Report

Coventry Health and Wellbeing Board **20 April 2015**

From: Better Care Coventry Programme Board

Subject: Better Care Coventry Progress Report

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1 Purpose

This report provides the Coventry Health and Wellbeing Board with an update on progress towards delivering the Better Care Coventry Programme.

2 Recommendations

The Coventry Health and Wellbeing Board are asked to note the progress made to date on the Better Care Coventry Programme.

The Board are also asked to receive further progress updates over the coming months to ensure the momentum of the programme is maintained as it moves forward, and to provide strategic direction.

3 Background

In June 2013, the Government announced the £3.8billion Better Care Fund as part of its drive to integrate health and social care. Plans were required to be submitted identifying a national minimum of £3.8billion of pooled resources with an expectation larger sums would be pooled. The value of the fund is now £5.3billion, based on the plans submitted nationally. The Better Care Fund is described as a “single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and Local Authorities”.

To ensure integration is delivered, the Better Care Fund required a pooling of resources delivered through a Section 75 agreement in place for 1 April 2015. This is a partnership agreement whereby NHS organisations and local authorities contribute an agreed level of resource into a single pot (the pooled budget) that is then used to drive the integration and improvement of existing services.

The Health and Wellbeing Board approved Coventry’s first Better Care Plan and this was submitted in April 2014. Subsequently, new requirements were announced and plans had to demonstrate how they would reduce emergency admissions to hospital, with a target set of 3.5%. Coventry’s revised plan was re-submitted in September 2014 and was fully approved by NHS England on 22 December 2014.

Better Care Coventry (Coventry’s Better Care Fund Programme), totals £52m for 2015/16. The Governing Body of the Coventry and Rugby Clinical Commissioning Group approved entering into a Partnership Agreement with the City Council, and that the City Council is the host for the

pooled budget, on 11 March 2015. This was approved by Cabinet and Council on 17 March 2015. The Section 75 agreement was formally signed by both partners on 30 March 2015.

The Better Care Coventry Programme supports the delivery of integrated models of care, improving outcomes for people across the health and social care economy.

Four core projects form the structure of the Better Care Coventry Programme as follows:

- Urgent care - delivering a reduction in emergency admissions to hospital
- Home First (short-term support to maximise independence) - providing a single point of access to short-term support at home
- Long-term care - integrated working that ensures people receive personalised support that enables them to be as independent as possible for as long as possible within their local community
- Dementia - enabling people and their carers to live as independently as possible, and to 'live well'

In addition to these specific workstreams, other shared priorities were included such as information sharing, support for the implementation of the Care Act 2014 and protecting adult social care services.

4 Better Care Programme Governance

Strong leadership and governance are integral to the implementation of the Better Care Coventry Programme and the following arrangements have been put in place.

A Better Care Programme Board, which has membership from senior leaders from Coventry City Council, Coventry and Rugby Clinical Commissioning Group, University Hospital and Coventry and Warwickshire NHS Trust and Coventry and Warwickshire Partnership NHS Trust, provides the operational oversight for delivery of the programme.

The Joint Adult Commissioning Board (Coventry and Rugby Clinical Commissioning Group and the City Council) are responsible for commissioning decisions relating to ensuring Better Care Coventry is delivered and the pooled budget is managed in line with the partnership agreement.

The Health and Well-Being Board holds the Joint Adult Commissioning Board to account for the delivery of Better Care Coventry and provides strategic direction.

As from 1 April 2015, with the introduction of the pooled budget, there is further reporting to Health and Social Care Scrutiny Board 5.

Although the pooled budget is created from allocations from Coventry and Rugby Clinical Commissioning Group and the Council, the arrangements do not constitute a delegation of statutory responsibilities and these are retained by Coventry and Rugby Clinical Commissioning Group and the Council. Any future financial implications will be reported through each organisation's existing financial reporting arrangements.

5 Progress made on implementation

Prior to 1 April 2015, the programme had been piloting a number of changes across health and social care, enabling teams to build a good knowledge of approaches that can be scaled up. The following paragraphs outline the work of the projects to date and highlights progress made.

Urgent Care

A new Falls Pathway was implemented on 1 December 2014, and during the 17 week period 118 patients have followed the pathway with only 10 people being conveyed to hospital.

Referrals are made to the Falls Pathway via NHS 111 or direct from Ambulance crew where it is considered A&E attendance may not be necessary. In these situations, a nurse practitioner has responded within 15 minutes, undertaken an assessment and arranged for some conditions to be treated (e.g. urinary tract infection). Where necessary, the nurse also arranges for care and support services/equipment to be provided and engages other professions to assist in supporting the person at home i.e. GP, district nurse, therapy and mental health services. This approach has led to the avoidance of 108 attendances to A&E and enabled people to remain in their own homes.

The Mental Health Street Triage service commenced in December 2014 and the team has responded to 225 situations. This has resulted in the prevention of 73 ambulance requests and on-going conveyance to A&E. The service has prevented 48 Section 136's (where a Police Officer removes a person considered to have a mental disorder from a public place) and diverted 8 arrests.

Coventry has also been successful in securing an additional £4m from the Prime Ministers Challenge Fund, to be used over the next two years. Three services will be developed and implemented using the funding and include:

- Extension of opening hours at the current GP hub at Coventry City Health Centre creating an extra 25,000 appointments a year so improving primary care access
- A Primary Care Frailty team will be established helping elderly patients at home once discharged from hospital and preventing unnecessary admission to hospital. It is estimated over 115,000 consultations will be provided over the two year programme. This initiative links with the Integrated Neighbourhood Teams (see below)
- A GP will be based within the Emergency Department at University Hospital Coventry and Warwickshire NHS Trust to treat and advise on minor illnesses, reducing the demand on emergency department resources

Home First

The Home First project has led to a number of changes within the hospital, including access to all community based services for both hospital and social care staff to use when planning patient discharge. This has helped to start a change in culture, towards working more collaboratively and in an integrated way.

There has been an increase in capacity across a number of short term services including the Housing with Care Short Term Tenancies that have increased to 30 flats. These flats provide people with a home like environment. Within the flats, telecare equipment has been installed to enable people to use, and become familiar with it, ensuring that they are able to use the equipment when they return home. The numbers of people who are being discharged home with only a medication dispenser, supported by a pharmacy to fill and deliver the dispenser is increasing. This is due to the period of support they have received in Housing with Care that has enabled them to build their skills and knowledge to be able to return home independently with limited on-going support.

Long Term Care

The practitioner team are now in place and joint reviews of people placed out of city in care home placements have commenced. The intention is to support as many people as possible to return back to the city. This means working closely with providers to ensure the most appropriate accommodation is available.

Grapevine has been commissioned to provide support to 10 people who currently receive support out of city. They will work with the person and their family to ensure a transitional plan is put in place that enables them to move back to Coventry and rebuild local support networks.

Dementia

Positive work continues with the delivery of the 'dementia discharge to assess' pilot. This is being delivered in partnership with Crossroads, and commenced in September. The service works with individuals and their carers and to date 21 people have accessed the support.

The aim of the service is to enable the individual to undertake activities for themselves rather than carrying out care and support for them. The approach allows the amount of support an individual needs to be reduced over time as they regain the skills and ability to live independently. The amount of time someone spends with the service will vary according got their need and ability to meet their goals. The current average length of stay with the service is 33 days.

Integrated Neighbourhood Teams

Two GP Practices in Coventry have been piloting Integrated Neighbourhood Teams (INT) since July 2014. At the heart of this model was the establishment of multi-disciplinary teams, and they have worked with around 30 people.

The teams consist of a GP, Community Matron, Community Nurse, Social Worker, Community Development Worker, Occupational Therapist, Mental Health Worker, along with some support from the voluntary sector (Age UK). While detailed evidence is currently being collated, initial feedback shows specific and measurable benefits from working in this way as follows:

- People are benefiting from having to tell their story only once, as staff from different agencies share information between them

- People are benefitting from having joined-up resources working on their behalf. For example, one woman who relied heavily on the district nursing team was introduced to some social activities through the Community Development Team, and is now relying less on the nursing team

- GPs have reported that they spend less time dealing with people with complex needs, as work is undertaken by the INT, and have also made less home visits to this group of people

Work is now being undertaken to scope the scale-up of this model, and how the concept of INTs can be implemented across the city. A business case is in preparation, and presentations have been made to GPs to seek their support. It is possible that implementation of INTs across Coventry could commence in summer 2015.

Information Sharing

The project has made progress in scoping out the requirements for an integrated care record system. The aim of the integrated system is to enable a single shared view of relevant patient information that allows health and social care to fully understand an individual's history.

Health and social care staff have been visiting sites across the country to understand what options are available for integrated care records. This has resulted in four providers being invited to give demonstrations of their systems. These demonstrations will be evaluated to identify a preferred supplier. By the end of April a preferred supplier will have been identified. There will then need to be a decision made about funding for the integrated care record system. At this time no funding has been committed to procure and implement the system.

University Hospital Coventry and Warwickshire and Coventry and Warwickshire Partnership Trust are currently procuring their own in-house client record systems. It is envisaged the design and development of these solutions will link into and enhance any future integrated care record requirements across the health and social care economy.

Communication

The Better Care Programme Launch Event was held on 23 February at University Hospital Coventry and Warwickshire. The event was for representatives of the health and social care economy in Coventry. Over 70 people attended, providing feedback that will be used to inform any future Better Care Coventry events.

There has been 30 days of public engagement sessions for schemes within the Better Care Coventry Programme. This included targeted social media advertising, and handing out leaflets in high footfall areas. The learning from these activities will be used to inform future communication approaches.

4 Key risks

Three key risks have been identified, with the main risk being capacity in the system to deliver rapid change. The other two key risks are not achieving the reduction in Emergency Admissions and activity volumes not changing as planned. The Better Care Programme Board will put mitigating actions in place.

5 Next steps

There has been significant progress made to date and this has created a solid platform from which to move forward. Future updates on the progress of implementation will be provided to the Health and Wellbeing Board. It is suggested that the next report updates on the work on INTs (integrated neighbourhood teams) and social prescribing.

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