Coventry City Council

To: **Health and Well-Being Board**

From: **Better Care Programme Board**

Date: **5 September 2014**

Subject: **Better Care Fund (BCF) – Coventry Resubmission**

Purpose

The purpose of this report is to:

- Inform the Health and Well-Being Board of changes to Better Care Fund programme.
- Inform board on the progress towards completion of the Better Care Fund Resubmission Planning Template to support integration across Health and Social Care.
- Describe the refreshed vision for Health and Social Care integration in Coventry.
- Outline the initial planned changes to be progressed as part of the Better Care Fund.
- Inform board of the proposed process to be used to complete the submission.

Background and National Context

The Better Care Fund was announced in late 2013 with regional submissions in February 2014 then updated submissions in April 2014. In July 2014 NHS England announced that following Central Government and Treasury discussions there would be a major shift in the payment for performance element of the fund that would require a resubmission of BCF Plans.

Better Care Fund Summary as at April 2014

The Better Care Fund nationally totals £3.8bn for 2015/16. However, this is not new or additional money: £1.9bn will come from Clinical Commissioning Group (CCG) allocations in addition to NHS money already supporting social care. The funding already identified comprises of: £130m Carers Break funding, £300m CCG reablement funding, £354m Local authority capital funding (including £220m Disabled Facilities Grant) and £1.1bn existing transfer from health to adult social care. In addition, for 2014/15 there is a further £200m transfer from the NHS to adult social care to 'accelerate the work required' for the Better Care Fund.

Identifying money for the Better Care Fund involves redeploying funds from existing NHS services. The Better Care Fund does not address the financial pressures faced by Local Authorities and CCGs in 2015 which are already very challenging.

All Better Care Fund submissions were subject to a validation process undertaken by ADASS (Association of Directors of Social Services) and Local Area Teams which rated plans on the scale of Red, Amber, Green. Coventry's submission received the highest number of 'greens' in the region.

Progress since April 2014

The introduction of the Better Care Fund is a significant opportunity to deliver a step change in services and outcomes for the people that use them and has been welcomed as such across the Coventry Health and Social Care economy. In April we launched our Better Care Programme to deliver against our Better Care Plan and there has been significant time and resource devoted to providing the appropriate level of leadership and ownership across key organisations so that the aspirations of the Better Care Fund are translated into reality. This leadership has been

evidenced across the City Council, the CCG, Coventry and Warwickshire Partnership Trust (CWPT) and University Hospital Coventry and Warwickshire (UHCW).

All 4 partners have worked together to establish the programme deliverables and governance together with launching 4 specific projects (Short Term Care To Maximise Independence, Long Term Care, Dementia (through the Dementia Strategy Board) and Integrated Neighbourhood Teams. Each project has an agreed set of deliverables and target dates which support the delivery of our Better Care Plan.

Changes to the Better Care Fund July 2014

In July 2014 changes to the Better Care Fund were announced which require a review and re-submission of the Better Care Fund template submitted in April 2014.

In summary:

- The £1bn BCF performance based fund is now paid only for Reduction in **TOTAL** Emergency Admissions (general & acute non-elective) by at least 3.5%. The 3.5% relates to all emergency admissions and not just the proportion linked to BCF i.e. it also includes children's emergency admissions. Achieving a 3.5% reduction nationally would provide a national performance pot of £300m; this is the planning number used by NHS England.
- Coventry's proportion of the £1bn not assigned to performance pools (£1bn less £300m) will be available up-front in 2015/16 for the CCG to spend on NHS Commissioned out-of-hospital services these can be existing as well as new services and therefore can presumably be used to support services that would otherwise be at risk through other financial pressures. The higher the submitted target the lower this number will be.
- Existing metrics remain but don't affect payment. These are however still required for the sign off of local plans.
- We can set our own target, other than 3.5%, for the reduction of Emergency Admissions and we can set a lower target (subject to NHS England approval). There is no additional payment for over-achieving our agreed local target.
- If we achieve our target the money is transferred into our BC Fund for investment in locally agreed priorities as set out in our BCF plan.
- If the reduction in emergency admissions target is not met then the money remains in the local area to be used by the CCG to fund the pressures caused by failing to reduce emergency admissions or on NHS commissioned services in consultation with Coventry HWB partners.
- An important part of the revised submission is provider sign off. To complete the submission providers are required to submit commentary that the assumptions in the BCF plan are built into their own plans.
- Better Care Scope is Adults (mainly elderly) but Emergency Admissions target includes all admissions including children.
- £130m Carers funding remains in the BCF but plans are to set out how the chosen methods for the use of Carers funding will help meet the key outcomes i.e. reduced delayed transfers.

Impact on Coventry's Better Care Programme

The performance fund of the Better Care Programme is solely liked to reductions in Emergency Admissions, which for Coventry's over the period Jan-Mar 2014 were running at circa 1060 per week, 14% higher than same period last year. At 3.5% reduction this would equate to keeping 37 adults per week from emergency admission to hospital.

Currently, Reduction in Emergency Admissions is a key deliverable for Coventry's Urgent Care programme. The BCF focus on Emergency Admissions necessitates a strong link between Urgent Care and Better Care Programmes.

To meet the requirements of the revised submission we need to show robust measures to reduce Emergency Admissions while also maintaining focus on the original measures as these will continue to be monitored and are essential for BCF Submission sign off and overall system sustainability.

Completing the Resubmission

Resubmissions have to be submitted to NHS England by 19th September 2014 and the Local Area Team are involved in the development stage with 3 Checkpoints requiring reporting and draft submissions between August and October 2014 to gauge resubmission progress and agree any changes and support needs prior to official submission.

There is also a much more formal development structure with what appears to be an improved level of support. Coventry BCF contacts report to the Arden, Herefordshire and Worcestershire Area Lead who reports to a Regional Lead who reports to the Central NHS England BCF Programme Office.

There are a number of pre-requisites to the successful completion of the re-submission , these being:

- Evidence of provider involvement with providers being asked to expressly confirm their agreement with the impact of BCF
- Evidence of engagement with service users, carers, NHS providers, primary care, social care and voluntary sector providers
- Accurate data on which to base planning assumptions and then on-going performance management
- An cross-partner agreed measure definition for Emergency Admissions that reflects the new BCF measure
- Clear governance in particular relationships between Urgent Care and Better Care Programmes
- Commitment to interventions that will (with a good degree of certainty) reduce Emergency Admissions and avoid escalation of health issues requiring A&E

Progress to Date

Resubmission Progress

The re-submission is due to NHS England on 19 September 2014 and has two key parts:

Template 1 (Narrative): using re-developed Terms of Reference from existing projects and a new Terms of Reference for Emergency Admissions project. The draft is making progress and will be submitted to BC Programme Board for comments by Thursday 11th September. Following this the template will be completed ready for sign-off as detailed below.

Template 2 (Metrics & Finance): meetings have been held between CCG and CCC Finance together with Project Leads to establish where benefits can be quantified or re-quantified and any pump priming costs established. Next step is to prepare a draft template for comment.

Sign-off Process

The re-submission has been shared, through Better Care Programme Board members with all 4 organisations at board/exec level. The submission timescale of 19 September 2014 did not allow HWBB sign off in advance of submission, hence is being shared with the Board in retrospect. Between submission and the remainder of the year further changes are likely to be required to the submission, which is being regarded as an iterative process. There will therefore be opportunities for all partners and the HWBB to contribute to further developments of the Better Care Plan.

It should be noted that the re-submission requires the sign-off of UHCW and CWPT along with the City Council and CRCCG. Therefore, although timescales did not allow HWBB sign-off in advance of submission the board should be assured that the re-submission has had an appropriate level of organisation sign-off.

Health and Well-Being Board member organisations are also encouraged to take the submission through their governance structures to ensure visibility and on-going support for this important work to improve outcomes across Health and Social Care in Coventry. A progress report on the revised Better Care Programme Plan will be included on the agenda of the next Health and Well-Being Board with an update on implementation.

Planned Changes to Better Care Programme

The focus on Emergency Admissions has resulted in a cross-partner agreement for the Urgent Care Programme to deliver the reduction in emergency admissions reporting to the Better Care Programme Board. The new programme governance model is outlined in appendix 1:

The Coventry Better Care Fund resubmission will contain four key projects each having a detailed Terms of Reference including deliverables and target dates. The four projects are:

- Scheme One: Urgent Care Transformation Programme
- Scheme Two: Short Term Support to Maximise Independence
- Scheme Three: Long Term Care
- Scheme Four: Dementia

A summary of each project can be found in Appendix One. In addition, the Integrated Neighbourhood Team workstream, which is an underpinning enabler, is expected to be developed to a position of roll out across the city over the next year.

Recommendations

It is recommended that Coventry Health and Well-Being Board:

- Support the inclusion of a fourth ‘Emergency Admissions’ workstream to the Coventry Better Care programme in order to meet the requirements of the revised programme
- Endorse the Coventry Better Care Programme re-submission and provide comment for the Better Care Programme Board to take into account in further revisions as appropriate
- Endorse the proposed governance structure for the Better Care Fund at Appendix Two

Mike Jones, Programme Manager, Better Care Programme

Appendix One
Better Care Projects

Scheme One: Urgent Care

The Urgent Care Board will be utilised as the responsible Board to develop and ensure the delivery of future plans and an integrated whole journey pathway that results in a reduction in emergency admissions that achieves Coventry's Better Care target.

Overview: Urgent Care will focus on achieving the target reduction in urgent admissions as laid out in the BCF Submission. The Urgent Care Transformation Programme will be delivered through a number of work streams: -

Primary Care – increasing capacity to ensure timely access to primary care including implementation of admission avoidance DES (in place), GP federations (in discussion).

Care Homes – reducing the number of attendances and admissions to hospital using a combination of Telehealth (pilot in started Jan 14), Enhanced GP support (pilot started Sept 13) and joint contract monitoring arrangements.

Community Flow – up scaling the Integrated Neighbourhood Teams to support over 75's and over and those with complex needs (linked to scheme 2)

Hospital Flow – redesign of complex discharge process to include a fully Integrated Discharge Team (linked to Scheme 2)

Pre-Hospital Urgent care Model – providing a real alternative to A&E including a communication & market strategy. The Model will provide a co-ordinated and deliver of care via an integrated Urgent Care Hub, including elements of admission avoidance and using a range of clinicians, protocols, diagnostic equipment and communication mechanisms so a significant number of patients can be safely and effectively deflected away from A&E. An aligned communications and behavioural intervention strategy will also be developed. The initial implementation of the model will be on 1st December 2014.

Key Deliverables are:

- Reduction in A & E attendance
- Reduction in non-elective admissions
- Reduction in excess bed days
- Achieve DToC targets
- Monitor 4 hr targets
- Primary Care appointment available within 24 hours
- Reduce attendances to the walk in / urgent care centre
- Patient Experience – surveys undertaken by the CCG

Scheme Two: Short Term Support to Maximise Independence

Vision: 'We will work alongside older people and their carers to support, maintain and improve independence primarily at home'

Overview: 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 has been further progressed through a 'Hothouse Event' which included professionals and practitioners from local NHS providers, primary care, social care and commissioners. As a direct product of this event commitment was given from the four organisations (Coventry City Council, Coventry and Rugby Clinical Commissioning Group, University Hospital Coventry & Warwickshire NHS Trust and Coventry and Warwickshire Partnership Trust) to implement the first integrated team with 90 days of the Hot House. This is now in live pilot until December 2014

The City Council and CRCCG have also made substantial progress on short term support services having commissioned new short term support homecare contracts which will commence in June 2014 for a period of 18 months. Also a new, comprehensive Telecare service has been procured by the City Council and is now being implemented across Coventry. Both of these developments are expected to support the delivery of the target for reductions in Delayed Transfers of Care (DToC) and residential and nursing and sequential services (new indicator).

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 with Dementia** – a number of plans for integrated delivery are being 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
- **Older People With Complex Needs** – Using Public Health data and expertise 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.

Key Deliverables are:

- **Short Term Home Support Contracts:** Implementation of cluster based Home Support contracts
- **Telecare:** Implementation of a new Telecare offer linked to STSMI with a responder service
- **Single Access To Short Term Care:** Implement a single access pathway to an agreed level of short term care at home, a Discharge to Assess model that initially focuses on CHC, that links with INT and that covers 24 hour 7 day working
- **STSMI Dementia:** Development of a specific home based STSMI service for people with dementia
- **Housing With Care:** The use of Housing with Care STSMI where people are not able to be supported in their own homes using a new model including Telecare and Therapy
- **Therapy & Equipment:** A Health & Social Care therapy and equipment offer that is initiated quickly in order to maximise chances of success

Integration will result in:

- Personalised support to deliver better outcomes through an integrated locality approach
- Improved citizen experience as people will know who the support co-ordinator is and will have timely reviews
- More responsive support and expansion of seven day availability
- Co-ordinated and timely support to carers
- People will be supported to remain in their local communities, leading to greater emotional and psychological well-being and maintenance of roles and the values attached to them

Scheme Three: Long Term 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'

Overview: 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. The co-ordination of support through this scheme will be assisted through the implementation of integrated teams including staff from all key organisations.

The following groups of people will benefit from this work:

- Long Term Care and Support For Learning Disabilities & Mental Health (all ages)
- Long Term Care and Support for Older People (75+)
- Younger People with Physical Disabilities

Key Deliverables are:

Existing Risk Profiling: Identify the factors relating to placement stability, duration since last review, cost, and complexity of need in order to profile where greatest gains are likely to be made, cross referencing with existing work i.e. CQINN

Management of Future Risk Profiling: Identify groups that are currently not high cost that are at risk of doing so (i.e. PWLD living with elderly carers and transitions), apply commissioning and case management approaches to ensure risk of high cost placement is avoided should circumstances of the individual change

Individual Commissioning Arrangements: Review and revise individual commissioning arrangements for high cost (>£1000/week) packages so that any new requirements are managed jointly, and effectively

Reduction in care costs for Joint Packages: Review need, eligibility & whether current package meets needs for all joint packages costing >£1000/week

Joint Assessment and Decision Making: Review of current processes and staff resource and review benefits of joint working and opportunities for improvement. Utilise tools to support assessment and utilisation

Budget and Resource Management: Develop a risk & benefits sharing agreement in relation to joint reviews & explore options for pooling resources.

Market Development: Develop a new housing demand model using analysis and best practice. Engage with providers and particularly RSLs to stimulate development of Housing options as alternatives to residential care/more expensive and restrictive care settings. Also develop opportunities for personal budgets (including PHBs) and Individual Service Funds (where appropriate)

Strategic Commissioning Planning: Using the analysis from existing risk profiling output understand the commissioning requirement for the next 5 to 10 years using JSNA and Public

Health/demographic data. Identify current service provision, gaps & commissioning arrangements with a view to aligning commissioning arrangements between health & LA

Integration will result in:

- People supported closer to home
- Fewer people go into long term care, achieve better outcomes and costs the social and health economy less money
- Long term care is better co-ordinated between health and social care leading to reduced risk of breakdown and flexibility to adjust support in line with changing needs

Scheme Four: Dementia

Vision: 'We will enable people with dementia and their carers to be as independent as possible, for as long as people, and for people with dementia to 'live well.' We aim to fully engage people with dementia and their Carers in the design and evaluation of services and support. The needs and wishes of people with dementia and their carers will be at the heart of action planning and delivery of this project.'

Overview: 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.

The following services will be included in this project:

- 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

Key Deliverables are:

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 standalone items, such as GPS trackers

Effective promoting independence and short term support 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)

Integration will result in:
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 and enables carers to continuing caring.

Appendix Two

Better Care Fund Governance Structure (proposed)