Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Warwickshire county Council**
Clinical Commissioning Groups	**Coventry & Rugby CCG**
	South Warwickshire CCG
	Warwickshire North CCG
Boundary Differences	Coventry and Rugby CCG spans two Local Authorities and two Health and Wellbeing Boards. This plan covers the Rugby population. There is a separate plan for the Coventry population
Date agreed at Health and Well-Being Board:	**11/02/2014**
Date submitted:	**14/02/14**
Minimum required value of ITF pooled budget: 2014/15	**£17462**
2015/16	**£65583**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Coventry & Rugby CCG
By	Steve Allen
Position	Accountable Officer
Date	14th February 2014

Signed on behalf of the Clinical Commissioning Group	South Warwickshire CCG
By	Gill Entwistle
Position	Accountable Officer
Date	14th February 2014

Signed on behalf of the Clinical Commissioning Group	Warwickshire North CCG
By	Andrea Green
Position	Accountable Officer
Date	14th February 2014

Signed on behalf of the Council	Warwickshire County Council
By	Wendy Fabbro
Position	Strategic Director for the People Group
Date	14th February 2014>

Signed on behalf of the Health and Wellbeing Board	Warwickshire Health & Wellbeing Board
By Chair of Health and Wellbeing Board	Isobel Seccombe
Date	14th February 2014

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

This plan has been developed alongside the 5 year system plan as the BCF is central to the delivery of a clinically and financially sustainable care system. Therefore the strategic direction set out in this plan has been widely discussed with providers through: -

a) Routine dialogue between commissioners and providers;
b) Urgent Care Working Groups and;
c) Coventry and Warwickshire Integrated System Board that brings together leaders of the health and care system. As the specific initiatives outlined in this plan are developed in greater detail there will be focused discussions with relevant providers.

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

The three CCGs and Social Care have well developed engagement networks. These networks will continue to have a core role in shaping the direction of travel. Our vision for integration has been informed through engagement with a variety of stakeholders alongside the outputs of the JSNA and the Health and Wellbeing Strategy. This vision underpins the 5 year system plan and the BCF. The high level content of this plan has been shared with patient, service and user groups and they have been supportive of the direction of travel. As with service providers we will continue to engage these groups as we develop schemes in greater detail.

e) Related documentation
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	**Synopsis and links**
Health & Wellbeing Strategy	
JSNA	
Quality of Life Report	
Commissioning intentions SWCCG	
Commissioning intentions WNCCG	
Commissioning intentions CRCCG	
Warwickshire county council commissioning intentions	
Public Health Commissioning intentions	

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Our vision is nothing less than a fundamental transformation of the quality and experience of care, across all elements of commissioning and provision, and on behalf of our communities as a whole.

As a partnership we believe that joining together will make us stronger commissioners and enable us to respond so that:

Our Vision

Individuals will experience better outcomes by delivering the Right Care at the Right Time, in the Right Place – Every Time – Together.

We will know this by using the 'I' statements for example: *"I can plan my care with people who work together to understand me and my carers, allow me control, and bring together services to achieve the outcomes important to me."*

We recognise that change on this scale will mean consistently providing care that is planned and tailored to individual capabilities and needs; care that is delivered in partnership, to the highest possible standards. This will involve putting individuals at the heart of everything we do because this is the only way we will ensure a sustainable, healthy future for the communities we serve.

We will know we have been successful in five years time through the 'I' statements for example:

Patients/users of health and social care services will feedback that services delivered to them enabled them to make good lifestyle choices in the knowledge that services will wrap around their needs at key stages throughout their life;

Patient/users and their carers will feedback that they were able to make informed decisions about their health and social care needs and were able to remain in control, directing care through personal budgets and personal health budgets. They provide feedback on the quality of services that they had commissioned and/or directed their care co-ordinator to deliver on their behalf;

Staff will equally feedback the positive contributions that they made to a patient/users care and the benefits of joint assessment and care planning;

Patients/users and their carers confidence will increase in the quality of care and the levels of satisfaction in terms of people's dignity and respect across all health and social care services would define Warwickshire as an exemplar of health and social care services.

b) Purpose and Objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Purpose

The core purpose of this integrated model is to improve outcomes for all people who need health and social care services. This means:

- People will be helped in their goal to manage their own care and remain healthy and independent;
- People will have real choices and greater access in both health and social care;
- Far more services will be delivered – safely and effectively – in the community and/or at home.

Objectives:

- To build relationships with patients and our communities and determine how the voice of the public remains central to the evolution of the BFC and the associated work programme;
- To identify opportunities for prevention and to promote wellbeing as underpinning patient/user contact;
- To facilitate a risk based model and act as an enabler for people to retain their independence and autonomy;
- To re-engineer how the public and the workforce consider this revised core offer from the health and social care economy to the public;
- To systematically tackle the pressures within the health and social care system to deliver better outcomes for our people and support the transformational, transitional and transactional elements of integration, within available resources;
- To stimulate and drive innovation across the health and social care economy ensuring continued safety and quality of services;
- To build further the close working relationships between all partners to deliver improved outcomes within local resources and establish a single solution to meet need that is affordable for the whole system and each agency;
- To recognise each partners strategic priorities, constraints and responsibilities in order to achieve mutual beneficial outcomes;
- To secure strong and effective clinical and professional practice engagement and leadership across the health and social care economy;
- To demonstrate system wide projects and programmes that deliver value for money;
- To collective agree the priority work programme to deliver a system wide change in how services are commissioned and delivered on the ground.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The BCF is central to the delivery of the 5 year system plan. In the 5 year system plan we articulate how we will: -

a) Radically change our approach to wellbeing and self-management
b) Take a systematic approach to transfer activity that should be undertaken by primary care back to primary care. This will include relocating the workforce that currently sits within acute services to the community;
c) Remove the boundaries between practice staff and those working in the community to deliver team based care to individuals who need the support of care professionals to manage their care;
d) Reconfigure site based services in order to deliver safe and effective services within the constraints on the money that we have available.

The content and yearly expansion of the BCF reflects the phasing of the 5 year system plan. The 5 year plan has been developed with a bottom-up approach and builds on each CCGs plan to address the health needs of its population. There are demonstrable links to the JSNA, JHWS, NHS Outcomes Framework, Public Health Outcomes Framework and the Peoples Group Outcomes Framework, (all attached as related documentation) the basis of which will form our Joint Outcomes Framework and Success Criteria. This will be underpinned by a benefits realisation model with incorporating the key national metrics as well as some locally defined measure.

Our agreed target operating model is one which puts the patient, service user and carer at the heart. It begins and ends with their voice being heard and acknowledges the expertise that patients and services users and carers bring to a solution based integration model.

The operating model will be built on an evidenced based approach and will recognise the assets people and communities have. It will facilitate a risk based model and act as an enabler for people to retain their independence and autonomy and will re-engineer how the public and the workforce consider this revised core offer from the health and social care economy to the public.

It will be built on the premise of self service and management and will focus on acting as a support mechanism to allow people to make the right choices and decisions about their own health and wellbeing throughout their life course.

Scheme 1: Joint assessment and care planning

Prevention is part of the process of joint assessment of need. We know that approximately quarter of the population smoke across all ages, hospital admissions as a result of alcohol and just under half of the population are overweight or obese. Identification and signposting particularly through the use of the Making Every Contact

Count philosophy is an important part of the assessment process and a key of underpinning a better quality of life for patients/users. To make integration effective Warwickshire is committed to the principle of joint assessments and care planning and to do this with the patient/user at the heart. We have already begun this work with the development of the ECAT and Common Assessment Framework (CAF) as examples, but further work is required to bring more formally the process of assessment together. We will develop a joint assessment and care planning process building on the trusted assessor model and using technology in its wider capabilities. Our transactional business processes will need to be agreed and embedded across the health and social care economy. We will be investing in co-ordinated care that promotes a holistic view of an individuals need and works with people to empower them and enable them to stay as independent as possible.

We want to move towards a model of integrated assessment of need across health, public health, housing and social care needs. This will begin with empowering the public to determine their own needs and to do this in advance of their need for more formal forms of support. We anticipate that this will also act as a tool to empower people to self manage their own care within the most appropriate environment. Core will be a mobilised and competently trained workforce. A key element of the model is the introduction of housing to improve the environments within which people live either to postpone or delay their need for formal support or to ensure that they enter into more appropriate forms of support for their eligible needs. Using technology the assessment function would be available for all citizens in Warwickshire irrespective of eligibility criteria or ability to pay for a service. In other words, the assessment service would help self-funders to manage their own care and would provide a platform for those on the edge of care. This would mean one assessment shared across organisations that is visible to the patient/users and with permissions to the primary carer.

Scheme 2: Promoting Independence through Self-management and Community Resilience

We have already begun the work to support local communities to galvanise around those who need support, such as the Safer Places scheme across the County which has seen the communities and local businesses engaging in making our streets safer for vulnerable people. And as well as the MECC approach highlighted above a key to promoting individual and community resilience is our effective public mental health strategy which prioritises; the three tier approach with; universal interventions, targeted intervention and early intervention for patients/users.

We need to continue to build on our information strategies and support people by providing the right information, advice and signposting to appropriate forms of support that are available and accessible within the communities in which they live. It means shifting from a model of dependency and direct provision to one of self management and care. It means people taking some responsibility for their own health and wellbeing and reducing the recourse to formal forms of support. Incorporated into this principle is the concept of community resilience and empowering communities to support local initiatives and forms of support eg; self management programmes for people with long terms

conditions, financial advice, housing improvement schemes, building local community enterprises, peer support groups for carers, supporting the growth of voluntary activity for example through time banking. It will require investment in technology enabling people to identify and manage their own care or the care of those close to them. It will mean a different mind set to the potential of technology not just in the way we process our business but also in the way we deliver services. And the voluntary and community sector would need to reconfigure its offer to the public and build resilience to support our drive to invest in the army of informal carers.

Scheme 3: Care at Home

The main thrust of the Better Care Fund is to secure the transition of care from Acutes to Communities. This accords with the preferences of patients and users of services who confirm that they wish to remain at home, living independently for as long as possible. By improving individual health and wellbeing, and access to home and community based services, we will relieve pressures on Acute Services and help to eliminate the costs that arise from failures to provide adequate help to those at greatest risk of deterioration. We will work to reduce unnecessary admissions to hospitals and to residential and nursing care through enhanced preventative and community support in the home. Further and wider attention needs to be given to the role of GPs and Primary Care with services wrapping around the individual to avoid such admissions.

We want to create a more holistic recovery based model which promotes the independence of patients/users to enable them to lead the life they choose and reduce their dependency on packages of care and support by using a reabling/recovery model. It means commissioning a model of service interventions that is based on reablement and rehabilitation. This means working with a belief that assisting older people within their communities is an important part of the task and that providers of this service can demonstrate person centred approaches that deliver the outcomes defined by customers. It means commissioning an outcomes based model for care at home that is predicated on the ability of older people to recover (albeit it different rates). It would have an emphasis of capturing community support, would utilise equipment and assistive technology and would expect access to housing grants and home improvements to align with discharge from hospital. This multi layered approach would begin with a response from a joint emergency response unit to avoid admissions, it would be complimented by a workforce of generic health/care assistants delivering a range of outcome based home care services and it would link with the voluntary and community sector to support and sustain vulnerable people at home.

Scheme 4: Accommodation with Support

Through the provision of accommodation with support and access to efficient delivery of home improvements more older people and those with complex needs would be supported to remain at home for longer. Through the use of technology and access to equipment there would be an expectation that people would be able to return home much

more quickly and not be diverted into residential and/or nursing care as the only option.

We want to explore how to support older people to live independently by promoting the development of 'lifetime neighbourhoods'. These are places that are designed to be lived in by all people regardless of their age or disability. Part of our ambitions is to continue to develop the model of Extra Care so that people can remain in their own homes for as long as possible.

And for those who genuinely cannot live independently we will continue to build and focus on improving outcomes through transforming the quality, consistency and co-ordination of care within residential and nursing care provision across the County.

All of this, of course, links to our initiative to support people to die a place of their choosing. By supporting and enabling people to remain at home (and within this definition we include residential and nursing care) we will be supporting people to achieve their final ambitions at the end of their life.

Scheme 5: NHS Continuing Health Care

Currently health and social care are operating independently in relation to NHS CHC in terms of practice and commissioning activity. Whilst the key issues continue to be around market capacity and value for money, there are also missed opportunities in relation to personalisation (e.g.; Direct payment users), quality and choice within the market, all of which impact on the patients experience of service provision. There are opportunities through joint commissioning to;

- Develop a commissioning market strategy
- Improve the quality, diversity, and sustainability of provision

Redesign the pathway and processes for CHC across the health and social care system to improve outcomes and deliver value for money.

Some of the priorities as defined in the plan include:

- Commitment to addressing inefficiencies in CHC processes
- Securing better prices and higher quality within commissioned services
- Increased diversity in the market
- Priorities for commissioners versus demand management ie' expectation of increasing demand/need to manage down.

NHS data shows that the numbers are rising and are significantly higher than the local, regional and national benchmark. In partnership we can work together to address this and to ensure that the system(s) works for patients and carers.

We want to use the BCF to explore better more joint ways of managing Continuing Health Care

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The BCF will be included in each of the CCG's 2 year operating plan and will be part of their QIPP programme. Each CCG will be talking to their main NHS provider about the impact of the QIPP programme.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Since the inception of the Health and Wellbeing Board the council and the three clinical commissioning groups have built a strong alliance to the delivery of services within Warwickshire alongside other key partners such as; the Acute sector, Pharmacy, District and Borough Council. In addition the chief Officer of each of the Clinical Commissioning Groups and the Portfolio holders of Health and Adult Social Care respectively with the Leader of the Council meet on a quarterly basis to identify key issues and themes for partnership work. The Health & Wellbeing Board is therefore well placed to oversee the progress of the BCF plans.

The BCF and the initiatives that it encompasses will be overseen by the Warwickshire Joint Commissioning Board which is chaired by the Strategic Director for the People Group within the Council and reports progress through the Warwickshire Health and Wellbeing Board to the respective accountable bodies of the Council and the CCGs.

Where relevant we will use the scrutiny role of the council to assure ourselves of the progress and direction of travel taken.

The 5 year system plan of which the BCF is part will be overseen by the Coventry and Warwickshire Integrated System Board.

Using a Programme Approach the Local Authority and CCGs Governing Bodies will receive progress reports and outcomes achieved across the BCF programme. A governance structure chart together with the terms of reference for the Joint Commissioning Board is available on request. A Partnership Agreement is being scoped for approval and will be the precursor during 2014/15 to more formal agreed arrangements such as a Section 75.

We have already aligned the timetabling of our commissioning intentions which will assist in developing joint schemes and proposals for S256 allocation as well as opportunities for joint commissioning and pooled budget arrangements. Further work is progressing to draw together key performance data through improved data sharing. There is already a strong integrated quality assurance framework for the monitoring of quality within residential and nursing care homes. We want to review this and bring together our respective quality premium payments and CQUINs to incentivise and drive quality even further to improve outcomes and reduce the admissions to acute care.

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

BCF funding will be made available to complement available, recurrent social care funding to ensure the core, statutory, 'FACS-eligible' social care services will continue to be delivered safely and appropriately, thus avoiding adverse impact on health (such as delayed discharges). And that the impact of any additional demand on social care (within the above definition) resulting from successful initiatives to transfer activity from the acute sector to community services is recognised and financed via the BCF.

We recognise that 'demand management' success is actually going to be predicated on activity largely 'outside' adult social care, because it needs to happen 'before' people come to the adult social care 'front door' as much as possible. Examples include – good housing / planning strategies, community health services, community capital and voluntary sector contracting etc.

Working with Public Health with a the focus on prevention, early help and targeted support will act as a protection from rising demand on social care, via the aim of enabling people to remain as independent and healthy as possible for as long as possible.

We have also looked at a number of national examples of 'budget management' techniques that have been used in other Local Authorities and may need to be considered unless a whole system approach continues to be maintained.

We will also build on our nationally recognised models of improving discharge processes and admission avoidance through the utilisation of Discharge to Assess Beds and Moving on Beds.

Please explain how local social care services will be protected within your plans

The BCF funding will be made available to complement available, recurrent social care funding to ensure the core, statutory, FAC eligible social care services will continue to be delivered safely and appropriately, thus avoiding adverse impact on health (such as delayed discharges or increase admissions to hospital. And that the impact of any additional demand on social care (within the above definition) resulting from successful initiatives to transfer activity from the acute sector to community services is recognised and financed via BCF.

NATIONAL CONDITIONS

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

There are already some good examples of 7 day working across the health and social care economy; emergency duty team, access to emergency short stays, re-ablement. However more can been done as we recognise that one part of the system cannot function effectively at the weekend if other parts don't, it has to be a whole system wide approach. 7 day working opportunities are being scoped across the health and social care landscape to improve performance and outcomes. Given the complexities of achieving this across the whole system further work is being progressed to scope and cost a 7 day service to reduce the pressure on the health and social care economy at key points. Some of the areas being considered and/or scoped include; 7 day access to information and advice, improvements to EDT, reablement, home care, night support and carer support.

There are clearly complexities inherent within this such as; exploring the different working patterns and changing traditional 5 day service model (37hrs per week 5 times 9-5pm shifts) to 7 day service model (37hrs per week, 4 times 8 – 6pm shifts) for social care services. However, health and social care are committed to exploring this across commissioning and operational team and work has already begun to scope extending services such as; 7 day per week hospital social care cover – full team in each hospital, Re-ablement presence in each A&E to ascertain and advise of existing support packages in place or negotiate small temporary changes with providers, to prevent admissions.

Work will commence in 2014 to build on current 7 day provision with the intention to increase 7 day working before the Autumn.

NATIONAL CONDITIONS

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

No we do not currently use the NHS number but have plans to do so in the future

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Plans developing to use the NHS number and progress will be enhanced by the review and retender of the local authorities' main data system and the implementation of the data sharing protocol.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

No we do not currently use the NHS number but have plans to do so in the future

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Yes

NATIONAL CONDITIONS

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

The Risk Model
In Warwickshire we offer the Combined Predictive model[1] which uses an algorithm developed by the Kings Fund, Health Dialog and New York University. It uses both primary and secondary care data to produce a risk score between 0 and 100% - this is the patient's risk of being admitted for an emergency chronic admission within the next 12 months.

To support the Risk profiling of patients, the Ventris report provides the following information;
NHS Number, Age, Gender
Current & Previous Risk Score (%)
Long Term Conditions/Co-morbidity
Hospitalisation (A&E)
Substance Misuse
Multiple Drug Use

The data is refreshed on a monthly basis using data feeds from GP Clinical Systems (via Apollo/MSDI), SUS and Exeter.

Access and Usage
All GP practices in Warwickshire have the ability to access Risk stratification reports via Ventris, the CSU Business Intelligence solution. Access is granted via strict data sharing agreements and 64 out of 76 (84%) practices have these agreements set up to view these reports. By locality this is;

South Warwickshire – 31/36 (86%)
North Warwickshire – 21/28 (75%)
Rugby – 12/12 (100%)

The uptake has increased significantly since the start of the Risk Profiling DES (April 2013) which recommends practices use a Risk Stratification tool to profile their most 'at risk' patients. The necessity to monitor these patients will intensify even more next year (April 2014) with the roll out of the 'Unplanned Admissions LES'[2].

Ventris usage statistics (for South Warwickshire only) for the last 2 months (Dec – Jan) show practices have accessed these reports 77 times.

[1] http://www.kingsfund.org.uk/sites/files/kf/field/field_document/PARR-combined-predictive-model-final-report-dec06.pdf

[2] http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/general-practice-contract/unplanned-admissions-2014

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk Rating	Mitigating Actions
Inability to meet financial challenges across the health and social care economy	16	• Agreed understanding to share wider financial envelope and challenges across the health and social care economy to better understand the respective pressures.
Failure to secure capacity, capability and quality provision from the market	12	• Renegotiate contracts based on outcomes framework and revised financial envelope. • Complete soft market testing for some niche areas. • Introduce quality premium payment for key areas e.g. dementia
Political and GP member buy in for proposed new service model	12	• Establish strong brand and key message. • Demonstrate financial viability across the economy. • Evidence value for money and outcomes to be delivered for each scheme.
Leadership and continuity of the new service model	16	• Produce robust communication strategy. • Strategic Director lead for Integration agreed and owned across the health and social care economy.
Introduction of the Care Bill, will result in a significant increase in the cost of care from April 2016 which will impact on social care funding and any associated savings plans	16	• Scoping the impact of the Care Bill is underway and will be further refined and updated as the Bill progresses through Parliament.
Moving resources to fund new joint interventions and schemes will destabilise current service providers, particularly the Acute Services.	16	• A Whole Systems integrated Care model will need to be mapped and further developed with all key stakeholders engaged and involved . • Co-design of the system including key transitional points to be mapped and agreed across all stakeholders.
Insufficient and therefore confidence in the baseline data.	9	• Further investment throughout 14/15 and beyond will ensure that data sharing and performance will improve.
Lack of understanding of the BCF function and intentions resulting in little change in behaviours/systems and outcomes forpatients/users	12	• Strong Communication Strategy needs to be developed alongside the BCF that is implemented across the whole system.