Coventry City Council

Report

To: Coventry Health and Wellbeing Board **Date: 6 July 2015**

From: Better Care Coventry Programme Board

Subject: Better Care Coventry Progress Report

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 is asked to:

Note the progress made to date in relation to the following aspects of the Better Care Coventry Programme:

- Social Prescribing/Social Navigation
- Integrated Neighbourhood Teams
- Information Sharing

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) which is then used to promote the integration and improvement of existing services.

The Health and Wellbeing Board approved Coventry's first Better Care Plan which 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 be 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.

A report was presented to the Health and Wellbeing Board on 20 April 2015, providing an initial update on progress. A further report was to be presented in July outlining three aspects of the implementation of the Better Care Programme, specifically Social Prescribing/Social Navigation, Integrated Neighbourhood Teams and Sharing Information.

4 Progress made on implementation

Prior to 1 April 2015, work had commenced on a number of approaches that could improve health and social care within Coventry. An update in relation to three specific elements is detailed below.

Social Prescribing/Social Navigation

The purpose of social prescribing/social navigation is to improve the health and wellbeing of people who are in contact with their GP, who do not require medical intervention but do require support to minimise their social isolation.

The role of a social navigator is to work with individuals and assist them to maximise their independence through accessing support from the voluntary and community sector. Supporting people through this preventative approach can result in better outcomes for people, a more cost-efficient and effective use of NHS and social care resources and a wider, more diverse and responsive local voluntary and community sector base.

There is evidence that social prescribing/social navigation has a positive impact on the health service, including reducing the number of GP visits, A&E attendances and unplanned admissions to hospital. However, much of the existing evidence base has involved significantly larger scale proposals.

It is proposed that the social prescribing/social navigation service will be commissioned on a recurrent basis (for three years in the first instance) by Coventry and Rugby Clinical Commissioning Group. In recognition of the local health impact, Public Health will be providing 'pump prime' funding to support the first two years of the service.

The evidence from a number of different social prescribing models has been evaluated to develop the service for Coventry. Options have been presented to GP locality meetings in Coventry, and a model with a single point of access to a social navigator was the preferred option. It was also considered that links to statutory services as well as the voluntary and community sector should be included.

It is proposed that a 'hub' be established to act as a link between GP practices and social navigators. Following a referral to the hub, contact will be made with the person to determine the level and type of support required. The hub will include a mix of employed and volunteer navigators and buddies to provide appropriate support to those referred. The hub will be responsible for identifying and training volunteers and engaging with GP practices to ensure that the number of appropriate referrals are maximised. The hub will also have a function to identify

different types of support requirements through engagement with individuals, health and social care staff and other stakeholders and develop this support through the voluntary and community sector.

Following involvement of a social navigator, the outcome will be reported back to the referring GP practice so that they are kept fully informed of what has happened.

An engagement event with the voluntary sector took place on 15 June to gauge the feasibility of the model, understand any capacity issues and to undertake some market engagement. Subsequently, a business case was presented to the Coventry and Rugby Clinical Commissioning Clinical Development Group on 23 June 2015.

It is planned that a procurement process would take place in August 2015 with initial implementation between September and December 2015 and to fully roll out to all GP practices in January 2016. An interim evaluation of the service will take place in March 2016.

The development of Social Prescribing/Social Navigation is closely aligned with the work being undertaken for the scaling up across the city of the Integrated Neighbourhood Team pilots.

Integrated Neighbourhood Teams

Integrated Neighbourhood Teams (INTs) comprise of staff from across health and social care organisations, working in a multi-disciplinary way to support people with multi-complex needs to maximise their independence and prevent avoidable admissions to hospital.

Pilots have been operating with two Coventry GP Practices (The Forum and Jubilee) since July 2014. Both practices have a well-established INT which meet on a fortnightly basis. These meetings are chaired by a GP and supported by a Community Matron, District Nurse, Social Worker, Occupational Therapist, Mental Health Worker and Physiotherapist. There has also been input from the Council's Community Development Team, University Hospital Coventry and Warwickshire and other specialist areas. In addition, Age UK has been working with both practices as a Social Navigator. Since the pilots have been running there have been approximately 35 people referred from both practices.

There is evidence that INTs are having a positive impact on people and services 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 as work is undertaken by the INT, they have made less home visits to this group of people

Public Health is leading on a comprehensive evaluation of the pilot and this is informing the scale up of the model.

It is proposed that three INTs be established across Coventry, with every GP practice allocated to one of these teams. Each INT will comprise of the following dedicated staff: Community Nurse,

Community Matron, Social Worker, OT Team Leader, Mental Health Worker, Social Navigator and UHCW Link Nurse. It is anticipated that each of the INTs will be chaired by a GP.

It is considered that a centralised dedicated point of contact is needed to receive referrals from GPs. The feedback from engagement with GPs identified that, in order for both Social Prescribing/Social Navigation and INTs to be successful, the method for referral needs to be simple, with a common referral into both services being the preferred option.

It is therefore proposed that there will be a single hub, as described above that will take referrals from GP practices, and undertake an assessment as to whether the person requires INT support, social navigation or both.

If referred into the INT a Clinical Care Co-ordinator will be the key contact point for that person, and will arrange for the referring practice to be advised on what actions and plans have been put in place. The INT teams will also include a social navigator to link individuals to relevant voluntary and community activities where appropriate.

The INT will also link with the Frailty Unit being established at University Hospital Coventry and Warwickshire to ensure that where people receiving INT support are admitted to hospital they can be quickly assessed and where possible discharged back into INT care.

Presentations have been made to GPs to seek their support for the scaling up of this model and a business case was presented to the Better Care Coventry Programme Board in April and approved in principle.

The scaling up of INTs across the city is supported by the work being undertaken on information sharing.

Information Sharing

This programme of work is to facilitate the sharing of information between health and social care staff across the city.

The sharing of information between health and social care organisations is a key enabler to deliver integrated arrangements in Coventry to improve outcomes for people. The key strategic drivers are:

- Improving people's access to their own information, providing greater control and enabling people to make the right choices about their care and support

- Improving the person's experience of the health and care system by reducing the requirement to repeat their story to multiple agencies

- Providing suitable and scalable infrastructure to support integrated working across health and social care

- Consolidating on the range of care plans created for individuals across the system

- Improving the depth and breadth of informatics available to commissioners through the development of population health management capability

- Improving business efficiency across the health and care system and reducing duplicated administrative effort

- Embedding the NHS number as the single unique identifier across health and social care

An Information Sharing Programme Board provides a robust assurance mechanism to develop this work. There is a joint commitment to explore the opportunity for the consolidation of health and social care systems across the city. The Board provides support to and oversight of programmes that require data sharing including:

- Prime Ministers Challenge Fund e.g. GP in the Emergency Department at University Hospital Coventry and Warwickshire and extended GP hours to support the demand for primary care services

- Development of a medium-term ICT solution to support Integrated Neighbourhood Teams, Urgent Care services and End of Life services.

- Development of a longer term ICT solution for the health and social care system

- Development of population health management across Coventry and Rugby

All partner organisations have agreed and signed an Information Sharing Protocol (ISP). In addition, with involvement of the Local Medical Committee, a separate ISP has been developed for GP practices.

5 Next steps

The business cases in relation to the three specific areas outlined above are now being considered by the Adult Joint Commissioning Board and the Governing Body of the Coventry and Rugby Clinical Commissioning Group.

The delivery of Better Care Coventry will continue to be led through the Adult Joint Commissioning Board and Better Care Programme Board as a distinct programme of work.

Health and Social Care organisations in Coventry are working closely together to meet the challenges faced in the health and social care economy of increasing demand and limited resources which are resulting in on-going pressures to deliver against key targets.

In order to respond to the broader challenges of system wide transformation and integration, a Transformation Programme Board across health and social care has been established and a Programme Director has been appointed. The establishment of this system wide Transformation Programme Board has been communicated to NHS England and the Trust Development Agency through the System Resilience Group. A further report will be presented to next meeting of the Health and Wellbeing Board to describe in detail the scope of this programme, deliverables and timescales and the relationship with the Better Care Coventry Programme.

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