Integration and Better Care Fund

Coventry Narrative Plan 2017/19

Version: Revised Final - 20/09/17

Contents

Approval and sign off

The Coventry Better Care Fund Plan 2017-19 has been reviewed and signed off by each of the representative organisations involved and, through delegated responsibility, by the Coventry Health and Wellbeing Boards.

Coventry and Rugby CCG	Clare Hollingworth
Position	Chief Finance Officer
Date	11th September 2017

Coventry City Council	Peter Fahy
Position	Director of Adult Services
Date	11th September 2017

Coventry Health and Wellbeing Board	Cllr Kamran Caan
Position	Chair of Health and Wellbeing Board
Date	11th September 2017

Introduction/Foreword

The focus across the Coventry Health and Social Care system is on carrying through our strong resolve to significantly improve pathways and interventions by working together to provide a better level of care and to keep people healthy and well. This was initially introduced in our original Better Care Plan and has since been incorporated and enhanced in the current **Coventry and Warwickshire Sustainability and Transformation Plan** (STP).

We recognise that services in Coventry can improve and we are committed to improving patient and service user experience and outcomes by integrating health and social care pathways where this creates system benefits with the intention for health and social care to be more fully integrated by 2020 in line with the 2015 Spending Review and BCF Policy Framework. However we are acutely aware that the integration of the health and social care sectors is a significant challenge at a time when both sectors are under pressure both financially and in terms of increasing demand.

With each commissioning organisation required to pool a minimum level of budget to support and deliver health and social care services, the focus has been on maximising the level of pooling to reflect joint areas of activity whilst focusing additional resources to make improvements to existing services. The total value of the 2017-2019 pooled budget is **£179.502m** made up of **£63.897m** of local authority resources and **£115.605m** of CCG resources spread over the 2 year period as shown in the table below.

Funding levels have been increased in line with nationally set inflation for the minimum contribution as well as other specific changes to the resourcing such as Disabled Facilities Grants (DFGs). Changes to the budgets have been discussed and agreed through the Adult Joint Commissioning Board, and through the Preventative and Proactive workstream of the Sustainability Transformation Programme and, finally, formally approved through the Health and Wellbeing Board. There is a continued commitment in Coventry to maintain the level of the Pool and seek opportunity where possible to expand it further as part of continuing discussions regarding future integration. Further details are outlined in the financial submission template.

The funding agreed will contribute to maintaining existing services that support discharge and social care provision as well as extending opportunities in areas such as targeted prevention, improving whole system flow and promoting independence in the community.

Table 1: Funding Contributions

Better Care Fund (incorporating iBCF)	**2016/17 £m** **for reference**	**2017/18 £m**	**2018/19 £m**	**Total Plan £m**
Coventry City Council	**20.005**	**30.920**	**32.977**	**63.897**
Coventry & Rugby Clinical Commissioning Group	**35.895**	**57.258**	**58.347**	**115.605**
Total Pooled Budget	**55.900**	**88.178**	**91.324**	**179.502**

This is resourced from:	2016/17 £m for reference	2017/18 £m	2018/19 £m	Total Plan £m
LA Minimum Contribution	**2.851**	**3.133**	**3.415**	**6.548**
LA Additional Contribution	**17.154**	**19.672**	**18.481**	**38.153**
iBCF	**0.000**	**8.115**	**11.081**	**19.196**
CCG Minimum Contribution	**22.338**	**22.738**	**23.170**	**45.908**
CCG Additional Contribution	**13.557**	**34.520**	**35.177**	**69.697**
Total Pooled Budget	**55.900**	**88.178**	**91.324**	**179.502**

The CCG Minimum Contribution is made up of the following elements, in line with the planning requirements.

Table 2: CCG Minimum Contribution

CCG Minimum Contribution	2016/17 £m for reference	2017/18 £m	2018/19 £m	Total Plan £m
Planned Social Care Expenditure	**8.135**	**8.322**	**8.480**	**16.802**
Ringfenced NHS Commissioned OOH Spend	**14.203**	**14.416**	**14.690**	**29.106**
Total Minimum Contribution	**22.338**	**22.738**	**23.180**	**45.908**

Further detail regarding specific funding streams can be found within the Funding Contribution section of the Plan and the Financial planning template.

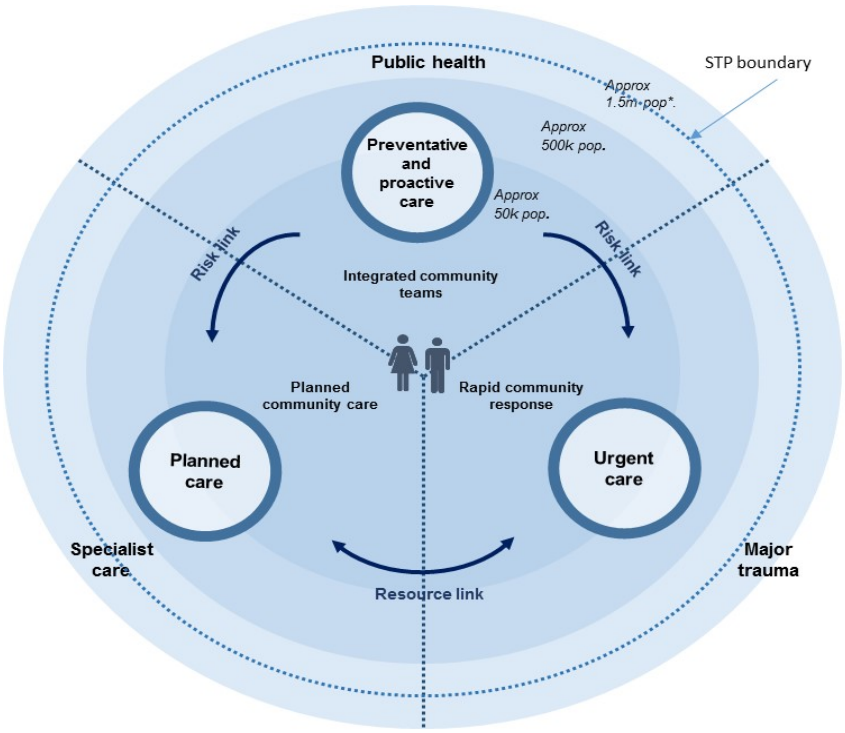
What is the local vision and approach for health and social care integration?

This integrated transformational work across the system health and social care system is summarised within the **Coventry and Warwickshire Sustainability and Transformation Plan** (STP) vision:

'To work together to deliver high quality care which supports our communities to live well, stay independent and enjoy life.'

When designing the future care model, we wanted to move away from current service and organisation boundaries, and reflect a simpler patient focussed view. We aim to design all services within three domains shown in the diagram below: preventative/ proactive care, planned care, and urgent care.

Diagram 1: The Coventry and Warwickshire STP Model



We aim to develop an accountable care system which will have the following key characteristics:

- All services (health, social care, community, mental health) are commissioned for long term outcomes on capitated budgets;
- At the core of the new system, there will be a focus on proactive and preventative care, delivered across approximately 15-18 integrated teams/ communities (covering around 50k population each);
- Services will be commissioned and delivered at the scale most appropriate for clinical and financial sustainability, (e.g. specialised services at a West Midlands level;

- Acute provider will be an active part in managing population demand; and
- Future system will be enabled by integrated IT systems and the use of data.

This reflects a move away from current service and organisation boundaries, towards a simpler patient focussed view which aims to design all services within three domains: preventative/ proactive care, planned care, and urgent care.

Additionally the **Joint Health and Well Being Strategy (2016-19)** for Coventry references the following cross-cutting themes:

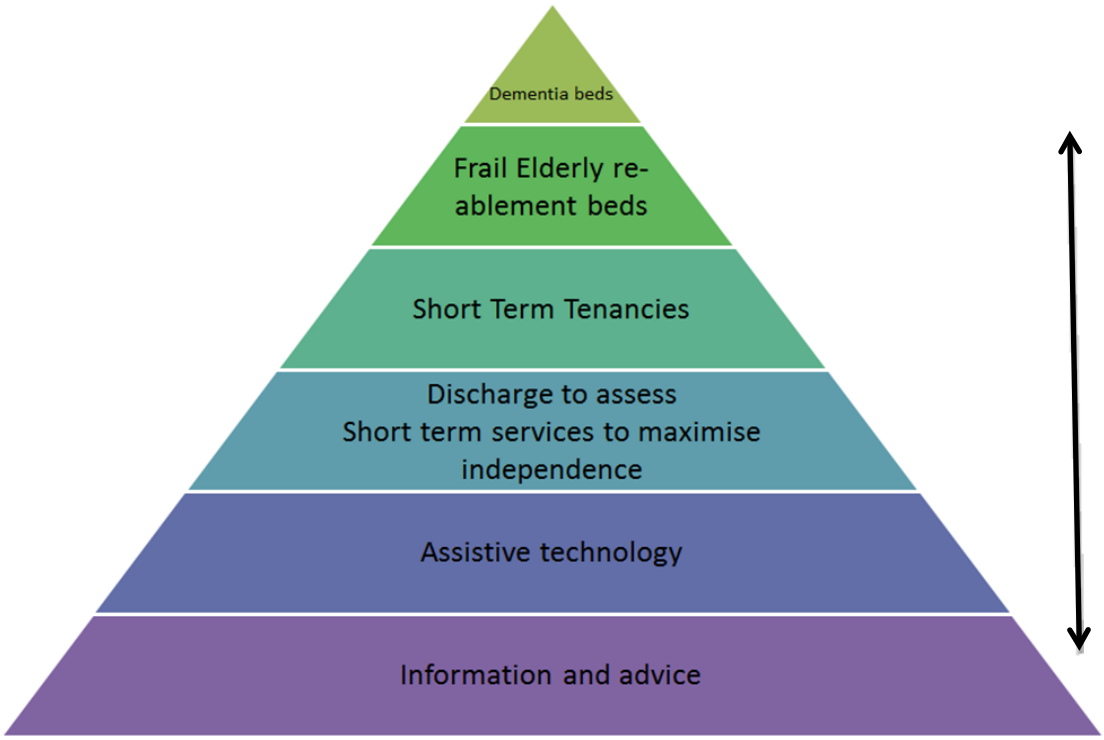
- Reducing Health and Wellbeing Inequalities
- Improving The Health and Well Being for individuals with multiple complex needs
- Developing an integrated health and care system that provides the right help and support to enable people to live their lives well.
- A transformational approach

As such the key aims and objectives of our on-going **Better Care Coventry Programme** compliment and contribute towards the overarching strategic approach to the wider health and care system by having focussed over the last two years on:

- 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 keep 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, which 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 and effective support to carers as an integral part of all work undertaken
- 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
- Roll out of a fast change integrated neighbourhood team approach across the city which will support the delivery of our better care schemes

These still remain pertinent to the next iteration of the BCF Planning cycle for 2017-19 as does the current approach to meeting assessed need shown in Diagram 2.

Diagram 2: Promoting Independence - Hierarchy of service provision based on assessed needs



Importantly and more specifically this approach to the BCF programme supports the key themes of the STP, now renamed as 'Better Health, Better Care, Better Value', which is aligned through the three priority areas identified as the key work streams in the model in Diagram 1.

- **Proactive & Preventative Care**
  Which specifically expands on existing activities contained within the 2016/17 Better Care Fund plan. Put simply this means better general physical and mental health for all and helping people to stay healthy and independent. This should result in fewer visits to hospital for those with ongoing conditions, less time in hospital and more rehabilitation.
- **Urgent & Emergency Care** - Which focuses on providing unplanned care quickly.
- **Planned Care** - Which is needed by patients and service users but not always immediately and helping to reduce the necessary visits to hospital before and after hospital treatment.

The key themes are supported by additionally enabling improvements across the system in:

- **Productivity & Efficiency** – By continuing to look at how our back office functions such as finance and IT can be combined or aligned to reduce cost and improve effectiveness.

Delivering our Better Care programme is an important step in the delivery of the local commitment to the integration of health and social care by articulating how we will improve the lives of local residents:

- 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 STP, Joint Strategic Needs Assessment (JSNA), Joint Health and Well Being Strategy (JHWS), NHS Outcomes Framework, and Public Health Outcomes Framework.
- System shifts away from hospital care are integral to the STP and also underpin our Better Care approach

Additionally the Better Care programme between 2017 and 2019 also supports the key priorities of our **JSNA (2016)** which are:

- Mental Health and Wellbeing
- Long-term conditions
- Physical wellbeing
- Infectious diseases
- Resilience of the health and social care system

More information can be found in the following document links.

Document or information title	**Synopsis and links**
Coventry and Warwickshire Sustainability and Transformation Plan	http://www.coventry.gov.uk/downloads/file/23430/coventry_and_warwickshire_stp
Coventry's Joint Strategic Needs Assessment 2016	http://www.coventry.gov.uk/downloads/file/21652/joint_strategic_needs_assessment_2016
Coventry's Joint Health and Wellbeing Strategy 2016-19	http://www.coventry.gov.uk/info/190/health_and_wellbeing/2864/coventry_health_and_wellbeing_strategy
Coventry & Rugby CCG Strategic Plan 2014-19	http://www.coventryrugbyccg.nhs.uk/About-Us/Publications-and-Policies/Coventry-and-Warwickshire-CCGs-Strategic-Plan
Coventry Carers Strategy: 2016-2019	http://www.coventry.gov.uk/downloads/download/2306/coventrys_carers_strategy
Coventry: A Marmot City	http://www.coventry.gov.uk/info/176/policy/2457/coventry_a_marmot_city

Background and context to the plan – Changes in Demand

Population Growth

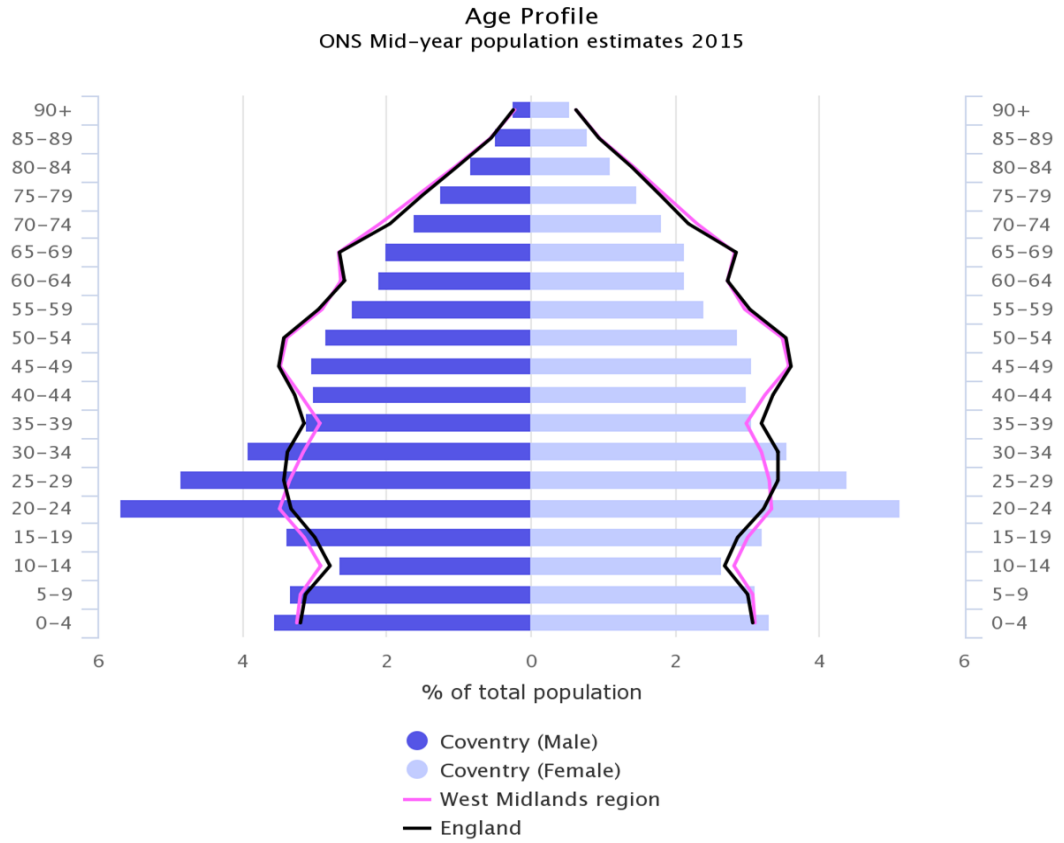
The city of Coventry is the thirteenth largest in the UK. The current estimated population of Coventry (2016) has 345,400 people living in the city which is the 10th largest of all local authorities. This is 8,000 more people than in 2014 when the population was estimated to be 337,400. This is an increase of 2.4%, compared to the England average of 0.9%. Between June 2014 and June 2015 Coventry's population was growing at the 9th fastest rate out of all council areas in Great Britain. Based on current estimates by the year 2025, the overall population is estimated to increase to 376,800. The population of people aged 65 and over is expected to increase to 57,100.

Currently 33.4% of the population comes from ethnic minority communities and this is likely to increase as 46% of school pupils are from backgrounds other than White British. Additionally over 100 different languages are spoken across the city with 8.7% of households contain no people with English as their main language.

Age Profile

The city has a much younger age profile than the national average, with the average age of residents being 33.

Diagram 3: Coventry Age profile



The growth of the city's two Universities has been a factor in recent population growth and has also impacted on the age profile.

An Ageing Population

We expect our older population to increase in the coming years with the proportion of 65+ in the overall population rising to 16% by 2030. The increases in an aging population can be regarded as positive in terms of longevity and improved quality of life but older people become, the more pressure they put on finite health and social care resources.

Table 3: Coventry – Estimated Population Change by Age Band (Source: POPPI & PANSI)

Population aged 18-64, projected to 2030

	2015	% of All	2020	% of All	2025	% of All	2030	% of All
People aged 18-24	47,000	14.0%	45,600	12.8%	46,000	12.2%	51,100	12.9%
People aged 25-34	52,700	15.6%	58,100	16.2%	59,400	15.8%	57,800	14.6%
People aged 35-44	41,200	12.2%	44,100	12.3%	49,100	13.0%	52,700	13.3%
People aged 45-54	40,600	12.1%	40,600	11.4%	39,500	10.5%	41,800	10.6%
People aged 55-64	31,200	9.3%	34,900	9.8%	38,000	10.1%	37,900	9.6%
Total population aged 18-64	**212,700**	63.1%	**223,300**	62.4%	**232,000**	61.6%	**241,300**	61.1%

Population aged 65 and over, projected to 2030

	2015	% of All	2020	% of All	2025	% of All	2030	% of All
People aged 65-69	14,200	4.2%	13,400	3.7%	14,900	4.0%	17,000	4.3%
People aged 70-74	11,800	3.5%	13,000	3.6%	12,400	3.3%	13,800	3.5%
People aged 75-79	9,400	2.8%	10,300	2.9%	11,600	3.1%	11,100	2.8%
People aged 80-84	6,800	2.0%	7,600	2.1%	8,600	2.3%	9,700	2.5%
People aged 85-89	4,400	1.3%	4,800	1.3%	5,500	1.5%	6,400	1.6%
People aged 90 and over	2,900	0.9%	3,400	1.0%	4,100	1.1%	5,100	1.3%
Total population 65 and over	**49,500**	14.7%	**52,500**	14.7%	**57,100**	15.2%	**63,100**	16.0%

People aged under 18	74,700	22.2%	81,800	22.9%	87,700	23.3%	90,800	23.0%
Total population - all ages	**336,900**	100.0%	**357,600**	100.0%	**376,800**	100.0%	**395,200**	100.0%

The phenomenon of an ageing population and increasing urbanisation is impacting on Coventry with the most recent population estimate indicating that nearly 15% of the population is over 65yrs and over 2% are over 85 yrs. As the population ages more people will be living with multiple health conditions that require support because increasing age is an important risk factor for higher mental health needs. There are a number of conditions that older people are more likely to experience, particularly as this group is frequently associated with a wide range of diseases such as cancer, heart and respiratory disease, diabetes, hypertension, dementia etc. Additionally older people are more prone to social isolation, financial difficulty, chronic physical health problems (long term conditions) and loss/bereavement.

Isolation

There is a projected increase of those aged 75 years+ living alone (approx. 10% increase) from 2015 to 2020. However those aged 65-74 years living alone are projected to remain relatively stable (1.4% increase).

Table 4: Increased numbers of people are living alone (estimated 2015-16)

Age range	% males	% females
65-74	20	30
75+	34	61

Loneliness and social isolation are harmful to health and can have an 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. Those who are socially isolated are 2-5 times more likely to die prematurely than those with stronger social ties.

Deprivation

We also know that a large proportion of our inward migration from new migrants tends to be into the more deprived areas of the city. The levels of deprivation in the city, although improving, will remain relatively high and those living with lower levels of wealth are more likely to develop poor health. Currently 8.5% of the population live in neighbourhoods that are amongst the 10% most deprived in the city. Deprivation is also associated with poorer mental health. The Mental Illness Needs Index (MINI) estimates levels of mental health need relative to England; and includes admissions related to mental health conditions. A number of wards within Coventry have higher scores than the England average indicating a higher prevalence of mental ill health.

Life Expectancy

Coventry's life expectancy at birth is 82.3 years for females and 78.6 years for males. This is lower than the national average, but it is at the level expected given the city's level of deprivation. The life expectancy gap for men is similar to the national figure but for women is significantly higher at 8.7yrs. Improvements in mortality rates have been greater for men than women, with the number of men aged 75 years and older increasing by 149% since mid-1974. By comparison, the number of women in the same age group has increased by 61%. Premature mortality (deaths under the age of 75) is higher in Coventry than the national average from cardiovascular, cancer and respiratory disease.

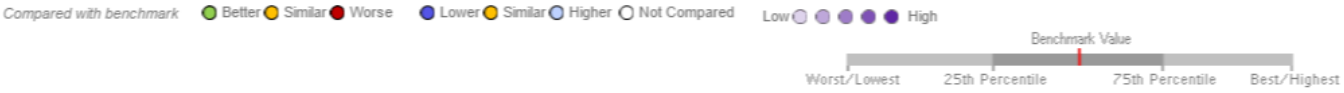
In terms of healthy life expectancy, the figures are 60.6 years for males and 62.7 for females. Whilst this is similar to the combined authority area figures of 61.5 and 62.3 years, it is below the England figures of 63.4 and 64.0 respectively.

Health Inequalities

Health inequalities exist between people of different socio-economic groups and also between genders and ethnicities. However the underlying causes of health inequalities are complex as some of these may be because population groups differ genetically, so that some diseases are more prevalent in certain ethnic groups and also includes altered prevalence and patterns, in different ethnic groups for common conditions such as cardiovascular disease (CVD) and type II diabetes. Others are due to specific lifestyle factors that range from smoking and alcohol consumption to nutrition and exercise.

There may also be wider determinants involved such as poverty, housing, education and access to healthcare. Therefore as a local system we must strive to understand the levels of significance in respect of how disadvantaged or protected groups (under the Equalities Act) fare compared with people overall in being able to access appropriate services or care and the broader health inequalities agenda.

Table 5: Public Heath England profile – Coventry Health Outcomes



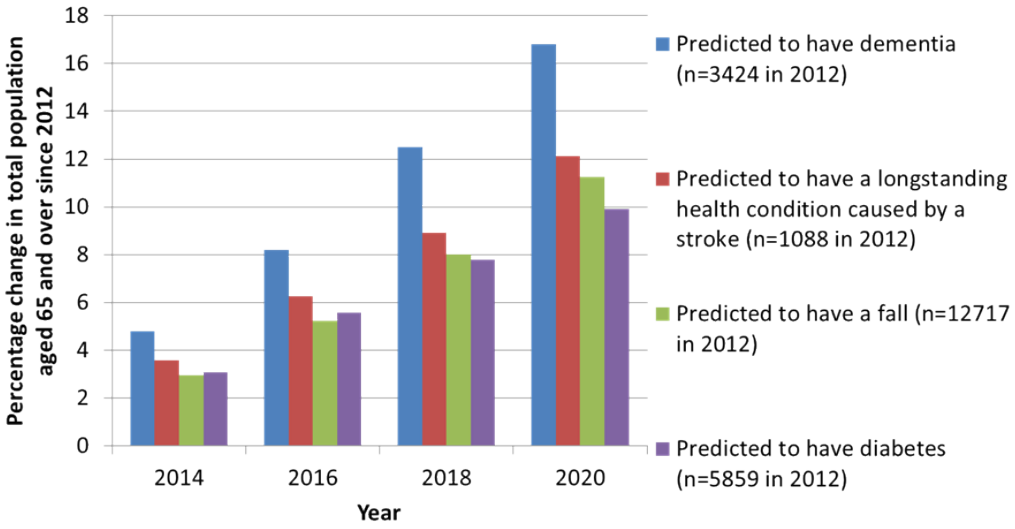
Indicator	Period	Coventry			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Life expectancy at birth (Female)	2013 - 15	–	-	82.3	82.7	83.1	79.4		86.4
Life expectancy at birth (Male)	2013 - 15	–	-	78.4	78.7	79.5	74.3		83.4
Healthy life expectancy at birth (Female)	2013 - 15	–	-	63.8	-	64.1	52.4		71.1
Healthy life expectancy at birth (Male)	2013 - 15	–	-	62.9	-	63.4	54.0		71.1
Inequality in life expectancy at birth (Female)	2013 - 15	–	-	9.6	-	-	-	-	-
Inequality in life expectancy at birth (Male)	2013 - 15	–	-	9.4	-	-	-	-	-
Inequality in healthy life expectancy at birth (Female)	2009 - 13	–	-	18.0	-	-	-	-	-
Inequality in healthy life expectancy at birth (Male)	2009 - 13	–	-	17.1	-	-	-	-	-
Mortality rate from causes considered preventable	2013 - 15	–	1,707	219.6	197.2	184.5	320.5		130.5
Under 75 mortality rate from all cardiovascular diseases	2013 - 15	–	604	87.9	78.9	74.6	137.6		45.4
Under 75 mortality rate from cancer	2013 - 15	–	1,025	149.1	143.6	138.8	194.8		105.8
Under 75 mortality rate from liver disease	2013 - 15	–	158	22.0	20.3	18.0	44.4		10.0
Under 75 mortality rate from respiratory disease	2013 - 15	–	290	43.3	34.7	33.1	68.3		16.5
Health related quality of life for older people	2015/16	–	-	0.723	0.719	0.733	0.642		0.799

Long-term illness

Although life expectancy is increasing, the number of years people are living without a limiting long-term illness is decreasing, particularly in males. It is estimated that 17.7% of the population have a limiting long term health problem or disability with the latest figures suggest that on average males in the city are not quite reaching their 60th birthday without having a limiting long-term illness.

Due to these factors there is likely to be an increase in the number of people that require additional support in order to continue to live independently. The forecast increases in key health conditions are shown in the graph below.

Diagram 4: Changes in key Health Conditions since 2012



An important initiative (See Scheme 1 Targeted Prevention in the Appendix) within the BCF plan will focus on the promotion of improved health outcomes for the citizens of Coventry by reducing the risk factors in the general population and links into the upgrade in preventative work within the STP to deliver long term sustainability. This will involve a variety of interventions to change behaviour, reduce the impact on the health and social care system of preventable diseases and alleviate and/or delay the pressure caused by some long term conditions.

Evidence has shown that interventions that are made earliest in a potentially negative health outcome are the most likely to be effective. Moreover for many health problems in the population a combination of primary, secondary and tertiary interventions are needed.

Other areas impacting on Demand

At least 1 in every 4 people will experience a mental health problem at some point in their life. One in six adults has a mental health problem at any one time.

Additionally the numbers of people with severe physical or learning disabilities living into adulthood will continue to increase as long term survival rates improve.

Should all other factors remain the same it is predicted that one of the greatest increases in demand with mitigating actions will be in non-local authority care homes, with an increase from 1,242 in 2015 to 1,365 people (65+) in 2020. In Coventry we have a long history of supporting people to live independently using alternatives to residential care, and this needs to continue in order to ensure that residential care is not overused.

There will be a continued increase in the provision of unpaid care. Currently 40% of all carers provide support for their parents or parents-in-law and 26% care for their spouse or partner.

It is estimated that about 30% people aged 65 and above living at home and about 50% of people aged 80 and above living at home, or in residential care, will experience a fall at least once a year.

Approximately 1 in 20 older people living in the community experience a fracture or need hospitalisation after a fall (NICE, 2015). When measured between April 2016 and March 2017, falls and frailty accounted for 14.6 % of 75+ years Non Elective Admissions for registered Coventry GP practice patients.

Progress on Better Care projects initiated to date

Integrated Neighbourhood Teams (INT)

Upwards of 50% of unplanned admissions to hospital are in the over 75 age group. This has led to the development of a multi-disciplinary process centred on cross-agency assessment and care planning to support older people with complex needs where they require specialist levels of support in order to return them to their pre-event level of health and well-being. This reduces reliance on statutory services and helps maintain these people at this level or steps them down to a more preventative stage.

During the 2015/16 BCF programme the Integrated Neighbourhood Team was developed, it has since been rebranded as “Your Health at Home” and was launched to the public in June 2016. The focus of the INT is primarily aimed at reducing hospital admissions through the early identification of needs. This work-stream has now successfully moved through the development and implementation phases into an on-going operational service with three clusters of GP practices now referring ‘high risk’ patients into a central Hub. Triage arrangements are working well and referral momentum continues to build with a good spread of GP’s now actively engaged. The service was also nominated for a national community health award.

Joint working agreements and the development of joined up commissioning

A well-established Adult Joint Commissioning Board (AJCB) is in place which meets monthly, chaired by the DASS and attended by CCG directors and senior commissioning and finance staff. This Board steers the delivery of joined up care, receiving reports in relation to key policy, planning and commissioning practice and oversees a programme of integrated commissioning. The Board reports to the Coventry HWBB. Additionally a ‘commissioning collaborative’ group has been established across Coventry and Warwickshire included the two local authorities and three CCGs.

Recent integrated commissioning initiatives include joint re-commissioning of short and long term home support and care home provision for all adults customer groups. There are also jointly commissioned short term reablement services in care homes and housing with care. These joint arrangements are overseen by the AJCB.

The integrated commissioning team also deliver joint quality monitoring initiatives with nurses co-located with the City Council's strategic commissioning staff to form a joint Quality assurance function. Arrangements include a Provider Escalation Panel which reports to the Quality and audit Sub group of Safeguarding Board and which is a multi-disciplinary, multi-agency group including stakeholders from the City Council, Coventry and Rugby Clinical Commissioning Group (CRCCG), Coventry and Warwickshire Partnership Trust (CWPT) and Care Quality Commission (CQC). An annual report on QA is taken to Coventry Safeguarding Adult Board.

Provider relationships for jointly commissioned services including home support and care homes are jointly managed through a number of initiatives including provider forums and workshops. Regular multi-disciplinary meetings take place in relation to home support services to ensure joined up delivery including targeting of therapy resources for short term provision in service users own homes and bedded provision. The Council have been instrumental in facilitating the re-constitution of a Registered Managers network which re-launched in May 2017.

The focus has been on building on the work underway with a renewed focus on market development and completion of trusted social care and CHC assessments. This work will continue into 2017-19 and includes plans to strengthen the on-going Learning Disability and Mental Health commissioning arrangements.

In addition the joint re-commissioning of care home beds is underway and will take place in the coming year and further opportunities for joint commissioning will be considered going forward. This will build on the joint work regarding quality assurance and the successful initiatives such as 'React to Red' which has resulted in a sustained reduction in pressure ulcers. Development of Discharge to Assess services have also been the product of a joint commissioning approach.

Opportunities for people to use these arrangements to provide personalised support will underpin the delivery of these contracts.

Information Sharing

The Coventry and Warwickshire Digital Transformation Board is now providing oversight to the on-going information sharing project within Coventry with the local GP Alliance now fully integrated into the programme of development. This includes the distribution of a letter to all households in the city, explaining that GP's have agreed to share appropriate patient information with partner health and social care organisations and an individual's choices in relation to this.

A workshop has taken place with practitioners and clinicians to gather requirements on system integration and information sharing which will inform the programme for the next 18 months.

There has been significant progress in the development of a data sharing agreement across organisations. Continuing work with the Black Pear software solution provides a suitable

portal for accessing data from the different partner organisations enabling this to be viewed jointly and this development currently covers INT and End of Life care.

Coventry Social Care is now using the NHS number after integration of the social care system with the NHS spine.

'Why not Home Why not today'

The Why not Home, Why not Today' initiative was first trialled at UHCW with patients that were considered suitable with the overall objective being for services to work together in order to both reduce the number of admissions of frail elderly patients over the age of 75 into hospital, and to reduce the time spent in hospital if they are admitted. One of the key activities was to identify and implement the most appropriate packages for these patients and their carers' in order for them to be supported in their own home environment.

The initial overarching project has now ended and the ethos of and learning from this programme has been mainstreamed into the on-going development of the three pathways within the Discharge to Assess model now being implemented in Coventry and the continuing operation of the GP-led Frailty team at UHCW.

GP-led Frailty Team

The historical approach to treating frail elderly patients in Coventry has been a siloed model of working between the different agencies involved in caring for frail patients, mainly from the acute, primary, community, social, and voluntary sectors. The care provided has tended to focus more on the patient's medical conditions and is usually in response to a medical or social crisis.

Analysis has shown that frailty is one of the leading causes of Non Elective admissions for over 75s at UHCW. Further analysis into this patient cohort highlights a number of performance challenges within the system, including:

- Increased length of stay
- Delayed transfers of care
- Prolonged wait in ED
- Higher readmission rates

The GP-led Frailty Team is located at the 'front door' of the hospital in the Emergency Department and has been in operation since October 16 and was initially funded non-recurrently via the Prime Minister's Access Fund (PMAF). This initiative was then joined up with the wider system transformation programme for frailty within the 'Why not home why not today' programme at UHCW.

Research evidence suggests that frail patients benefit from a service model based around ongoing proactive person-centred, co-ordinated care via care and support planning, all of which are hallmarks of the MDT approach adopted by the Frailty Team.

As the GP-led Frailty team is at a relatively early stage of development and not yet running to full capacity, it is not yet possible to provide a full evaluation of its impact and cost

effectiveness. However initial qualitative and quantitative analysis undertaken by the GP Alliance indicates that the Frailty approach has potential to deliver benefits for the health economy in Coventry with the expectation that the Team will have a positive impact on both the clinical management of frail elderly patients, on hospital flow and on ongoing support requirements.

Dementia

A multi-agency approach to supporting people and their carers through the dementia pathway has featured prominently in previous BCF plans and the implementation of the 'Living Well with Dementia' strategy across the city is being overseen by the Dementia Strategy group.

This has led to an number of achievements to date including the implementation of a Dementia navigator service for Coventry and also the recruitment of both Admiral nurses and Dementia 'Locksmiths' that have been working alongside the INT multi-disciplinary teams. The work done to improve the dementia environment of people living in care homes has also demonstrated improved outcomes for this group and Coventry has recently seen the opening of a new specialist dementia housing with care scheme with 33 flats which increases the capacity of the City to provide appropriate support for people with this condition. Briefly, some major improvements delivered include:

- Coventry is a better place to live with dementia with the city being awarded Dementia Friendly Community status by Alzheimer's Society.

- It is quicker and easier to get an assessment and timely diagnosis if you may have dementia. Waiting times for a memory assessment have reduced from over 20 weeks to 3 weeks, against a 12 week target and diagnosis rates for Coventry and Rugby have increased from 48% in 2013 to 60% in 2017.

- Overall there is more support available for people living with dementia and their carers in Coventry.

Long Term Care

Interim capacity was secured in the latter part of 2016 to focus on a range of key areas which included Section 117 and Continuing Health Care cases plus 'out of city' placements. Over ninety long term care cases, involving residential or nursing care, were allocated during the year resulting in a number of the 'out of city' placements being relocated back into Coventry which enabled both additional independence for a number of service users and placement cost savings for both health and social care.

Moreover, the decision has been made to continue this successful approach as part of the standard operating model through the recruitment of one FTE Social Worker and a part-time administrator from March 2017. This will enable further significant work to be done in terms of assessments and further cost savings.

Frailty, Step up and Therapy

A system wide transformation programme was included in last year's BCF that encompassed three core projects:

- Establishment of a step up Community response and crisis reduction capacity
- Establishment of a trusted frailty assessment pathway
- Creation of a Community Therapeutic pull model

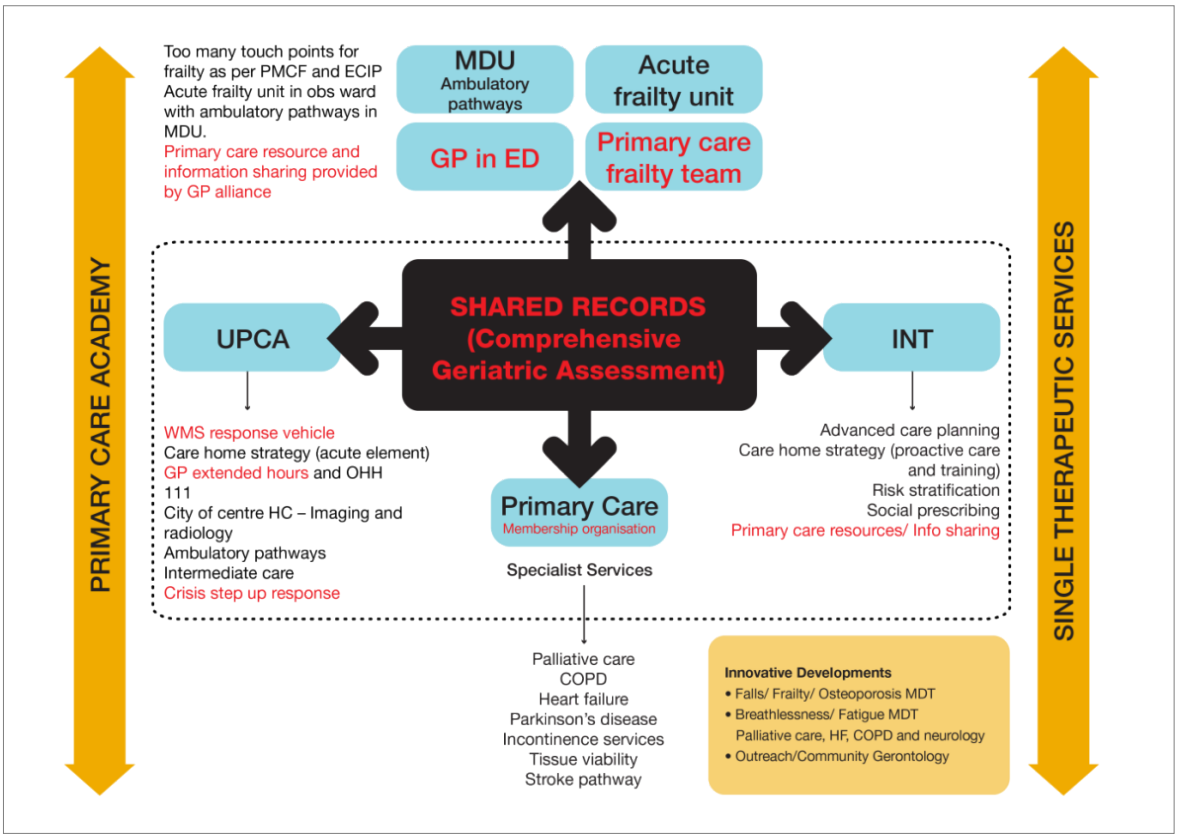
These elements were subsequently incorporated into the Coventry and Warwickshire STP and progress on developments was reported through the Proactive and Preventative Care workstream. This followed a 90 Day Frailty project between June and September 2016 that was instigated by the NHS Emergency Care Improvement Programme Team (ECIP) based at UHCW and which involved partner organisations across the city.

Recent evidence suggests that frail patients benefit from a service model based around ongoing proactive person-centred, co-ordinated care via care and support planning, all of which are hallmarks of the MDT approach which has been adopted by the Frailty Team at UHCW.

According to British Geriatrics Society, the gold standard for the management of frailty in older people is the process of care known as Comprehensive Geriatric Assessment (CGA), involving a holistic, multidimensional, interdisciplinary assessment of an individual by a number of specialists of many disciplines in older people's health.

A patient who receives CGA during an illness is 30 per cent more likely to be alive and living in their own home at six months than a person receiving standard care. The introduction of the CGA is expected to lead to better outcomes for this vulnerable patient group including reduced readmissions, reduced long term care, greater patient satisfaction and lower costs.

Diagram 5: The alignment and interdependencies of system wide initiatives including the GP-led Frailty team.



BCF Performance 2016/17 continuing system issues

Overview

The Health and Social Care system in Coventry is considered to be challenging and is currently in national escalation through NHSE and NHSI. It has also recently been selected as one of the twelve CQC Local System Reviews based on performance across a range of indicators at the health and social care interface.

The local system in Coventry is currently characterised by 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.

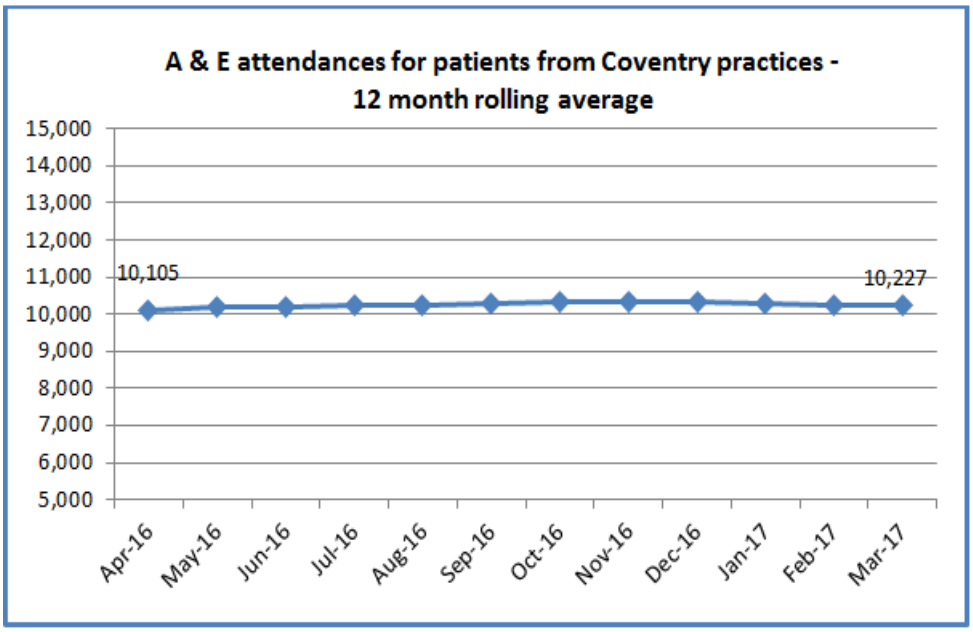
This contributes to increasing health and social care activity overall and diverts capacity from responding proactively and early to prevent deterioration in the community. The need to shift activity to the 'front door' is accepted and understood by partners and activity has been targeted in this direction over the last 12 months, however realising this shift in resources and activity to deliver this remains challenging.

The Coventry and Warwickshire A&E Delivery Board oversees the implementation and monitoring of the A&E Improvement plan, including the DToC plan based on the High Impact Change Model, to address these established issues within the urgent and emergency care system as it has a direct impact on, and is intrinsically linked to the BCF plan and improvement and sustainability of the whole health and social care system. (*See Governance arrangements on Page 41*.)

A&E Attendances

UHCW attendances were lower between January and March than in the same period in 2015/16 and continued to follow last year's trend.

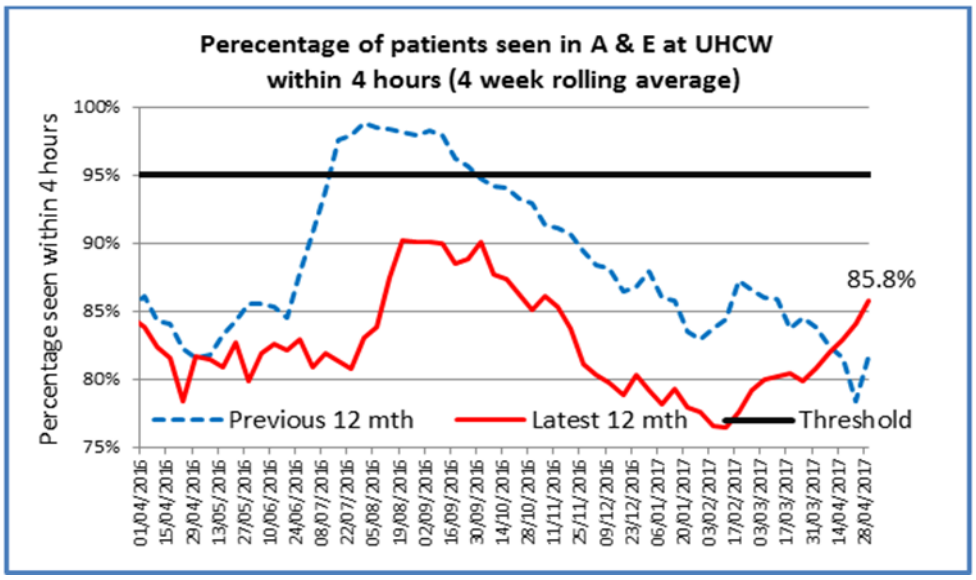
Diagram 6: A&E Attendances 2016-17 (Source – SUS)



A&E Waiting Times

The recent increase in A&E attendances has resulted in additional pressure at the 'front door' at UHCW with the percentage of patients seen within 4 hours in A & E remaining below 95% throughout the last year and reached its lowest point over the last 12 months in February.

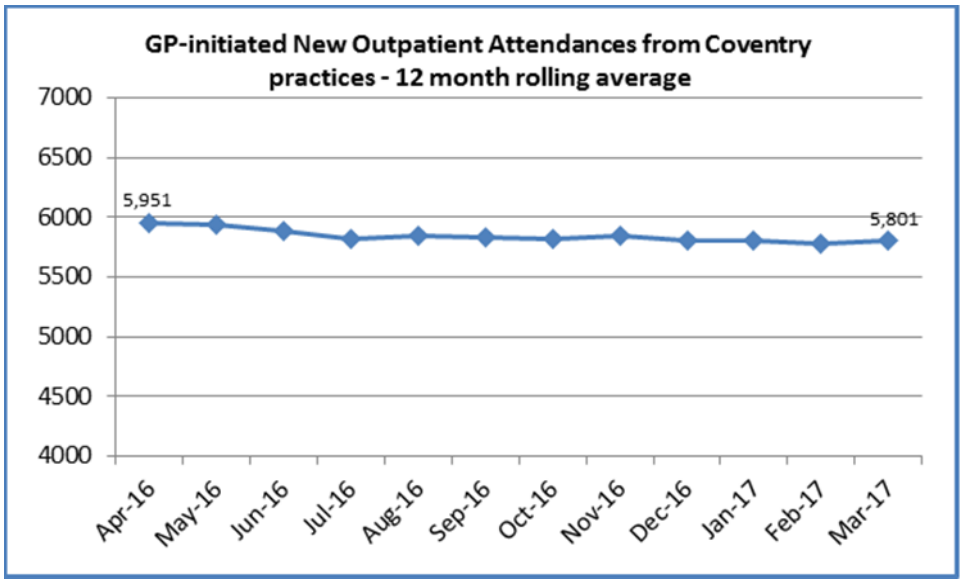
Diagram 7: A&E Waiting Times 2016-17 (Source - UHCW A&E Exception Report)



Outpatient Attendances

Attendances over the course of the last 12 months have seen a 2.5% reduction in the MAT (Moving Annual Total) figure. Over recent years GP-initiated new outpatient attendance rates for Coventry and Rugby patients have been running below national average levels and the latest CRCCG rate is again slightly lower than the England median and 4% lower in 2016/17 than in 2015/16.

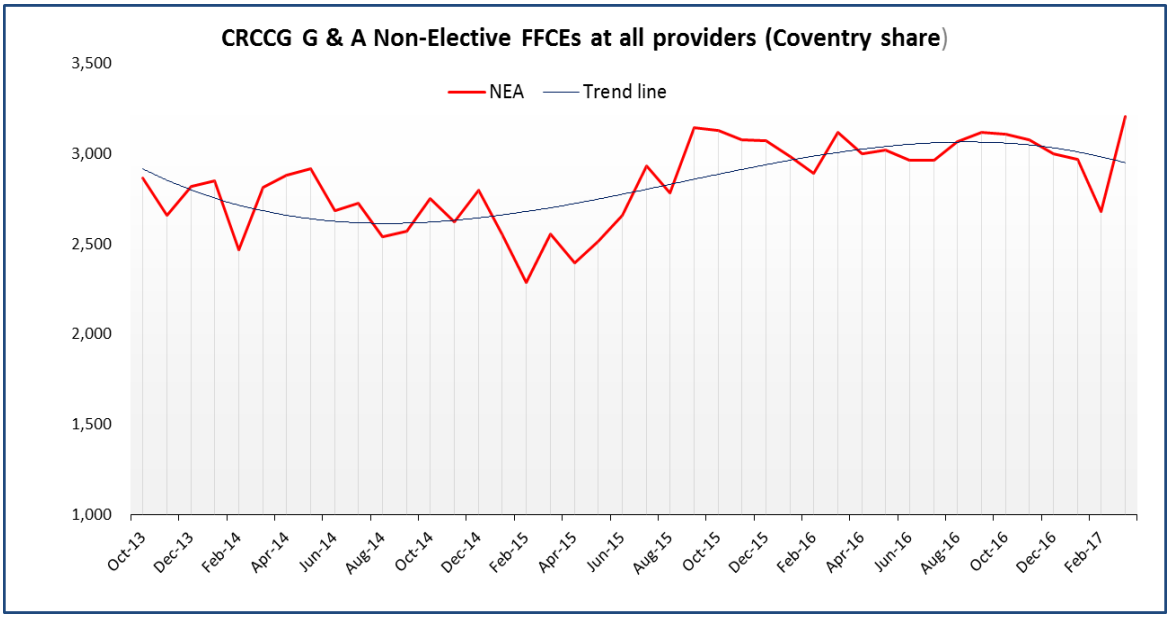
Diagram 8: GP initiated New Outpatient Attendances 2016-17 (Source – SUS)



Non Elective Admissions

The latest reported MAT figure for emergency admissions is 36,179 (12 months total as at the end of March 2017) which is 7.0% higher than the BCF plan target of 33,801 for the financial year. The figures from April to August saw increases against the same months last year, however the six months between September and February produced small decreases against 2015-16 indicating some stabilization in Emergency admissions. The Coventry LA element is calculated as 73.9% of total Coventry and Rugby CCG Non Elective Admissions (as per the BCF template guidance).

Diagram 9: Non Elective Admissions October 2013 to March 2017 (Source – MAR)

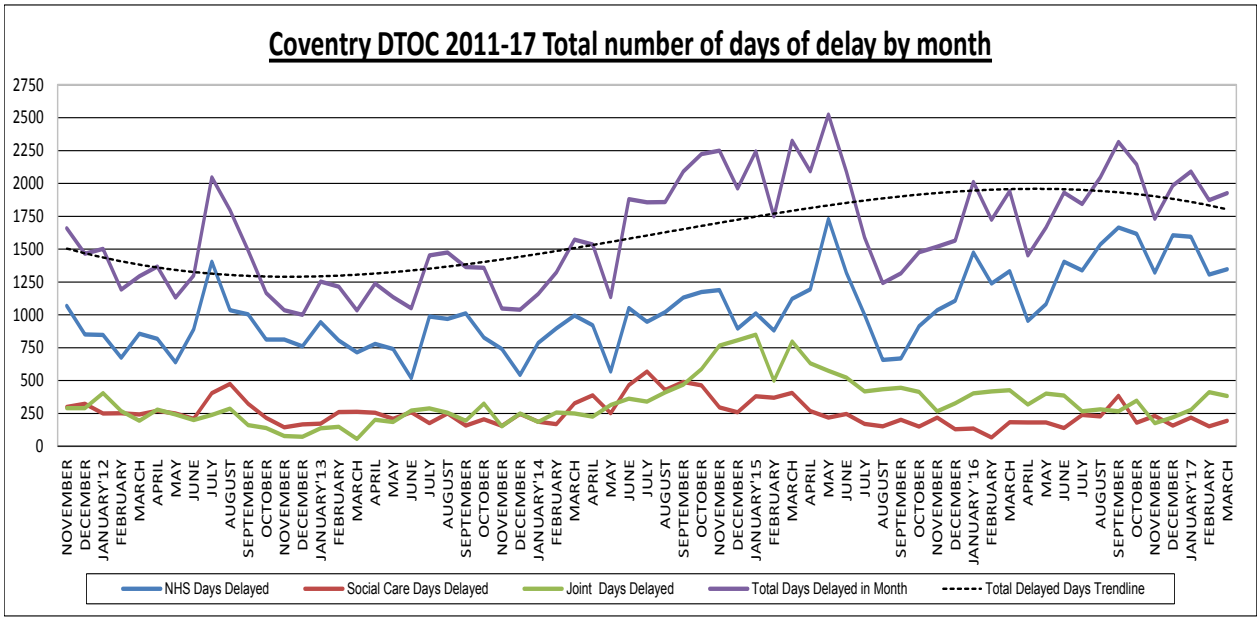


Delayed Transfers of Care

DToC performance has been a significant challenge to the partner organisations in Coventry over recent years. However there was an improvement in year on year performance in 2015/16, following a period of relative stability in the reported days of delay during the year. However the latest MAT figure for total delayed days as at the end of March 2017 (23,000) reflects a rise of 9.1% on the outturn at last year end but a 0.5% reduction on 2014/15. The first quarter of the financial year saw a brief respite in the mainly upward trend in delayed transfers but since August this has resumed. The proportion of days of delays attributable to social care and jointly with health have declined over the last 24 months from a peak in early 2015 as shown in the graph below.

The latest target trajectories for Delayed transfers submitted to NHSE on July 21st are shown on Page 47.

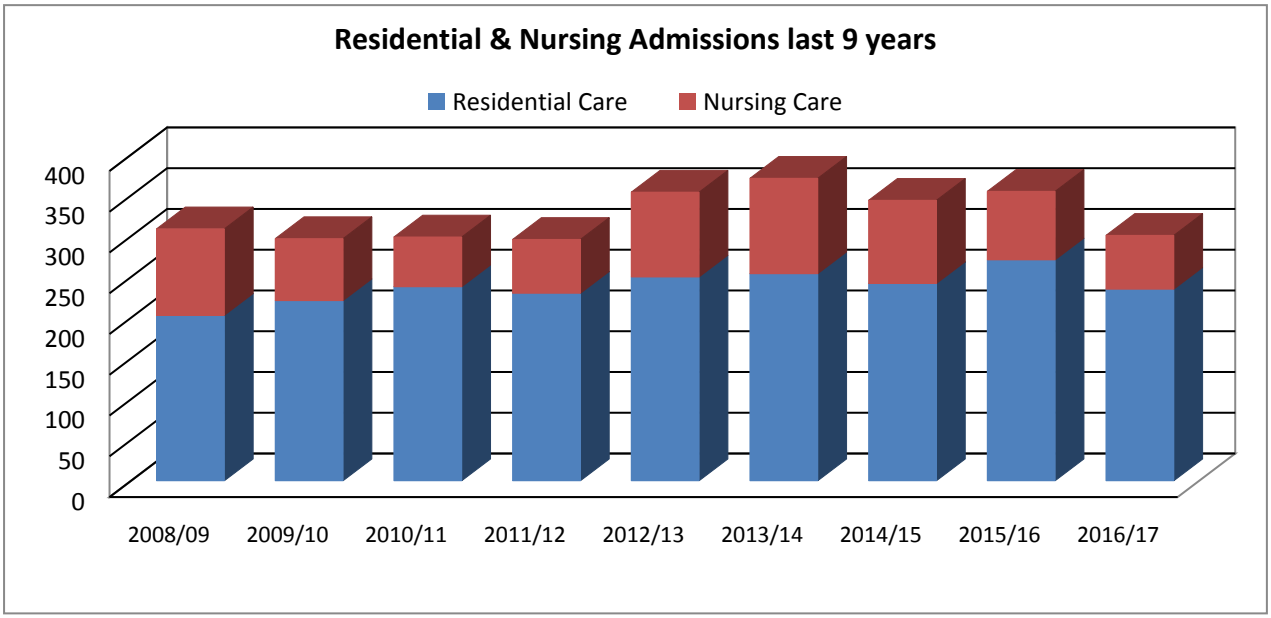
Diagram 10: Delayed Transfers of Care 2011 – 2017 (Source – UNIFY)



Permanent Admissions

Over the period from 2010-11 to March 2016 the numbers of people entering residential and nursing care increased by 13%. However the latest figure reported for the 12 months to the end of March 2017 is 301 which is 15.2% below the year end outturn for 2015-16 and which reflects an increase in activity to prevent permanent admissions and promote alternative community based support.

Diagram 11: Permanent Admissions to Residential & Nursing Care 2008 - 17 (Source - CCC)



Better Care Fund plan 2017-19

Overview

The integration of health and care has been a long standing policy ambition based on the premise that more joined up services will help to improve the health and care of local populations and make more efficient use of available resources.

Whilst the Sustainability and Transformation Programme (STP) is the primary planning tool for health and care, the Better Care Fund is the only mandatory policy to facilitate integration. The Better Care Fund (BCF) is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.

The planning and implementation of the BCF Fund in Coventry over the last couple of years has been successful in providing a practical opportunity for all partners in the local health and social care system to appreciate that they have something to gain by actively working together to collectively focus on what is best for the patient. This cultural shift has also resulted in improved working relationships at various levels across the system between

stakeholders and encouraged the articulation of a common direction of travel with ownership of the transformation activity required to achieve improved integration by 2020.

This is at the same time that the Coventry health and care system faces increasing challenges to improving our residents' health and wellbeing and maintaining the quality of care whilst experiencing a widening gap between available funding and growing demand.

There is now a collective understanding that there needs to be a unity of voice to what will be different in the future and that commissioning will play a crucial role in enabling the integration of provision across health, social care, mental health, community and primary care by supporting sustainability in the provider sector, through providing strategic direction, assuring outcomes and creating capacity.

The regular oversight of BCF activity is now being managed and controlled through the Adults Joint Commissioning Board where programme delivery and performance is reported monthly. Additional system governance is also in place to ensure alignment with broader objectives and plans and this is discussed in more detail on Page 41.

As a local area Coventry has mirrored national improvements in reducing permanent admissions of people aged 65 and over to residential and nursing care homes and by increasing the proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation services (*Page 45*).

BCF Plan 2017-19

In March 2017 a new policy framework for the Better Care Fund covering the period 2017 to 2019 was issued at the same time as significant additional funding being made available to councils in order to protect adult social care. These sums arise from the 2015 spending review and the 2017 spring budget and taken together comprise the Improved Better Care Fund (iBCF).

This additional funding, which is being made available by the Department for Communities and Local Government direct to councils is intended for three purposes:

i. To meet adult social care need
ii. To provide support to the NHS (especially through application of the 8 High Impact Changes)
iii. To sustain the social care provider market

Plans for use of the grant have been agreed by the City Council with Coventry and Rugby Clinical Commissioning Group (CRCCG), through City Council Cabinet and with the local Health and Well-being Board.

Since the implementation of the Better Care Fund (BCF) in 2015, the City Council has had a BCF plan facilitated by the Health and Wellbeing Board supported by a section 75 partnership agreement with Coventry and Rugby Clinical Commissioning Group (CRCCG).

The basis of the pooled funding for the Better Care Fund in previous years has been money that has already been committed to health and social care services through a variety of funding streams. The schemes that were identified in the resultant plans were developed in order to target investment and resources into transforming the system and improving

outcomes for citizens and the entire care economy. Some of the learning and evidence from projects completed and others still on-going has been incorporated into the discussion and development of new initiatives for 2017-19.

The same intentions underlie the current version of the Better Care Plan, which now spans two fiscal years, and a similar set of detailed financial and operational plans have been developed to reflect the current CCG and Social Care commissioning priorities within Coventry.

There is a growing acknowledgement that a focus on admission prevention is as crucial to the effectiveness of the health and care system as enabling discharge and this is accepted at a strategic level across partner organisations. The iBCF grant announced in the spring budget has made significant extra funding available between 2017 and 2020 and this has been put in place with the aim of providing additional stability and capacity in local care systems and specifically to 'impact on front line care'. This additional funding will also enable the continued sustainability of provision that may otherwise have closed or reduced as a consequence of reduced local government funding.

With this in mind the health and social care partners in Coventry will continue to focus the resources and activities of the Better Care Coventry Programme to deliver on the following aims in line with wider STP aspirations.

- Ensuring that people who require care and support are assessed and provided with the necessary treatment or services in a timely and effective manner which are fundamental to preventing further deterioration as well as helping to ensure that people's individual outcomes are met.
- Focuses on promoting wellness by keeping people well, reducing demand and providing ongoing support to patients and service users.
- Reduce health inequalities across the city by early intervention, changing behaviours and providing the opportunities to improve lives.
- Maximisation of the capacity and strengths that the person and their family bring and what is already available within the community.
- Provide simple access to care and support without duplication and moving towards integrated delivery through multi-disciplinary teams.
- Primary care at the core, with social care, mental health, community services, and acute services out-reach and in-reach, forming a network of care and support.
- Reduced reliance on urgent and emergency care over time, with integrated teams within communities' proactively managing people at higher risk.
- Patients and service users are supported in the most appropriate setting and helped to access their care in a planned way through earlier intervention where appropriate.
- Improving system performance and patient flow prior to admission, whilst in hospital and then at the point of and following discharge.
- Optimising the capacity and processes to facilitate hospital discharge through continuing to support system change that will in turn improve long term performance.
- Maximising the independence of people either after a stay in hospital or when they first come into contact with social care, by investing in community based preventative services that reduce the requirement for health and/or social care in the longer term.

- Supporting the sustainability of social care and mitigating the local market pressures associated with increasing costs and recent funding reductions to local government.
- Commissioners need to work together across the system to develop the capability and capacity around a common vision and make best use of the collective assets available.

Existing BCF schemes carried over

This current BCF Plan will continue to deliver and monitor the impact of schemes that were implemented or already in place during previous years of the programme and with expenditure detailed in the finance template:

- **Acceleration Fund** (Driving Change)
- **Care Act Implementation**
  - Personalised healthcare at home
  - Physical health / wellbeing
- **Carers services**
  - Carer advice and support
  - Respite services
- **Dementia**
  - Residential placements
  - Dom care packages
- **Disabled Facility Grants**
- **Out of Hospital and Nursing Care**
  - Personalised healthcare at home
  - Physical health / wellbeing
- **Short Term Care**
  - Personalised healthcare at home
  - Physical health & wellbeing
  - Residential placements
- **Domiciliary care at home**
- **Urgent Care**
- **Voluntary Sector Review** (Primary prevention & early intervention)

We are also developing and implementing a number of **new key schemes** which are shown in more detail in Appendix 1 and in Table 6 below.

BCF Initiatives 2017- 2019

The aims stated above are reflected in a programme of initiatives focused on:

1. **Targeted Prevention** - this will involve a variety of interventions to change behaviour, reduce the impact on the health and social care system of preventable diseases and alleviate and/or delay the pressure caused by some long term conditions and lifestyle choices.

2. **Improving Whole System Flow** - improving the flow of patients, service users, information and resources within and between health and social care organisations have a crucial role to play in coordinating care around the needs of patients and service users, and driving up service quality and productivity.

3. **Hospital Discharge Support** - moving patients promptly when they are ready to be discharged from hospital, not only frees hospital beds for people that need them, it also benefits the patient themselves as their health should improve further once they are back in their own place of residence.

4. **Community Promoting Independence** – 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 the necessary ability and confidence and reduce their potential dependence upon long term care and support.

5. **Integrated Commissioning and Improved Programme Management** – improve the capacity and ability to deliver change towards 2019/20 through joint working across commissioning organisations within Coventry

6. **Protecting Social Care** - ensuring that the social care market is sustainable and that system capacity is not reduced or put at risk.

Each is based on a case for change and has its own objectives and deliverables that in turn will ensure the delivery of the plans for integration and change in our overall Better Care Plan and also importantly the wider Sustainability and Transformation Plan.

The six work streams are explored more in Table 6 below in terms of how each will deliver against the four national conditions, the three primary purposes of the new iBCF grant and how they link to the various delivery themes within the High Impact Change Model approach to reducing Delayed Transfers.

Table 6: BCF Coventry Programme Planned Workstreams

Coventry Better Care Fund - Provisional Planned Workstreams 2017-2020						
BCF Workstreams 2017-2020		National Conditions	Primary Purpose	Link to High Impact Change Model	Contribution to Metrics	Notes
1	Targeted Prevention	i, ii, iii	Reducing Pressure on NHS & Meeting Social Care Need	Enhancing Health in Care Homes	Non-elective admissions, Delayed Transfers	Including Public Health, Mental Health & Voluntary Sector initiatives
2	Improving Whole System Flow	i, ii, iii, iv	Reducing Pressure on NHS	Systems to monitor flow	Non-elective admissions, Delayed Transfers	CCG develop and lead a circa 18 month project.
3	Discharge Support	i, iii, iv	Supporting Discharge	MDT's, Early Discharge Planning, D2A, Trusted Assessors	Delayed Transfers, Effectiveness of Reablement, Admissions to Residential	Continuation of investment in D2A
4	Community Promoting Independence	i, ii, iii, iv	Meeting Social Care Needs	MDT's, Early Discharge Planning	Effectiveness of Reablement, Admission to Residential	To support people in their own homes by providing short term 'step up' support
5	Integrated Commissioning and Improving Programme Management	i, ii, iii, iv	Capacity to Deliver Workstreams	N/a	N/a but enabling of those above	Support BCF for programme and various joint commissioning projects underway
6	Protecting Social Care	i, ii, iii	Meeting Social Care Needs & Sustaining Provider Market	Discharge to Assess	Non-elective admissions, Delayed Transfers	Sustaining social care and meeting additional demand previously met through council reserves

National Conditions
i Jointly Agreed Plan
ii Social Care Maintenance
iii NHS commissioned 'Out of Hospital' services
iv Implementation of the High Impact Change Model for Managing Transfers of Care

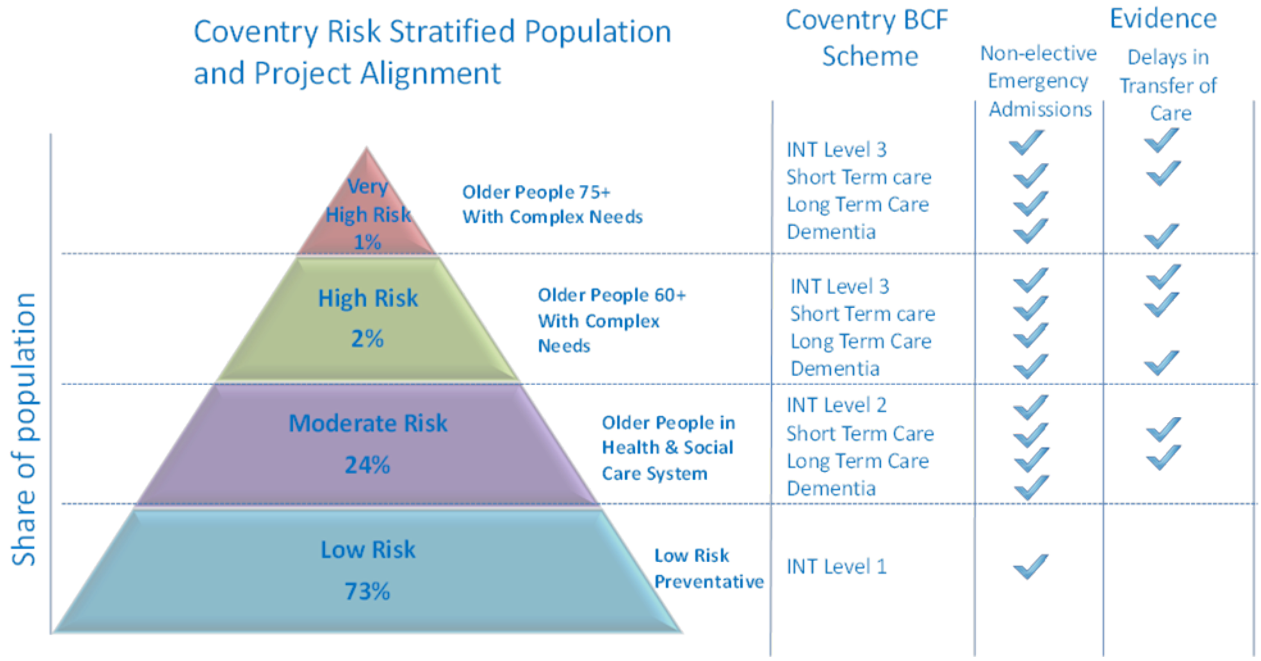
Population health risk and stratification

Identification and case management of patients with current long term conditions and at risk of developing or exacerbating a long term condition is key to delivering the key aims and objectives of our transformational plans, by providing appropriate care in appropriate settings and reducing the reliance on hospital services and ongoing social care support. These should, in turn, reduce A&E attendances, subsequent non elective admissions, reduce discharge delays (through enhanced supported discharge and appropriate reablement packages) and reduce the need for long term care and residential home admissions through better patient centred support and self- management of their conditions.

Patient experience of services should also improve due to better facilitation of their treatment, 'telling their story' only once due to integrated patient records, seamless joined up services between community, social and acute care and less time spent in hospital.

We have previously matched our on-going projects to these high risk cohorts as well as focusing effort on keeping lower risk people out of hospital:

Diagram 12: Risk Stratification Model in Coventry



Coventry has a total population of 345,400 (ONS, 2015) of which around 49,500 (14.3%) are aged over 65. The risk pyramid shows within this age group in Coventry, circa 500 are at very high risk of a non-elective (emergency) admission to hospital, 1000 are at high risk, and 12,000 present a moderate risk and the majority (36,000) a low risk.

The current INT service operating across Coventry focuses on patients identified in the top 3 levels of the pyramid through GP practice risk stratification tools, face to face patient assessments and referrals from hospital, community and social care discharge teams. The INT multi-disciplinary teams assess referrals and review patients to agree how best to manage their health and potential long term conditions to keep them in their own homes and

mitigate the need for hospitalisation. If case managed patients' conditions do exacerbate the patient is referred to out of hospital rapid response and 'step-up' services and only conveyed to hospital if absolutely necessary. Patients can then receive the treatment required in a more appropriate setting and return to their own home more quickly and safely.

Developing the Frailty and Musculoskeletal pathways are key work streams within the Coventry and Warwickshire STP and the progress to date made through existing Better Care projects have been aligned to the wider system footprint during the last year.

Further analysis of the flow of patients through the whole system is planned to fully understand where services can be improved, to deliver better patient outcomes, and the extent of financial efficiencies that can be made. Proposals are being developed and reviewed through the BCF and STP Programmes and iBCF resources have been targeted at this important piece of work however actions and timescales are yet to be confirmed.

National Conditions

National condition 1: jointly agreed plan

The local health and social care system benefits from good working relationships between the council and NHS partners with well established relationships at senior levels which are open and honest and work positively towards collective perspectives and joint approaches to local issues.

Since the implementation of the Better Care Fund (BCF) in 2015, the Council and CCG have a BCF plan facilitated by the Health and Wellbeing Board supported by a section 75 partnership agreement.

The current Coventry BCF plan has been jointly developed and agreed through the following committees with various drafts and summaries of the plan and the financial template shared for comment and amendment:

- Coventry & Rugby Clinical Commissioning Group Executive
- Coventry City Council Cabinet and Full Council
- Coventry Health and Wellbeing Board of which the member organisations are:
    - *Coventry and Rugby Clinical Commissioning Group*
    - *Coventry and Rugby GP Federation*
    - *Coventry and Warwickshire Partnership Trust*
    - *Coventry City Council*
    - *Coventry Healthwatch*
    - *Coventry Safeguarding Children's Board*
    - *Coventry University*
    - *NHS England*
    - *University Hospitals Coventry and Warwickshire*
    - *Voluntary Action Coventry*
    - *Warwick University*
    - *West Midlands Fire Service*
    - *West Midlands Police*

Additionally the plan has been communicated to and discussed with:

- Coventry Adults Joint Commissioning Board
- Coventry and Warwickshire Collaborative Commissioning Group
- Coventry Accident and Emergency (A&E) Delivery Group
- Coventry and Warwickshire A&E board
- Better Care, Better Health, Better Value (formerly STP) board

The plan is also aligned to, and overlaps considerably with the wider Coventry and Warwickshire STP.

National condition 2: social care maintenance

An important element of the wider BCF and the specific iBCF grant provision is to support the sustainability of social care provision. This reflects the recent ongoing pressures on Adult Social Care as a result of reductions in local government funding and the impact this has had on the wider city council resources.

It is also recognised that the City Council has put significant sums from its own reserves or savings delivered elsewhere across its operations into sustaining social care and delivering its statutory responsibilities. For 2015/16 and 2016/17 social care overspend by £5.2m and £3.4m respectively and has delivered savings of approximately £6m since 2015/16.

There are continuing significant market cost pressures associated with the national living wage and also as a result of recent HMRC guidance on sleep-ins.

In recognising these pressures on social care the CRCCG have transferred to the local authority the various sources of funding identified nationally to protect adult social care as outlined in the previous BCF guidance.

The proportionate spend of the BCF pooled budget against each of the local services and new initiatives has been a matter for local determination between Coventry City Council (CCC), and the Coventry and Rugby Clinical Commissioning Group (CRCCG) in consultation with other partners. As such the proposals put forward in the BCF plan represent a combination of additional capacity required to improve the effectiveness of health and social care, sustaining existing capacity and schemes that will further improve the system and contribute to longer term sustainability beyond the current two years for which the BCF Plan applies.

Both CCC and CRCCG are committed to a joint commissioning approach that develops and maintains a modern and responsive market providing care and support for people and their carers when and how they need it and is underpinned by a commitment to:

- Provide high-quality, affordable and personalised care and support
- Promote and improve wellbeing, independence and individual outcomes through person-centred care
- Empower individual decision-making, control and ownership over care and support needs and options
- Shape and enable range of sustainable and flexible care services for the future that provide real choice for the local population

For residential and nursing homes, commissioning work in underway jointly to deliver a more stable and joined up contractual basis for this important element of the market. Although the provider market has remained relatively stable with only one closure of a care home since 2015/16 the number of providers seeking additional resources has increased and is expected to rise further.

This process will continue but is expected to be put under increasing pressure as a result of market forces. The additional resources available through the iBCF will support the City Council in meeting these costs without further impacting on the need to use reserves to support social care as a result of incurring significant overspends

A failure to meet these growing cost pressures within the local market will potentially result in the social care provision becoming unsustainable, resulting in closures and having a direct impact on the capacity within the health and social economy. This in turn could result in more delayed transfers of care and possibly more admissions to hospital if providers were forced to withdraw services at short notice and where no alternatives sources of provision were readily available.

Activity is currently underway to review and update Coventry's Market Position Statement (MPS) within the next 12 months, for which the intention is to develop a combined health and social care picture of the local market. CCC and CRCCG commissioners have recently began working within integrated project teams across core areas of provision; care for older people, community and preventative care, learning disability and autism services, and support for people with mental-ill health. This will enable a growing focus on developing a common insight on demand, provision trends, capacity, market gaps and commissioning intentions that will inform a refreshed MPS.

National condition 3: NHS commissioned out-of-hospital services

A significant amount of 2017/19 BCF investment (**£35.6M or 40.3% in 2017-18**) is aimed at keeping people well and out of hospital.

Agreement of the areas and services to be developed out of hospital has been driven through robust patient data and trend analysis to understand how and why our population use our acute hospital services as opposed to other services available in the City and also through evaluation of the current out of hospital services we have in place. Identification of gaps in services have led to a prioritisation in investment in order to service our population in the most appropriate settings for our frail elderly, who have a significant number of support needs and put the most pressure on our health and social care services.

The BCF plan is committed to investing in out of hospital services to empower our population to not be reliant of health and social care and to seek alternatives to hospital through better awareness of alternatives. Where individuals have more complex needs, proactive case management will ensure a co-ordinated package of support to maximise well-being and avoid exacerbations and hence unnecessary hospital admissions.

A prime focus for 2017/19 will be the implementation of the recently agreed Coventry & Warwickshire clinical model for Out of Hospital Care. A single point of access will provide a single referral route into all adult community services, with signposting into the most appropriate service. Community staffing (health and social care) will be reconfigured around

clusters of GP practices covering a neighbourhood population of circa 30-50k. A single neighbourhood team approach will be encouraged, reducing hand offs between different professionals and enabling the workforce to be deployed more flexibly. The focus of the neighbourhood teams will be to encourage healthy lifestyles, facilitate self-care, promote the use of community assets and provide personalised care to those with more complex and long term needs.

We envisage that we will contract for Out of Hospital Care through a lead provider contract (subject to final Governing Body decision) with a percentage of payment linked initially to achievement of transformation milestones and ultimately to delivery to improved outcomes. There is an OOH commissioning Board in place along with an OOH design board to progress this work across the three Coventry and Warwickshire CCGs and the two local authorities (Coventry and Warwickshire).

During 2016/17, the BCF invested in a GP-led Frailty service to work within the local Acute hospital, case finding at the A&E front door, deflecting patients into alternative community pathways where possible, and working with wards to facilitate earlier discharge and providing proactive follow up to prevent readmissions. Over the next twelve months we will work closely with the GP team to ensure that the benefits of this substantial investment (£1.5m) is maximised.

We will also build on the work started in the winter of 2016 to improve discharge pathways, with health and social care colleagues working together to ensure individuals are assigned to the pathway that is most appropriate to their needs, whether this is early discharge home with a short term support package, intensive reablement to ensure independence is maximised or a short stay in a nursing home where long term care needs can be assessed.

We expect these work programmes in combination to support the achievement of:

- Reduced A&E attendances
- Reduction in Non-Elective admissions (NEAs)*
- Reduction in Readmissions within 30 days
- Reduced Delayed Transfers of Care (DToC)
- Reduced hospital length of stay
- Reduced permanent admissions to residential care

*Our Out of Hospital work programmes are intended to deliver the reduction in NEAs as planned within Coventry and Rugby CCGs 2017/18-18/19 Operational plan (recalibrated). These plans are seen as challenging enough to deliver so no further reductions are being planned specifically for BCF, and no additional financial contingency for non-achievement of this is therefore required.

National Condition 4: Managing Transfers of Care

The health and social care system in Coventry has adopted the 'High Impact Change Model' which identifies eight areas of change that can help local systems to ensure people do not stay in hospital for longer than they need to. There has also been significant work with ECIP (Emergency Care Improvement Partnership) to deliver improvement in this area.

Significant progress has been made in implementing the high impact change model in Coventry and this is overseen by the Coventry and Warwickshire A&E Delivery Board. The iBCF funding is intended to support acceleration in the delivery of the 'High Impact Change Model' across the wider health economy where this is likely to result in benefits for both health and social care and within the Coventry plan there is resource specifically identified to invest in work to improve flow. While also focusing on the achievement of the NHS target that delayed transfers must make up no more than 3.5% of occupied bed days by September 2017.

The current Coventry position in respect of each area of the model is as follows:

- **Early discharge planning**: Preoperative assessments are now in place and social care are notified via a joint assessment form.
- **Systems to monitor patient flow**: Revised discharge pathways are now established that enables patients to be tracked. Additionally a 'red to green' initiative is being implemented to embed a 'no lost days' culture.
- **Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector**: Multi-disciplinary teams are established for people who have been discharged into short-term services which have third sector representation e.g. Heart of England Carers Trust.
- **Home first/discharge to assess**: A focus on returning people 'home first' is in place alongside a range of other provision to be used based on people's needs.
- **Seven-day service**: The hospital social work team is present in UHCW on Saturdays and bank holidays. Other constituent parts of the system are now being put in place to facilitate discharges over the whole weekend.
- **Trusted Assessors**: Trusted assessor arrangements are in place for home support providers and residential homes providing discharge to assess resources.
- **Focus on choice**: The consideration of long term options for individuals are being made outside the hospital setting where people are more aware of the available options and their likely ongoing needs.
- **Enhancing health in care homes**: The CRCCG have employed a care homes nurse to support local residential homes and initiatives such as 'React to Red' are showing benefits through reduced pressure ulcers.

Some of the proposals described above will further the delivery of the model by increasing the 'Discharge to Assess' capacity which is often a barrier to effective discharge. As implementation of the model progresses locally additional iBCF resources will be utilised where appropriate to ensure the model continues to be delivered and that patient/service user benefits are realised.

Discharge to Assess

There has recently been considerable focus by partner organisations within Coventry on improving the process and approach to hospital discharges. This is in the light of the rising level of delayed transfers of care and the variety of discharge pathways that previously existed across the health and care system, as shown in Table 7 below.

Table 7: Previous Coventry Discharge pathways

Pathway A	Pathway B	Pathway C	Pathway D	Pathway E	Pathway F
Voluntary Sector Support at Home	Home with Short Term Package of Care : With or without Therapy	Bedded Unit with Therapy with the aim to return home.	Social Care increase in existing Services	Period of Assessment	Fast Track : less than 8 weeks of life
Support to ensure patient safe and well. No personal care involved. Support may include; shopping, transport home, safe and well-being check. Options are; • 4hrs post discharge. • 7 & 30 days *Provider gate keep access to provision*	Home based support for up to 6 weeks to regain independence which includes goal based enablement: washing, dressing, meal preparation. In addition therapy based support to improve mobility and transfers to regain independence. Telecare: Std packages *Social Care gate keep access to provision*	Bed based support for up to 6 weeks to regain independence which includes goal based enablement: washing, dressing, meal preparation. This pathway is also for patients where safety between calls and overnight needs to be considered. In addition therapy based support to improve mobility and transfers to regain independence. *Social Care gate keep access to provision*	Existing Social Care service users that may need an increase to their existing package or placement to return home *Provider management by Social Care*	Patients that require a period of assessment outside of an acute setting to determine their long term care and support needs. Options are; • Home (POC) • Residential Home (Recovery & Recuperation) • Nursing home • Unstable Fractures • Non Weight Bearing (NOF) • CNRT *Provider management by CCG*	Patients who are in the last 8 weeks of life Options are; • Home (POC) • Residential Home • Nursing Home • Housing with Care *Provider management by CCG*
Case Manager: Ward	**Case Manager**: IDT / React / Social Care	**Case Manager:** IDT / React / Social Care	**Case Manager**: Social Care	**Case Manager:** IDT / Social Care with CCG	**Case Manager:** IDT / Social Care with CCG

The process that was in place was creating a range of issues all of which impacted on the ability to control delayed discharges.

- Duplication of assessment
- Inconsistency
- Communication
- Family expectation
- Culture
- Technology

It has become apparent from the experiences and results provided by early adopters that establishing a 'Discharge to Assess' process improves patient flow through the system, brings a number of benefits for the patient and the family, and removes many barriers that have delayed discharge in the past. Moreover it has allowed the establishment of closer links with community colleagues, and facilitates a timely and safe transfer of care between hospital and home as soon as patients no longer require acute hospital care.

Therefore a redesign and streamlining project has recently been completed that has involved participation, experience and expertise from all the partner organisations within the existing process. This is delivering a number of significant benefits:

- Established robust working relationships across Health & Social Care economy
- Redefined and clarified access criteria for each pathway
- Trialling various documentation
- Robust checks & balances across each organisation
- Opened access routes to all pathways for all organisations
- Working towards trusted assessment
- Working towards reducing referral to discharge time

This means patients no longer have to wait in hospital for assessments, and are impacting on levels of delays by removing steps, handovers and activities within the discharge process which consume valuable resources and do not add value for the patient.

Table 8: Coventry & Rugby Discharge to Assess Model

Pathway 1	Pathway 2	Pathway 3
Home with short term package of Care: With or without Therapy	**Therapy based bedded units** in care homes and HWC with the aim to return home.	**Period of Assessment** to determine long term needs
Home based support for up to 6 weeks to regain independence which includes goal based enablement: washing, dressing, meal preparation. In addition, therapy based support to improve mobility and transfers to regain independence. Telecare: Std packages *Social Care gate keep access to provision*	Bed based support for up to 6 weeks to regain independence which includes goal based enablement: washing, dressing, meal preparation. This pathway is also for patients where safety between calls and overnight needs to be considered. In addition, therapy based support to improve mobility and transfers to regain independence. *Social Care gate keep access to provision*	Patients that require a period of assessment outside of an acute setting to determine their long term care and support needs. Options are; • Home (POC) • Residential Home (Recovery & Recuperation) • Nursing home • Unstable Fractures • Non Weight Bearing (NOF) • CNRT *Provider access and management by CCG*
Case Manager: IDT / React / Social Care	**Case Manager**: IDT/REACT/ Social Care	**Case Manager:** IDT / Social Care with CCG

The implementation of the new process shown in Table 8 above has enabled existing teams to establish clear roles and responsibilities by working more closely to provide an accurate and precise assessment of the person's needs, the recommendation of a discharge pathway and to collate any specialist reports and treatment plans including Therapy.

Once the pathway is confirmed a Case Manager is required to liaise with patient and family/advocate to manage expectations and to update all parties on progress/issues.

Additionally the team is able to receive or carry out a review of the patient on a daily basis and update colleagues if the patient has improved as the pathway may need to change. Finally this provides the appropriate integrated process to ensure that equipment, prescriptions and transport are all ordered and in place to meet the agreed discharge date.

Weekly data is now provided to the Coventry A&E delivery group to demonstrate the utilisation of capacity across the D2A pathway and the numbers of people delayed waiting for pathway capacity.

Delayed transfers of care (DTOC) plan (High Impact Change Model)

Impact Change	Where are we?	What we intend to do next?	When by?	How we will measure success?
Early Discharge Planning	Established - discharge dates within 48 hours of admission, Nugensis system to monitor dates and assist with Red to Green Safer approach across the Trust. Trust wide view on patient status available to Managers to oversee issues by department.	Extend the work of early discharge planning into the community for onward flow through community, LA, Residential Home, and Nursing Homes - facilitated by community Red to Green initiative. Workshops already held.	Sep-17	Reductions in volume of patients identified as MFFD, and reduced DTOC level, reduced patients in hospital over 7 days, and reduced Excess Bed Days resulting from DTOCs. Fewer issues in relation to onward flow from hospital as capacity availability becomes predictable.
Systems to monitor patient flows	Established - Pathways agreed, regular point prevalence surveys to compare demand against capacity, daily report on referrals and discharges across teams and organisations, revised pathway protocols developed via joint workshops across agencies IDT, CCG, CHC, LAs, GPs.	Dashboard to be in use operationally, and monthly reports up to and through local A&E delivery Board to review constraints in the system, for action.	Jul-17	No CHC assessments taking place within the acute hospital (other than fastrack). No patients identified without a management plan in place and agreed within 24 hours of referral to discharge pathway.
Multidisciplinary Discharge Teams	Mature - in place, trusted assessors within the local organisations and between teams, larger RH / NHs accepting trusted assessments outside hospital.	Continue to develop trusted assessor model to cover majority of RH/NHs, work with other areas on cross boundary flow to ensure trusted model can be adopted as widely as possible.	Sep-17	No duplicate assessments taking place. Reduced need for escalation across organisations operationally.
Home First / Discharge to Assess	Mature - People return home with reablement support from integrated team, most people return home or go to supported care in RH/NH before assessment of future care needs. No CHC assessments inside hospital, clear pathways for Discharge to Assess with dedicated capacity, based around demand from point prevalence surveys, and daily weekly monitoring.	Work to embed CHC work being taken back from CSU within the CCG, to ensure onward case management of patients in D2A capacity, and early onward movement.	Aug-17	No CHC assessments taking place within the acute hospital (other than fastrack). No patients in D2A pathways having final option assessment outside timescales set for pathway - i.e. no one in D2A capacity beyond 6 weeks of initial placement. Reductions in average length of stay especially in pathway 2 placements.
Seven Day Services	In place - Health and social care working to 7 day pattern, plans in place to get assessment in hospital from RH/NHs some do this already (larger ones), part of revised contract specification for 2017/18 with homes.	Seamless provision of care regardless of time of day or week - working with all organisations to have common SOPs that are in place 7/7.	Mar-18	Discharges at weekends at least 60% of normal weekday discharges, admissions from RH/NH equalised across the week, matched with discharge back on day identified in EDD.
Trusted Assessors	Established - assessments some by different organisations and resources committed, development of care prescription in liaison with homes, so that payment based on patients needs rather than type of home, reduces time to assess and the needs for separate assessment and negotiation on prices.	Continue to develop trusted assessor model to cover majority of RH/NHs, work with other areas on cross boundary flow to ensure trusted model can be adopted as widely as possible.	Sep-17	No duplicate assessments taking place. Reduced need for escalation across organisations operationally.
Focus on Choice	In place - admissions advice and leaflets in place, choice protocol developed by the Trust, choice occurs outside hospital in the main especially on pathways 2 and 3, rehabilitation support, and potential ongoing care needs.	All patients aware of choice directive and that they do not have the right to remain in an acute setting longer than they need to for clinical reasons, and that onward placement prior to final choice decision is recognised by patients and their families.	Sep-17	Fewer DTOCs related to patients choice issues.
Enhancing Health in Care Homes	Established - new care prescription as part of new contracts with RH/NHs, with clear timescales for responding and reducing the need for separate assessment, dedicated support to residential and nursing homes especially linked to pathways 2 and 3.	Working to ensure that all new contracts for placement and assessment are under the new contract specification. Clinical support to NHs consistent with clear expectations of what this support means in practice, simplifying how primary and community providers interact with RH/NHs.	Aug-17	Less short time admissions from RH/NHs as they feel supported to maintain that patients in the home.

How the previous National Conditions will be maintained.

Previous National Conditions from Better Care Fund 2016-17	Continuing plans to meet condition?	Actions that are being taken to meet the condition, or any other relevant information.
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes	Urgent Care Primary Assessments - These allow for the safe treatment of patients either in their own home, or to be treated and discharged by A&E where the patient might otherwise have required a hospital admission. Some services now actively support the facilitation of weekend discharges. Expanding 7 day working across the system is integral to the Coventry and Warwickshire STP and will be further developed through this programme.
ii) Better data sharing between health and social care, based on the NHS number	Yes	The 'Digital Coventry' Programme is well underway which includes a number of Inter-operability solutions between partner organisations across the city. The Black Pear system to share key patient data, is to be launched in 2017/18 to support INT, frailty and End of Life patient care.
iii) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes	Full coverage of INT in place across Coventry to support complex patients with multi-disciplinary primary care and community teams working together across health and social care. Three discharge to assess pathways have been agreed and implemented which are supported by a multidisciplinary team based at UHCW.
iv) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes	This plan has been shared with, commented on, updated and agreed by providers represented at the A&E Deliver Board and Health and Wellbeing Board as part of the governance and approval process, also feeds into the Sustainability and Transformation Plan. Healthcare provision contracts have been jointly agreed between commissioner and providers for 2017/19, with implications for providers acknowledged. Engagement and buy-in of both commissioners and providers is now embedded across the local economy through the forums already described in this document – Health and Wellbeing Board, A&E Delivery Board, Joint Commissioning Boards.

Overview of funding contributions

Additional funding priorities

All the specific funding allocations as requiring by the planning guidance have been incorporated in the completed Financial Planning template. However the Care Act 2014 introduced significant changes to Social Care legislation in April 2015 including the introduction of a national eligibility threshold; a new duty to carry out assessments for all carers regardless of the level of care provided, and an expanded role in market shaping.

Enhancing the way we work with customers and carers has been at the heart of our response to the Care Act 2014. Work has progressed on reducing waiting lists and completion times for assessments, and there has been a marked improvement in both the number of people waiting and timescales. This has focused on social worker and team leader performance and through-put including setting out clear expectations, in terms of both professional practice and the contacts they have with the people they are working with.

Some services that were previously considered carer support (short breaks and respite) are now being classed as support for the cared for person, as receiver of the service.

Coventry has developed a Multi-Agency Carers Strategy with partner organisations which covers the period 2016-19 and relates to carers of all ages. The Strategy is accompanied by a comprehensive implementation plan which is overseen by the multi-agency Carers Strategy Steering Group. Key improvement priorities within the plan fall under four areas:

- Identification and Recognition
- Realising and Releasing Potential
- A Life alongside Caring
- Supporting Carers to Stay Healthy

We will also be building on and complementing the short term services which enable people to be discharged from hospital, we have developed plans to enhance our service which helps people living in the community who have lost the capacity to carry out tasks of daily living. This focuses on helping people to regain skills and confidence in living independently and reduces their reliance on long term support services and the risk of being admitted to hospital or other care setting. The service will operate using dedicated occupational therapy and social work staff who will support people through the service.

Our approach to the targeting of the increased Disabled Facilities Grant is to focus on improving the environment for people living with dementia following research by the University of Stirling which shows that using effective dementia-friendly design can result in reduced instances of violence and aggression, reduced falls, reduced staff sickness within the care environment, and improved way-finding for people with dementia. The DFG will also be used to support the shared aims of increasing independence within the community and the reduction of hospital admissions.

The spend at Scheme Level is shown in Table 9 below and further break down of this is available in the financial planning template:

Table 9: BCF Scheme Expenditure 2017-19

BCF Coventry Programme Scheme Name	2017/18 £m	2018/19 £m	Total Plan £m
Whole Population Prevention	0.300	0.500	0.800
Improving System Flow	0.200	0.300	0.500
Discharge to Assess Support	1.300	1.300	2.600
Community Promoting Independence	0.300	0.600	0.900
Integrating Commissioning – improving Capacity	0.200	0.200	0.400
Protecting Social Care	13.253	15.761	29.014
Care Act Implementation	0.883	0.900	1.783
Dementia	11.075	11.281	22.356
Disabled Facility Grants	3.901	3.416	7.317
Out of Hospital & Nursing Care	35.636	36.347	71.983
Short Term Care	9.853	9.604	19.457
Acceleration Fund	2.093	2.133	4.226
Urgent Care	6.587	6.712	13.299
Voluntary Sector Review	2.597	2.270	4.867
Total Schemes	88.178	91.324	179.502

Pooled Budget

The grant determination associated with the iBCF requires that the BCF is transferred into one or more pooled funds established under section 75 of the NHS Act 2006. In Coventry previous Section 75 partnership agreements were established to oversee the Better Care Funds expenditure in 2015-16 and 2016-17.

The purpose of these Partnership Agreements was to support the delivery of the Better Care Fund by setting out the governance and practical management arrangements specifically associated with the Better Care Fund pooled budget.

In extending the use of the existing pooled budget, which is created from allocations from Coventry and Rugby Clinical Commissioning Group and the Council, all statutory responsibilities are retained by both partner organisations. Progress on expenditure and budget positions will be reported through each organisation's existing financial reporting arrangements.

The regulations require that one of the partners is nominated as the host of the pooled budget and this body is then responsible for the budget's overall accounts and audit. In Coventry, it is agreed that the Council continues to be host for the Better Care Fund pooled budget.

The Partnership Agreement includes scheme specifications which will provide the detail for each work-stream including aims and outcomes, level of the pooled budget, the specific management arrangements and risk sharing.

Programme Governance

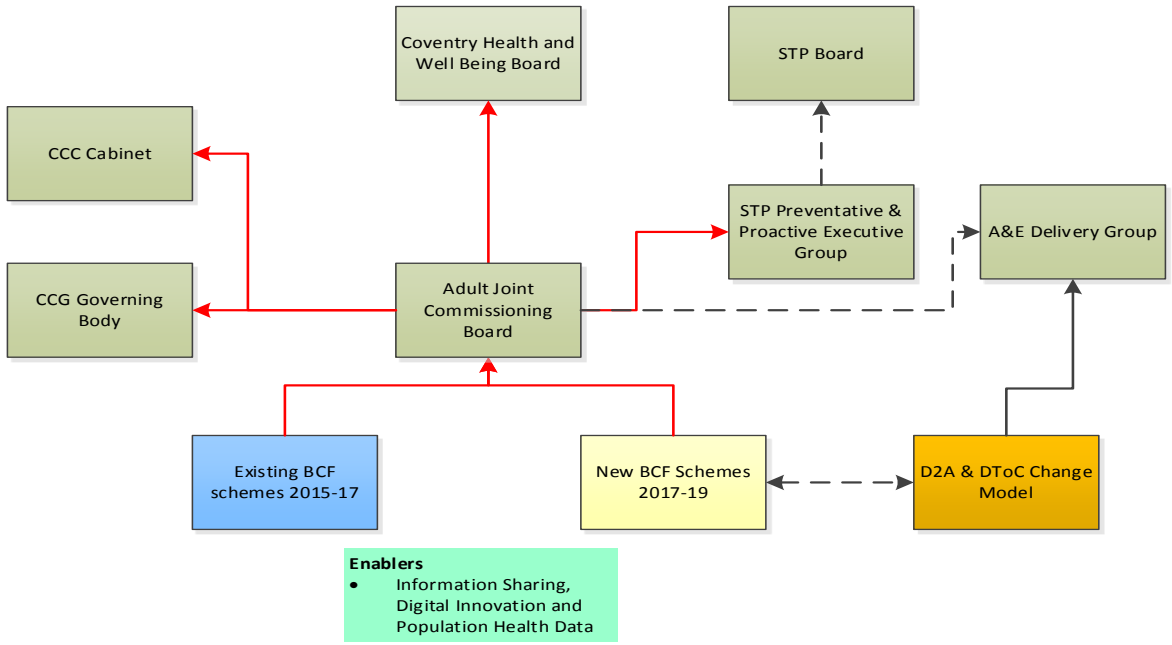
Since the implementation of the Better Care Fund (BCF) in 2015, the BCF plans have been approved through the Health and Wellbeing Board supported by section 75 partnership agreements with Coventry and Rugby Clinical Commissioning Group (CRCCG).

The Adults Joint Commissioning Board (AJCB), held every month, will take prime responsibility for the discussion of the progress on the BCF programme including benefits realisation and metrics plus the approval of specific business cases and new developments. The AJCB will be the operational delivery and decision making body for the BCF programme. Additionally AJCB will have a link to the A&E Delivery Board to ensure alignment with broader objectives and plans.

As the new improved grant and the associated projects and priorities are to align with the Proactive and Preventative workstream of the STP it is proposed that the existing STP P&P Executive Group is used as a regular oversight body rather than establish a separate BCF Board. However both the final BCF Narrative Plan and Financial Template will be ratified at the Coventry Health and Well-Being Board (HWBB) to ensure ultimate local system oversight. Additionally regular briefings will also be made as required to the HWBB as the various aspects of the current BCF plan are finalised, developed and implemented.

The relevant BCF funding decisions are approved by the Council's Cabinet and full Council plus the CCG's Governing Body.

Diagram 13: Coventry BCF Governance Hierarchy (red lines represent formal oversight links, dotted lines show operational alignments)



The governance arrangements put in place are to ensure that there is clear ownership of and system wide understanding of the process for reporting progress and performance on individual projects and the programme as a whole. The frequent cross communication between the BCF and STP programmes and also the activity and developments associated

with the High Impact Change model are essential to ensure an integrated approach to the transformation of the local health and care system.

Further interim arrangements for the quarterly reporting from local authorities to the Department for Communities and Local Government (DCLG) in relation National Condition 4 (Managing Transfers of Care) were issued on May 26th with the Quarter 1 return having subsequently been completed and submitted. The Quarterly reporting to the Secretary of State is also a requirement of iBCF providing central government oversight of the programme at a national level.

A key element of all governance arrangements will be performance against the National Performance Metrics associated with the iBCF. These are the following four indicators:

- Delayed Transfers of Care
- Non-elective admissions (General and Acute)
- Admissions to residential and care homes (ASCOF 2a Part 2); and
- Effectiveness of reablement - (ASCOF 2b Part 1)

We also plan to retain and monitor the local indicator reported in previous years.

- Sequel to Short Term Service (ASCOF 2d)

Performance as a system against each of these are shown in the previous BCF Performance 16/17 section on Pages 20 to 24 and the BCF Dashboard for the last financial year on Page 45.

Assessment of Risk and Risk Management

Governance and Risk log

Our Programme Plan and Programme Risk Register are being refreshed for 2017-19, with both of these being reviewed operationally and strategically at regular intervals as part of the routine work of the Adults Joint Commissioning Board and by the assigned Operational leads for each scheme. Additionally the individual schemes are also subject to delivery plans and risk mitigation and issue resolution. Major issues that impact significantly on the BCF programme as a whole or any aligned transformational programme activity will be escalated through the appropriate governance channels.

The main risks identified which may affect delivery of the BCF programme during 2017-19 are shown on the end of this section on Page 44.

Risk Sharing

The Better Care Fund was launched in 2013 as part of a government drive to integrate health and care. The resources covered by the BCF required the development of a Section 75 agreement which 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. In Coventry a total of £52m for 2015/16 and £56m for 2016/17 was pooled between the City Council and

Coventry and Rugby Clinical Commissioning Group (CRCCG) across a series of project areas.

The City Council is currently the host of the section 75 Partnership Agreement and it is agreed that this arrangement continues once the new BCF plan is completed and approved, the timescale for which is currently October 2017. It has been agreed by all partners there will be **no financial risk share agreement in place for 2017/19** within the Better Care Fund. While no specific risk share is in place the partner organisations will work closely together to mitigate against any financial impacts across the health and social care economy.

The risks of failing to reduce emergency admissions and delays to discharge are recognised and understood by all stakeholders. This is especially in the light of the potential review in November of the 2018-19 allocations for social care funding provided in the Spring Budget for areas that are poorly performing in terms of reducing delayed transfers.

However the overall assumed risk is similar to that considered in the two previous BCF plans where no risk share was put in place. As in previous years both the BCF metric and project performance will be regularly monitored and any appropriate resulting financial implications will then be managed as necessary.

These arrangements will be refreshed as part of the Section 75 Pooled Budget Agreement.

Non-financial risk

The impact on patient journeys and experience as a result of pressures on the front door and back door at the University Hospital can impact on the wider health and care system. There are also significant risks other than those directly related to the provision of acute services. For example, a failure to appropriately support carers will result in more people in long term support services. Similarly the failure to support people in the community in a way that enables them to maximise their independence risks the take up of on-going care and support and the potential for much greater lifetime system costs.

Delays to discharges affect patient flow through the hospital, reduce mobility and increase frailty or ill health, which can lead to readmissions and also have a negative impact on A&E waiting times and available bed capacity for patients requiring admission.

The use of long term care reduces capacity for new patients entering social care, and has a knock on effect on future discharges and care planning.

Acknowledged risks exist in trying to treat our population in ‘out of hospital’ locations because bed capacity in hospital may still be filled by other patients potentially requiring admission, at an additional cost to commissioners. As such we will continue to evaluate the impact of out of hospital investment on acute demand to mitigate this and to understand if our service redesign has been successful. As no financial risk contingency is currently in place we will need to address any issues when and if they occur as swiftly as possible.

Risk Log

A BCF Programme Risk Log has been developed to monitor and report progress against each identified risk as shown below in Table 10: Coventry BCF Programme Risk Log

Better Care Fund Programme 2017-19 - Risk Log

At: 04/09/2017

Ref	Name	Risk Description	Programme/Scheme	Category	Open/ Closed	Impact	Likely	Score	Mitigating actions	Mitigated Score
Programme-level Risks										
1	System Capacity	Not enough capacity in the system to deliver change. This may impact on timescales and delivery.	Better Care Programme	Capacity	Open	4	2	8	Identifying necessary resources to meet and deliver the change. System wide view of transformation to be taken. Funding of additional commissioning capacity through iBCF. (See other programmes).	3
2	Reduction in DToC	Failure to achieve reduction in DToC trajectory.	Better Care Programme	Metrics	Open	5	3	15	Implementation of High Impact Model and recovery plan in progress. Amended DToC trajectories agreed at A&E Delivery Board and submitted.	12
3	Reduction in Emergency Admissions	Failure to achieve reduction in non elective admissions.	Better Care Programme	Metrics	Open	5	4	20	Further analysis of reasons for admissions to focus resources on front door. New activity with link to Proactive & Preventative Workstream of STP.	12
4	BCF Budget	BCF Pooled Budget is significantly overspent.	Better Care Programme	Budget	Open	5	1	5	Joint monitoring of expenditure by quarter, potential for contingency allocation in pooled budget yet to be agreed.	4
5	Financial Pressures outside BCF	Financial pressure in the local system outside the BCF diverts resources away from programme.	Better Care Programme	Delivery	Open	3	2	6	Sufficient regular representation from all partners on the programme Board and individual project meetings. Governance and escalation processes in place.	3
6	Lack of commitment to the Plan	Not all Partner organisations accept the funding and work stream arrangements set out within the BCF plans.	Better Care Programme	Stakeholders	Open	3	1	3	A commitment and understanding from all partners to the agreed BCF plan and how this will fit into other system improvement programmes.	2
7	Agreement on Strategy	No agreement across local system on plan priorities or expenditure across system partners.	Better Care Programme	Stakeholders	Open	3	2	6	All Partner organisations contribute to a citywide vision and develop shared plans that will clearly set out how they will improve patient and service user outcomes in the short and medium term.	3
8	National Conditions	The 4 National Conditions are not met in full.	Better Care Programme	National Conditions	Open	2	2	4	Plans for how each will be met are detailed in the BCF Plan and will be monitored on a quarterly basis.	3
9	Provider Failure	Failure of local providers destabalise the market.	Better Care Programme	Provider Failure	Open	4	3	12	Market management and analysis to ensure potential local provider issues are understood and mitigated.	8
10	Strategic differences between health and social care	Funding and strategy differences materialise between health and social care organisations.	Better Care Programme	Stakeholders	Open	3	2	6	(Link to 7) All Partner organisations contribute to a citywide vision and develop shared plans. Extended footprint organisations are signed up to wider STP.	3
11	Section 75	Section 75 not completed/agreed on time.	Better Care Programme	Section 75	Open	5	2	10	Due to the nature of central government planning arrangements the Section 75 cannot be in place in time for the commencement of the pooled budget. Management & mitigation through agreed Governance arrangements	5
12	Changes in regulation or policy	A change in national regulation, policy or direction undermines the BCF/iBCF.	Better Care Programme	Central Government	Open	3	2	6	Lack of certainty following recent election outcome. Management & mitigation through agreed Governance arrangements	6
13	Benefits Realisation	Failure to deliver expected benefits of schemes/programme.	Better Care Programme	Delivery	Open	4	3	12	Recovery Plans being developed. Metrics being developed top track progress and take corrective action.	9
14	Plan fails audit assurance	Failure in programme governance or financial assurance.	Better Care Programme	Audit	Open	2	1	2	Management & mitigation through agreed Governance arrangements	1

National Metrics

A BCF dashboard report has been developed and is used to report progress against plan each month as shown below:

Better Care Coventry

Better Care Coventry Programme Dashboard

Prepared by: Mike Holden
Reporting Month: May 2017

Metrics for Coventry		BCF 14/15 Plan					BCF 15/16 Plan					BCF 16/17 Plan					Performance - Year End 16/17				
		Q1 2014/15 Plan	Q2 2014/15 Plan	Q3 2014/15 Plan	Q4 2014/15 Plan	Total 2014/15 Plan	Q1 2015/16 Plan	Q2 2015/16 Plan	Q3 2015/16 Plan	Q4 2015/16 Plan	Total 2015/16 Plan	Q1 2016/17 Plan	Q2 2016/17 Plan	Q3 2016/17 Plan	Q4 2016/17 Plan	Total 2016/17 Plan	Latest MAT, Month or Actual	% +/- 2015/16 Actual	Against Last Year	% +/- 2016/17 Plan	Against Plan
1. Non-Elective Admissions (General & Acute) All age per 100,000 population	Metric	10221	10333	10333	9845	10082	10039	9277	9677	8686	9324	9753	10050	9873	9699	9786	10598	4.2%	▼	8.3%	▼
	Numerator	8496	8589	8589	8292	33966	8455	7813	8150	7413	31831	8324	8577	8525	8375	33801	36179	4.2%		7.0%	
	Denominator	332492	332492	332492	336894	336894	336894	336894	336894	341389	341389	341389	341389	345400	345400	345400	341389	0.0%		-1.2%	
	Actual	*8480*	*7837*	*8175*	*7399*	*31891*	*7567*	*8862*	*9279*	*8998*	*34706*	*8983*	*9156*	*9182*	*8858*	*36179*					
2. Permanent Admissions of Older People per 100,000 population (ASCOF 2a)	Metric					700.8					586.1	646.8	646.8	639.5	639.5	639.5	608.4	-15.2%	▲	-4.9%	▲
	Numerator					342					290	80	80	80	80	320	301	-15.2%		-5.9%	
	Denominator					48803					49476	49476	49476	50043	50043	50043	49476	0.0%		-1.1%	
	Actual	*86*	*84*	*94*	*80*	*344*	*92*	*109*	*78*	*76*	*355*	*85*	*70*	*86*	*60*	*301*					
3. Older People discharged at home 91 days later per 100,000 population (ASCOF 2b)	Metric					83.5					86.5					80.0	85.2	6.4%	▲	6.4%	▲
	Numerator					284					294					272	109	N/a		N/a	
	Denominator					340					340					340	128	N/a		N/a	
	Actual					*75.0*					*80.0*					*85.2*					
4. Delayed Transfers of All Adults 18+ per 100,000 population (Linked to ASCOF 2c)	Metric	7028	7180	6684	6387	6753	6184	6060	5909	5662	5899	7232	6705	6177	5589	6372	8665	9.1%	▼	36.0%	▼
	Numerator	4550	4648	4327	4188	17713	4055	3974	3875	3758	15662	4800	4450	4100	3750	17100	1917	9.1%		34.5%	
	Denominator	258949	258949	258949	262301	262301	262301	262301	262301	265481	265481	265481	265481	265481	268369	268369	265481	0.0%		-1.1%	
	Actual	*4550*	*5805*	*6435*	*6317*	*23107*	*6705*	*4148*	*4561*	*5677*	*21091*	*5047*	*6205*	*5859*	*5889*	*23000*					
5. Patient/Service User experience (% extremely satisfied)	Metric										80.0					80.0	84.6	4.6%	▲	5.8%	▲
	Numerator										N/a					N/a	33	N/a		N/a	
	Denominator										N/a					N/a	39	N/a		N/a	
	Actual					*N/a*					*80.9*	*80.0*	*87.5*	*90.0*	*85.7*	*84.6*					
6. Local Metric - Sequel to short term service (ASCOF 2d)	Metric					70.0					65					70.0	66.9	2.9%	▼	-4.5%	▼
	Numerator					1016					N/a					N/a	836	N/a		N/a	
	Denominator					1451					N/a					N/a	1250	N/a		N/a	
	Actual		*59.3*			*70.0*		*58.2*	*68.1*	*66.2*	*67.2*	*60.3*	*68.2*	*70.2*	*66.9*	*66.9*					

▲ Above Plan/ LY ▶ Close to Plan/LY ▼ Below Plan/LY

On-going performance, delivery and the tracking of benefits and outcomes and issues is being reported through the production of timely and appropriate programme information and project briefings as part of the regular monthly progress updates to the Adults Joint Commissioning Board as part of the agreed governance arrangements as detailed in Diagram 13. The BCF Dashboard above is also used to monitor and escalate under performance to the A&E Board, which maintains ownership of the DToC and A&E Delivery plans, in order to enable actions as necessary in relation to local activity and process on Non-Elective Admissions and Delayed Transfers of Care.

The rationale for setting trajectories for the national metrics is detailed below:

National Metrics	**Rationale**
1. Non-Elective Admissions (General & Acute) All age per 100,000 population	Our Out of Hospital work programmes are intended to deliver the reduction in NEAs as planned within Coventry and Rugby CCGs 2017/18-18/19 Operational plan (recalibrated). These plans are seen as challenging enough to deliver so no further reductions are being planned specifically for BCF, and no additional financial contingency for non-achievement of this is therefore required.
2. Permanent Admissions of Older People per 100,000 population (ASCOF 2a)	Recent analysis for the West Midlands has shown that permanent admissions in Coventry are made at an older age and for a shorter period than regional comparators. Additionally the Service approval panel was reintroduced in 2015-16 to restore oversight of packages in conjunction with a cultural change which will shift emphasis towards alternatives to residential care. This recent trend in reducing permanent placements in care homes in favour of community based support wherever possible is therefore planned to continue.
3. Older People discharged at home 91 days later per 100,000 population (ASCOF 2b)	This has always been a problematic indicator to complete due to the Information Governance issues that prevent the sharing by UHCW of personal information on patients discharged to enable matching against social care records. This has necessitated the measure to be calculated using the data collated for the national SALT Return. However the underlying local system aim still remains to increase the percentage of service users' still at home 91 days after discharge.
4. Delayed Transfers of All Adults 18+ per 100,000 population (Linked to ASCOF 2c)	The target for the coming year will reflect the programmes of work to improve performance in this key area in conjunction with the DTOC trajectories that have been agreed through the Coventry and Warwickshire A&E Delivery Board comprising health and social care BCF stakeholders. See section on 'National Condition 4: Managing Transfers of Care (Page 29). The aim is therefore to reduce the rate of delayed bed days per 100,000 population in line with final NHSE expectations.

Targets have been agreed by Coventry and Rugby CCG for Non-Elective admissions and DTOC % of beds with Provider Organisations, with the latter converted to represent days of delay (see note below). The planned year end results for the other national and local indicators have been agreed with Coventry City Council.

The following table shows the currently agreed target figures for each national metric.

Table 11: National BCF/iBCF Metric Targets 2017-19

NATIONAL INDICATORS	Planned Activity 2017-18					Planned Activity 2018-19				
	Q1	Q2	Q3	Q4	Total/Target	Q1	Q2	Q3	Q4	Total/Target
Non Elective Admissions	9330	9426	9426	9220	37402	9188	9286	9286	9084	36844
Delayed Transfers of Care - Days Delayed	5857	4788	3684	3433	17762	3470	3508	3508	3432	13918
Admissions to Residential/Nursing (ASCOF 2a)	78	82	75	75	310	75	80	73	72	300
65+ Discharged still at home after 91 days (ASCOF 2b)	N/a	N/a	N/a	N/a	83%	N/a	N/a	N/a	N/a	83%

LOCAL INDICATORS	Planned Activity 2017-18					Planned Activity 2018-19				
	Q1	Q2	Q3	Q4	Total/Target	Q1	Q2	Q3	Q4	Total/Target
% Sequel to Short Term Service (ASCOF 2d)	N/a	N/a	N/a	N/a	73%	N/a	N/a	N/a	N/a	73%

- The Q1 2017-18 DToC activity figure is actual performance as per instruction from the BCF Support Team
- The NEA targets above are not the same as are pre-populated in the Financial Template as all CCGs have had to amend their 17/18 and 18/19 activity plans

Current DToC trajectories

The DToC targets by quarter detailed in Table 11 above reflect the recently revised NHS England DToC trajectories and the current overall recovery target will require a significant improvement in performance.

By planning to reduce the levels of delays attributable to the NHS plus maintaining the average levels of delay for both Joint and Social Care over the 12 months, the total rate of delays per 100,000 18+ population for Coventry will be below the expectation originally set by NHSE.

Table 12: Delayed Transfers of Care Trajectories (revised 19th September 2017)

Coventry	NHS Expected Rate per 100,000 based on Local Area Dashboard (July 4th)	Actual Average Rate per 100,000 18+ over last 12 months (June 16 to May 17)	NHS Expected % Reduction on Average over 12 months	Latest Proposed Rate per 100,000 for Trajectories	Proposed % Reduction on Average over 12 months	Proposed Equated to Days per average month	Proposed equated to Delays per day
Social Care	2	2.6	-23.1%	2.6	0.0%	218.9	7.2
NHS	8.4	17.4	-51.7%	7.8	-55.2%	654.8	21.5
Joint	5.3	3.4	55.9%	3.4	0.0%	285.8	9.4
Total	15.7	23.3	-32.6%	13.8	-40.8%	1159.5	38.1

Note on the reporting of Delayed Transfers

The DToC part of the NHS DTOC metric is 'total days delay reported in a month' rather than 'days per 100,000'. The figure is shown from the NHS Provider's perspective, delays in a particular hospital as a % of Occupied Bed Days (OBD) in that hospital, so if a HWB area is served by 4 hospitals it will receive 4 different performance scores for "DTOC as % of OBD". This is the metric that is increasingly the focus for the local system A&E Delivery Boards (driven by NHSE).

Additionally the OBD performance reported by a single NHS Providers is made up of both local system and out of area residents' delays. Therefore a reduction to 3.5% of OBDs is a matter for all of the Local Authority (LA) areas contributing to the OBD performance and not just Coventry i.e. Warwickshire, Leicestershire and Solihull etc.

However, DToC as included in the ASCOF (and BCF) looks at delays experienced by people who are residents of a single LA area, regardless of where they are delayed. Therefore the Coventry HWBB will only receive one score for "DToC per 100,000 population". This is the figure that LAs focus on because it most effectively reflects what is in 'their' control.

ANNEXE 1 - BCF 2017-19 Planning Work stream Outline Business Cases

Scheme 1

Targeted Prevention

Overview of the scheme and case for change

There is widespread recognition that the current model of social and health care is unsustainable as demand outstrips supply and the gap between the income for health and care services and the costs of these services widens.

This is not down to changes in demographics alone. Although people are living longer this has not been matched by similar improvements in people living longer in good health - so as a result we are spending more years experiencing ill health.

In addition, the burden of ill health is not felt equally – falling to a much greater extent on the most vulnerable and deprived in society. The challenge across health and social care is therefore to improve healthy life expectancy and reduce health inequalities to change the demand for services.

This initiative will focus on the promotion of improving health outcomes for the citizens of Coventry by reducing the risk factors in the population most likely to need both health and social care and links into the upgrade in preventative work within the STP to deliver long term sustainability.

This will involve a variety of interventions to change behaviour, reduce the impact on the health and social care system of preventable diseases and alleviate and/or delay the pressure caused by some long term conditions.

Evidence has shown that interventions that are made earliest in a potentially negative health outcome are the most likely to be effective. Moreover for many health problems in the population a combination of primary, secondary and tertiary interventions are needed.

The BCF supports the key themes of the Better Health, Better Care, Better Value programme and is also aligned in particular to the Proactive & Preventative Care workstream.

Acknowledging both the organisational nature and the significant overlap between existing and anticipated programmes of work, the Proactive and Preventative workstream has adopted the following intervention based model:

- Community Capacity and Resilience – this will change population health outcomes at scale to address how do we keep people healthy and prevent health risks arising. This will be aimed at the general population who are not in direct receipt of services.

- Prevention Framework – this will manage individual health risks by focusing on early intervention to prevent health risks turning into ill-health and where people have health problems to stop those health problems escalating to the point where they require significant, complex and specialist health and care interventions. This will be aimed at those who are ‘at risk’ and will take an early intervention/prevention approach.

- Out of Hospital – better well-being by putting people at the centre of their care through improving quality of live and enhancing people’s ability to have control over their lives by focusing on the whole person. This is aimed particularly for those individuals with long term conditions or with multiple health problems. This work will aim to take a transformational approach that focusses on care and support to allow people to maximise the quality of life and wellbeing rather than delivering specialist interventions.

These principles will be used to progress a number of preventative initiatives as part of the BCF programme specifically targeted at:

a) **Reducing isolation/loneliness** in older people

b) **Making Every Contact Count (MECC)** specifically aimed at points which will have the greatest level of impact on the metrics associated with BCF i.e. at care providers, at admittance, in GP surgeries and at discharge.

c) **Nutrition** linked to MECC above because good nutrition and hydration plays a protective role in various age-related conditions including cardiovascular disease and cognitive decline and can help to protect oral, bone and joint health and wellbeing in later life.

d) Implement a **Warm Homes Initiative** because cold can exacerbate existing long term physical health conditions, especially respiratory and cardio vascular disease, as well as mental health conditions, which result in increased GP and A & E attendances

e) **Improve Mental Health assessment** by increasing Arden Mental Health Acute Team (AMHAT) capacity in A&E in order to signpost and avoid hospital admittance.

These 5 areas are currently being developed to clearly identify the contribution each will be expected to make towards the BCF metrics and the improved performance of the local system as a result the proposed investment before final decisions are made.

Objectives

Objectives of this scheme are:

- Promote and innovate preventative approaches to healthy living and lifestyle choices that improve health and well-being across the City.
- Influencing behaviour and lifestyle changes for the whole population to maximise 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.

Deliverables

- A programme of health promotion and interventions targeted at the residents of Coventry
- Support for people to change lifestyle behaviours

Metrics

1. Non-Elective Admissions (General & Acute) All age per 100,000 population
2. Older People discharged at home 91 days later per 100,000 population (ASCOF 2b)
3. Delayed Transfers of Care All Adults 18+, Days of Delay per 100,000 population
4. Permanent Admissions of Older People to Residential & Nursing per 100,000 population (ASCOF 2a)
5. Health related quality of life

Governance

The scheme has governance arrangements in place through Adults Joint Commissioning Board to monitor progress of the project.

Benefits
Benefits for this scheme include: • Improved range of health outcomes • People encouraged to improve their lifestyle behaviours and live healthier lives • Help improve the quality of life for older people • Preventing / delaying re-entry to health and social care system • Reducing isolation and loneliness

Scheme 2
Improving Whole System Flow
Overview of the scheme and case for change
There is an increased emphasis on health and social care organisations working together to tackle the quality and productivity challenges that all systems are facing, and to ensure that care is 'genuinely coordinated around what people need and want'. Improving the flow of patients, service users, information and resources within and between health and social care organisations can have a crucial role to play in coordinating care around the needs of patients and service users, and driving up service quality and productivity. Poor flow is not only a source of significant waste and delay, but it can also be devastating for patients and service users and deeply frustrating for people working in health and social care. Recent flow-related initiatives in Coventry to date have focused on limited sections of the patient or service user journey, usually within hospitals. There is a need to look beyond the hospital and to give attention to every team, service and organisation that patients and service users encounter. Flow is not about the what of clinical or social care decisions, but about the how, where, when and who of care provision. 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. The concept of using flow to improve care has received increasing traction within the health economy, especially in relation to reductions in patient waiting times for emergency and elective care. This is of particular interest given some of the pressures across the health system in Coventry which is currently characterised by 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. This contributes to increasing social care activity overall and diverts capacity from responding proactively and early to prevent deterioration in the community. The need to shift activity to the 'front door' is accepted and understood by partners, however realising the shift in resources and activity to deliver this remains challenging. This is a large transformational change project which has value and importance across the Health and Care system in Coventry and following completion of the business case and specification, which will be led by the Clinical Commissioning Group, there is the need for additional resources to be allocated. This may lead to a formal joint decision to procure and engage the appropriate external expertise or alternatively provide an opportunity for partners to secure the appropriate skills and capacity

internally and so potentially increase the pace of delivery.

Objectives

Objectives of this scheme are:

- Understanding of the whole system.
- Establishing and managing the relationship between flow, quality and cost.
- An optimised system with co-ordinated activities and processes that facilitate effective health and social care delivery.
- Meet demand and speed up flow.
- An integrated health and social care system
- Effective use of resources and technology to support the delivery of integrated care.

Deliverables

- 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.
- Maximise preventative opportunities

Metrics

1. Non-Elective Admissions (General & Acute) All age per 100,000 population
2. Older People discharged at home 91 days later per 100,000 population (ASCOF 2b)
3. Delayed Transfers of Care All Adults 18+, Days of Delay per 100,000 population
4. Permanent Admissions of Older People per 100,000 population (ASCOF 2a)
5. A&E Attendances
6. A&E 4 Hour waits
7. Referral to Treatment times

Governance

The scheme has governance arrangements in place through Adults Joint Commissioning, A&E Delivery and Urgent Care Boards to monitor progress of the project.

Benefits

Benefits for this scheme include:

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

Scheme 3

Discharge Support

Overview of the scheme and case for change

The Discharge to Assess (D2A) pathway aims to help those who might need support on leaving hospital earlier, by arranging a care package to support them at home. The ward-based discharge assessments can be time-intensive and once the patient is medically fit to leave hospital, it can take significant time to get their home support in place.

The aim is to deliver care in a more appropriate setting and improve the experience of patients who no longer need the care of an acute hospital but are able to manage at home with support or in a residential setting.

By moving patients home when they are ready to be discharged from hospital, not only frees hospital beds for patients that need them, it also benefits the patient themselves as often we see patients health improve further once they are back in the comfort of their own home. They are then given appropriate support at home until a full assessment can take place and longer term care package implemented.

Currently a range of 'Short Term Support to Maximise Independence' (reablement) is available within the City as follows:

Pathway 1 - Home Based Support

- 1750 hours per week rising to 1,995 per week
- 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: -

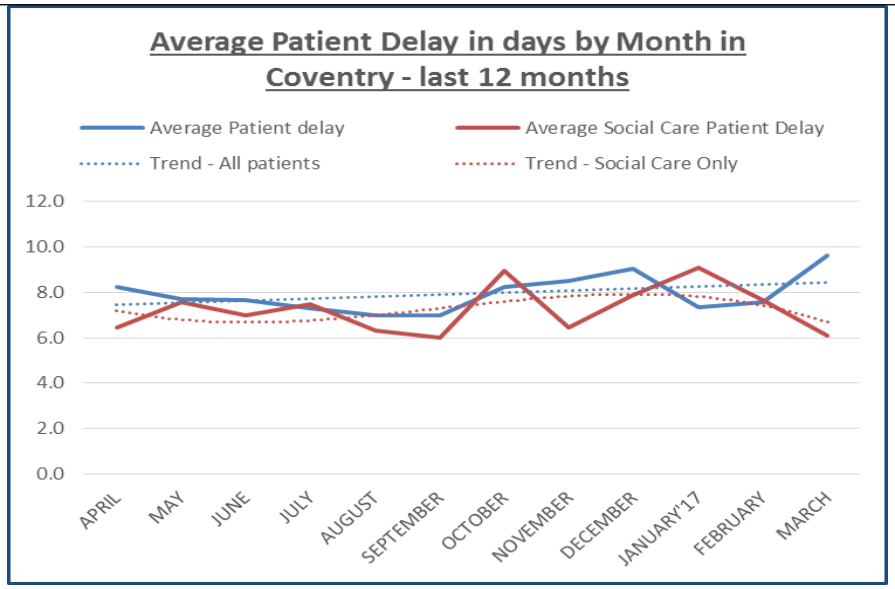
- 83 STSMI bed places
- 1850 home support hours which are block funded

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)

Improving the DToC performance has been a significant challenge to partner organisations across Coventry and Warwickshire and therefore the wider signatory organisations to the STP submission. In Coventry the most recent year end total for days delayed in 2016/17 exceeded that of 2015/16 by 9%. Following a peak in September there was a short period of reduction in the reported days of delay, however the latest figure for March (1565) reflects consecutive monthly increases since August. The delays attributable to social care and jointly with health have declined since the peak in early 2015 at the same time at the same time as those due the NHS have increased.

As such the average patient delay has been rising over the course of the most recent financial year, as shown in the trend graph below.



Source: Unify

During the 2016-17 financial year Coventry CCG have funded additional bedded capacity on a short term basis to meet the increased pressure on the D2A pathways with a plan to reduce this as more home based support became available.
However the increased demand has not abated and there is a significant risk in decommissioning the currently available bedded D2A capacity given recent discharge data for May 2017 shows utilisation of capacity as follows:

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

Given the extremely high occupancy levels it would seem prudent to maintain the D2A bedded capacity that is currently available as to remove beds from the system and therefore would increase delays.

This represents a commitment to maintain this service over the current BCF planning timeframe of two years but also the life of the iBCF funding settlement and does not include the commissioning of additional capacity.

This workstream will also include an element of contingency planning to cover winter pressures for the next two years.

Objectives

Objectives of this scheme are:

- Maintain D2A bedded and domiciliary based enablement capacity within the community
- Maintain system flow
- Reduce DToC
- Meet winter pressures

Deliverables

- Reduce number and duration of delays to a sustainable level
- Reduce length of stay for complex patients
- Reduction in excess bed day costs

- Work to understand and meet the capacity requirements for winter pressures

Metrics

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

Governance

The scheme has governance arrangements in place through Adults Joint Commissioning and A&E Improvement Boards to monitor progress of the project.

Benefits

Benefits for this scheme include:

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

Scheme 4

Community Promoting Independence

Overview of the scheme and case for change

There is a substantial promoting independence offer available for hospital discharge, however currently limited promoting independence services are available for use within community services, as these are almost completely focussed on 'step down' from hospital.

This forms the rationale for developing an additional Promoting Independence service which is planned to be in place later in 2017 with an aim to support people in their own homes by providing short term 'step up' support.

A business case has been developed to scope an "invest to save" model for community-based support which focuses on "step up" intervention rather than hospital discharge support. This will establish a community-based promoting independence service for older people, people with physical impairment and those with learning disabilities who are ordinarily resident in Coventry.

The 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 dependence upon long term care and support. In doing so, those people in receipt of the service will be less likely to have unnecessary hospital admission or admission to residential care.

Providing an increase in community-based promoting independence capacity, by putting in place the required resources to move these cases through the system, will enable savings and cost avoidance to be achieved.

There is an intention to deliver this service through the Gilbert Richards Centre with the development of Therapy rooms and facilities funded through the Disabled Facilities Grant.

The proposed approach is consistent with the requirement of Local Authorities to provide preventative services and promote wellbeing under the provisions of the Care Act 2014 and is aligned to the Adult Social Care Vision:

To enable people in most need to live independent and fulfilled lives with stronger networks and personalised support.

and

Effective enablement and prevention and wellbeing - We provide support to people in cost effective ways to enable them to reach or regain their maximum potential so that they can do as much as possible for themselves.

Anticipated Demand

The average number of ST Home Support hours per person is 20. Assuming people would receive the service for six weeks, approximately 2,640 commissioned hours per week would cover demand.

There will be approximately a maximum of 150 people in the promoting independence service at any point in time.

Potential Impact

The average number of people starting a long-term support package per week, from the community, without receiving a short-term service prior to this, was 22 per week over the 12 months between February 2016 and February 2017, or circa 1150 in total.

However approximately 50% of people who receive the current Short Term Home Support service do not require long-term support on exit.

Assuming that, as referrals will only be directly from social care staff, and not for people who are being discharged from hospital, it is estimated that between 10% and 50% of people who receive this promoting independence service will not require long-term support on exit.

Cost avoidance will be a combination of reduced numbers of people requiring long-term home support, and also, a reduction in the level of hours provided for those in long-term support.

This would result in potential cost avoidance as follows:

	10% reduction	**20% reduction**	**50% reduction**
Cost avoidance per week	£10k	£21k	£52k
Cost avoidance per year	£543k	£1,086k	£2,715k

Evidence shows that people that do go on to have a long-term package of support following a short-term service also require less hours - resulting in further cost avoidance as follows:

All Age Disability: £50 per week

Older People: £20 per week

	Based on 90% of people receiving a long-term service	**Based on 80% of people receiving a long-term service**
Cost avoidance per year	£28k	£25k

These are estimated figures based on an 'invest to save' model and there are risks associated with this as savings may not be realised and appropriate actions will be developed to mitigate these.

Objectives

Objectives of this scheme are:

- Promote independence
- Prevent or delay the deterioration of wellbeing and 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

Deliverables

- Community-based promoting independence model.
- Targeted, timely, goal focused interventions to support the potential for independence.
- Part of the service will be dedicated to people living with dementia or cognitive impairment.
- Reduce the dependence upon long term care and support.

Metrics

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

Governance

The scheme has governance arrangements in place through Adults Joint Commissioning Board to monitor progress of the project.

Benefits

Benefits for this scheme include:

- Timely and appropriate interventions
- Helps improve outcomes and quality of life for older people
- Promote and enable independence, choice and control
- More care and more support provided in people's own homes/the community
- Cost avoidance, based on a combination of reduced numbers of people requiring long-term home support, and also, a reduction in the level of hours provided for those in long-term support.

Scheme 5

Integrated Commissioning and Improving Programme Management

Overview of the scheme and case for change

This initiative looks at ways in which the capacity and ability to deliver change towards 2019/20 can be improved through a greater emphasis on instigating joint working across commissioning

organisations within Coventry.

This will focus on a collaborative approach to managing demand and market provision through pooling capacity, expertise and knowledge and minimising professional, cultural and organisational barriers.

Promote a culture that considers the individual's health, well-being, safety, independence and choice through shared commissioning intentions.

It is intended to recruit 2.5 FTE posts to work across the council and CCG 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:

- The effective engagement and deployment of combined resources across the system
- Ensuring that the appropriate knowledge, skills and experience are available to deliver the agreed system-wide transformation
- Joint working to manage and develop current and future health and social care provision.
- Optimise the financial commitments across the LA and CCG through the shared commissioning of services so enabling value for money service provision
- Improve the understanding and management of the provider market within the health and social care economy

Deliverables

- Project management and commissioning coordination
- Enhanced contract initiation and management
- Benefits management and realisation: defining, quantifying, measuring and monitoring benefits
- Stakeholder management and communications: ensuring that relationships are developed and maintained jointly
- Better knowledge, skills mix and potential co-location

Metrics

1. Work streams delivered to plan
2. BCF programme issues and risks mitigated
3. Reduced duplication of specifications

Governance

The scheme has governance arrangements in place through Adults Joint Commissioning Board to monitor progress of the project.

Benefits

Benefits for this scheme include:

- More effective management and coordination of limited resources
- Improved knowledge, expertise and capacity

- Enhanced stakeholder engagement
- Better market and contract management
- Economies of scale

Scheme 6

Protecting Social Care

Overview of the scheme and case for change

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.

This has resulted in fewer people getting help despite demographic trends suggesting increasing demand as councils have concentrated on the most vulnerable in society leading to growing concerns about rising levels of unmet need, the impact on carers (exacerbated by the welfare reform changes) and the cumulative pressures these will place on the NHS.

Ensuring that people who require Adult Social Care receive it in a timely and effective manner is critical to preventing further deterioration as well as helping to ensure that individual outcomes are met by creating social care capacity in order to meet the needs of the local population.

A significant element in the allocation of the iBCF grant is the recognition of the on-going pressures on Adult Social Care as a result of reductions in local government funding, the impact this has had on wider city council resources and the need to sustain provision.

Investing in Adult Social Care also means ensuring that the social care market is sustainable and that system capacity is not reduced or put at risk by local providers ceasing to operate as a result of financial failure or deciding to withdraw elements of uncommercial provision.

Objectives

Objectives of this scheme are:

- Maintaining capacity across the market to deliver safe, accessible and high quality care services.
- Improve the understanding and management of the provider market within the health and social care economy.
- Ensuring the best use of resources to enable sustainable value for money service provision
- Investment in community based preventative services and place based systems of care in line with STP priorities.
- Monitoring of the performance and finances of the most significant care providers within the local (and national) market

Deliverables

- Contingency planning - management of risks around service interruption and the potential financial failure of providers
- Early identification and avoidance of quality failings
- A care market that remains vibrant and stable

- Improved demand management

Metrics

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

Governance

The scheme has governance arrangements in place through Adults Joint Commissioning Board to monitor progress of the project.

Benefits

Benefits for this scheme include:

- Ensure a sustainable social care market
- Sound risk management
- Protection of difficult to replace services for the future as well as present day
- Maximise the independence of service users and reduce the uptake in long term services
- Focus on prevention and early intervention to reduce the Health and Well-Being gap, in line with the Marmot principles