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

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

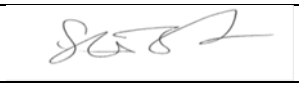
To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAIL

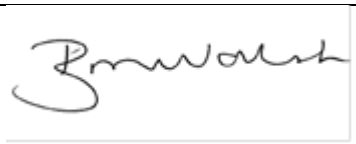
a) Summary of Plan

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:	**Submitted to HWB 19th September for approval at 22nd September meeting**
Date submitted:	**19th September 2014**
Minimum required value of BCF pooled budget: 2014/15	**£0.00**
2015/16	**£24.167M**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£52.106M**

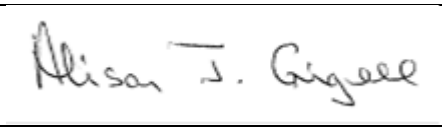
b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Steve Allen
Position	Chief Clinical Officer
Date	20th September 2014

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	
By	Brian Walsh
Position	Executive Director - People Directorate
Date	19th September 2014

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Alison Gingell
Date	20th September 2014

c) Related documentation

Document or information title	Synopsis and links
Coventry's Joint Strategic Needs Assessment	http://www.coventry.gov.uk/jsna
Coventry's Joint Health and Wellbeing Strategy	http://www.coventry.gov.uk/downloads/download/2061/joint%20health%20and%20wellbeing%20strate%20gy
Coventry and Warwickshire Clinical Commissioning Groups' Strategic Plan 2014-2019	http://www.coventryrugbyccg.nhs.uk/About-Us/Coventry-and-Warwickshire-CCGs-Strategic-Plan?Highlight=2+year+operational+plan
Coventry & Rugby CCG 2 year Operational Plan	http://www.coventryrugbyccg.nhs.uk/DocLib/ae2a80ab-3e79-445c-9f16-852e53d1a4f1
Coventry City Council 10 Year Plan	http://moderngov.coventry.gov.uk/documents/s14136/Coventry%20Council%20Plan%20-%20Appendix%201%20-%20Our%20Vision%20and%20Priorities.pdf

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Understanding population needs

Our population is expected to continue to grow by 15% between now and 2021.

Our growing and ageing population means increasing pressure on health and social care services. More people are likely to suffer from long term physical and mental health problems such as heart disease, high blood pressure and dementia and people living with multiple health conditions will become the norm. This trend brings with it poorer quality of life, higher hospital admissions and increased mortality.

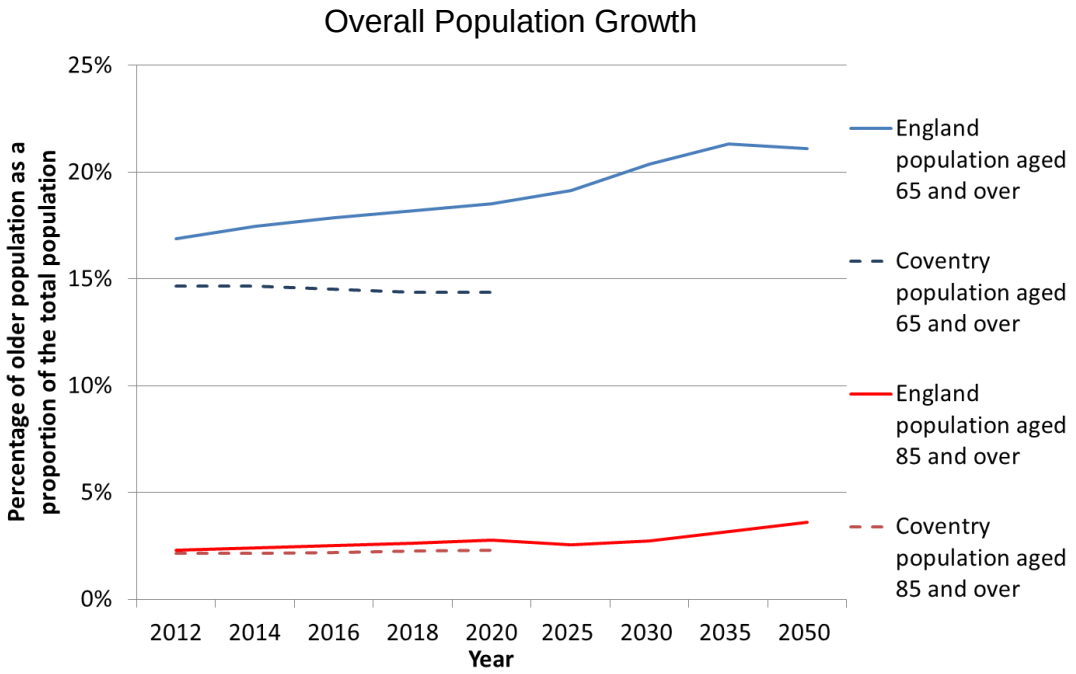
Further Public Health data indicates that although the Coventry older people population is expected to remain relatively static and not expected to increase in line with the England overall population, if current demographic trends continue, the population of residents aged 65+ will start to increase by more than the average in Coventry.

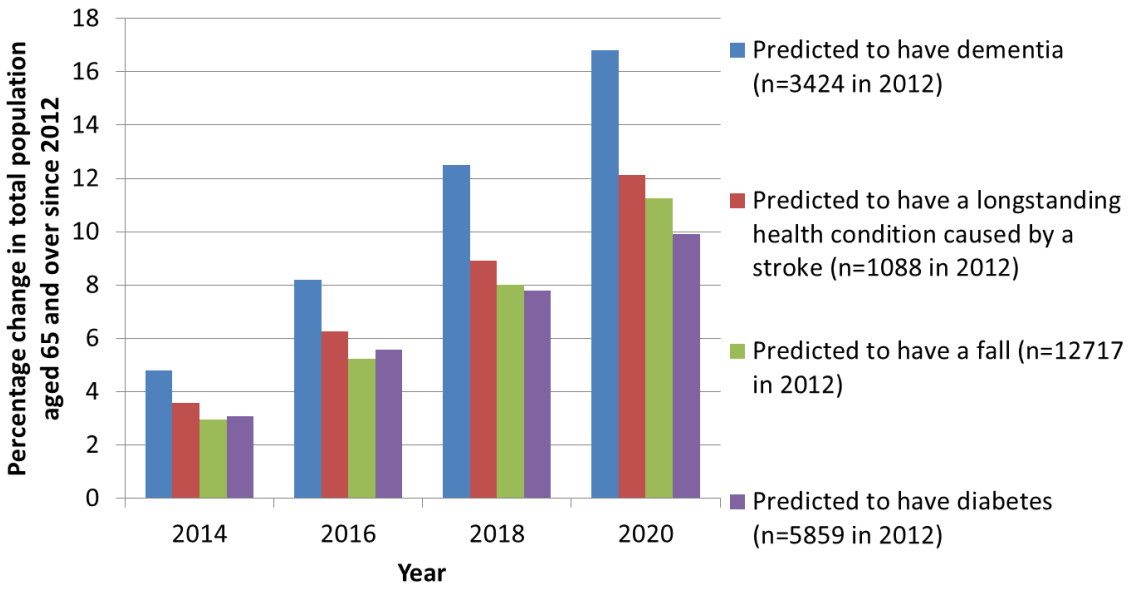
There is likely to be an increase on demand for social care due to the forecasted increases in key health conditions.

The three graphs below show:

- Expected changes in Coventry Older People population
- Expected changes in key health conditions
- Demand for social care services in residential care homes.

(source: Coventry Public Health, Projecting Older People Population Information (POPPI) and Health and Social Care Information Centre.



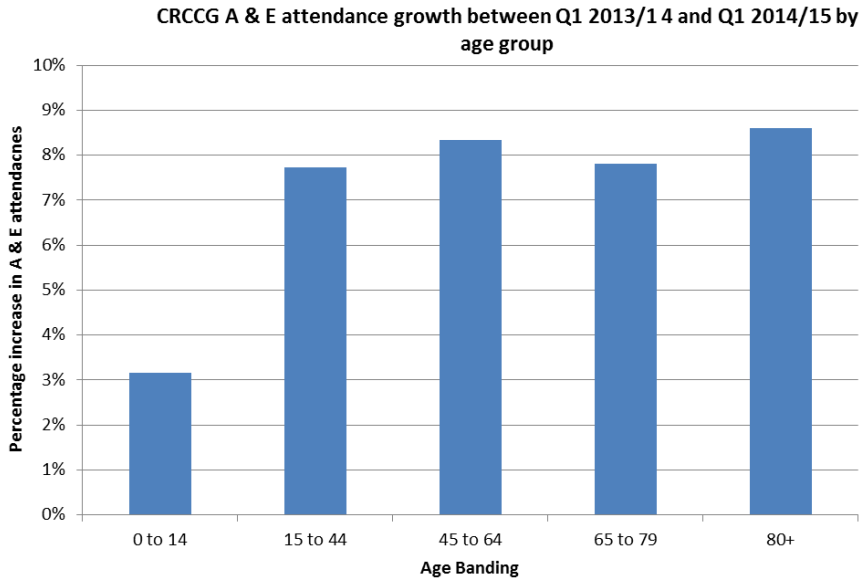


Further analysis shows:

Age	Population	Mostly healthy	Limiting long-term illness	Extremely Limiting long-term illness	Unable to manage on their own	Dementia	At least one fall in last 12 months	Learning Disability
65+	48,700	22,407	12,964	13,882	20,120	3,538	13,074	1,008

The Health and Social System in Coventry is currently characterised by high levels of admissions and attendance at A&E and comparatively high levels of residential care *(source: UHCW & CRCCG)*

Upwards of 50% of unplanned admissions to hospital are in the over 75 age group. Through better coordination and collaboration between primary, community, mental health and social care services it should be possible to prevent some admissions completely (e.g. through better control of long term conditions, or providing treatment in their own home) or enable people to regain their independence more quickly, both of which provide better patient experience. Source: Coventry's JSNA (2012)



Although multi-agency working is considered a strength this is impeded by information systems and organisational configurations, including access criteria, that contribute to a care system that appears disjointed to the end user and is not supporting our ambition to keep our population healthy and away from high cost health & social care services.

National Voices, a coalition of health and social care charities, has identified the lack of joined-up care as a source of huge frustration for patients and carers and has said that "achieving integrated care would be the biggest contribution that health and social care services could make to improving quality and safety". National Voices has reported that "people want to experience seamless care, where it comes from is secondary". Linked to this, a key recurring theme from discussions with GPs and the general public has been the need to share patient records and care plans to improve the co-ordination of care.

To address these challenges our Better Care 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'

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

- 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 keeps 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, that 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 support to carers as an integral part of all work undertaken in the context of the Care Bill
- 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.

This approach supports Theme 1 in our JSNA (2012) - *Healthy People* and also JHWS (2012) with reference to older people and also the following cross-cutting themes:

- Prevention - in line with Marmot, we will focus on prevention and early intervention
- Partnership working – identified as a key strength in Coventry, more will be done to join up services which should be aligned and designed around the needs of the service user
- Community engagement - an asset-based approach will be used; Coventry has many strengths and we will ensure that those strengths are identified and built upon, rather than focusing on problems

b) What difference will this make to patient and service user outcomes?

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

- Improved care experience
- They will tell their story once
- Able to access a full range of personalised support
- Care provided when and where agreed
- Empowered to manage their own condition(s)
- Access to care seven days a week
- Co-ordinated and timely support to carers
- Greater emotional and psychological well-being
- Better long term health
- Reduced need for emergency services
- Reduced dependency on longer term care

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded works contribute to this?

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

- 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 JSNA, JHWS, NHS Outcomes Framework, and Public Health Outcomes Framework.
- System shifts from hospital care are integral to the 5 year plan also underpin our Better Care approach
- Roll out of an integrated neighbourhood team approach across the city which will support the delivery of our better care schemes

BCF Schemes

The schemes that we will be progressing through the Better Care Fund are summarised below and detailed in the Annexe.

Scheme One Urgent Care Transformation Programme

Reduction in non-elective hospital admissions and attendances to hospital through the Coventry & Rugby Urgent Care Transformation Programme which includes providing alternative services to reduce reliance on hospital care.

Scheme Two: Short Term Support to Maximise Independence

Improving access to an agreed level of personalised short term care that keeps people well and out of hospital and provides a positive experience for people, their carers and staff.

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

Joint work to identify current health and social care individual care costs from the LA and CCG to understand and tackle change provide a more cost effective and sustainable care package to people with complex needs.

Scheme Four: 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.

Delivery Vehicle: Integrated Neighbourhood Teams

Proving fast paced delivery of change across the programme using a 'Hot House' approach to deliver change in a 90 day period. Currently focusing on developing a multi-disciplinary process to support older people with complex needs to maintain their health and well-being in the community and reduce reliance on statutory services.

Enabler Projects

Carers Project: Support to carers will be provided by the Carers project reporting to the Adult Joint Commissioning Board and providing enabler support to various workstreams with the Better Care Programme.

Information Technology: delivering the BCF NHS Number requirement, together with Shared Record and Care Planning requirements for each workstream.

Communications and Development: Providing support to work streams to ensure the work and objectives of Coventry's Better Care Programme are correctly communicated.

3) CASE FOR CHANGE

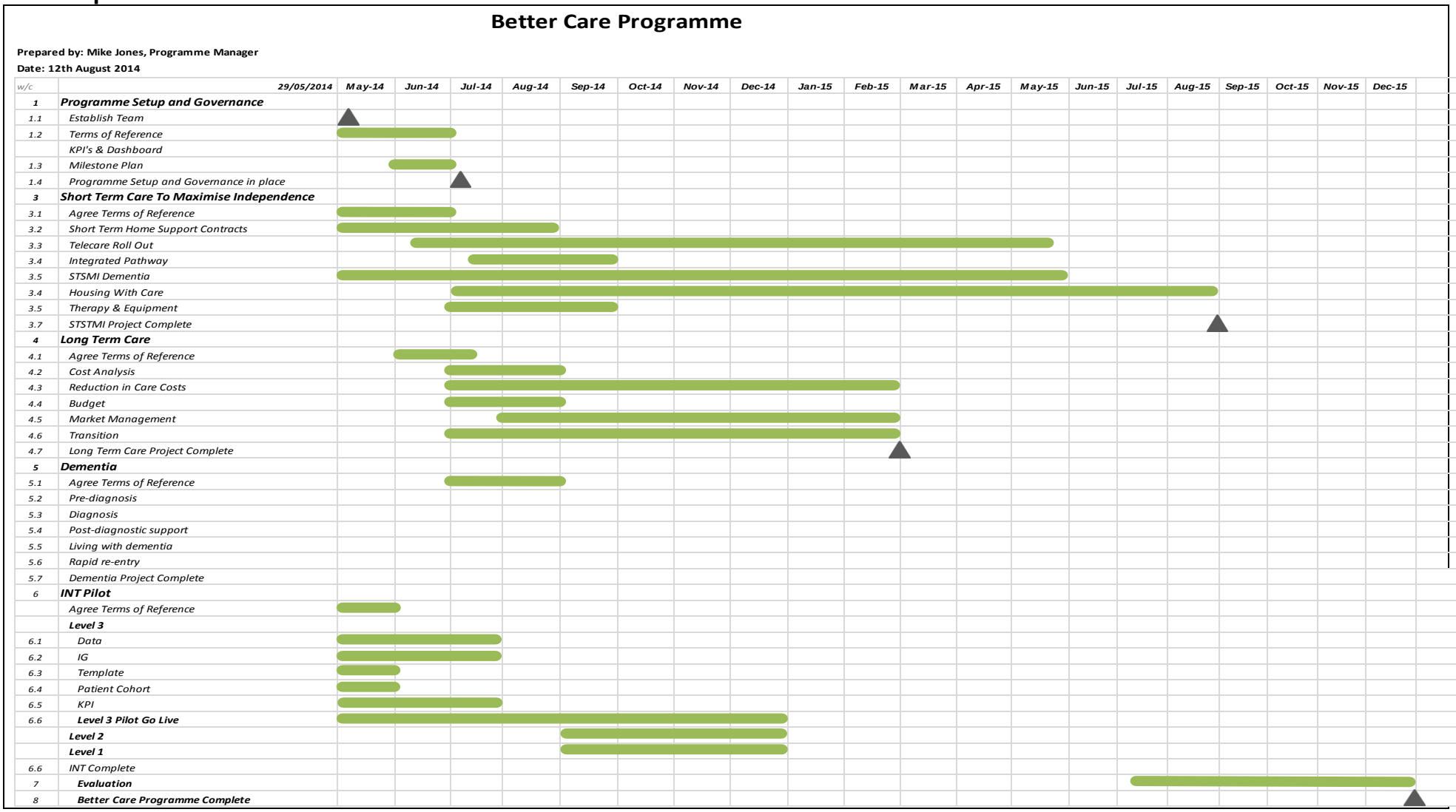
Integration will result in considerably improved cohesiveness between Health Care and Social Care, refocusing resource on delivering better outcomes for individuals. Co-ordinated care will reduce delays and admission to unnecessary care settings (including acute hospitals).

Specific problems that we are seeking to address are as follows:

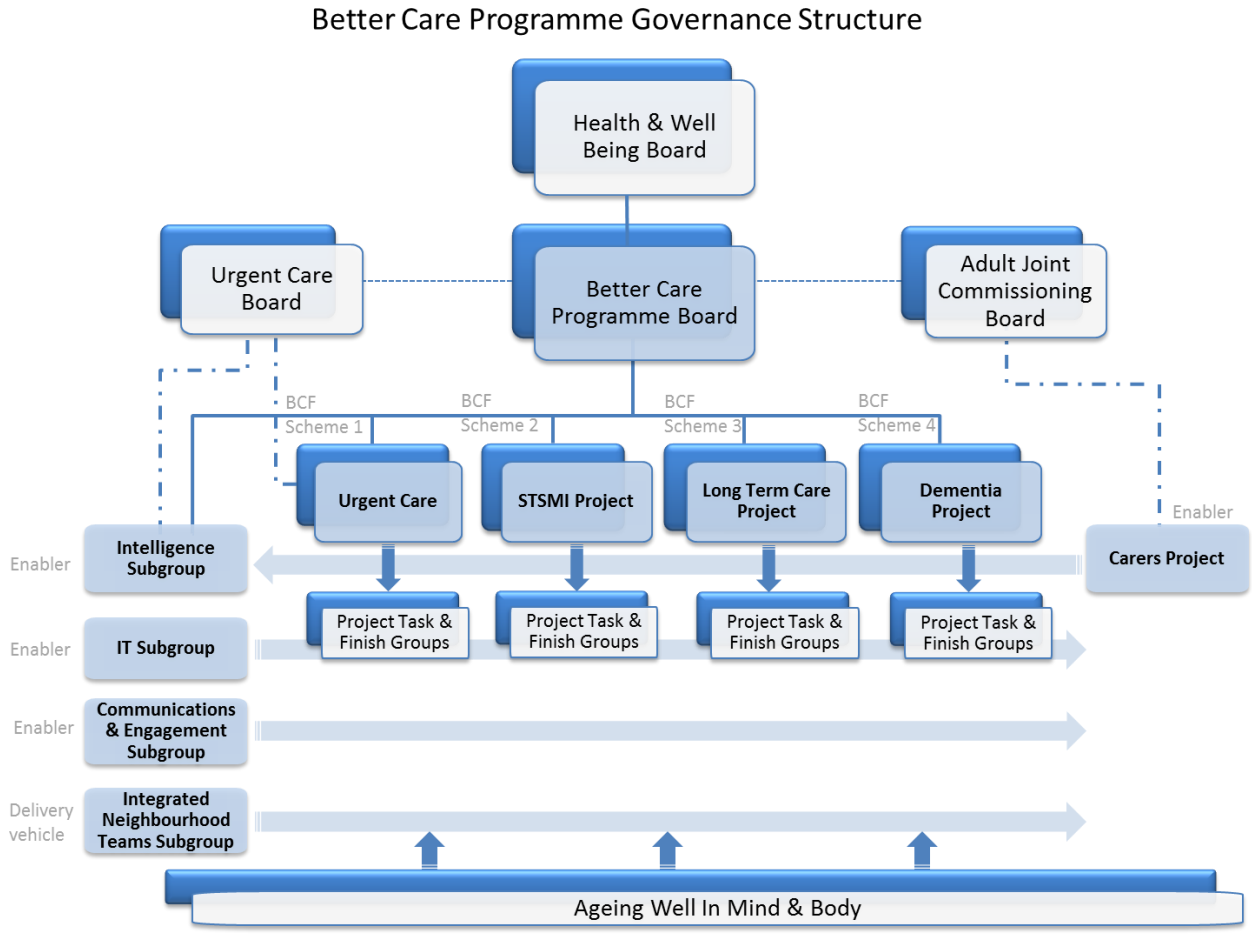
1. Emergency Admissions have increased by 10% between April-July 14 on the same time period last year of which over half were aged over 51 years
2. The Acute is forecasting a 5.4% increase in emergency admissions in 2014/15 compared to 2013/14, based on activity recorded between April and July 2014. This would be 44.2% higher than the level recorded in 2008/09
3. A&E attendance rose by 18% from 2008/9 to 2013/14
4. Outpatient attendance rose by 19% from 2008/9 to 2013/14
5. The cost of achieving the 95%, 4-hour wait target is adversely affecting efficiency and financial targets
6. Delayed Transfers of Care from hospital to short term care at home or continuing health care is showing a worsening trend and we are currently 10% below target
7. Number of people aged 65 and over predicted to have a limiting long term illness is set to rise by 10% over the next 6 years
8. From 2010/11 to 2012/13 total numbers of people in residential and nursing care increased by 19% whereas the comparator average has decreased by 1.4%. (HSCIC Older People Comparator Report 2012-13)
9. Compared with the 15 comparable Councils Coventry is:
    a. 8th for permanent admissions to residential and nursing care homes for older people (ASCOF 2012/13)
    b. 3rd for proportion of older people who were still at home 91 days after discharge from hospital into reablement/rehabilitation (ASCOF 2012/13)
    c. 10th for people offered reablement services following hospital discharge
    d. 15th for delayed transfers of care from hospital (ASCOF 2012/13)
    e. 15th for delayed transfers of care from hospital attributable to joint health/adult social care and adult social care only (ASCOF 2012/13)

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies



b) Please articulate the overarching governance arrangements for integrated care locally



This governance structure, as shown above, has been developed in partnership with the following four Health and Social Care organisations and has been formally agreed by the Health and Well-Being Board and Adult Joint Commissioning Board:

- Coventry City Council including Public Health
- University Hospitals Coventry & Warwickshire NHS Trust
- Coventry & Warwickshire Partnership Trust
- Coventry & Rugby Clinical Commissioning Group

Overall programme governance is tightly controlled across all 4 partners with strong linkages with aligned local and cross-partner programmes.

The Better Care Programme Board reports to the Health and Well-Being Board who have overall leadership and accountability for delivery of the Better Care Programme with periodic oversight through HOSC. There are four main Projects that reflect each BCF Scheme with three Enabler Subgroups (Carers, IT & Communications) together with a delivery vehicle subgroup that provides a fast change methodology. Each project is led by members of the Programme Board and managed by a Project Steering Group. Nominated members of each Project Steering Group lead a number of Task & Finish Groups who are responsible for delivering tasks set by their Steering Group.

The Urgent Care deliverables are developed jointly between the Better Care Board and Urgent Care Board and progressed through the Urgent Care Programme with monthly progress reports to the Better Care Programme Board (some members of which also sit on the Urgent Care Board).

c) Please provide details of the management and oversight of the delivery of the Better Care Fund plan, including management of any remedial actions should plans go off track

Deliverables

The project deliverables to impact on reducing emergency admissions are developed and monitored through the Urgent Care Board. There is recognition that there is considerable overlap between the UCB and Better Care Programme Board and so monthly progress reports are provided to the retrospective boards (some members of which also sit on the Urgent Care Board). The UCB has agreed Terms of Reference and focus on delivery from each of the project streams.

The Better Care Programme Board has an agreed Terms of Reference that provides focus on programme deliverables; each Project Steering Group then has its own Terms of Reference with a Deliverables Plan detailing key project deliverables, ownership and milestones for each of its Project Task & Finish Groups.

Progress Reporting

Each Task & Finish Group provides monthly updates to the Project Steering Group by way of a Project Plan Update.

Each Steering Group provides a monthly Project Highlight Report to the Better Care Programme Board which in turn provides a Programme Highlight Report to the Health & Well-Being and Adult Joint Commissioning Boards.

Each Better Care Programme member uses the Better Care Highlight Report to inform their own organisations.

Remedial Actions

Any remedial actions are agreed at the respective Steering Group or Board; these are minuted and tracked to completion.

d) **List of planned BCF schemes**

Ref no.	Scheme
1	BCF Scheme 1: Urgent Care Transformation Programme
2	BCF Scheme 2: Short Term Care To Maximise Independence
3	BCF Scheme 3: Long Term Care and Support
4	BCF Scheme 4: Dementia
5	Delivery Vehicle: Integrated Neighbourhood Teams
6	Enabler: Carers
7	Enabler: Information Technology
8	Enabler: Communications & Engagement

5) RISKS AND CONTINGENCY

a) Risk log

Better Care Programme	Risk Log	Prepared by:	Mike Jones
		Date:	08-Sep-14

Risk Identifier	Title of Risk	Description of Risk	Date Reported	Raised By	Date last reviewed	Probability	Impact	Risk Estimate	Resolved	Owner	Status	Current Owner (If escalated)	Target Date	Actions to Mitigate Risk
1	BCF Formal Sign-off	Achieving sign-off and agreement across all partners	31-Jul	MJ	09-Sep	Possible	Major	Medium	No	BC Board	Open		31-Dec-14	Urgent Care delivering EA reporting into Better Care programme. All project deliverables to be reviewed/amended to reflect new focus
2	Performance Management	In particular management of reduction in Emergency Admissions	01-May	MJ	14-Aug	Almost Certain	Major	High	No	MH	Open		31-Dec-15	Intelligence Group created and setup as an enabler to BC Programme. Focus is on agreeing definition for EA measure and resolving other BC Measure definistions and data extarction issues
3	Shared Record	No IT strategy to deliver Shared Record or Care Planning	12-Jun	MJ	01-Sep	Possible	Moderate	Medium	No	MJ	Open		15-Oct-14	Possibility of expanding CWPT Communityt Nursing project. User Spec being prepared by INT Data Team. Wider Information Sharing Group meeting planned for 15th Oct 2014 CCG now appointed a Programme Manager for the Information Sharing Programme
4	Activity volumes	Activity volumes do not change as planned	01-May	PF	09-Aug	Possible	Major	Medium	No	Board	Open		21-Dec-14	Ensure programme management arrangements in place and robust delivering regular performance updates to allow remedial action to be taken promptly Risk sharing across organisations Behaviour change programme to underpin delivery of integration
5	Financial challenges	Inability to meet financial challenges across the health and social care economy	01-May	PF	09-Sep	Possible	Major	Medium	No	Board	Open		21-Dec-14	Agreed understanding to share wider financial envelope and challenges across the health and social care economy to better understand the respective pressures
6	Market supply	Failure to secure capacity, capability and quality provision from the market	01-May	PF	09-Sep	Possible	Major	Medium	No	Board	Open		21-Dec-14	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.
7	Cross-partner buy-in	Political and professional/clinical buy in for proposed new service model	01-May	PF	09-Sep	Unlikely	Major	Medium	No	Board	Open		31-Oct-14	External consultation across all Leaders being organised. 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.
8	Leadership	Leadership and continuity of the new service model	01-May	PF	09-Sep	Possible	Major	Medium	No	Board	Open		31-Oct-14	External consultation across all Leaders being organised. 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
9	Service model failure	Service model fails to deliver as planned (either financially or to outcomes)	01-May	PF	09-Sep	Possible	Major	Medium	No	Board	Open		21-Dec-14	Undertake reviews and evidence based progress tracking at frequent intervals. Retain flexibility in arrangements to adjust as required and in response to changing circumstances.
10	Primary Care Capacity	Primary care may not have the capacity and/or capability to make the required changes to support the BCF programmes	12-Sep	JH	12-Sep	Possible	Moderate	Medium	No	JH	Open		21-Dec-14	On-going CCG support to General Practice, including backfilling clinical roles, supporting the wider primary care team (practice nurses, practice managers and medicines management support), training and innovative use of IT.

b) Contingency plan and risk sharing

Risks are currently managed through contracting processes where providers and commissioners, through regular dialogue and contract management mechanisms, can agree revised actions if required to ensure emergency admissions targets are met. Risk sharing and contingency planning also takes place through the Better Care Programme Board and Urgent Care Board where programme and project level risks are agreed with mitigating actions and responsible authorities held to account for delivery.

There is currently no formal risk sharing in place between commissioners across health and social care. Both risk and benefit share will be determined as part of our Better Care approach involving all relevant parties.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

The plans align with the following initiatives within the area:

Urgent Care Transformation Programme

There is an existing programme of change led through the Urgent Care board that will support the work of the Better Care Programme through positive steps to reduce emergency admissions and facilitate speedier discharge through supporting people in their local communities. See link to Urgent Care Plan in section 1.

Coventry City Council Commissioning & Personalisation Plan 2014-16

This is an ambitious plan to deliver more personalised support across adult social care within a changing financial and policy context. It includes implementation of a new resource allocation system and prepares us for the Care Act.

Coventry & Rugby Capacity & Resilience Plan

This plan focusses on system resilience across the local economy and is agreed with all key health and social care partners. This plan specifically aligns with both the Emergency Admissions and Short Term Services to Maximise Independence workstreams.

A Bolder Community Services (abcs)

This has been the City Councils key change programme within Adult Social Care. Phase One of the programmes was delivered in 2014/15 and included the re-commissioning of short term home support services which was also a deliverable under the Short Term Services to Maximise Independence workstream. Further work to be done under abcs is the introduction of Telecare and the commissioning of further Short Term Tenancies in Housing with Care, both of which also support the Short Term services workstream.

Dementia Strategy

Coventry has recently agreed a new Dementia Strategy. This has been signed off through both City Council and CRCCG governance structure and was co-produced with the involvement of a range of other partners, including police and Fire service as well as voluntary sector organisations. The plan sets clear outcomes and deliverables which align with the Dementia workstream of the Better Care Plan See link to Dementia Strategy in section 1.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

As described earlier, the BCF is central to the delivery of the 5 year Strategic Plan and links to the JSNA, JHWS, NHS Outcomes Framework and Public Health Outcomes Framework.

Within the 2 year Operating Plan, which covers the period to March 2016, the CCG's ambitions and specific schemes are set out and explicit reference made to linkages with the Better Care Fund Schemes.

The operating plan contains dementia and urgent care transformation work programmes that link to the Better Care Fund.

Within the City Council the Better Care Fund plans will link to the Medium Term Financial Strategy for 2015/16 onwards as a key part of ensuring sustainability of City Council services. In addition the BCF aligns with the City Council ten year plan through improving the health and well-being of local people, protecting and supporting the most vulnerable and reducing health inequalities. See link in Section 1 to Operational Plan and City Council Ten Year Plan

c) Please describe how your BCF plans align with your plans for primary co-commissioning

We have applied to co-commission Primary Care strategy (including primary care estates) and to jointly specify future APMS and PMS contracts and enhanced services. We are also supporting the development of a GP Federation in Coventry. Our BCF delivery requires community and social care services to be based around risk stratified GP populations and we are encouraging our GP providers to work collaboratively with other health and care providers. Co-commissioning will enable us to support and enforce primary care service transformation and BCF delivery through our contracting mechanisms. Formal co-commissioning is not yet in place (to be established by 1/4/15). Engagement with primary care has been on-going through the CCG engagement mechanisms (member practices and locality events), service redesign workshops such as the 'hot houses', and through GP clinical leaders involvement within the BCF planning process. The Accountable GP responsibility is supported by the integrated neighbourhood teams (INTs). There is a risk that primary care will not have the capacity and/or capability to make the required changes to support the BCF programme. This is mitigated by on-going CCG support to General Practice, including backfilling clinical roles, supporting the wider primary care team (practice nurses, practice managers and medicines management support), training and innovative use of IT.

7) NATIONAL CONDITIONS

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

In the local context protecting social care is interpreted as ensuring the City Council is appropriately resourced to meet its statutory duties in respect of eligibility for social care as current defined through FACS (recognising that the introduction of the Care Act on 1 April 2015 with the implementation of new national eligibility criteria).

The Care Act also introduces new duties in respect of Prevention and Health and Well-Being although we are still awaiting final guidance following consultation on what these duties mean in practice. Meeting these new duties is equally important although exact impacts have not yet been scoped.

Resources freed up through BCF projects, particularly Long Term Care, will be made available to complement available recurrent social care funding to ensure the City Council can continue to deliver its statutory functions and make a system wide contribution to preventing hospital admission and the long term costs that this can then induce.

It is acknowledged that due to the on-going and significant financial pressures on Local Government funding that all existing Adult Social Care services may not be sustainable, even with the contribution arising from implementation of the BCF. In order to ensure the most cost effective use of resources, assessed needs will increasingly be met as a result of implementing the Better Care 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 (Scheme 4).

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 (Scheme 3).

In addition to financial sustainability supported by the Better Care Fund, as part of Coventry City Council's asset based approach there will also be an emphasis on people taking responsibility for their own well-being in order to reduce avoidable demand and manage public expectations.

ii) Please explain how local schemes and spending plans will support the commitment to protect 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 however the implementation of the Care Act combined with on-going financial pressure on local government finance mean there is still risk in this area. Independently of (but aligned with) the Better Care Fund the City Council is progressing its own plans, with partner involvement where appropriate to support its own sustainability.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The totality of the Coventry proportion of the £135m available nationally for delivering the requirements of the Care Bill (£841k) is included in Template 2 (Finance – schemes). This is integrated into the existing lines for BCF investment and not shown as a separate line.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

The new duties will be met mainly from new burden monies plus the implementation of a comprehensive change management programme process overseen by the Care Act implementation board.

v) Please specify the level of resource that will be dedicated to carer-specific support

Existing identified Carer Spend reflecting Care Act enhancements.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

Nil extent

b) 7 day services to support discharge

Health & Social Care are committed to 7 day working and already have some services providing this level of cover. 7 day working is an integral part of the 5 year plan.

Planning has begun with our Acute Trust on how to achieve the 10 evidence-based clinical standards to end current variations in outcomes for patients admitted to hospital at the weekend.

Consideration is being given to making best use of existing contractual arrangements that enable seven day working. 2014/15 CQUIN monies have been used to incentive early adoption of several of the standards and the acute contract requires the production of a detailed implementation plan. As UHCW is the major acute hub for Coventry & Warwickshire, and major trauma centre, there is less variation in weekend care than at other smaller sites. The five year plan includes the achievement of clinical standards as a core theme with networking and consolidation across hospital sites being essential to addressing affordability and workforce issues.

Within Social Care, 7 day working commitments are reflected in a range of Home Support contracts including short term support at home. Also Housing With Care is being redeveloped as part of our short term support offer and a new 24/7 responder system is about to be launched as part of a major new Telecare service.

As system wide integrated working progresses, expectations around what is required to achieve seven day working, and the other parts of the system that are required to change to deliver this, will be clarified along with the implications of any changes in contractual arrangements required for delivery.

Seven day working is an integral part of the Urgent Care Transformation Programme across hospital and community services.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

NHS Number

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 in July 2014 complete providing a platform for NHS Spine connection.
- DBS batch cleansing to commence October 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.

Data Sharing

Appropriate levels of record sharing, as well as the presence of the primary identifier was recognised as a key enabler to delivering multi-disciplinary team working following the learning from Hot House. As multi-disciplinary teams are progressed the processes to support these will also be re-designed to deliver transformational change as part of the INT Project (Scheme 5). The INT Pilot developed a proof of concept model to test the effectiveness of data sharing within integrated multi-disciplinary teams and concluded that it is essential for scaling up INT and other projects such as STSMI through 2015. An IT programme, led by the CCG, has now commenced to deliver Information Sharing across all four partners. INT has also started developing a User Specification for a solution to support scaling up through 2015.

ii) Please explain your approach for 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.

iii) Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements and professional clinical practice, and in particular requirements set out in Caldicott 2.

All four partners are committed to ensuring that appropriate IG controls are in place for the Better Care programme and this is especially the case for record sharing e.g. the INT Project has a specific IG Task & Finish Group to ensure cross-agency compliance. The following approaches underline each partner's commitment to Information Governance.

University Hospitals Coventry & Warwickshire:

- UHCW ensures that it remains compliant with NHS Information Governance requirements by the annual submission of the Information Governance Toolkit, which also covers IGSoC accreditation and Caldicott 2.
- The NHS Standard Contract technical requirements are also included.
- There is a robust accountability framework in place with board level responsibilities for IG; the Chief Medical Officer and Director of Governance share the Caldicott Guardianship, and the Chief Operating officer is the SIRO.

Coventry City Council:

- The Authority is committed to ensuring appropriate information governance controls are in place and has submitted for 2013-14 Information Governance Toolkit Version 11 and operates a link to the NHS network via Coventry & Warwickshire Partnership Trust
- The Authority provides IG training for all staff on an on-going basis.
- The Authority's information governance framework, which is overseen by qualified information practitioners, is independently audited on a regular basis
- The Authority led on the development and implementation of Coventry's Multi-Agency Safeguarding Hub Information Sharing Agreement

Coventry and Warwickshire Partnership Trust:

- CWPT uses the Standard NHS Contract Agreements which are regularly updated by NHS England – these include the main confidentiality clauses as required
- The trust is committed to ensuring that the appropriate Information Governance controls are in place and has submitted for 2013-14 Information Governance Toolkit Version 11 a "Satisfactory" Self-Assessment return, thus confirming the Trust's IG Statement of Compliance
- CWPT provides on-going updates/training for all staff including clinical staff in regard to all aspects of Information Governance aligning it to day to day working/clinical practice
- The trust has noted the 26 Recommendations and table of commitments as outlined in the Government's Response in September 2013 to the Caldicott2 Review Report (April 2013) and has reviewed the commitments relevant to it as a provider organisation

Coventry & Rugby CCG:

- The CCG achieved level 2 compliance of the Information Governance Toolkit for 2013/14. The local system has been working within the requirements of Caldicott 2 and IG governance as exemplified by the recent multi-agency information sharing agreement in place for safeguarding. Health, social care and police are partners to this agreement
- A system-wide information sharing programme is in place that will take forward the supporting work to ensure record sharing across health and social care is compliant with IG controls and Caldicott 2

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

3% of our older people have been determined to represent the proportion of people at high risk of hospital admission and is a key part of our Integrated Neighbourhood Teams (INT Scheme 5) project. This cohort is identified as being 75+ and requiring intensive support and reliance on statutory agencies. This builds on the current risk stratification that is used by community matrons with GPs across the city and incorporates Gold Standard Framework (GSF) for Palliative Care.

All Coventry practices use a risk stratification tool to identify the top percentage of patients most at risk of admission. Practices have access to a local tool (Ventris) which receives same day information from the hospital providers (including A&E data) as well as having access to the risk stratification tools provided by their clinical systems.

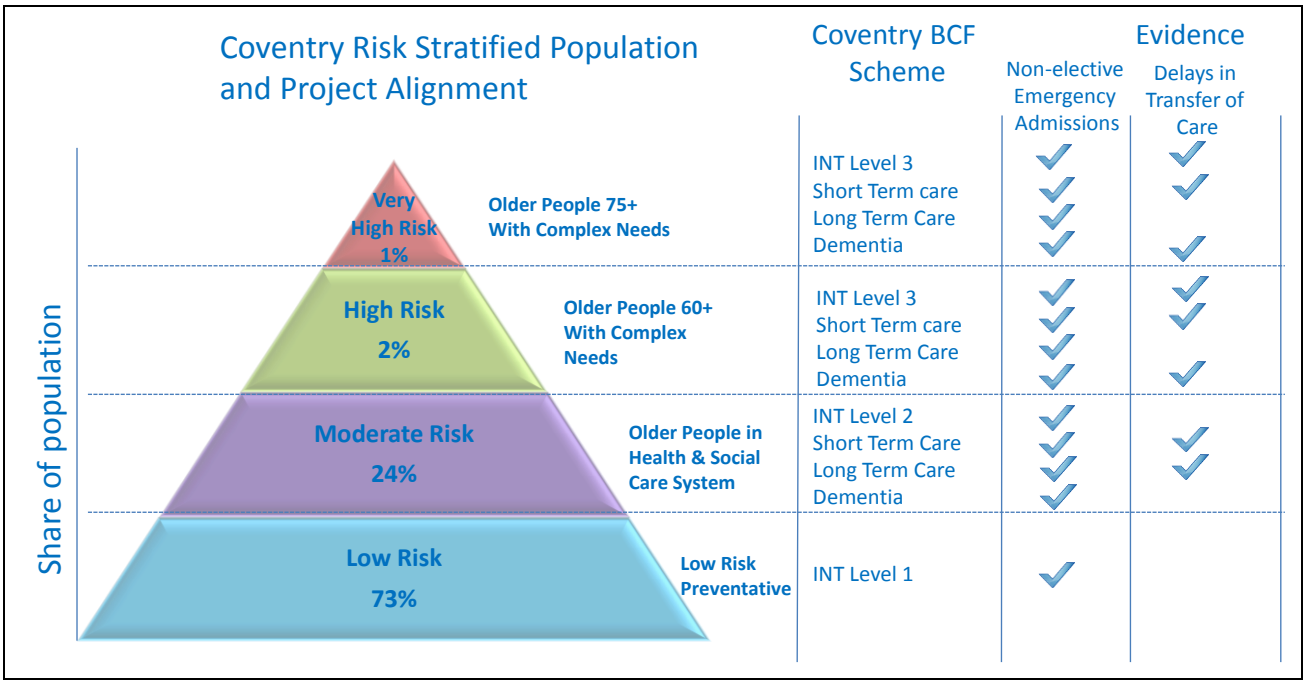
GPs are putting care plans in place for high risk patients in line with the Accountable GP approach. In addition, risk stratification data is shared with the community nursing teams to inform case load planning. As part of the INT approach, local intelligence from other agencies is being added to the practice level data to ensure that the patients most at risk (See page 48 - Level 3) are reviewed within a multi-disciplinary meeting. The system is progressing a health information exchange solution to allow the sharing of records and shared care plans between agencies.

The current risk stratification and GSF meetings cover an average of 10 to 15 patients per GP Practice, the practices and Matrons identify patients who have either recently attended A&E and those patient they believe at risk of calling 999 should their condition deteriorate, management plans are developed to reduce the risk of inappropriate admissions and root cause analysis undertaken on those patients who have been admitted to secondary care inappropriately.

Combining all the analysis from INT, Short Term Support to Maximise Independence, Long Term Care and Dementia, that we have exampled elsewhere in this plan we will focus on the following cohorts:

- Improving the care of older people with complex needs who are at a high risk of being admitted into hospital or nursing care.
- Improving care planning and education of older people who are in the health and social care system
- Educating the majority of older people who are otherwise healthy and well to prevent them needing emergency care

Comparing these cohorts with planned projects we have matched our projects to these high risk cohorts as well as focusing effort on keeping lower risk people out of hospital:



ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

The City Council has recently procured an assessment, support planning and resource allocation system from an external provider (FACE RAS). Health and Social Care are currently exploring the potential to use the tools for health assessments in order to progress integrated assessments, support plans and reviews. This aims to align systems towards integrated cross agency working. Through the Integrated Neighbourhood Team (INT) Pilot we have agreed the following processes for patients:

Patient presenting at ED:

- On arrival at ED if the patient is 75+ and registered with one of two GP Practices in the Pilot Project, they will be checked to see if they are in INT Level 3 Care (A flag will be attached to patient record)
- If a person is flagged as under INT Level 3 care, then UHCW informs Care Coordinator via the Administrator of the Pilot Project
- On eventual discharge from UHCW then IDT will liaise with the INT and detail whether patient needs to be re-admitted to Level 3 care, with appropriate discharge information

Patient being discharged from hospital care:

- If the patient is registered with either of GP practices in Pilot, and is 75+, a decision is made by IDT as to whether patient is appropriate for INT Level 3 care
- If patient is to be discharged to Level 3 care then this information is notified to Administrator for next INT meeting

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

A small number of individuals have an existing joint care plan as part of the INT Pilot. Care planning is a CCG key deliverable over the next 2 years. Scaling up of the INT Pilot through 2015/16 will significantly increase those with joint care plans.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

A key part of the successful development and implementation of changes required for our plan is to use patient and service user feedback and public engagement.

Proposals contained in this plan have been discussed with Coventry Healthwatch and, as a member of the Health and Well-Being Board, they have signed up to the proposals and direction of travel. We have also agreed a process to keep them informed of our progress.

We have a Patient Representative on our INT Steering Group to provide input and feedback. Also we have in place a Patient Survey process and case study within the INT process. On-going engagement with 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.

Since the February submission a Hot-house event (accelerating change - three day whole system event) was held which included experts by experience who will be further involved as we move towards implementation of the first locality. A further hothouse event was held in June to develop a pre-hospital model to support urgent care that involved users to co-produce the model and support implementation.

In other projects families and service users have been involved in developing personalised solutions for long term support (Scheme 3) such as in the development of proposals for an All Age Disabilities Service to be implemented from 29th September.

Our redesign process has been fully aligned with preparation for implementation of SEND reforms. Experts by experience involved in development of dementia strategy and action plan (Scheme 4).

The CCG commissioned an Attitude and Behaviour Study to utilise local research alongside three recent and particularly relevant research papers which have assessed factors influencing the use of primary and unscheduled care services. This is being used to inform the Urgent Care Programme including the Hot House 2 Communication Subgroup.

This submission also 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.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Together with the above 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 plan 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. Direct representation on the Health & Well-being Board and Better Care Programme Board
b. Urgent Care Working Group
c. On-going dialogue between commissioners and providers
d. Coventry and Warwickshire Integrated System Board
e. Workshop sessions including Hot House approach 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.

The Urgent Care Transformation Board is represented by senior leaders and clinicians from across health and social care (provider & commissioning organisations). This group has been instrumental in developing and implementing the UC Transformation Programme.

ii) primary care providers

Primary Care are integrally involved in our Integrated Neighbourhood Teams (INT Scheme 5) project, building integrated neighbourhood teams around primary care infrastructure to support decision making, better information sharing and integrated care at point of delivery.

GPs have provided and will continue to provide, valuable input and management into the INT process as it continues through its pilot stage and throughout 2015 as INT is scaled up to cover all cohorts across all Coventry practices.

iii) social care and providers from the voluntary and community sector

There are regular forums for Social Care providers within the City. Earlier in 2014 and as part of the original submission a market development session was help with providers to introduce the BCF and describe how services would need to change to respond to the changing health and social care agenda.

More specifically Age UK are involved in the Integrated Neighbourhood Team, a key delivery vehicle for BCF.

Coventry has also completed a Market Position Statement describing requirements for social care. This has been shared through provider forums with specific provider engagement on meeting the priority areas for development.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The main emphasis of our BCF plans is 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 2015/16 is therefore anticipated to be modest.

In the first four months of 2014/15, we have experienced a 6% increase in A&E attendances and an 8% increase in Emergency Admissions compared to the same period the previous year. Our population is one of the fastest growing in the country, with much of the growth in segments of the population that use A&E as their first port of call in preference to traditional primary care services. Against this backdrop, we believe that slowing the rate of increase in emergency activity in 2015/16 will be a success even if admissions are not reduced below 2014/15 levels.

As can be seen from Template 2, we have modelled a 3.5% reduction in emergency admissions as a result of our BCF initiatives. Setting this against an expected 2% growth gives a -1.5% net increase.

The modelled impact of BCF initiatives is based upon a set of working assumptions which Providers have agreed are reasonable. These will continue to be refined over the next couple of months as part of the work to agree 2015/16 contracts. The outcomes achieved by our pilot schemes will inform this work. We have also established an economy-wide Intelligence Group, bringing together analysts from each Provider, the CCG, Social Care, Public Health and the Ambulance Service to improve our understanding of activity drivers and trends and to better align the modelling work and hence operational plans of each organisation.

In the medium term, the impact on the Acute sector will be more significant. Whilst further modelling work is required to fully understand the combined impact across Coventry & Warwickshire, some reduction in Emergency 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.

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 Elective work currently outsourced to the Independent Sector; detailed, costed reconfiguration plans will need to be developed and agreed across the health economy.

The success of any changes will also be dependent on changes to workforce, including behaviour change across both Health and Social Care. This will be factored into more detailed as plans as they are developed.

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.

In relation to Parity of Esteem, we believe our BCF workstreams should improve the experience of people experiencing mental health problems. We will seek to

i) avoid unnecessary admission to hospital through enhanced community alternatives
ii) ensure a more holistic assessment of physical and mental health needs within our integrated teams and Urgent Care Centres
iii) reduce delays in discharge from hospital (including our discharge to assess model for people with dementia) and iv) increase social support via our community resilience work.

ANNEX 1 – Detailed Scheme Description

Scheme ref no.
1
Scheme name:
Urgent Care Transformation Programme
What is the strategic objective of this scheme?

This will be achieved through the following strategic intentions: -

- Establishing a communication strategy which positively impacts on the behaviours of the public and professionals in delivering our overarching vision and a consistent message which empowers self-management.
- Embracing technology and innovation i.e. with shared clinical information where necessary in a secure method
- Supporting patients to manage their own condition to prevent admission and/or to promote early discharges, thereby maintaining independence in the community and primary care.
- Widening the range of alternative packages of care or care pathways for those who need to use them with alternative means of support and advice.
- Providing ready access to urgent primary care, mental health and community services in a timely way and which are delivered as close to home as care needs dictate i.e. right place, right time, every time ensuring the right option is the easiest option
- Providing appropriate urgent and emergency care services seven days a week to one consistent standard across community services, mental health, primary and secondary care.
- Ensure a robust diversion strategy is in place to direct people to alternative pathways and sign posting i.e. Pharmacy, GP appointments, help and support.
- Reducing ambulance conveyances to hospital by providing alternative community and primary care pathways
- Utilising hospital Emergency Departments for accident and emergency conditions only and reduce unnecessary attendance at and admission to hospital

Overview of the scheme

The Urgent Care Transformation Programme will be delivered through a number of work streams and each of these workstreams will deliver a reduction in Emergency Admissions: -

- 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 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.

The delivery chain

Coventry & Rugby Local Health Economy (LHE) established an Urgent Care Board in January 2013. The board includes managerial and clinical representatives from the following stakeholders: -

- Coventry & rugby Clinical Commissioning Group (Chair)
- University Hospitals Coventry & Warwickshire NHS Trust
- Coventry & Warwickshire Partnership NHS Trust (Community & Mental Health)
- South Warwickshire NHS Foundation Trust (Community)
- West Midlands Ambulance Trust
- Arden, Herefordshire & Worcestershire Area Team
- Coventry City Council
- Warwickshire County Council

Other providers involved in the individual projects include: -

- Voluntary Sector
- Independent providers e.g. Out of Hours, Walk-in Centre, Care Homes
- GP providers

The evidence base

Considerable analysis is under way to drive deeper into root causes of emergency admissions. Two major studies are:

Quantitative Analysis of emergency admissions data undertaken by the CCG in conjunction with University Hospitals Coventry & Warwickshire.

A&E Attendances

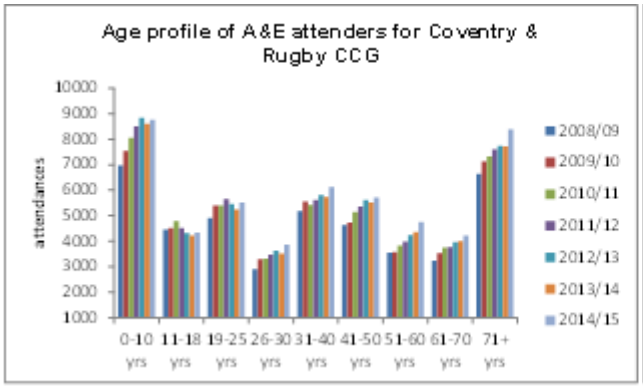
- A&E attendances have increased by 8% between April-July 14 on the same time period last year.
- 80.0% of A&E attendances come from Coventry and Rugby.
- Patients aged 0-10 and 71+ still generate the majority of attendances
- There has been a slight increase (0.4%) in the proportion of patients in the 71+ age bracket.
- Ambulance conveyances have increased by 6.1% in the same time period.

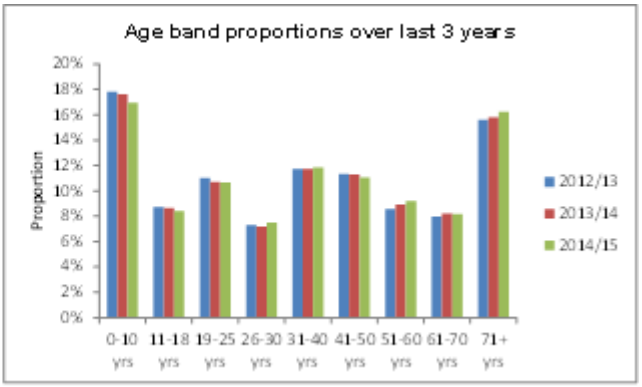
Admissions

- Despite the increase in attendances, the conversion rate has marginally increased by 0.9% overall.
- A&E activity growth is mirrored by the growth in admissions which currently stands at 10.0% between April-July 14 on the same time period last year.
- The biggest driver of this growth (in absolute terms) is within the 0-1 day length of stay time-band. However, the overall proportion of 0-1 day admissions has not materially changed.

A&E Activity

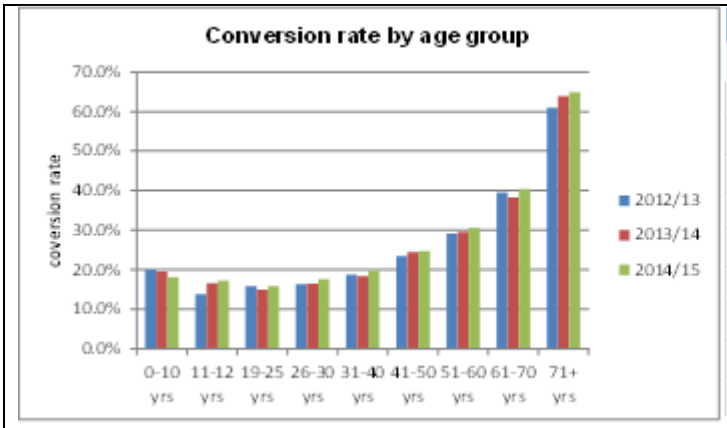
- A&E ambulance conveyances have increased by 6.1% (n=768) in 2014-15 compared to 2013-14.
- Coventry & Rugby CCG patients represent over 80% of the total number of A&E attendances. UHCW is anticipating growth of 7.5% (n=10,705) in A&E attendances in 2014-15 compared to 2013-14.
- The age profile of A&E attenders has not materially changed over the last 7 years. Whilst there are more patients in the system in each age band, the proportions remain relatively stable.





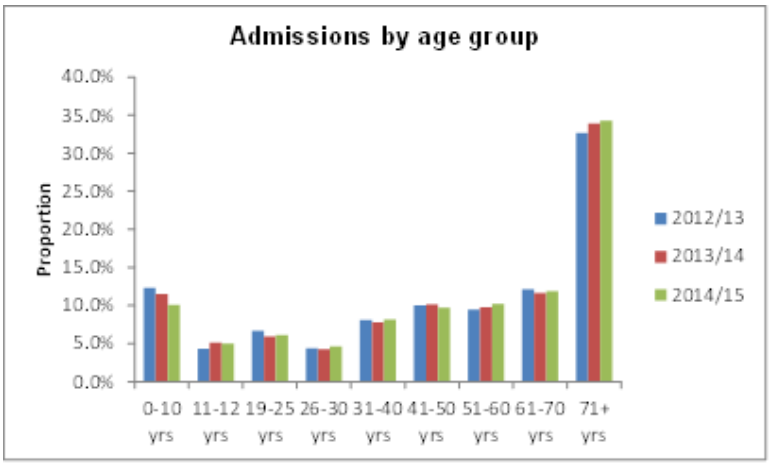
Emergency Admissions

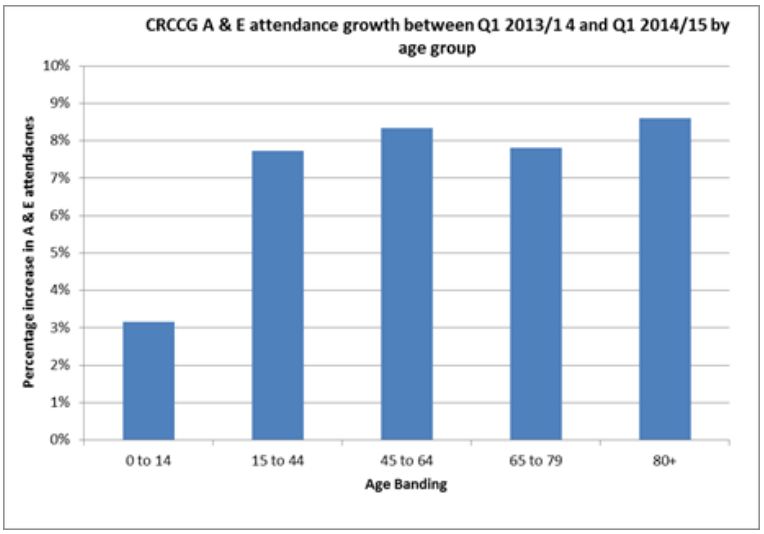
- The conversion rate so far in 2014-15 has averaged 28.9%, which is 0.9% higher than the same time period in 2013-14.
- Some 60% of patients over the age of 71 attending A&E are admitted and 40% of patients between the ages of 61-70 are admitted. There has been no material change to the conversion rate in any particular age group between April-July 14 on the same period last year. However the conversion rate for patients in the 71+ age bracket has increased on average by 2% over the last 3 years.



Conversion rate			
Age Group	2012/13	2013/14	2014/15
0-10 yrs	20.0%	19.5%	18.1%
11-12 yrs	13.8%	16.5%	17.2%
19-25 yrs	15.8%	14.9%	15.8%
26-30 yrs	16.3%	16.4%	17.6%
31-40 yrs	18.7%	18.4%	19.7%
41-50 yrs	23.4%	24.4%	24.7%
51-60 yrs	29.1%	29.6%	30.5%
61-70 yrs	39.6%	38.3%	40.4%
71+ yrs	61.0%	64.0%	65.0%

- Unsurprisingly, the over 71 year age group constitutes just over a third of the total number of emergency admissions. Indeed, over half of the admissions are related to patients who are over the age of 51.





- The growth in 0-1 day emergency admissions in absolute terms has been primarily driven by the 61+ age groups. However, this increase is distributed in a similar way to previous years. Those patients admitted for 0-1 day represents the initial target cohort for providing care at home in a way that significantly reduces the need for admission to A&E.

Investment requirements
£6.294m
Impact of scheme
£0.936m made up from: • Implementing Telehealth • Recommissioning of urgent care centre • Reducing A&E attendances • Reducing ambulance journeys Other non-quantifiable benefits include: • Increased use of alternative healthcare provision other than A&E • Increased awareness of prevention and infection control • Increased ownership of care homes to avoid acute hospital admissions • Increased access to GP appointments • Increased access to alternatives services reducing avoidable admissions
Feedback loop
• 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
What are the key success factors for implementation of this scheme?
• Integrated working across all stakeholder partners • Reduction in Emergency Admissions • Reduction in A&E attendances • Increased use of alternative services other than hospital

Scheme ref no.

2

Scheme name:

Short Term Support to Maximise Independence

What is the strategic objective of this scheme?

- 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
- Makes effective use of new technologies to support the delivery of integrated care
- To contribute towards managing demand through changing general public and care provider behaviours and expectations
- Identify other short term care pathways (outside of the primary cohort) where opportunities exist to integrate as part of a single pathway over the medium/longer term

Overview of the scheme

Providing a single point of access to short term support at home.

We plan to move away from bed-based short term support to a more holistic level of support provided in the person's home. The current discharge process is unduly complex and results in delays transferring patients out of hospital. It is a bed-based model for short term care that does little to reduce emergency admissions and risks people moving into long term care pathways.

We will streamline the discharge process to provide a single point of access to short term care and developing a suite of support packages at the person's home at the time agreed. This will both reduce the need for long term support from health and/or social care and reduce demand on acute services through preventing hospital attendance and admission for conditions that could have been avoided through more timely and integrated community based support. We are currently developing a new single access process using integrated multi-disciplinary teams comprising of health, social care and allied professions together with the effective use of new technologies to support the delivery of integrated care.

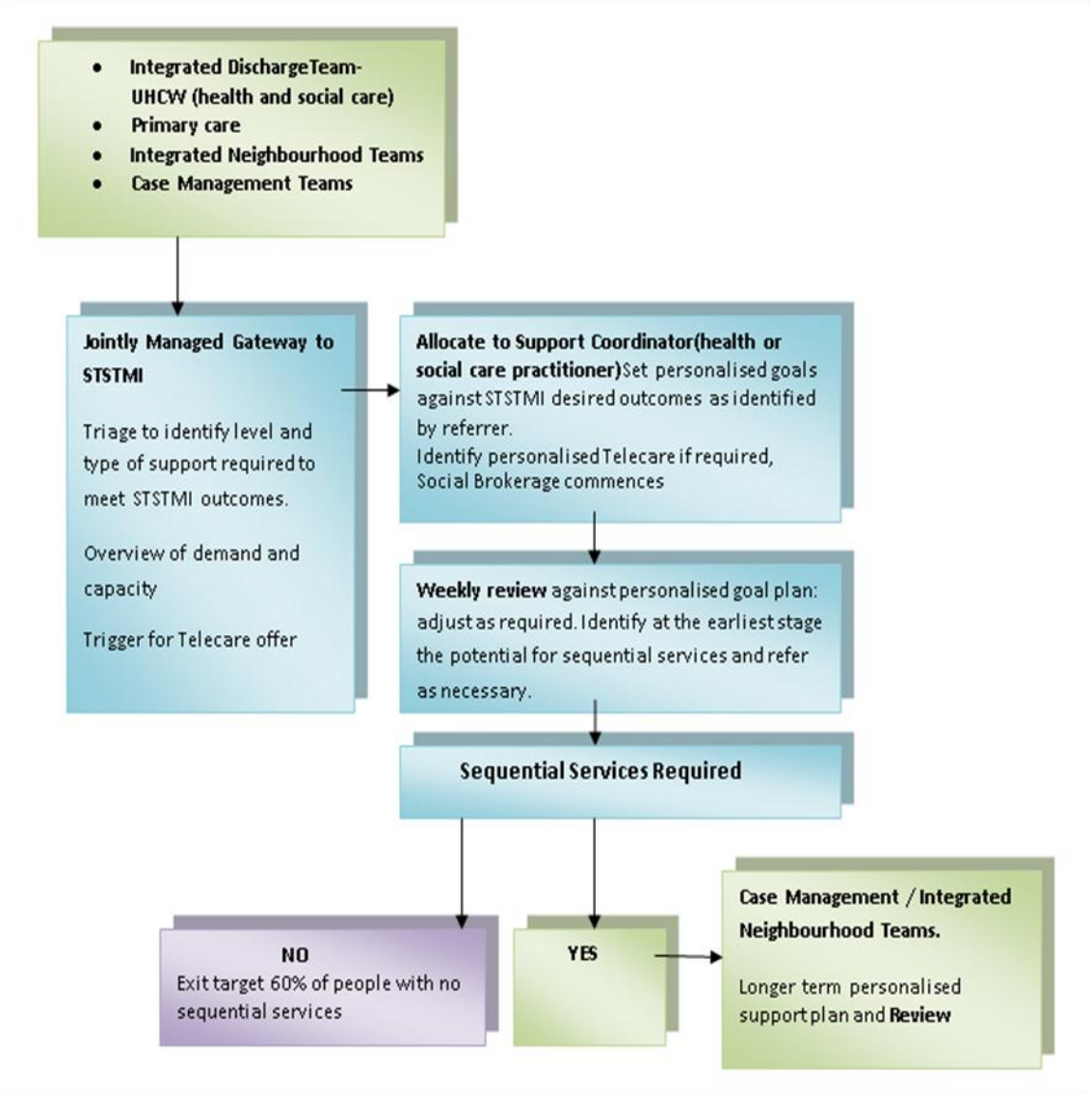
The focus of the new multi-disciplinary integrated discharge team will be to speed up the discharge process to a new, bespoke care at home service.

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, including a Discharge to Assess model that initially focuses on CHC, and 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

Single Access Discharge Pathway to Agreed Level of Care



The project's delivery principles are:

- Person-centred integrated care; the person is at the centre with an integrated care plan and motivated to manage their own support as far as possible with a focus on promoting an individual's maximum level of independence before determining their need for on-going health or social care needs
- Carers recognised as key partners in the delivery of care and support and a recognition that some carers will need support in their own right
- Integrated discharge team at UHCW, bringing together the existing health IDT and social work teams. The focus of the integrated discharge team will be to work with new people to social care and manage their discharge arrangements.
- Discharge process starts at admission using a single trusted multi-agency assessment, including social worker where the process includes planning for and actual provision of care at home

- Quality of discharge planning and communication with patients, their family and service providers is key
- Unless not required, all individuals have a short term outcome focused plan with specific goals and appropriate therapy input; weekly reviews are undertaken to determine improvement and adjust plans
- The care plan and subsequent provided care should ensure the person stays healthy and well and out of hospital (reducing emergency admissions)
- All care improvements to be measured quantitative and/or qualitative analysis of people requiring different levels of care using measures that underpin the Better Care Dashboard Measures.
- All requests for care provision are allocated to a nominated appropriate member of staff who is responsible for ensuring an individual receives the right level of support to ensure that they reach their agreed outcomes
- De-selection Model – the model is inclusive and works on the principle that everyone has the potential to improve or maintain their level of functioning with the right support and encouragement. Consideration to include those who checklist into CHC and those people not currently supported such as NWB
- Telecare, Assistive Technologies, and Integrated Care Record are an integral part of service delivery and support to carers. All individuals receiving STSMI will receive a Telecare Basic offer.
- Using and developing frontline staff to use, Social Brokerage approaches that encourage and support people to take control of their lives and the way they are supported. Enabling people to meet their desired outcomes through a blend of formal, informal and community support focusing on connectivity and relationships to develop solutions that replace or reduce dependence on commissioned services.
- Equipment provision will form an effective part of the solution and support to carers under i) & j); replacing reliance on formal services particularly in relation to manual handling
- At the point of determining that the individual requires sequential services, long term support planning commences which identifies an individual's personal budget

We have already made progress on radically improving short term support services and have commissioned new Short Term Home Support Contracts which commenced in June 2014. The City Council has also extended its use of Telecare with the objective of implementation of a renewed and comprehensive Telecare offer in place for short term support commencing September 2014. New Telecare services include:

- Tailored Telecare package free of charge for up to 6 weeks
- Four level offer dependent on need
- New 24 hour Responder service available
- Post event at home support via Crossroads
- 24 hour 7 day a week support

Other developments include improving the provision of Therapy & Equipment services to ensure they are delivered on time and also reviewing Housing With Care services where people cannot be treated in their own homes. All of these developments are expected to support the delivery of the target for reductions in hospital admissions and residential nursing home admissions.

Key groups who will benefit from this integrated approach to short term support include:

- People aged 75+ - we will develop our approach to targeting support at older people (particularly 75+ with complex needs) 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.
- Carers - through targeted support enabling them to continue caring as the needs of the cared for fluctuate.

The delivery chain

Commissioners – CRCCG & CCC

Single Access to an agreed level of Short Term Support: CCG Commissioned short term care services provided by Coventry City Council and Coventry & Warwickshire Partnership Trust working with the Integrated Discharge Team at University Hospitals Coventry & Warwickshire

Care Home Providers

Short Term Home Support Contracts: Coventry City Council have recently commissioned Home Support Contracts supplied by three external providers:

- Care UK
- Radis
- Sevacare

Housing With Care: The provision of short term care services in short term housing provided by Coventry City Council.

Telecare: Coventry City Council commissioned care at home service supplied by Tunstall Group

Therapy & Equipment: A Health & Social Care therapy and equipment offer provided by Coventry City Council and Coventry & Warwickshire Partnership Trust

The evidence base

The following analysis underpins our focus on improving our Short Term Care service.

Compared with the 15 comparable Councils Coventry is:

- 10th for people offered reablement services following hospital discharge
- 15th for delayed transfers of care from hospital (ASCOF 2012/13)
- 15th for delayed transfers of care from hospital attributable to joint health/adult social care and adult social care only (ASCOF 2012/13)

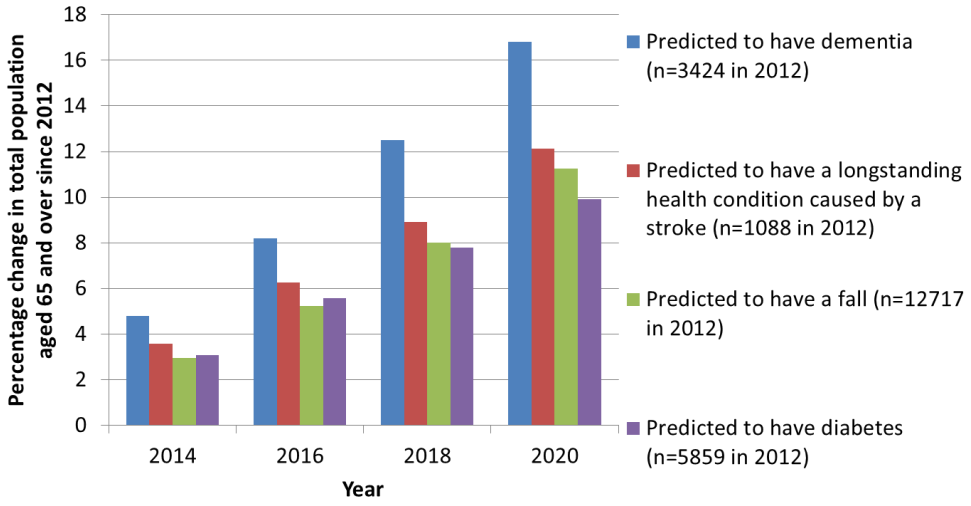
Our DToC Measure is increasing at some 7% above 2013/14 figure with an upward trend since June 2014 due to delays in carrying out assessments prior to discharge.

Looking at Coventry Public Health's analysis of service use by year of age against population projections by year of age would indicate the following numbers of 65s and over are receiving a Care Service in their own home *(Source: Home Support Services for Adults and Older People tender document)*:

	2009	2012	2014	2016	2018	2020
Estimated Population Over 65:		***47,300***	***48,700***			
Those Using Services:						
65-74	*166*	*176*	*181*	*184*	*184*	*183*
75-84	*428*	*428*	*436*	*444*	*458*	*485*
85+	*594*	*585*	*620*	*646*	*671*	*706*
Total	***1188***	***1189***	***1237***	***1274***	***1313***	***1373***
% of Older People using services		***2.5%***	***2.5%***			
Those admitted to hospital with a length of stay 0-1 days:	***979***	***1031***	***1381***			

By comparing this with Admissions 0-1 Day Length of Stay by Age Band *(Source A&E and Emergency Admissions Trends at UHCW paper)* i.e. fast discharges, there is sufficient scope for improved short term services at home to be used to avoid emergency admissions for a proportion of these people.

Further, Public Health predictions for Health and wellbeing of an aging population in Coventry show that there is likely to be an increase on demand for social care due to the forecasted increases in key health conditions. Each of these conditions could result in periodic discharges from hospital into a period of short term care. An example of likely impact would be re: Falls data with our new Telecare offer (currently planned for implementation from October 2014) offering a range of support through a Responder Team e.g. in the case of a fall a sensor would alert the Call Centre and a Responder would go to the person's home and seek to provide support at home to avoid hospital treatment ensure the person is supported to avoid the need for hospital treatment. A post-event service would then be provided to ensure the person is properly settled.



Investment requirements
£9.319m
Impact of scheme
£1.787m **Strategic Benefits:** • In developing a robust home offer fewer people will suffer an event which needs admittance to hospital or move into long term residential care • Through providing a more robust short term support offer in people's own homes it is also possible to give greater flexibility to cope to spikes or peaks in demand as it is far more practical to increase capacity in home based support as opposed to increasing building based assets • Home based support is more cost effective than residential care in most cases in both the short and long term. Therefore adopting this approach will support the financial sustainability of the Health and Social Care economy in light of both increasing demand and reducing resources • Reduced readmission to hospital following a period of enablement and improved DTOC performance – both important performance measures and both included in Better Care Fund metrics • Commissioning efficiencies can be realised through market management and assessment, and management efficiencies through effective co-ordination with other professionals • Reduced system costs through decreasing acute demand and requirement for on-going community based health and social care support • A new performance measure is being introduced in 2014/15 'sequential service to reablement' – this is the local metric chosen for the Coventry Better Care Fund programme and delivering a good short term support service is key to good performance in this regard **People Benefits** • 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
Feedback loop
• Emergency Admissions of people receiving short term care services • Permanent Admissions – Admissions to permanent residential and nursing care homes • Proportion of older people (65 and over) who were still at home 91 days after

discharge from hospital into short term care services

- Delayed Transfer of Care From Hospital –attributable to social care or health
- Patient Experience Surveys and Case Studies

What are the key success factors for implementation of this scheme?

- Integrated working across all stakeholder partners
- Ability to develop and implement a discharge model that ensures people do not stay longer than needed in hospital, yet are not inappropriately discharged
- Provision of bespoke package of care at home services that ensure they are received on the dates agreed
- Ability to measure the real effects of short term care on reducing emergency admissions

Scheme ref no.
3
Scheme name:
Long Term Care
What is the strategic objective of this scheme?
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 of the scheme
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 children and young people with complex needs in transition, 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 including the commencement of a new All Age Disability Approach to be formally launched in November 2014. **Key Objectives are:** • 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 resources model with risk and benefit share arrangements in place • Integrated approach from assessment through to care management in both commissioning and service development • Clear and robust decision making process for high cost placements and packages of care incorporating both health and social care • 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 option • 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 • An effective approach to market management and market development to ensure a suitably diverse model of community support is available • A effective strategic commissioning plan to ensure appropriate provision for current and future cohorts of service users

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

The key delivery principles of this project are to:

- Development of whole life course planning with a community settings focus using consistent application of NHS CHC criteria that enables safe and local support services with an investment in behavioural support and community based accommodation options
- Improve 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
- 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
- Ensure people are offered a personal health budget
- Ensure all people in Long Term Care receive an assessment then regular reviews of intervals of approximately 12 months apart through adopting an appropriate approach to risk management
- Commission efficiencies through market management, assessment and management efficiencies through the removal of disputes over the funding stream
- Control financial risk

- Improve quality, diversity, and sustainability of provision
- Co-ordinate timely support to carers of people with long term care and support needs
- Develop a whole system life course approach
- Ensure the effective use of Disabled Facilities Grant (DFG) to support long term care and support arrangements where required and explore options to extend its use
- Move to asset based approach
- Use of equipment

The delivery chain

- Coventry & Rugby CCG and Coventry City Council
- Providers include:
    - Coventry & Warwickshire Partnership Trust (Mental Health & Learning Disabilities)
    - Care Home providers
    - Domiciliary Care Homes
    - Non NHS providers
    - Housing

The evidence base

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.

At present we have identified six people with learning disabilities who live with elderly carers whom we would identify as high risk of becoming high cost.

A review of Out of City joint funded placements has been completed and a cohort for potential return to City has been identified who have a total spend of £5,993,493.

There are 24 Out of City ordinary residence clients identified for progress and update, with a total spend of £934,661.

A Repatriation team is in place, working on S117 cases only that covers 70 clients in total amounting to a spend of £30,812 per week.

Investment requirements

£15.191m

Impact of scheme

Financial Benefit: £1.256m

People Benefits:

- 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 be offered a personal health budget
- People supported closer to home
- 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
- Co-ordinated and timely support to carers of people with long term care and support needs
- The development of a whole system life course approach
- The effective use of Disabled Facilities Grant (DFG) to support long term care and support arrangements where required.

Strategic Benefits:

- Fewer people go into long term care, achieve better outcomes and costs the social and health economy less money
- Financial risk being controlled.
- Improved quality, diversity, and sustainability of provision.
- Commissioning efficiencies through market management, assessment and management efficiencies through the removal of disputes over the funding stream.

Feedback loop

Long Term Care specific measures will be agreed as the project develops from the review stage, including but not limited to:

- Reduction in spend against jointly funded packages
- Complaints
- Surveys (tapping into CCC's Jan 2013 baseline ASCOF 3 measure)

What are the key success factors for implementation of this scheme?

- Full understanding of existing cost base vs. needs of people receiving high cost care
- Cost savings for existing joint funded and single funded packages
- A risk & benefits sharing agreement across CCG and CCC

- Implementation of a new housing demand model
- Development of Housing options as alternatives to residential care/more expensive and restrictive care settings
- Development of opportunities for personal budgets (including PHBs) and Individual Service Funds (where appropriate)
- Understand the commissioning requirement for the next 5 to 10 years
- Aligned commissioning arrangements between Health & Local Authority

Scheme ref
4
Scheme name
Dementia
What is the strategic objective of this scheme?
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 of the scheme

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 as will the new Single Access to Short Term Care pathway.

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 and enables carers to continuing caring.

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 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)

The delivery chain

Commissioners

- Coventry City Council
- Coventry and Rugby CCG

Providers

Type and service provided	Provider
Secondary care- inpatient, memory assessment, case management	Coventry and Warwickshire Partnership Trust
Third sector provider- information and advice, group-based support, befriending, memory cafés, training for carers	Alzheimer's Society
	Age UK
	Coventry Carers' Centre
	Coventry Crossroads
University- training for carers	Coventry University
Dementia-specific care homes	

The evidence base

In Coventry, it is estimated that there are 3,673 people living with dementia or 1.1% of our population which by 2021is forecast to rise by 18%. Although this percentage is slightly lower than the national average of 1.3% this is due to Coventry being a university city with a larger proportion of younger residents.

According to the Alzheimer's Society (2013), only around 50% of those people have received a formal diagnosis. The National Dementia Strategy highlights the importance of timely diagnosis, in ensuring that people receive appropriate treatment and support.

In response to the 'Living well with Dementia: A National Dementia Strategy' and the 'Prime Minister's Challenge on Dementia,' statutory and third sector organisations have worked in partnership with people with dementia and carers, to develop Coventry's 'Living Well with Dementia Strategy.'

Coventry's Public Health Department undertook a 'Dementia Needs Assessment' in 2012, identifying current and future prevalence of dementia, current service provision for people with dementia, and possible gaps. This piece of work has informed the production of this strategy.

The Strategy was developed through a series of engagement exercises with key stakeholders, including people with dementia and their family members and carers, staff from partner organisations, and third sector partners. The engagement exercises consisted of surveys, questionnaires, and workshops. People were supported to consider how things could be, how Coventry as a whole could be more dementia friendly, and current examples of good practice and gaps in service provision.

Qualitative analysis of the feedback received through the events and sessions was undertaken, to produce a set of outcomes. Work was then undertaken within the partner agencies, through Coventry's Dementia Strategy Board, to determine what achieving these outcomes would look like, and to identify priority action points.

A Dementia Needs Assessment was carried out by Public Health Coventry in 2012 and concluded that:

- Coventry is challenged by aging population, leading to increasing prevalence of dementia, similarly to the UK general population.
- Coventry benefits from relatively younger population profile, but also has aggravating risk factors, mainly higher proportion of ethnic minority and deprivation groups, leading to inequalities and higher prevalence of mental and physical health problems.
- Epidemiological indicators for dementia (prevalence, mortality, diagnostic rates) are within the national average at present.
- Despite the number of existing general and specialised health, social and community services, dementia remains under-diagnosed, over-hospitalised, over-prescribed with anti-psychotic drugs and managed in the long-term mostly at home by informal carers
- There is no clear, time-bound, integrated care pathway, mapping the services and the patient route from the initial assessment in primary (community) care through the Memory Clinic and other specialised mental health services to an appropriate long-term care solution either in a care home or at home (in the community)
- Data collection for dementia-specific indicators and services appears challenging and incomplete due to aggregation of data for elderly / overall mental health as well as poor reporting capacity in commissioning and social care

Investment requirements

£10.19m

Impact of scheme

Financial Benefits: £0.95m

Strategic Benefits:

- Co-production and engagement becoming key to developing and improving services
- Coventry becoming a dementia-friendly community

People Benefits:

- 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
- Reduction in dementia related acute demand

- People having rapid access to specialist support when required
- Seven day support available where required and appropriate
- People having access to a timely and accurate diagnosis
- People being supported to live well with dementia, from pre-diagnosis to end of life

Feedback loop

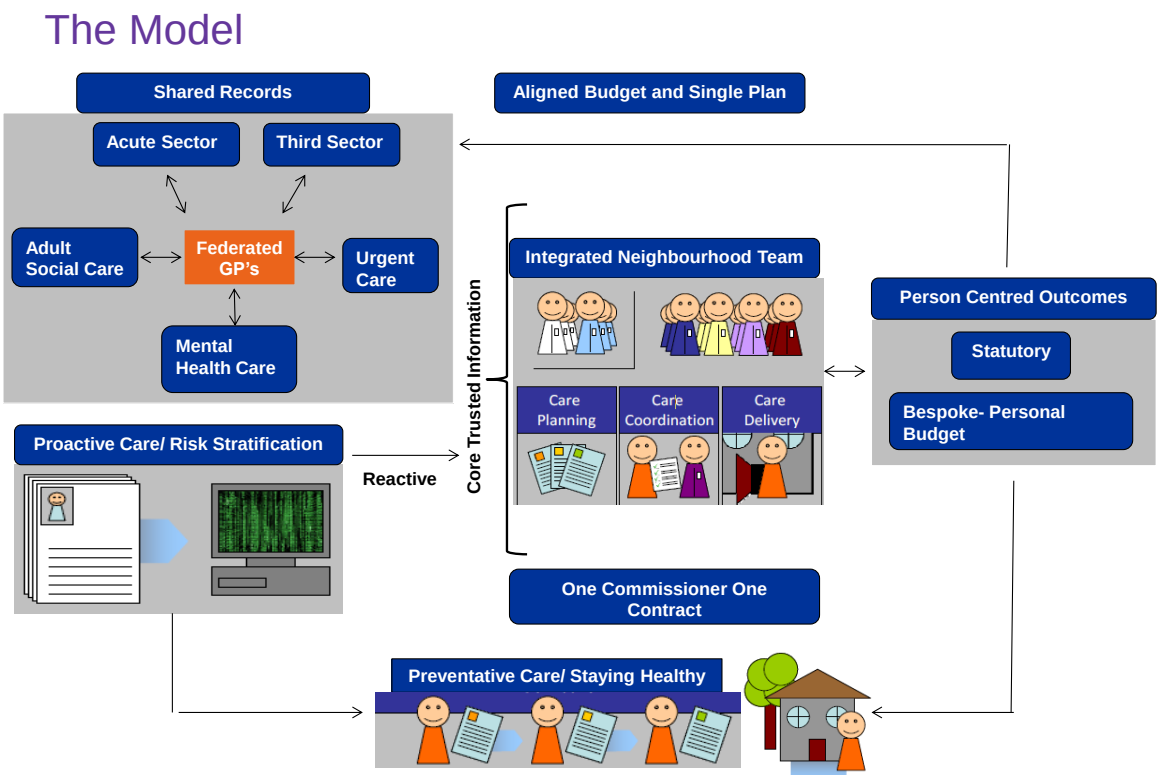
- Overall government target of 15% efficiency saving
- Reduced hospital admissions
- Reduced care home placements by 8%
- Reduced numbers of people requiring funded services following a period of reablement
- Reduced average cost of care home placements
- Reduced memory assessment waiting times to ensure that no one waits more than eight weeks for a specialist memory assessment
- Rapid re-entry for people requiring support from secondary mental health
- Increased number of people diagnosed with dementia to 67% (currently c 50%)
- Increased numbers of people dying in place of their choosing
- People with dementia receiving support closer to home
- Identified lead care co-ordinator for those open to services

What are the key success factors for implementation of this scheme?

- Reduction in the number of long term care home placements
- Integrated working across all stakeholder partners
- Development and implementation of a short term service for people being discharged from hospital
- Development of a comprehensive and flexible ‘menu’ of post-diagnostic support for people with dementia

Ref
5
Delivery Vehicle
Integrated Neighbourhood Teams
What is the strategic objective of this scheme?
To develop a multi-disciplinary process to support older people with complex needs to maintain their health and well-being in the community and reduce reliance on statutory services wherever possible.
Overview of the scheme
One of the key challenges we face is the ability to ensure fast-paced change across the 4 partner organisations. In order to develop a workable methodology we engage with a private management consultancy organisation to test their 'Hot House' change model. We then held 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 within 90 days of the Hot House. Cohort Scope: Older People With Complex Needs This team is now in live pilot until Dec 2014 whereupon it will be scaled up across all GP practices and all cohorts of older people with complex needs providing three levels of support: **Level 1: Preventative:** supporting patients to stay well in the community, engaged in active lives using the assets of their local neighbourhood supported by technology and making every contact count. It focusses on de-medicalising patients, using the public health asset based strategy. Patients are encouraged to take charge of their own management plans as well as encouraging patients to set goals for themselves. Even complex patients such as mild dementia patients should be encouraged to remain independent through activity thus reducing the rate of cognitive decline **Level 2:** Joining up resources between primary, social and community care and the voluntary and community sectors to develop shared care with the person supported by a 'view only' shared care record and allowing the persons story to be told only once. It centres on current integrated teams. It builds relationships between key professionals and aims to build trusted assessments and to develop pathways through different organisations. Integrated teams using primary care as the centre of the team, giving the accountable GP easy access to community services such as district nurses, therapy services, palliative care etc. **Level 3:** When needs escalate the team deliver and co-ordinate care through an multi-disciplinary team, comprising of nursing, therapy, social care, secondary care specialists and a GP to assess older people who have complex needs, agreeing and implementing a care plan. Any person referred into the INT would continue to be monitored and assessed until their health improved and they could be stepped down into Level 2 or 1.

The delivery chain



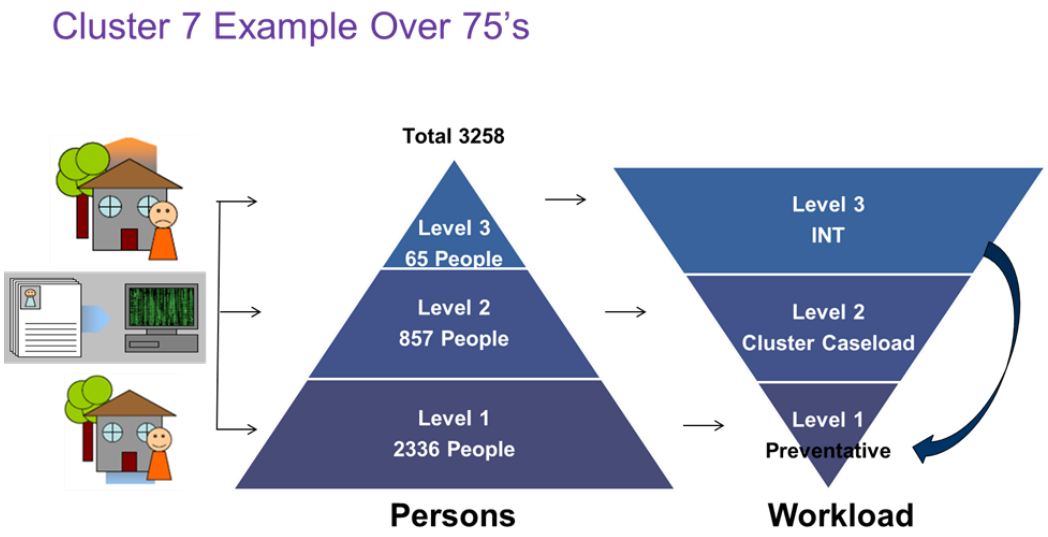
- Coventry and Rugby Clinical Commissioning Group: Commissioners
- Coventry City Council: Social Care Providers Short Term Support
- University Hospital Coventry & Warwickshire NHS Trust: Health Providers - Integrated Discharge Teams
- Coventry and Warwickshire Partnership Trust: Continuing Health Care Providers
- Voluntary Action Coventry
- Third Sector groups

Core Members of the INT Teams include:

- GP
- Community Matron
- Community Nursing Staff
- Social Worker
- Physiotherapist / OT
- IAPT
- Broker
- Community Development Officer
- Member of UHCW IDT team

The evidence base

From our risk stratification modelling we established the following pattern showing that older people with complex needs, although the smallest cohort, required the highest level of health and social care resource.



Investment requirements

Included in Scheme 2 STSMI costings

Impact of scheme

Financial Benefits: £0.49M

Strategic Benefits:

- The proof of concept can be scaled up to provide a sustainable and effective model for preventing hospital admissions for level 3 patients
- The model of joint care will form the basis for future planning of health and social care delivery
- Third sector organisation links will be greatly improved which will ease the resource burden for Health and Social Care organisations
- Improving knowledge and awareness of support provision/availability within Levels 1 and 2: this will reduce the number of people requiring care at Level 3 and the concomitant resource required to support people at this level
- Hospital admissions and associated costs will be reduced because improved community support of individuals will prevent unnecessary admissions

People Benefits:

- The patient experience will be improved in areas like 'telling my story once'
- The staff experience will be improved because there is effective shared working with increased knowledge and awareness of other organisation provisions
- 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

Feedback loop
• Patient / Carer Satisfaction – Interviews and questionnaires will be used to assess the patient experience • Staff Satisfaction – Interviews and questionnaires will be used to assess the staff experience • Case Studies – specific case studies covering patients/carers and staff
What are the key success factors for implementation of this scheme?

• Integrated working across all four partners and community organisations
• Development of a robust shared record and care planning IT system
• A successful pilot will have the following implications:
  ○ The proof of concept pilot can be scaled up to provide a sustainable and effective model for preventing hospital admissions for level 3 patients
  ○ The model of joint care will form the basis for future planning of health and social care delivery

Ref
6
Enabler Workstream
Carers
What is the strategic objective of this scheme?
To develop and launch a new multi-agency Carers' Strategy across Coventry that meets legislative requirements, including the Care Act, to ensure: • There is consistency in access to the wide range of good quality support and services available to carers in Coventry • Information and advice for carers is readily accessible, consistent and meaningful • Resources available are targeted to provide the types of support and services that carers value enabling them to have a life alongside their caring role • Carers have access to leisure, education and employment opportunities to enable them to fulfil their potential
Overview of the scheme
1) Review of carers provision in the City A holistic review of carers service provision is undertaken across People Directorate and Coventry and Rugby CCG (CRCCG) over the next 6 months to ascertain: - • The effectiveness of current services (including usage, demand and efficiency) • A true reflection of the total financial envelope across carers services • How the new Care Act will impact on the delivery of carers services in the City • The effect of the customer journey work within Adult Social Care • The outcome of the carers survey recently undertaken by Adult Social Care • A definitive model for carers services which is sustainable across Health and Social Care **2) Development of a new Carers' Strategy for Coventry** In line with the legislative requirements and the Better Care Fund (BCF) programme, Coventry will be developing a new multi-agency Carers' Strategy. • The new strategy will recognise the key areas of the Care Act which impact on carers support (as outlined above) whilst also building in the integration between health and social care. • Although carers support is not a specific BCF project, carers support is integral to all services and will be a recurring work stream across both the BCF programme and Adult Social Care plans.

The delivery chain

Coventry City Council currently commission carers' support specifically through Coventry Carers' Centre, Coventry Crossroads and Coventry Alzheimer's Society. These organisations are contracted currently to provide support for carers, via the provision of information and advice, Carers' Short Breaks (replacement care), CRESS emergency response service and Carers' Training.

CRCCG also fund aspects of services with these providers

The evidence base

The upcoming Care Act will present local authorities with new duties in respect of carers in particular areas relating to, but not limited to:

- The entitlement to a carers assessments for all carers regardless of the eligibility criteria being applied
- Transitional arrangements and support for young carers as part of a family unit
- How carers, amongst other client areas, are supported through information, advice and advocacy services
- In summary, the Care Act gives carers, for the first time, equal recognition in the same way as those that they care for.

Investment requirements

£1.155m

Impact of scheme

Financial Benefit: £0

People Benefits:

- Carers will be respected and have access to integrated and personalised services
- Carers will be able to a have a life of their own
- Support for carers in regards to financial assistance
- Treating carers with dignity and support for mental and physical well-being
- Protection for children and young people who may be carers themselves

Feedback loop

- Carer satisfaction surveys
- Case studies
- Carers Forums and support groups

What are the key success factors for implementation of this scheme?

- Completion of the review
- Approval for implementation of the revised strategy

ANNEX 2 – University Hospitals Coventry & Warwickshire Provider commentary

Name of Health & Wellbeing Board	Coventry Health & Well Being Board
Name of Provider organisation	University Hospitals Coventry & Warwickshire
Name of Provider CEO	Andy Hardy
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	32,573
	2014/15 Plan	33,966
	2015/16 Plan	33,442
	14/15 Change compared to 13/14 outturn	1,393
	15/16 Change compared to planned 14/15 outturn	-534
	How many non-elective admissions is the BCF planned to prevent in 14-15?	115
	How many non-elective admissions is the BCF planned to prevent in 15-16?	1,315 *

* Note: 15/16 plan assumes growth minus BCF planned reductions

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions**	We are broadly content with the figures included within the current planning assumptions although somewhat concerned as to whether the schemes will deliver.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	

3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	As described in implications for Acute Providers above – there will be limited impact in 2015/16. Indeed emergency admissions will still be at levels higher than in 2013/14 based on the current planning assumption this will not see any reductions in our bed numbers. Our on-going concern is that we may have underestimated growth (given the rise experienced over the last six months, which is in excess of 8%) and that as a health economy we may have to do significantly more than current estimated plans to ensure the system can cope with the demand. Our final concern is around affordability within the

Name of Health & Wellbeing Board	Coventry Health & Well Being Board
Name of Provider organisation	Coventry & Warwickshire Partnership Trust
Name of Provider CEO	Rachel Newson
Signature (electronic or typed)