care and support away from long term institutionalised care.
- Development of a pooled or integrated budget for young people with disabilities in transition.
- Integrated/joint commissioning for a seamless pathway from assessment through to care management in both commissioning and service development for people with learning disabilities, with a particular focus on transition to adulthood.
- Development of whole life course planning with consistent application locally of NHS CHC criteria, to enable safe and local support services with an investment in behavioural support and community based accommodation options.

Older People

Work will include:

- Creation of a locality integrated care planning process targeting older people 75+. The aim will be for all older people 75+ to either benefit from a preventative health and care offer/approach or a full health and social care plan, dependent on need.
- Focus on ensuring as needs fluctuate people are given the opportunity to regain their level of independence within their original care setting so reducing the need for long term placement and/or NHS CHC

Scheme three: Dementia

Dementia is a growing issue in Coventry as elsewhere. A plan for integrated delivery will be developed and progressed through the Dementia Strategy Board including both pre and post diagnostic support, living with dementia and rapid re-entry to services when required. Discharge to assess models will actively be considered as part of this.

The Dementia Strategy Board will be utilised as the responsible Board to develop and ensure the delivery of future plans and an integrated whole journey pathway.

Integration will result in:

- An integrated health and social care plan with clear information and advice, tailored to individual circumstance.
- A new model of assessment that promotes independence and utilises strengths in the community, with a focus on self-care and empowerment.
- A tailored and flexible experience for citizens that harnesses resources to support people in their own homes and prevents admission to acute or long term care.

The following six stages of the pathway will be improved as follows:

Pre-diagnosis

- Coventry to become a dementia-friendly city, where there is greater awareness and reduced stigma of dementia.

Diagnosis

- Continued development of an age-independent, multi-disciplinary Dementia IPU (Integrated Practice Unit), to ensure timely and accurate diagnosis.

Post-diagnostic support

- Develop a 'menu' of post-diagnostic support opportunities.

Living with dementia

- Increased availability of technology to support people with dementia and their carers, including Telecare, Telehealth and stand alone items, such as GPS trackers.

- Effective promoting independence and reablement services designed to meet the specific needs of people with dementia, involving education and support for family carers.

Rapid re-entry

- Ensure rapid re-entry into services when required, for example, when the person's needs change. Those services would already have information about that person, so they do not have to tell their story again (links to record management).

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The emphasis of our BCF plans are to invest in strengthened primary and community services and thereby reduce the volume of both hospital admissions and residential and nursing home care. This investment is not about immediate financial returns, but rather creating the capabilities and infrastructure to enable sustainable reductions in demand in the medium term. The impact on the acute sector in 2014/15 and 2015/16 is therefore anticipated to be modest (with more savings in these early years being generated from re-commissioning services jointly and by using collective purchasing power to reduce prices where it is reasonable to do so).

In the medium term, the impact on the Acute sector will be more significant. This will be reflected in our 5 year plan. Whilst further modelling work is required to fully understand the combined impact across Coventry & Warwickshire, some reduction in Acute bed capacity is likely to be required. This will provide a further driver (along with Quality and Workforce) for a reconfiguration of acute services across the Unit of Planning footprint. By working collaboratively and transparently with our Acute providers, we believe that costs can be reduced in managed way, although some element of transition funding will be required until fixed overheads can be removed. The 1.0% of CCG allocation that is to be spent non-recurrently should contribute towards this – although at this stage the need for additional support cannot be ruled out. (UHCW have been active members of the groups that have led development of this Plan).

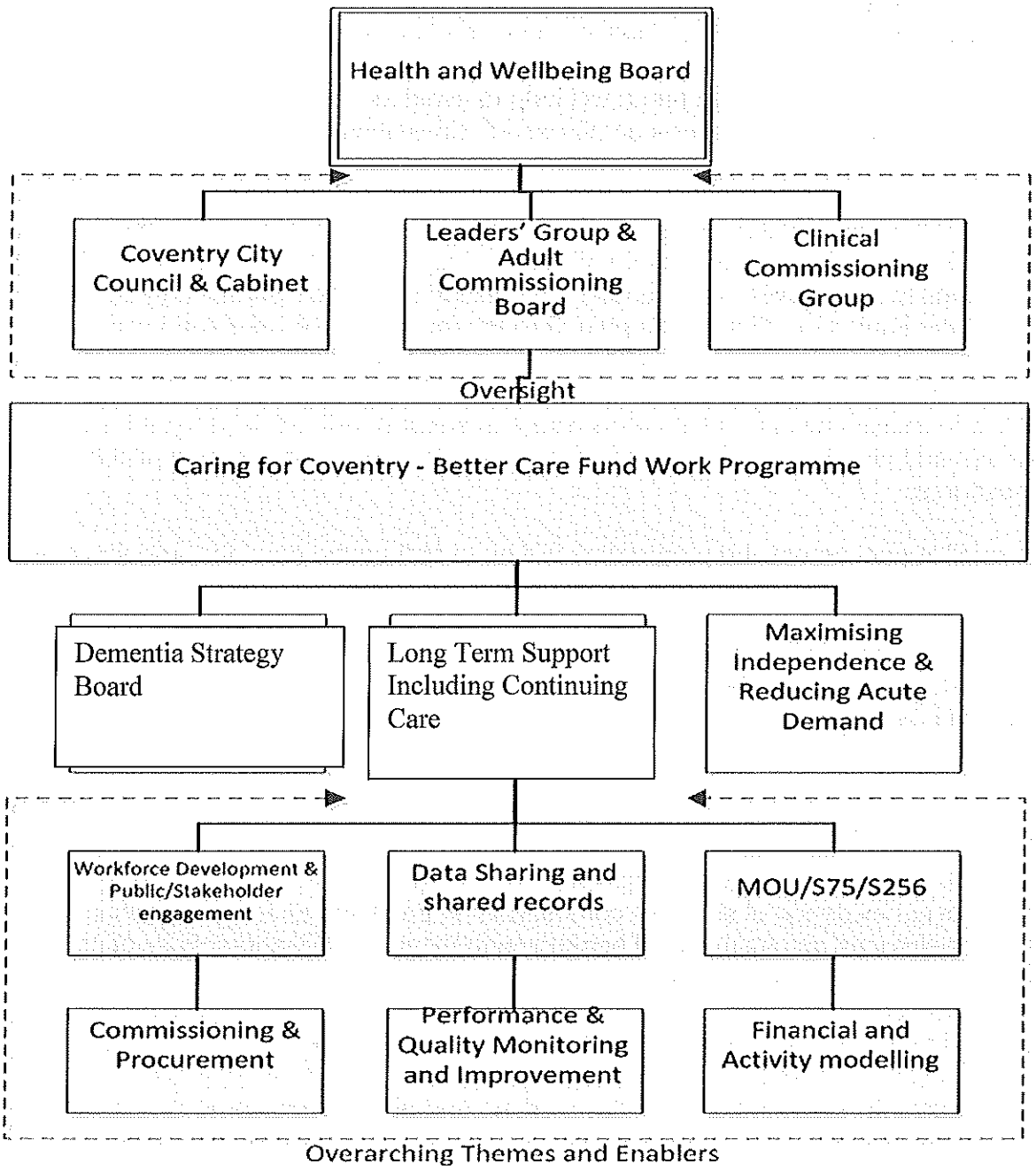
There is an expectation that Acute providers will continue to become more cost efficient and reduce their cost base. Reductions in length of stay achieved through more effective discharge arrangements should assist with internal Provider cost efficiencies; there is also the opportunity to repatriate work currently outsourced to the Independent Sector As before, detailed, costed reconfiguration plans will need to be developed and agreed across the health economy.

Should planned savings not be realised then partners will need to assess whether community based services can be re-specified to be more effective or whether they should be decommissioned. Admission and eligibility criteria would need to be reviewed. Funding set aside to support Acute downsizing would need to be redirected.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The following governance structure has been agreed by the Health and Well-Being in respect of the Better Care Fund. This structure gives key accountability to the Adults Joint Commissioning Board with oversight from the Health and Well-Being Board.



NATIONAL CONDITIONS

1. Protecting social care services

Please outline your agreed local definition of protecting adult social care services

Maintenance of existing Eligibility criteria

Please explain how local social care services will be protected within your plans

The BCF will be made available to complement available, recurrent social care funding to ensure the City Council can continue to deliver core statutory Fair Access to Care Services (FACS) to those eligible safely and appropriately. Using BCF the City Council will continue operate it's existing eligibility criteria of Critical and Substantial under FACS until a national criteria is introduced following implementation of the Care Bill in 2015.

Protecting the current eligibility criteria will help to avoid any potential adverse impacts on health (such as delayed discharges or increased admissions to hospital) that may otherwise occur.

Protecting the existing criteria for accessing local social care services will ensure the budget for Adult Social Care (Community Purchasing) is not disproportionately affected by reductions in local government funding. Assessed needs will increasingly be met, as a result of the implementation of this plan, through the use of telecare and assistive technologies, more effective use of short term support to maximise independence, and through the provision of integrated whole system dementia support. An integrated approach to transitions and to long term care and support for people with learning disabilities and people 75+ will also help the ensure best use is made of available social care resource.

The overall impact across the programme will be to reduce the need for on-going care and support across both health and social care.

The impact of any additional demand on social care resulting from successful initiatives to transfer activity from the acute sector to community services is recognised and financed via BCF.

2. 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

Health is currently is committed to 7 day working and already has some services providing this level of cover. 7 day working will be an integral part of the 5 year plan.

Some social care services currently operate seven days a week although it is recognised that capacity to respond is much reduced at the weekend and outside of office hours (Monday to Friday).

To progress our 7 day working at a level where a suitable response can be provided across the whole system further work will be progressed through the "Hothouse event" in March and will form part of our more detailed submission in April.

3. Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

The NHS number is not currently used as primary identifier in Adult Social Care.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

The NHS number will be the primary identifier for Adult Social Care records by April 1st 2015.

Delivery plan includes:

- Upgrade of case management application by May 2014.
- DBS batch cleansing to commence June 2014 with a mandate for 95% of social care users to be matched to an NHS number before HSCIC approval is granted.
- Connection of CareDirector to the Personal Demographic Service component of the NHS Spine by April 2015.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Coventry City Council aims to adopt Open APIs wherever possible, within the constraints of the existing application architecture.

The NHS Personal Demographic Service (PDS) Health Level 7 schema is being applied to the integration of CareDirector to the NHS Spine. By extension where the City Council progress any local integration we would mandate that works adopt ITK standards.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Coventry City Council is committed to ensuring that appropriate IG controls are in place.

Coventry City Council has achieved IGSoC accreditation and currently operates a link to the NHS network via Coventry & Warwickshire Partnership Trust.

4. Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

As part of work to achieve integration we will implement an integrated health and social care plan, and co-ordinated record and information sharing to facilitate effective health and social care delivery. This will include the identification of a care co-ordinator who will take the role of accountable lead professional for the individual.

GPs and community nursing teams currently use a local risk stratification predictive tool which uses health data only. This currently does not link to social care data although this will be achieved on integration of the City Councils Case Management record system (Care Director) with the NHS spine. As this work progresses we will explore the application of the existing tool across Health and Social Care as part of our development of an integrated health and social care locality model.

3) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
Inability to meet financial challenges across the health and social care economy	16	• Agreed understanding to share wider financial envelope and challenges across the health and social care economy to better understand the respective pressures.
Failure to secure capacity, capability and quality provision from the market	12	• Renegotiate contracts based on outcomes framework and revised financial envelope. • Complete soft market testing for some niche areas. • Introduce quality premium payment for key areas e.g.; challenging behaviour • Contract for key areas in a way that puts the onus on providers to make capacity available at key points and recognise the cost of this in any contract price, including the ability to recruit, retain and appropriately skill staff.
Political and professional/clinical buy in for proposed new service model	12	• Establish strong brand and key message • Demonstrate financial viability across the economy and fit with overall financial strategies of organisations. • Evidence value for money and outcomes to be delivered for each scheme.
Leadership and continuity of the new service model	16	• Produce robust communication strategy. • Leadership capacity in place with a named strategic lead for each of the partner organisations. • System leadership through Health and Well-Being Board and leaders sub-group chaired by chair of Health and Well-Being Board
Service model fails to deliver as planned (either financially or to outcomes)	16	• Undertake reviews and evidence based progress tracking at frequent intervals. • Retain flexibility in arrangements to adjust as required and in response to changing circumstances.