Coventry City Council

Briefing note

To: Health and Social Care Scrutiny Board (5) **Date: 21.11.17**

Subject: Proactive and Preventative Update: Out of Hospital

1 Purpose of the Note

1.1 To inform Health and Social Care Scrutiny Board (5) of the current status of the Out of Hospital project, key areas of development and the progress expected to be made up until March 2019 (12 months after contract commencement).

2 Recommendations

2.1 Health and Social Care Scrutiny Board (5) is asked to consider the content of this report and make any comments that may assist the CRCCG and its health and social care partners in ensuring that future development of the Out of Hospital model is sufficiently robust to meet population needs.

3 Information/Background

3.1 The Out of Hospital (OoH) Programme represents a significant component of the Health strategy for CRCCG and the Coventry and Warwickshire Better Care, Better Health, Better Value Partnership Plan. It is an ambitious programme across Coventry and Warwickshire which aims to achieve integrated community services capable of meeting population needs, through using an outcome based commissioning approach.

3.2 The OoH programme was developed in response to national policy and engagement with local stakeholders, NHS Coventry and Rugby, Warwickshire North and South Warwickshire Clinical Commissioning Groups who recognised that the current approach to commissioning OoH services would not be sufficient to meet future service requirements or ensure the most efficient use of resources. Commissioners therefore have jointly undertaken a process that aims to transform the commissioning and delivery of OoH services across Coventry and Warwickshire.

3.3 Delivering the transformation required to make the out of hospital system truly integrated will require sustained effort over a number of years. Underpinned by extensive public, patient and stakeholder engagement the programme seeks to address the structural, cultural and professional barriers to delivering person centred care.

3.4 Following extensive work by commissioners to identify the scope and develop an initial outcomes framework for OOH Services, providers within the Coventry and Warwickshire

footprint were asked to develop a Service Model that would deliver the commissioners objectives as identified through engagement with stakeholders and the local population.

3.5 Coventry and Warwickshire Partnership Trust and South Warwickshire Foundation Trust (SWFT) have collaborated to develop a new operating model to support the future delivery of out of hospital services across Coventry and Warwickshire.

3.6 The process for the development of the model involved engagement of all stakeholders, patients, carers and partners between September 2016 and February 2017. Design Boards were established involving clinicians and professionals from all sectors alongside public engagement events held in both Coventry and Warwickshire to test and shape the emergent thinking.

3.7 In April 2017 the Coventry and Rugby CCG Governing Body formally adopted the Clinical Model presented by Providers. The OoH Programme Board then undertook a process to identify the type of contract and way of awarding the contract that facilitated collaboration and would deliver the required outcomes. In July 2017 the CCG Governing Body gave approval to progress the Coventry component of the OoH Programme by developing a lead provider contract with Coventry and Warwickshire Partnership Trust (CWPT) via a Direct Award for a period of three years.

3.8 The following CWPT contracted services are in scope for the delivery of the Out of Hospital model. There are a number of other services outside the contract which are integral to the delivery of this programme such as Primary Care, Social Care and Voluntary and Third Sector organisations:

- Coventry Urgent Primary Care Assessment admission avoidance
- Coventry District / Community Nursing
- Coventry Integrated Neighbourhood Teams
- Coventry Community Diabetes under CWPT
- Coventry Parkinsons Nurses
- Coventry Intermediate Care including Fast Response
- Domiciliary Care Health Care Assistants
- Coventry Physio
- Coventry Speech and Language Therapy - Adult
- Coventry Continence Services/advisors
- Coventry Tissue Viability

4 Brief explanation of the project

4.1 The OoH has a set of number of objectives to deliver, these being:

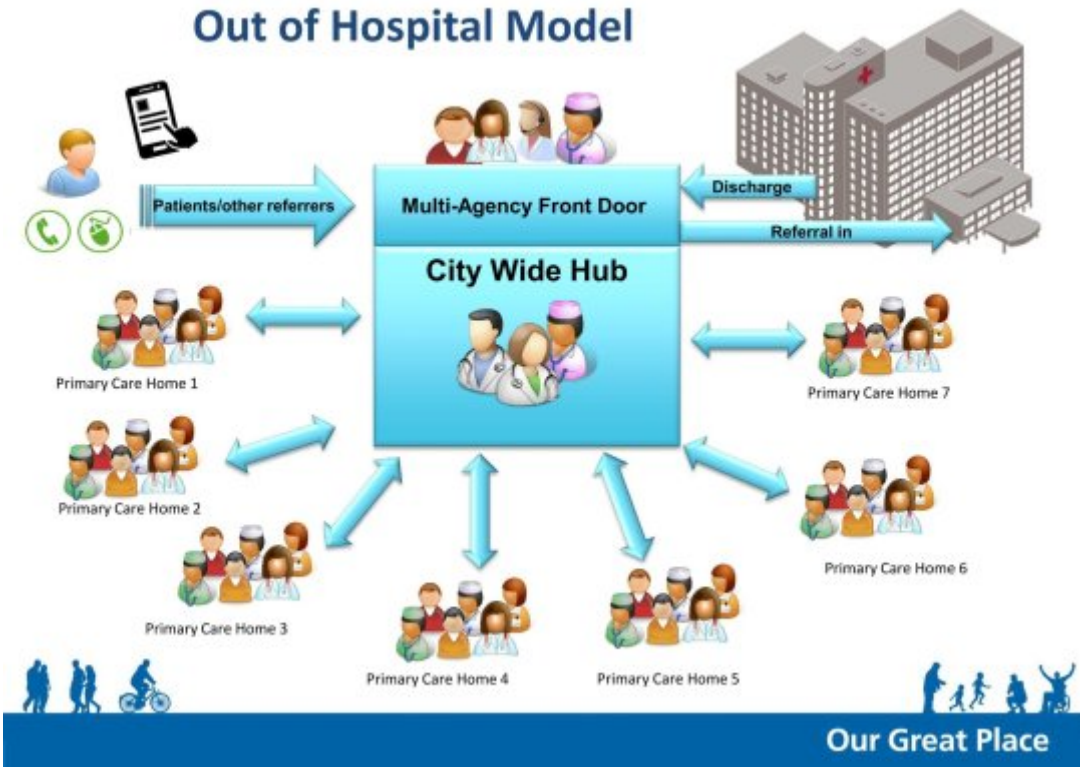
- To reduce the health and wellbeing inequalities
- To address the care and quality gap by ensuring more services use evidence based best practice

- Identify those in most need and co-ordinate their care more effectively, by commissioning and ensuring interdisciplinary working
- To work within tight financial parameters by developing and delivering services around the needs of patients and carers, and reduce duplication and waste of resources

Diagram One: Relationship between integrated Single Point of Access, City-Wide Hubs and Place Based Teams

4.2 The project will seek to address to deliver these objectives through the implementation of a model of care and support that has the following core elements, shown in the diagram above:

4.3 The key features of each of these delivery components are as follows:



4.4 Integrated Single Point of Access (iSPA)

- Incorporates a Multi-Disciplinary/Agency team of health and social care professionals to support admin staff with calls, giving advice on where people might go to get help, or receive those who need access to out of hospital services
- Digital channel providing online self assessment which guides people to sources of help
- Signposting system, ensuring that only assessments are targeted
- Conduit (co-ordinator) between referral to and discharge from inpatient services
- Key objective to deliver effective and early prevention

5 City-Wide Hub

- The City Wide Hub co-ordinates the delivery of Coventry and Rugby wide services. The City Wide Hub will support active case management for planned care and deploy resource responsively across the care system to manage the escalation of need and avoid reliance on secondary care. Coordinate access for urgent community and hospital services which has extended operating hours and is universally accessible to all healthcare professionals. The hub will use agreed assessment tools, will hold information, be the central contact for the local hubs supported by access to shared care plans. City Wide Hub will have access to the directory of services to improve the reliability and consistency of decision makers and resource allocators across the care system. Primary function is to manage system wide flow. The City Wide Hub co-ordinates the delivery of Coventry and Rugby wide services
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6 Placed Based Teams

- Built around populations of c50,000 based on groups of GP practices who will work together to co-ordinate and lead the local place based system i.e. Primary Care Homes (reliance on CCGs to identify Clusters)
- Multi-Disciplinary Team (MDT) with Primary Care at the centre
- Physical and mental health focussed
- Proactive care and prevention focussed
- Care Navigator central to coordination of care
- Minimum agreed services plus resources tailored to locality need
- Freedom to innovate and experiment
- Closely aligned to local community assets

7 What the first year will look like and the improvements we'll expect to see in the first year of delivery

7.1 Due to the scale of the programme implementation will be over a 3 year period. The first year will be used to agree and put into place the key infrastructural aspects of the service including the integrated Single Point of Access (iSPA) Locality Hubs and Place Based Teams (PBTs). By the end of the first implementation year (March 2019), all the main

elements of the new service should be in place. Specific timescales for each area are still to be finalised but an indicative timetable is shown below.

Activity	Timescale
Year 1	Apr 18 – Mar 19
Establish iSPA	Sept 18
Establish Place Based Teams (PBTs):	Sept 18
Implement MDT as part of the PBTs	Sept 18
Implement Electronic Patient Record with 'real time' access to appropriate staff across the system	Sept 18 for health Year 2 to include social care
Introduce effective Risk Stratification	Sept 18

8 What the impact will be on Coventry Residents

8.1 The impact on Coventry residents is expected to be that people will experience more person-centred and co-ordinated care and support in their community as a result of increased collaboration between GPs, community and hospital services, social care and third sector agencies. Some of the features of the model that will be developed to enable this impact to be realised are:

- The provision of Primary Care 'homes' built around registered populations on 50k
- Care navigators to support people in understanding the health and care system and supporting them to access the right support when its needed
- Access to urgent and same day and bookable appointments
- More joined up and personalised support
- Provision of a single front door into community health services and social care
- Better care planning and use of preventative measures
- Greater support for self-care, more support signposting
- Minimised unnecessary hospital attendances/admissions and minimised length of stay when admitted to hospital

9 What the cost implications are of the project

9.1 The total value of the in scope services for the Out of Hospital model was £57.4m for 2017/18 for Coventry and Warwickshire. From this total in scope amount the Coventry value was £21.7m.

9.2 The value of the contract awarded to Coventry and Warwickshire Partnership Trust for the delivery of the OoH model is approximately £19.5m. The payment mechanism will have two components:

- **Fixed element** – a regular payment for the delivery of services paid to the provider
- **Performance related element** – a regular payment based on the delivery of specified outcome/performance indicators paid to the provider. In year one this will be linked to the

delivery of agreed transformation milestones and will be valued at 6% of the contract price and by year 3 will be linked to improved outcomes and valued at 10% of the contract price

9.3 No additional investment has been made to secure this contract; current investment has been vied from the previous block contract into the new outcomes based contract.

10 How the Governance of the project is structured

10.1 The Governance arrangements for the OOH programme sit within the wider system Collaboration Commissioning arrangements previously out lined to the Coventry Health and Well Being at a previous meeting :

''The Commissioners across Coventry and Warwickshire support a collaborative working arrangement between the three CCGs and the two Local Authorities via the recently established CWCC Board. The details of the working arrangement are being finalised and will be captured in a formal agreement; this will detail how the working arrangements between commissioners will function including budgetary commitments and give potential early insight into delivery risks which can then be monitored and / or mitigated. The CWCC Board will be responsible for the next phase of development and on-going management of the contract. To support the Board, a dedicated Virtual Commissioning Team is being formed, with the most appropriate staff, from the five commissioning organisations, with the required breadth of skill to manage all the relevant contracts, performance, quality, transitions and the management responsibility of the relevant commissioning budget. They will have the expertise to develop whole system commissioning which reflects the diverse population needs and changing demands..

10.2 At a local level a Coventry 'Working Together Board' has been established and going forward this board will oversee clinical work streams, through which partners will collaborate to review and develop out of hospital pathways to support delivery of the objectives and outcomes for the out of hospital programme.

10.3 Local accountability for mobilising and overseeing ongoing delivery of the OOH services will be through newly established ' Working Together Boards', responsible for assuring delivery of the local OOH contracts that make up the OOH programme. The Coventry Working Together Board has already been established and has met several times; with good representation form all the key partners and stakeholders.

11 How this project will further integration between health and social care

11.1 There is a history of collaboration and integration between health and social care in Coventry, some of which already supports the OoH model. For example the three Your Health at Home (Integrated Neighbourhood Teams (INTs)) are multi-disciplinary teams established through the Better Care programme in 2015 and are based around GP clusters, working with older and frail people with complex needs. These teams are led by CWPT consist of Social Workers, GPs, Community Matrons, Community Mental Health Nurses, Occupational Therapists, Physiotherapists, and Care Navigators.

11.2 Although these teams cover the whole City geographically there is limited capacity. Nevertheless benefits have been achieved for people that access support through INTs in that care and support can be co-ordinated more effectively and intelligence that previously would have been known by only one organisation is shared with all which enables interventions to be targeted early and prevent more intensive support being required, including hospital admission. The case study provided in Appendix One provides an illustration of the work and impact of INTs.

11.3 Home support (domiciliary care) providers are jointly commissioned by the City Council and CRCCG and organised around a series of geographical areas and the City Council working with the CCG is in the approval stages for outcome based commissioning of preventative services from the voluntary and third sector.

11.4 The City Council has had a social work team permanently based at UHCW for a number of years, which although not integrated does work closely with the hospitals Integrated Discharge Team (IDT) in order to ensure individuals discharges are timely and co-ordinated.

11.5 This track record of integration is based on co-location, co-operation and working to agreed processes and outcomes as opposed to formal integration of staffing structures and budgets. The OoH presents an opportunity to further expand this approach in a manner that brings health and social care closer together for the people of Coventry.

11.6 Two specific areas of further integration related to the development of the OoH model are as follows:

- Integrated Single Point of Access (iSPA) - Many people known to social care are also known to CWPT. Opportunities exist to integrate access points so that people are triaged in the multi-disciplinary way in order to remove un-necessary duplication, speed and coordination of response and more positive outcomes. This is currently being scoped in respect of possibility, benefits, and impacts.

- Place-Based Teams - This work builds on the learning and development work completed so far on INTs. The intention is to enhance, scale up and mainstream the INT approach to create 7/8 clusters based around GP practices.

10.11.17

Appendix One - Case Study

Background

K is a 79 year old lady with a diagnosis of dementia. She lives with her daughter M who works full time and is due to have an operation. K had three care calls a day and had previously attended day care but had stopped due to poor mobility. This was impacting on M's wellbeing and ability to socialise with friends. In addition to this, K was experiencing pain in the arch of her foot and had frequent falls

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Information

Your Health at Home received a referral from her GP and planned their intervention in partnership with K, M and the care agency.

Following assessments by the occupational therapist, physio, community matron, care navigator and social worker a goal plan was developed; to reduce pain, to give the carer a break, to reduce falls and urine infections.

The physio showed K some exercises to reduce her pain, the social worker arranged some respite and an extra care call, and the occupational therapist arranged some equipment and the care navigator provided support and advice around services.

The community matron liaised with the heart failure nurse specialist to review patient and optimise medical treatment.

The team also worked with the care agency to ensure the carers recognised the importance of ensuring K had plenty of fluids and gave them directions for prompting K to eat.

Impact

The following feedback was received from M, K's Daughter as evidence of the impact of the interventions.

"I found the exercises the physio showed Mum really useful. She keeps saying how much better her legs and feet are feeling. I liked the fact the occupational therapist and social worker both knew what each other were doing and I did not have to wait long for either of them.

I have peace of mind now and can go out to work. I am even planning a little holiday.

When Mum was ill everyone responded so quickly getting the extra care in. I was so pleased that she did not have to go to hospital again. I feel the team listen to and involve me in my Mum's support.

I would describe the team as really, really, fantastic. Everyone was really friendly and I would always see the same people. This was really important to us.

It was nice only explaining things once."