Better Care Programme Progress Summary

Health and Well-Being Board

7 July 2014

Coventry City Council

Coventry and Warwickshire NHS Partnership Trust

University Hospitals Coventry and Warwickshire NHS Trust

NHS Coventry and Rugby Clinical Commissioning Group

Better Care Vision:

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

Scope

- Care Pathways and Interventions across the following services:
  - Dementia (older people with complex needs)
  - Short Term Care (older people with complex needs)
  - Long Term Care
    - Learning Disabilities & Mental Health (all ages)
    - Older People (older people with complex needs)

Aligned to National Objectives

- Protect Social Care services and deliver Care Bill Requirements
- 7 day services to support discharge
- 15% shift from acute to community
- Reduce demand on A&E
- Reduce hospital admissions and admissions into residential & nursing home care
- Data Sharing – use NHS Number

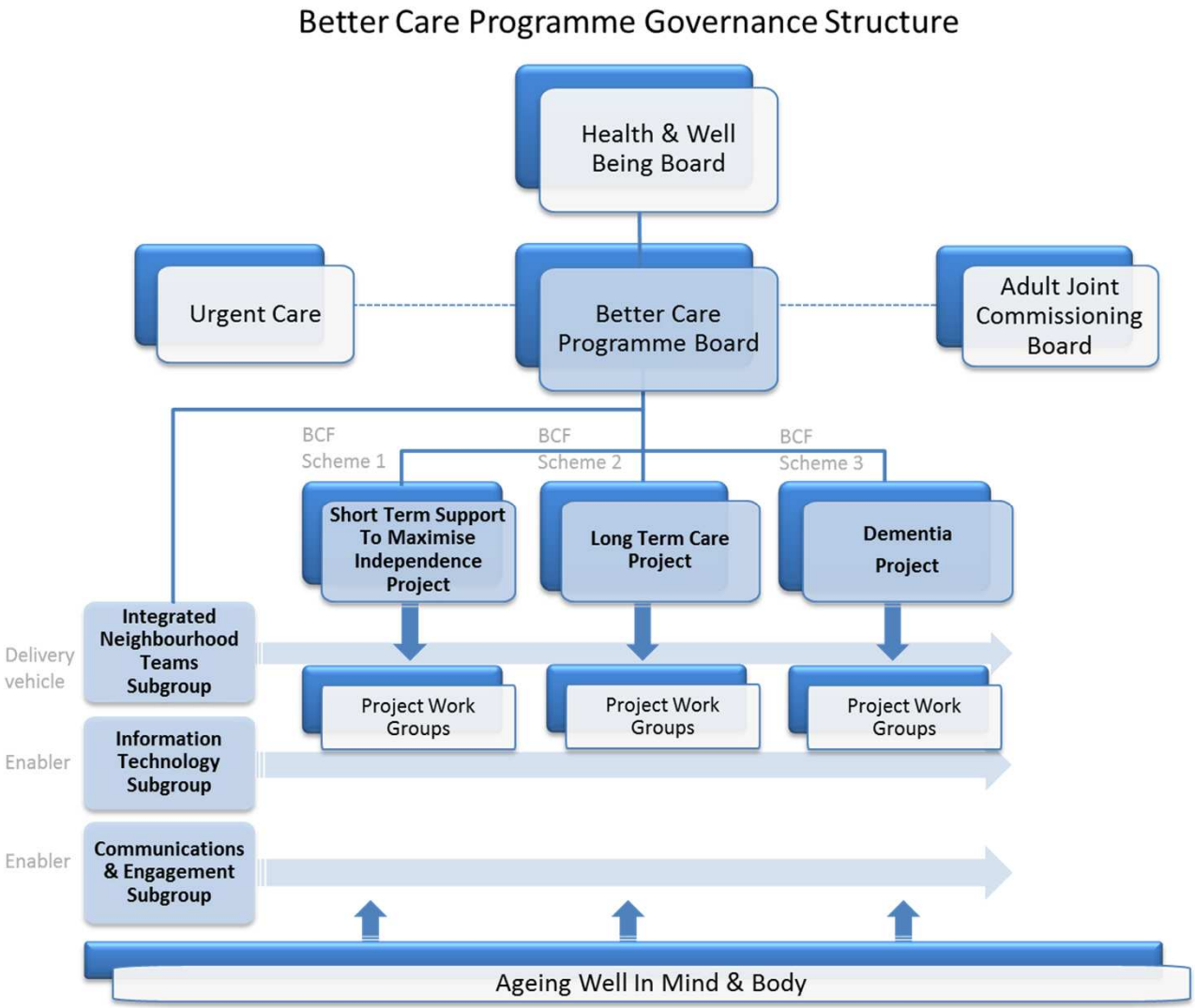
Key Deliverables

- Integrated health and social care plan that delivers:
  - Preventative approaches to healthy living and lifestyle choices
  - Personalised care planning
  - Integrated support pathways
  - Effective hospital discharge
  - Integrated care workforce
  - Supports carers in the context of the Care Bill
- Implement Shared Record system with NHS number
- Investment in primary care to:
  - enable innovative models of care
  - develop local areas of expertise
- Ensuring best use of combined resources that:
  - are responsive to population and community need
  - ensures value for money service provision

Measuring Outcomes

- KPI Framework established from ASCOF & QoF Measure overlaps:
  - Permanent Admissions (ASCOF 2a)
  - Older People at home 91 days (ASCOF 2b)
  - Delayed Transfer of Care (DToC) (ASCOF 2c)
  - Avoidable Emergency Admissions
  - Patient Experience
  - Sequel To Service (ASCOF 2d) new measure
- Underlying metrics include:
  - Number in receipt of telecare in 3 years,
  - Number in residential/nursing care etc.

Structure



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Progress to Date: Board

- Better Care Board established:
  - Representation from all partner organisations
  - Terms of Reference developed in line with BCF Submission
- BCF KPIs drafted and incorporated in BC Board Deliverables
- Dementia, Short Term Care and Long term Care Projects launched – i.e. supporting all Schemes in the BCF Submission
- Communications Enabler Workstream launched
- Integrated Neighbourhood Teams Project launched
  - Dry run completed
  - Shared Integrated Record nearing completion

Next Major Actions

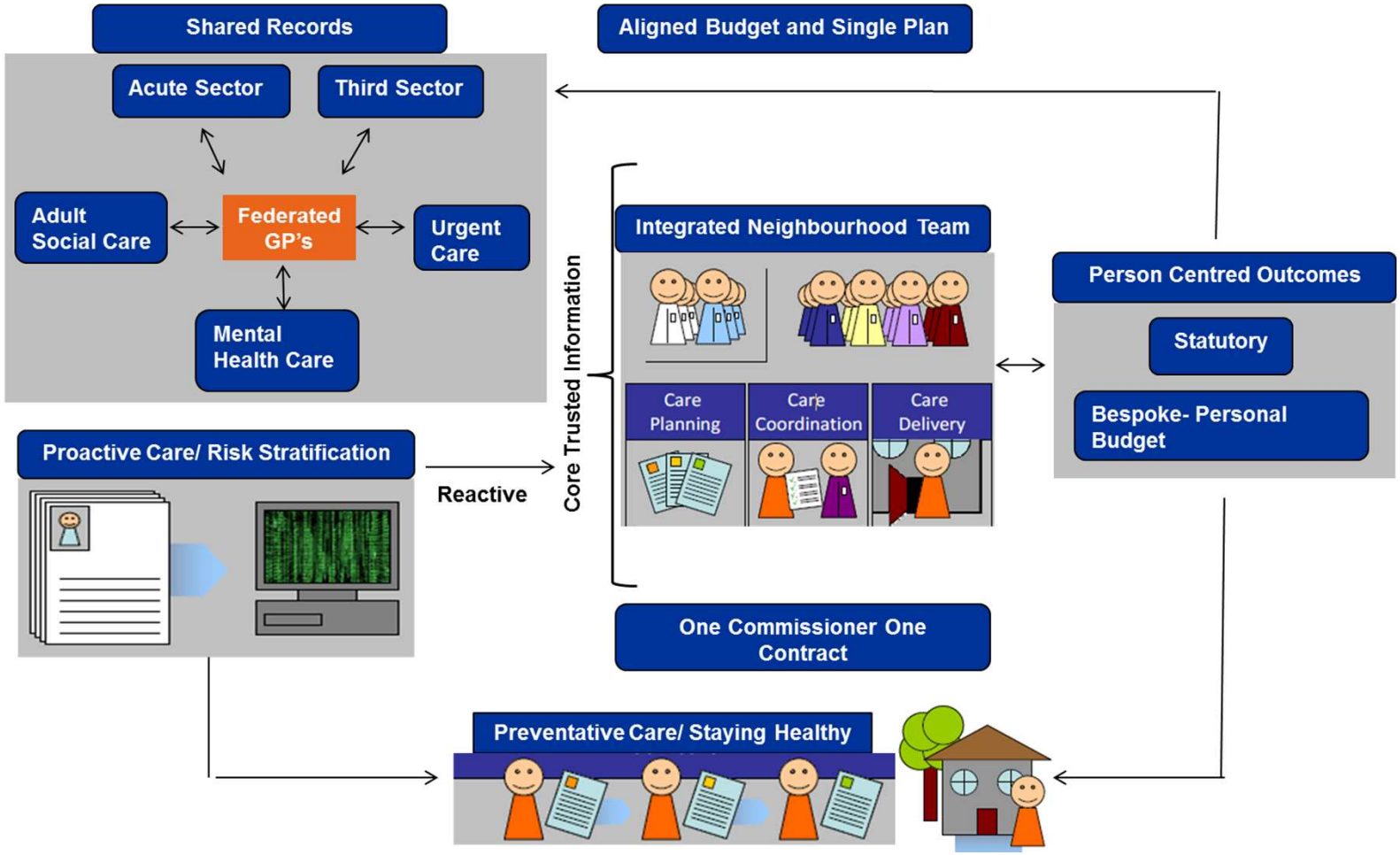
- Launch remaining IT Enabler Workstream
- Finalise BCF IT Strategy
- Finalise Better Care Dashboard
- Finalise ToRs & KPIs for each project
- Develop and agree Communications Plan
- Finalise resources management (funding etc.)

Integrated Neighbourhood Teams

- Scope: Older people with complex needs
- Uses BT Hot House fast track change model
- Multi-disciplinary team based around Primary Care clusters
- Delivers 3 levels of support
  - Level 1 - Preventative
  - Level 2 - Treating people already receiving some form of statutory service
  - Level 3 - Treating those who have complex needs

Integrated Neighbourhood Teams

The Model



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Progress to Date: INT

- Pilot Project launched on 8th April 2014
- Workshop held May 13th to develop the offer and deliverables
- Identification of GP Practices included within INT Pilot currently - Park Leys, The Forum and Jubilee Crescent
- Terms of Reference developed
- Sub-workgroups set up to:
  - Investigate and report on patient cohort selection
  - Capture Data
  - Develop Template for shared record
  - Develop KPIs
- Clinical Workshop held to define team composition and Levels 1,2,3 activities
- Successful trial held 3rd June with core team members from across all organisations
- Development of data harvesting process and methodology
- Formation of key workgroups: Data, KPIs, and Information Governance
- Operational pathway drafted

Short Term Care

- **Scope:** Short Term Care that supports Older People particularly older people with complex needs and their Carers
- **Overall aim:** Integrate the two current pathways for older people into a single short term support pathway so providing a more seamless experience for both people and staff using the service

Progress to Date: Short Term Care

- High level strategy approved by Adult Joint Commissioning Board
- High level Single Care Pathway drafted
- Project Group involving all key partners established
- Terms of Reference deliverables established
- Further review of short term support capacity undertaken:
  - Agreements to develop further support in the community
  - Decommissioning some bed-based services
- Substantial project development nearing conclusion on developing an enhanced Telecare offer at scale and pace to support approximately 3,000 people over 3 years. Cabinet report June 2014
- Short Term Home Care – 3 providers in place covering 7 GP clusters

Dementia Project

- Scope:
  - Memory assessment services (CWPT)
  - Post-diagnostic support services (CWPT, Alzheimer's Society, Carers' Centre)
  - Packages of support for people with dementia (residential and nursing care only)
  - Reablement services for people with dementia (currently Charnwood House)
  - Assistive technology for people with dementia
  - Carers' education and support services (Alzheimer's Society, Coventry University)
- Overall aims:
  - To develop and implement a plan for integrated delivery of care, including both pre and post diagnostic support, living with dementia and rapid re-entry to services when required.
  - To enable people with dementia to take control of their diagnosis, remain independent for as long as possible, and live well with the condition
  - To support carers to be well equipped for their role and to continue to provide care whilst ensuring a good work/life balance

Progress to Date: Dementia

- Consultation on Dementia Strategy completed
- Support received from Adult Commissioning Board and Adult Social Care Management Team
- Coventry's Dementia Strategy approved by Cabinet Member for Health and Social Care
- Programme of awareness-raising activities completed during Dementia Awareness Week, including information stalls in every library in the city, and 100 new Dementia Friends signed up
- Public and Patient engagement event held in Rugby, to support the development of the programme
- GP / Clinical Lead for Dementia approved six week pilot of computerised assessment software, designed to support the diagnosis pathway, at Park Leys Medical Practice

Long Term Care Project

- Two cohorts:
  - Long Term Care and Support For Learning Disabilities & Mental Health (all ages)
  - Long Term Care and Support for Older People with complex needs

Long Term Care Project

Cohort 1: Long Term Care and Support For Learning Disabilities & Mental Health (all ages)

Key Objectives

- 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

Long Term Care Project

Cohort 2: Long Term Care and Support for Older People (75+)

Key Objectives

- Creation of a locality integrated care planning process targeting older people with complex needs
- Provide older people with complex needs either a preventative health and care offer/approach or a full health and social care plan, dependent on need
- As needs fluctuate ensure 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

Progress to Date: Long Term Care

- Project launched
- Terms of Reference drafted and under-going refinement
- List of joint packages compiled by health and they have been cross referenced with LA information including costs, provider etc.
- Joint Funded packages data analysed and categorised to focus on packages over £1000/week
- Also to include review of jointly funded provision for LD services provided by CWPT

External Assurance

Overall Risk Assessment

		From your assessment is this a high risk plan?	If yes, why is it high risk, and what remedial actions do you propose?	Should the BCF plan be recommended for final sign off?
LA Code	**HWB name**	***Y/N (type "Y" or "N")***	***Free Text***	***Y/N (type "Y" or "N")***
E08000025	Birmingham	*Y*	*The plan is ambitious and the financial*	*N*
E08000026	Coventry	*N*	*[complete]*	*Y*
E08000027	Dudley	*N*	*[complete]*	*Y*
E06000019	Herefordshire, County of	*N*	*Risk inherent in the plan until the 2015/*	*Y*
E08000028	Sandwell	*N*	*[complete]*	*Y*
E06000051	Shropshire	*Y*	*Brief plan with much of the detail still wo*	*N*
E08000029	Solihull	*Y*	*Extent of changes in capacity, activity,*	*N*
E10000028	Staffordshire	*N**	*Plan well articulated, however inherent ri*	*Y**
E06000021	Stoke-on-Trent	*N*	*[complete]*	*Y*
E06000020	Telford and Wrekin	*N**	*Plan is well articulated, however impact*	*Y**
E08000030	Walsall	*Y*	*As outlined above, Walsall Healthcare*	*Y*
E10000031	Warwickshire	*N*	*[complete]*	*Y*
E08000031	Wolverhampton	*N*	*[complete]*	*Y*
E10000034	Worcestershire	*Y*	*The plan includes a high degree of risk*	*Y*

Note: Further assurance process initiated by DH and expected imminently

External Assurance

Confidence that plans will deliver national conditions

		Plans jointly agreed	Protection for social care services (not spending)	As part of agreed local plans, 7 day working in health and social care	Better data sharing between health and social care, based on the NHS number	Where funding is used for integrated packages of care, there is an accountable professional	Agreement on consequential impact of BCF plan on the provider sector, including consultation with providers
LA Code	**HWB name**	**R/A/G (type "R","A" or "G") - see info below table**					
E08000025	Birmingham	G	A	A	A	A	R
E08000026	Coventry	G	G	G	G	G	G
E08000027	Dudley	G	G	A	G	G	A
E06000019	Herefordshire, County of	G	G	A	G	G	A
E08000028	Sandwell	G	G	G	G	G	A
E06000051	Shropshire	G	A	A	G	G	A
E08000029	Solihull	G	G	G	G	A	R
E10000028	Staffordshire	G	G	G	G	A	A
E06000021	Stoke-on-Trent	G	G	G	G	G	A
E06000020	Telford and Wrekin	G	G	G	A	G	A
E08000030	Walsall	G	G	A	A	A	A
E10000031	Warwickshire	G	A	A	G	G	A
E08000031	Wolverhampton	G	G	G	A	A	A
E10000034	Worcestershire	G	G	A	G	A	A

"Only one plan (Coventry) has fully satisfied all of the national conditions. All other plans are likely to require further monitoring. "

External Assurance

Overall assessment of the plan

	Confidence that the plan is deliverable	Confidence that plan is affordable	The plan must not have a negative impact on the level and quality of mental health services	The plan includes a clear risk mitigation plan, covering the impact on existing NHS and social care delivery and the steps that will be taken if activity volumes do not change as planned	Patients and the public have been engaged in the development of the plan
HWB name	**R/A/G (type "R","A" or "G") - see info below table**				
Birmingham	A	R	G	A	A
Coventry	G	G	G	G	G
Dudley	A	G	A	A	G
Herefordshire, County of	A	G	G	A	G
Sandwell	G	G	G	G	G
Shropshire	A	G	A	A	G
Solihull	R	R	G	G	G
Staffordshire	G	G	G	A	G
Stoke-on-Trent	G	G	G	A	G
Telford and Wrekin	G	G	A	G	G
Walsall	A	A	G	A	G
Warwickshire	G	G	G	A	G
Wolverhampton	A	A	G	A	G
Worcestershire	A	G	A	A	A

"Once again, only Coventry's plan has satisfied all of the conditions / metrics in this category. "

Issues and Risks

- Culture and behaviour change
- Pooled budget (£46m) for 2015/16
- NHS finances and 15% transfer in context of overall NHS overspend
- Doesn't address the finance challenges faced by CCC and CCG though new models are designed to improve performance, drive efficiency gains and improve outcomes and people's experience
- Huge collaborative leadership challenge at every level

Recommendations

- Support the BCF content, the 3 main projects, the Integrated Neighbourhood Team delivery model and deliverables for Coventry
- Formally endorse the establishment of pooled budget arrangements for the £45.843m identified for 2015/16
- Accept further updates reports at each meeting with a detailed themed presentation on each workstream in turn