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Scheme One: Targeted Prevention

Overview

This project will involve a variety of interventions aimed at reducing demand on the health and social care system through targeting effort at a number of areas of activity.

This benefit of intervening early and supporting people to be more resilient is recognised through the STP programme which has established a Proactive and Preventative workstream. The work progressed under the BCF will link to and support the delivery of the aims of this important workstream of the STP which has set four priority areas:

- Smoking prevention
- Obesity
- Falls
- Thrive mental health commission report

More detailed work is to be completed as the STP develops to ensure that the resource available through the BCF is effectively targeted and promotes sustainability, however, at this point the following areas have been identified:

1. Reducing isolation and loneliness in Older People.

Loneliness and social isolation can have a negative effect on both physical and mental health. Stress hormones, immune function and cardiovascular function are impacted by chronic loneliness and it can also lead to anxiety and depression. Research shows that lacking social connections can be as damaging to our health as smoking 15 cigarettes a day.

An initial pilot project to reduce isolation was initiated by the City Council and CRCCG in 2016/17 which brought together Age UK and Hope Coventry. Options will be reviewed for how this approach and the capacity achieved can be used to further support the priorities of the Preventative and Proactive workstream and develop in a manner that can:

- Identify people with support needs, and at risk of developing support needs, and prevent them from entering crisis
- Grow capability in the people who impact on services the most to develop and maintain their own networks without the need for more intensive support from Health and Social Care

2. Developing resilience in respect of Mental Ill Health.

The risk of people developing mental health needs increases with age. There are a number of conditions that people are more likely to experience that impact on mental health, particularly as they age as this group are prone to social isolation, financial difficulty, chronic physical health problems (long term conditions) and loss/bereavement.

There are a range of potential opportunities for supporting people with mental ill health, including those who may not necessarily meet the thresholds for health or social care support.. These include social prescribing, which can lead to improvements in areas such as quality of life and emotional wellbeing, mental and general wellbeing, and levels of depression and anxiety including a reduction in the prescribing of anti-depressants and the use of technology through on-line support forums.

3. Non-social/clinical care support which enables people to return home from hospital.

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It is recognised that some people may be delayed in hospital for reasons other than requiring social care or health interventions. These may be matters to do with their domestic living environment and the impact these can have on the health of the person. It is possible that focussing on these areas, that are often more challenging to resolve, will support individuals to live successfully as part of their community. This could include, for example, providing a deep clean of a property ahead of someone returning home, or simply providing support to settle someone back home should family or friends be unavailable.

4. Supporting healthier choices.

Encouraging and helping people to make healthier choices to achieve positive long-term behaviour change by supporting people discharged from hospital or in social care, or those at risk of doing so, to adjust lifestyle behaviours. The behavioural / health issues will be tailored and will be likely to include:

- Diet, nutrition and hydration
- Physical activity, including strength and balance
- Warm homes
- Smoking
- Seasonal 'drives' including flu vaccination

Particular areas of focus will be working with people in care settings, in hospital and clients / patients who have been discharged from social care / hospital and also include specific training for domiciliary care workers to assist people receiving domiciliary care to have access to healthier, nutritious food.

Objectives

Objectives of this scheme are:

- Influencing behaviour and lifestyle changes to increase adoption of preventative activities
- Proactively seeking to intervene early and reduce health risk for individuals
- Influencing the way services are designed to maximise prevention for those at risk of mental or physical ill health and maintain quality of life.
- To improve nutrition among people at greater risk of re-referral / re-admission to social care and health services.

Benefits

Benefits for this scheme include:

- Improved range of health outcomes
- People encouraged to improve their lifestyle behaviours and live healthier lives
- Promote and enable independence, choice and control in the population
- Help improve the quality of life of older people
- Preventing / delaying re-entry to health and social care system
- Reducing isolation and loneliness
- People having stronger support networks

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Metrics
This project will contribute to the following BCF metrics: • Non-Elective Admissions (General & Acute) All age per 100,000 population • Older People discharged at home 91 days later per 100,000 population (ASCOF 2b) • Delayed Transfers of Care All Adults 18+, Days of Delay per 100,000 population • Permanent Admissions of Older People to Residential & Nursing per 100,000 population (ASCOF 2a)

Scheme Two: Improving Whole System Flow
Overview
How people are supported through the health and care system from pre-admission, admission, whilst in hospital and at discharge has a direct impact on the quality of outcome for the individual as well as system cost and efficiency. Therefore, ensuring that at each stage people are supported in the most appropriate and efficient way can both improve the customer experience and contribute to delivery of the metrics associated with the BCF. How services are accessed, when and where assessment and treatment is available, and who it is provided by, can have as significant an impact on the quality of care as the actual type of care received. Focussing on these areas has achieved increasing traction within the health economy, especially in relation to reductions in patient waiting times for emergency and elective care. Much work has been done in Coventry to deliver improvement in this area, this is as a result of previous interventions and partners recognising that improvements can be made. There is however more to be done. Through this project it is intended that some of the pressures across the health system in Coventry including increasing levels of attendance and longer waiting times at A&E, rising numbers of emergency admissions to the University Hospital combined with continuing high rates of delayed discharge can be improved. These factors contribute to increasing social care activity overall and divert capacity from responding proactively to support people more effectively in the community. The need to shift activity 'upstream' is accepted and understood by partners, however realising the shift in resources and activity to deliver this remains challenging. As one of the purposes of the BCF is to support NHS organisations it is proposed that an element of the BCF funding is used to support work to improve flow, and therefore outcomes and efficiency. The exact scope of this work is to be determined but is potentially a significant change project which will lead to sustained system improvement beyond the timescale for the BCF. It is currently proposed that this work will be led by CRCCG with the involvement of all key partners. A specification for this work is under development, following which the most appropriate way to source the required outcomes will be considered. This may lead to a formal decision to procure and engage the

appropriate external expertise or alternatively it may provide an opportunity for partners to secure the appropriate skills and capacity internally to increase the pace of delivery.

This project has strong connections to the work of the Accident and Emergency Delivery Board and the Urgent Care workstream of the STP.

Objectives

The draft objectives of this scheme are:

- Ensuring more people receive the support they need in the most appropriate place at the right time
- Establishing and managing the relationship between flow, quality and cost
- A more effective system with co-ordinated activities and processes that facilitate effective health and social care delivery

Expected Benefits

The expected benefits for this project include:

- Improved work processes and culture
- Improved patient flow through the whole health and social care system
- Improved service delivery
- Enhanced quality of patient care

Metrics

This project will contribute to the following BCF metrics:

- Non-Elective Admissions (General & Acute) All age per 100,000 population
- Older People discharged at home 91 days later per 100,000 population (ASCOF 2b)
- Delayed Transfers of Care All Adults 18+, Days of Delay per 100,000 population
- Permanent Admissions of Older People per 100,000 population (ASCOF 2a)

Scheme Three: Discharge Support

Overview

Discharge to Assess is one of the elements of the High Impact Change model which is advocated nationally as a tool to improve discharge performance. Effective Discharge to Assess (D2A) services help those who might need support on leaving hospital, by facilitating a support package, either at home or in a residential setting that enables a period of recovery and a more considered assessment of ongoing support needs to be made. Doing this effectively both speeds up discharge from hospital

and ensures that long term care and support decisions are not made in a hospital setting. The primary purpose of Discharge to Assess is to enable a period of enablement to minimise the possibility of ongoing care and support being required.

Using the Discharge to Assess approach hospital beds are vacated earlier than may otherwise be the case and benefits for the individual are also realised as health often improves further once they are outside of hospital.

Currently a range of support is commissioned that comprises the Discharge to Assess pathway (Note this is otherwise referred to as 'Short Term Support to Maximise Independence' or reablement) as follows:

Pathway 1 - Home Based Support

- 1750 hours per week rising to 1,995 per week by the end of July 2017
- 100 hours a week specialist dementia "Discharge to assess"

Pathway 2 - Bed Based support

- 48 care home places (residential and dementia residential beds)
- 35 places in housing with care schemes.

In summary the system has: -

- 83 STSMI bed places
- 1850 home support hours which are block funded

Additional complimentary support services exist through: -

- Coventry & Warwickshire Partnership Trust (CWPT) therapists
- Occupational Therapy (specific to dementia D2A project)
- Dementia locksmiths (specific to dementia D2A project but also working with dementia bedded step down provision)

The above capacity experiences high utilisation rates indicating that there is not an excess of supply, and, for example, data for May 2017 shows utilisation rates as follows:

Pathways 1 & 2	Home support	Housing with care	Residential Reablement	Dementia Residential Reablement
Occupancy	100%	91%-100%	90%-100%	90%-100%

The above figures include CRCCG funding of £750k of additional capacity on a short term basis which began in 2016/17 to meet the increased pressure on the D2A pathways. However the increased demand has not abated and as the additional funding identified by CRCCG was time limited there is a significant risk that Delayed Transfers of Care (DTOC) figures would increase should the capacity reduce. In addition, some of the resources identified to increase short term home support hours in 2017/18 are no longer available and without these extra hours, there is likely to be a further impact on DTOC.

If this capacity was reduced it would equate to a reduction of approximately 430hrs per week of home support and 12 residential care home places per week. This workstream looks to maintain the increased capacity to sustain and improve DTOC rates.

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Recognising that there are seasonal peak demands for health and social care particularly in winter months this project will also allocate resource to ensure that should additional Discharge to Assess capacity be required over winter months this will be able to be resourced.

Progressing this project directly meets one of the grant purposes of supporting NHS organisations, particularly to support discharges.

It should also be noted that although three year funding is proposed the way this funding is used across the D2A pathway may change, particularly as an outcome of project two, above.

Objectives

Objectives of this scheme are:

- Maintain D2A capacity in the community
- Maintain system flow
- Maintain enablement capacity
- Meet additional winter pressures

Expected Benefits

Benefits for this scheme include:

- Reduced delays
- Speeds up hospital discharge times
- Helps improve outcomes for older people
- Improved discharge planning
- Better patient flow

Metrics

This project will contribute to the following BCF metrics:

- Delayed Transfers of Care All Adults 18+, Days of Delay per 100,000 population
- DToC % of occupied beds
- Older People discharged at home 91 days later per 100,000 population (ASCOF 2b)
- Sequel to short term service (ASCOF 2d)

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Scheme Four: Community Promoting Independence

Overview

There has been significant investment in developing Discharge to Assess services to ensure that on discharge from hospital people have the opportunity for a short term service to provide reablement and prevent/reduce the need for ongoing support.

These same opportunities do not currently exist for people that come into contact with Adult Social Care direct from the community meaning that opportunities to reable people to improve outcomes and reduce long term costs are not being taken.

It is therefore proposed to develop a Community Promoting Independence service for people coming direct to social care from the community. This service is intended to provide a cost effective preventative intervention to people who, by virtue of ill health or disability have lost skill in managing daily living activities, to enable them to regain skill and confidence and reduce their potential dependency upon long term care and support.

This approach will be applied across all service user groups including older people, people with physical impairments and those with learning disabilities who are ordinarily resident in Coventry.

Recognising that the cohort of people targeted for this service would otherwise, in many cases, go direct into an ongoing social care package only the additional costs associated with providing a Community Promoting Independence service are sought from iBCF. These additional costs will include staffing costs in order to provide the additional social work and therapy capacity plus management oversight at Team Leader level.

In terms of anticipated service impact the average number of people commencing a long-term support package per week, from the community, without receiving a short-term service over the 12 months between February 2016 and February 2017 was approximately 1150.

Of those people who benefit from a reablement service on discharge from hospital approximately 50% do not require ongoing social care support. It needs to be recognised that the support needs of people on discharge from hospital will not be directly comparable to people contacting social care from within the community so the likelihood of achieving a 50% reduction in the community is unlikely.

Nevertheless, as the additional cost of providing a Community Promoting Independence service is approximately £570k per annum, should only a 10% success rate be realised in terms of people not requiring ongoing support the service will have almost covered its cost. In addition to this, even if people do require an ongoing service following a period of promoting independence this will often be at a lower level than would otherwise have been the case which would further contribute to the benefits to be realised from this service.

Objectives

Objectives of this scheme are:

- Promote independence
- Prevent or delay deterioration of wellbeing
- Delay the need for more costly and intensive services

- Reduce unnecessary hospital admission or admission to residential care
- Provide the right care, of the right quality, at the right time, as close to home as possible

Expected Benefits

Benefits for this scheme include:

- Timely and appropriate interventions.
- Helps improve outcomes and quality of life
- Promote and enable independence, choice and control
- More care and more support provided in people's own homes/the community
- Supporting long term financial sustainability of Adult Social Care

Metrics

This project will contribute to the following BCF metrics:

- Older People discharged at home 91 days later per 100,000 population (ASCOF 2b)
- Sequel to short term service (ASCOF 2d)
- Permanent Admissions of Older People per 100,000 population (ASCOF 2a)
- Re-admissions to hospital

Scheme Five: Integrated Commissioning

Overview

There a number of enablers in place to support the integration of commissioning activity across the City Council and CRCCG. These enablers include the Health and Well-Being concordat, the collaborative commissioning arrangements and the Coventry Adult joint commissioning board through which leads for key pieces of work on behalf of both organisation have been identified.

Over the two years of the BCF plan this project will focus on embedding a collaborative approach to commissioning in order to manage demand, capacity and market risk through pooling capacity, expertise and knowledge and minimising professional, cultural and organisational barriers within commissioning.

In order to progress with this and provide the commissioning capacity required to deliver other elements of the BCF programme it is intended to recruit 2.5 FTE posts to work across the council and CRCCG to support the management of the BCF programme work streams and provide additional capacity to the integration of commissioning functions.

Objectives

Objectives of this scheme are:

- Improve the understanding and management of the provider market within the health and social care economy
- To collectively ensure the best use of combined resources and expertise so enabling value for money service provision
- Increasing, (through better integration and reduced duplication) the capacity across commissioning organisations to plan, develop and deliver safe, accessible and high quality care and support services

Expected Benefits

Benefits for this scheme include:

- Effective management and coordination of limited resources
- Better management of risks, issues and changes
- Improved management of projects interdependencies
- Enhanced stakeholder engagement
- Strengthened relationships

Metrics

This project will contribute to the following BCF metrics:

- Work streams delivered to plan
- BCF programme issues and risks mitigated
- Reduced duplication of specifications

Scheme six: Protecting Social Care

Overview

In April 2017 the Institute for Fiscal Studies reported that overall local authority spending on social care fell by 11% in real terms between 2009/10 and 2015/16. It also found that six in every seven councils had made at least some level of cut to its care spending per adult resident over the same period.

In Coventry Adult Social Care has saved £5.99m since 2015/16 with a further £7.61m savings required by 2018/19. In addition, an overspend of £3.4m was incurred in 2016/17 as a result of meeting demand. The City Council has also made provision for £7m of additional investment in Adult Social Care for 2017/18 through its budget setting process. Where these additional resources are required from the local authority to fund Adult Social Care they are taken from reserves or savings elsewhere in the Council.

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Further pressures are expected on Adult Social Care through continued fee pressures from the market as a result of increasing costs as well as the impact on the City Council as a result of other projects including CRCCGs reviews against Continuing Health Care guidance.

Protecting Adult Social Care is one of the purposes of the iBCF funding in recognition of the significant budget pressures that local authorities have experienced in this area and that, should these pressures continue without additional resources being found, then reductions will be sought that are likely to impact on the health economy overall.

The element of iBCF funding proposed against Protecting Social Care provides some mitigation of these impacts and helps to ensure that the City Council has capacity to respond to issues of provider sustainability on a case by case basis and can meet its statutory duties in respect of Adult Social Care.

Objectives

Objectives of this scheme are:

- To collectively ensure the best use of combined resources and expertise so enabling value for money service provision
- Promote joint working with partner organisations to manage and protect current and future social care provision
- Maintaining capacity across the market to deliver safe, accessible and high quality care services

Expected Benefits

Benefits for this scheme include:

- Ensure a sustainable social care market
- Protection of difficult to replace services for the future as well as present day
- Improved partnership working with more joined up services which will be aligned and designed around the needs of the service user

Metrics

This project will contribute to the following BCF metrics:

- Delayed Transfers of Care All Adults 18+, Days of Delay per 100,000 population(due to awaiting social care)
- Older People discharged at home 91 days later per 100,000 population (ASCOF 2b)
- Sequel to short term service (ASCOF 2d)
- Permanent Admissions of Older People to Residential & Nursing per 100,000 population (ASCOF 2a)

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