19th September submission

Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

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 and 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:	**22/9/14**
Date submitted:	**22/9/14**
Minimum required value of BCF pooled budget: 2014/15	**£17,478**
2015/16	**£36,137**
Total agreed value of pooled budget:	**£0.00**

2014/15	
2015/16	**£36,137**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Coventry and Rugby CCG
By	Steve Allen
Position	Accountable Officer
Date	

Signed on behalf of the Clinical Commissioning Group	South Warwickshire CCG
By	Gillian Entwistle
Position	Chief Officer
Date	

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

Signed on behalf of the Council	Warwickshire County Council
By	Wendy Fabbro
Position	Strategic Director, People Group
Date	

Signed on behalf of the Health and Wellbeing Board	Warwickshire Health and Well Being Board
By Chair of Health and Wellbeing Board	Isobel Seccombe
Date	

c) 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**

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Our vision is nothing less than a fundamental transformation of the quality and experience of care, across all elements of commissioning and provision.

As partners we believe that together we are stronger commissioners amd that by working jointly we are more able to ensure:

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

We will work collaboratively across Warwickshire's health and social care system to ensure:

- **People are helped to remain healthy and independent;**
- **People are empowered to play an active role in managing their own care and the care they receive;**
- **People get the right service at the right time and in the right place – (this means services will envelop individuals close to their 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 make sure that the workforce and the public have a better understanding of what the health and social care economy will deliver;
- 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 including district partners to deliver wellbeing 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 ensure that collectively we achieve the best possible outcomes for our citizens ;
- To secure strong and effective clinical and professional, engagement and leadership across the health and social care economy;
- To demonstrate system wide projects and programmes that deliver value for money.

Our Vision for 2019/20 and beyond…

- People with health and/ or social care needs will know how to navigate the health and social care system;
- People with health and/or social care needs will be able to access the right information at the right time and will be able to access the support they need;
- Citizens of Warwickshire will have an increased understanding of the benefits of the five ways to wellbeing and will utilise local community resources to put this into practice;
- People in local communities will have a range of locally grown support mechanisms such as carer led support groups, patient led self-management groups for long term conditions;
- Through social prescribing GPs will support people to navigate to the right support to avoid more expensive and often unnecessary interventions;
- Integrated teams will work closely with GP practices and will envelop individuals and work closely with provider services including local community and voluntary sector services;
- People with long term conditions will have the ability to hold their own personalised care records and use Personal Budgets and Personal Health Budgets to manage their own care;
- People with long term conditions and those defined at risk (using the risk stratification tool) will have the ability to see and share their health and social care records;
- People will be able to have repairs, adaptations and improvements made to their homes quickly and within timescales acceptable to them;
- Carers will be supported to have a life outside of caring and will be supported in their caring role;
- There will be parity of esteem for all patients/clients especially those with mental health issues including children and young people with mental health issues. (This means much improved access to services when needed);
- Over time we will create a flexible workforce that can deliver more than one service for the benefit of patients and carers and the health and social care system;

b) What difference will this make to patient and service user outcomes?

The Warwickshire blue print illustrates a pluralistic multi-layered model of care which enables a range of packages to be provided, dependent on individual need. An advantage of this is that it allows care to converge where possible towards patient self-management and greater control to remain independent for as long as possible.

To explain further, as much as possible we want the population to remain independent and to be able to be self-sufficient and to only call on health and social care services for time limited re-abling interventions. This means commissioned services (and the market) need to recognise the value of re-ablement, rehabilitation and recovery as the drivers for the whole health and social care economy.

This is better reflected in the diagram below:

The County Council and Warwickshire 3 Clinical Commissioning Groups have agreed to work together as partners to to look across the health and social care economy to identify ways of helping people to manage their own care, through better access to information and advice, to deliver care closer to home and to build on the assets and community re-sources that are often untapped.

The vision set out above has been developed in line with Warwickshire's Joint Strategic Needs Assessment (JSNA) that identifies local needs and key pressures upon the local health and social care economy, including:

- **Population change and increasing dependency** - In Warwickshire, our population is ageing and more people are living for longer with long term medical conditions. The county currently has approximately 13,356 people aged over 85, and by 2021 this group is expected to grow by 42%. The demographic profile of Warwickshire identifies older people as a key priority for the health and social care economy and as is already demonstrated the impact of this is being felt significantly across the three acute services.
- **Lifestyle factors affecting health and wellbeing** - locally there is concern around obesity, a lack of physical activity and smoking
- **Long Term Conditions (LTCs)** - Around 1 in 3 adults live with at least one LTC and with a growing and ageing population; Warwickshire is predicted to see significant increases in these numbers.
- **Mental Wellbeing** - For people aged between 16 and 74 living in Warwickshire, an estimated 46,000 people have a common mental health problem.
- **Disability** - There are estimated to be 34,664 people aged 18-64 with a moderate or serious physical disability in Warwickshire and this is predicted to rise to 37,397 by 2030, contributed to by the ageing population.
- **Ageing & Frailty** -
  Warwickshire's population is forecast to grow by 4.7% over the next 5 years, with 11.3% growth in the over-65 population, altering the age profile of the county and increasing the median age. Although many people remain well, active and independent during later life, for others, increasing age brings an increasing chance of frailty, long-term medical conditions, dementia, terminal illness, dependency and disability.
- **Dementia** - In 2012, there were 3,169 patients on Warwickshire GP's disease register for dementia. However, data suggests that only 43% of people in Warwickshire with dementia have been formally diagnosed. This equates to over 4,000 people without a diagnosis. Between 2012 and 2028, the number of people with dementia is projected to increase by 57%.
- **Persisting inequalities**
- **The impact of technology on future need**

In addition, the Home Truths Diagnostic project in Warwickshire ran from November 2013 to April 2014, focusing on understanding the relationships, behaviours and trust levels between frontline practitioners delivering, and influencing older adults care identified that across the local health and social care system:

- Older adults in Warwickshire are largely satisfied with the services they receive; although a significant proportion (22%) feel that they do not receive sufficient support to remain independent.
- Early intervention activity is not prioritised; people may not receive the support they need until crisis. Therefore opportunities to support people earlier in the pathway are missed, potentially leading to an accelerated deterioration in condition.
- GPs are the most significant professional influencer on Older Adults when making

care decisions, and in many cases are as influential as family members.
- GPs lack knowledge of about the full range of services local services available, and will tend to refer to established 'traditional' social care services, community, voluntary sector offer is underutilised.
- Day to day frustrations regarding access and information frustrate practitioners and limit coordinated multidisciplinary working at the frontline.
- Poor communication and information flows can undermine the services offered.

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 envelop their needs at key stages throughout their life.
- Patients/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.
- Patients/users will 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 experience of services 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; defining Warwickshire as an exemplar of integrated health and social care services.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

Work Stream 1: Customer/Patient Journeys (Joint Assessment & Care Planning)

A key focus of our integration work is to improve accessibility and visibility of 'front doors' looking at how current services 'fit together' and how easy (or not), they are to access when they are really needed.

We will invest in integrated co-ordinated care that promotes a holistic view of an individuals need and work with people to empower them and enable them to stay as independent as possible for as long as possible. To make integration effective Warwickshire is committed to the principle of integrated teams at a local level, bringing together social care, community health and associated services to coordinate a range of inputs to prevent and delay care and support needs from escalating by providing greater stability to people who may otherwise become overwhelmed by their circumstances and recourse to acute services. This will include working with GPs using the risk stratification

tools to determine high risk patients develop anticipating care approaches.

Through the BCF we will move towards a model of integrated assessment across health, social care, public health and housing needs that is visible and owned by the public themselves. A key element of the model is 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.

This will include the continued development of joint assessment and care planning with the patient/user central to this. We will build on the ECAT tool and Common Assessment Framework (CAF) as just two examples of joint assessments and care planning. In addition we will build on the trusted assessor model using technology in its wider capabilities. This would mean one assessment shared across organisations and visible to the patient/users, and with permissions, to the primary carer and other key stakeholders in their care and support.

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 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. This will empower people to self-manage their own care within the most appropriate environment.

Work Stream 2: Promoting Independence through Self-management and Community Resilience

Community resilience is about supporting population groups either within specific communities, or vulnerable groups within populations, or larger population groups, to enable people collectively to “feel good and function well”. People will take increasingly more responsibility for their own health and well being.

Through the BCF the voluntary and community sector will be reconfigured to build resilience and support our drive to invest in informal carer and mutual exchanges of care. Taking a joint health and social care commissioning and operational approach it will mean a different offer from the voluntary and independent sector but better outcomes for the patient/client.

We will focus upon promoting independence through self-management and developing community resilience with the aim of enabling people to remain as independent and healthy as possible for as long as possible.

We will empower communities to support local initiatives and forms of support e.g. building local community enterprises, supporting the growth of voluntary activity for example through time banking, peer support groups for carers, and information and advice, including financial advice, and developing self-management programmes, and

expert patient programmes for people with long terms conditions.

We will invest 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.

Within this framework we will put strong mechanisms in place to support informal carers and work across the health and social care economy to minimise the impact of illness and disability on a carer's life. This will begin in earnest over the coming year, for example we are at the cusp of reviewing the support to informal carers of people with dementia. We have listened to them and redesigned services to better reflect their needs and reduce the risk of carer breakdown which is a primary cause of entry into residential care.

The BCF is acting as the catalyst to bring all contracts for the voluntary and community sector together to redesign and strengthen their core offer as it acts as the foundation on which community resilience should be built.

Work Stream 3: Care at Home

Joined up Care at Home services are at the centre of the BCF model to ensure that people remain independent for longer and prevent them from being unnecessarily admitted to or become stuck in inappropriate provision.

We will work to reduce unnecessary admissions to hospitals and to residential and nursing care through enhanced preventative and community services and support in the home. This will mean providing step down services to enable people to be discharged to their home as soon as possible and step up facilities to support people to stay out of hospital. It will mean providing services that support carers so that people can remain at home for longer.

Multi-disciplinary teams will work in localities in and around existing centres of service delivery, e.g. GP practices providing targeted services to individuals. Services will work holistically, using a recovery based model. Commissioning new interventions will be based upon the principles of reablement and rehabilitation and moves away from input and process based service specifications to outcome based service specifications.

A multi layered approach will begin with: a response from a joint emergency response unit to avoid admissions; 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.

Providers will be required to demonstrate person centred approaches that deliver outcomes defined by customers.

Work Stream 4: Accommodation with Support:

Through the BCF we will work in partnership to drive up the quality of care within residential care. As demand on these services increases, it is vital that the offer to customers and their families is one that meets expectations and outcomes.

We have already demonstrated the benefits of working together to secure quality services through our nurse and council monitoring team working together to resolve areas of concern; the BCF will enable this to be taken further. One team across Health and WCC commissioning that has the responsibility of lead commissioning quality in care within nursing homes, to ensure the nursing care element and the holistic social care element of care standards were appropriately set and monitored. The Quality team would also be responsible for commissioning a training programme that is accredited for all providers to undertake.

To compliment this, our community based peer audit team will be strengthened to work across the health and social care market. Peer audits are user led and developed from an expert by experience perspective.

In addition, GPs in some areas across the County have been commissioned to work closely with the homes, for example, on end of life care, to reduce the number of inappropriate admissions from care homes, where people spend their last days.

We already know, through the Home Truths project, that a % of admission to residential care is often influenced by patients GPs. We also know that often after a spell in a hospital setting, carer breakdown becomes more visible resulting in admissions to residential or nursing care. And we know that the profile of the people being admitted to residential and nursing is much more complex.

To counter this and to ensure that we have the right shape of market for the changing needs of our population we need to work closely with providers. We have already produced a detailed market analysis and already informed the market of the changes needed over the next few years if we are to ensure that those who need to be discharge to residential/nursing care are able to move to the right place at the right time.

Through the BCF we will be bringing this together to jointly manage and configure the market so that it reflects a) the changing needs of clients/patients, b) is available where it is needed and c) is focussed on individuals (individual personalised commissioning). We anticipate a move to jointly commissioning a market place that is of the highest standard.

The BCF, through the Disabled Facilities Grant and the Home Improvement Projects and other associated projects eg; ICES/AT, will provide a more robust efficiency to the installation and delivery of equipment and adaptations that enables people to be discharged much more quickly from hospital and to move people from permanent residential care into supported living.

Through the BCF we will develop and expand Discharge to Assess (D2A) model across the county. D2A is a transformation project that builds on local developments designed to

move care closer to home and reduce unnecessarily prolonged acute hospital stay. Evidence shows that frail elderly patients do not always make the right decision about their future long term care when in an acute setting and still recovering from an acute illness or accident.

D2A give patients an opportunity for further rehabilitation in a 24 hour care environment, and crucially allows for an assessment to take place outside of an acute setting over a longer period. This will improve the flow of people from acute care back into the community and/or the most appropriate destination, and reduce delayed transfers of care.

Work Stream 5: NHS Continuing Health Care

Through joint commissioning we will:

- Develop a sustainable residential and nursing care 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 better align the systems to improve outcomes and deliver value for money for the health and social care economy.

We will:

- Address inefficiencies in CHC processes across health and social care
- Secure better prices and higher quality within commissioned services
- Increase diversity in the market
- Manage demand i.e. expectation of increasing demand/need to manage down especially in light of increasing demographics and impact of Care Bill.

The Better Care Fund is enabling us to build on some excellent joint work and to now bring this centre stage through pooled budget arrangements. We will use the Council's individual personalised commissioning methodology to source and secure packages of care for people with PMLD where customers and their families can decide who is the best provider to provide for their care within their personal budget. This will, over time, extend to include personal health budgets.

Workstream 6 – Foundation/Enabling Projects

In addition, a set of five foundations projects will act as supporting projects. These projects will improve the BCF national conditions locally and ensure the necessary local support to enable the above schemes to progress. These are:

- Communication and Co-production
- Market Management & Development
- Workforce Development
- IT infrastructure
- Data and Analytics

ITEM 6

Some of the key aspects of service change that would not otherwise be delivered without the BCF include:

- Joint market management
- Workforce development across the whole health and social care economy
- Data and analytics sharing
- Fast paced progression of an IT infrastructure to support integration through shared information, assessments and care plans
- Data sharing (IT project to facilitate data sharing, joint assessments and care planning, self-assessment, health and social care navigation and access to tailored/personalised information and advice

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

In order to improve outcomes for the people of Warwickshire and meet individual's needs, health and social care services need to be rebalanced in order to support more people at home or in the community, thereby reducing avoidable admission to hospital and an over-reliance on acute care.

The quality of care of Warwickshire's frail and elderly populations and those with complex difficulties could be greatly improved through better targeted, better organised and better integrated care. Integrated care allows health and social care services to work together to deliver person-centred models of care based around multi-disciplinary teams positioned at the heart of the local community. However, there are significant challenges to joint working in Warwickshire, and radical changes to service structures, relationships and behaviours will be needed

Warwickshire's Population

Life expectancy for both men and women is slightly higher in Warwickshire than the England average, currently standing at 83.8 years for females and 79.8 years for males (versus F:83.0, M:79.2 in England).

Warwickshire's total population has grown by 6.5% in 10 years, from 513,062 in 2003 to 548,729 in 2013 (based on ONS mid-year population estimates), with 54% of the population over the age of 40 and nearly 20% over the age of 65. In Warwickshire North and Rugby CCGs the proportion of over 65s is similar, at 18.6% and 18.4% respectively. In South Warwickshire however, the proportion is higher, with 20.7% of the population over the age of 65.

Figure 1. Warwickshire's Total Population & selected age groups

CCG	Total	65+	75+
Warwickshire North CCG	188,127	35,038	14,956
Rugby CCG	101,373	18,675	8,328
South Warwickshire CCG	259,229	53,708	24,877
Warwickshire	**548,729**	**107,421**	**48,161**

Warwickshire's population is forecast to grow by 4.7% over the next 5 years, with 11.3% growth in the over-65 population, altering the age profile of the county and increasing the median age. Table 2 shows Warwickshire's population growth by age-group from 2012 to 2022.

Figure 2. Warwickshire's projected population change by age group, 2012-2022

Age	2012	2022	Percentage Change (%)
0-4	32,000	32,000	0%
5-18	92,000	97,000	5.40%
19-29	65,000	61,000	-6.10%
30-49	149,000	141,000	-5.40%
50-64	106,000	119,000	12.30%
65-74	57,000	64,000	12.30%
75-84	33,000	47,000	42.40%
85+	14,000	20,000	42.90%
Total	548,000	580,000	5.80%

Ageing & Frailty

Although many people remain well, active and independent during later life, for others, increasing age brings an increasing chance of frailty, long-term medical conditions, dementia, terminal illness, dependency and disability. Older people and those who are vulnerable due to ill health, disability, injury, poverty and/or social isolation rarely need support from a single service.

Too often, strategies associated with long term conditions fail to consider common conditions associated with ageing such as frailty; approaches often focus on individual clinical conditions rather than the person holistically. Information, services and support needs to be coordinated across agencies to provide help as early as possible, anticipating future needs as well as addressing immediate needs in the most appropriate setting. If frail, older people are assessed thoroughly using a multi-disciplinary approach, and underlying causes of deterioration are identified and treated, there is the potential to make them less dependent and more confident and, in turn, less reliant on care.

Dementia

One of the biggest challenges the county faces as the population ages is dealing with the increasing prevalence of dementia. The condition usually occurs in people over the age of 65, and the risk of dementia increases with age. As Warwickshire's ageing population grows, so will the prevalence of dementia.

Dementia is increasingly becoming one of the most important causes of disability in older people. It is a general term used to describe a decline in mental ability that is severe enough to interfere with daily life and includes Alzheimer's disease, stroke, and many other rarer conditions. In 2011/12, there were 3,169 patients in Warwickshire formally diagnosed with dementia, representing under half of those estimated to be living with dementia. Although diagnosing dementia is often difficult, it is estimated that there are approximately 3,800 people amongst the wider population who have dementia but have not yet been clinically diagnosed. The situation is likely to worsen as the population grows and ages, the total number of people estimated to have dementia in the county will increase by nearly 30% to just over 9,000 people in 2020.

Disability-free Life Expectancy

Disability-free life expectancy (DFLE) is an estimation of the length of time that an individual can expect to live free from a limiting long-standing illness or disability. In 2008-2010, DFLE for males in Warwickshire was 64.1 years and 66.6 years for females. This is longer than the England average of 63.6 years for males and 64.8 years for females. Although women have a higher life expectancy than men on average, women will spend a greater proportion of their life with a disability.

The table below shows disability-free life expectancy for males and females at birth by Clinical Commissioning Groups (CCGs) in Warwickshire, 2010-2012.

Figure 3. DFLE and LE at birth by CCG, 2010-2012

Sex	CCG Name	DFLE (years)	Statistical Significance	With disability (years)	LE (years)	Proportion of life spent disability free	Proportion of life spent disability free rank	DFLE rank	LE rank
Males	NHS South Warwickshire	67.7	*	13.1	80.8	83.8	20	21	26
	NHS Coventry and Rugby	63.5	**	15.2	78.7	80.7	113	116	129
	NHS Warwickshire North	62.8	**	15.5	78.4	80.2	124	137	139
Females	NHS South Warwickshire	68.4	*	16.4	84.8	80.6	33	23	10
	NHS Coventry and Rugby	63.8	**	18.7	82.5	77.3	137	142	133
	NHS Warwickshire North	63.8	**	18.7	82.5	77.3	134	141	134

* Significantly higher compared to the DFLE in England

** Significantly lower compared to the DFLE in England

DFLE differs across the county, with DFLE significantly higher in NHS South Warwickshire compared to the DFLE in England but significantly lower in NHS Coventry and Rugby and in NHS Warwickshire North. Across all CCGs in Warwickshire, women will live for fewer number of years disability free compared with men, however the proportion of life spent disability free in NHS South Warwickshire is higher than NHS Coventry & Rugby and NHS Warwickshire North. All 211 CCGs in the country were ranked by their DFLE and life expectancy (LE) with 1 being the top ranked CCG and 211 being the bottom ranked CCG in the country. NHS South Warwickshire is in the top quartile (25%) of CCGs in the country for both DFLE and LE for males and females whereas NHS Coventry and Rugby and NHS Warwickshire North are in the bottom half of the country.

Long term health conditions

A long term condition is defined as a condition that cannot be cured but can be managed through medication and/or therapy. Long term conditions include diabetes, asthma, arthritis, high blood pressure, coronary heart disease and certain mental disorders such as schizophrenia and depression. However, this list is not exhaustive and no definitive list exists. The five most common long term conditions are asthma, chronic obstructive pulmonary disorder, coronary heart disease, chronic heart failure and diabetes.

The Department of Health estimates that 70% of the total health and social care budget in England is spent on the care of people with long term health conditions. People live with these conditions for many years, often decades and they can impact on their quality of life by causing disability, loss of independence and early death.

It is estimated that about 1 in 3 people over the age of 16 live with a long term condition in Warwickshire, approximately 147,000 people. Figure 4 shows the ratio of reported to expected prevalence for a number of long-term conditions for each of the Clinical

Commissioning Groups (CCGs) across Warwickshire. (A ratio of less than 1 indicates that the expected count is higher than the reported count and a ratio of more than 1 indicates that the reported count is higher than the expected count.)

Figure 4. The ratio of reported to expected prevalence of long term conditions by CCG

Long-Term Condition	Rugby (excluding Coventry) CCG	South Warwickshire CCG	Warwickshire North CCG	Warwickshire	West Midlands Region	England
Coronary Heart Disease	0.78	0.81	0.74	0.78	0.74	0.80
Stoke & TIA	0.86	0.93	0.80	0.87	0.82	0.85
Hypertension	0.58	0.58	0.59	0.58	0.57	0.55
Diabetes (Aged >=17)	0.81	0.68	0.92	0.78	0.95	0.88
Chronic Obstructive Pulmonary Disorder	0.61	0.57	0.67	0.61	0.47	0.52
Epilepsy (Aged >=18)	0.98	0.80	0.93	0.87	0.95	0.87
Asthma	0.71	0.71	0.67	0.70	0.67	0.64
Heart Failure	0.47	0.47	0.55	0.50	0.54	0.51
Chronic Kidney Disease (Aged >=18)	0.42	0.44	0.50	0.46	0.48	0.47

Figure 4 indicates that all long term conditions in Warwickshire are currently either under-reported, there is a lower than expected underlying risk, effective prevention of incidence or a mix of all of these factors. However it is important to note that the Quality and Outcomes Framework (QOF) where these figures are obtained from is a *voluntary* programme for GP surgeries in England to opt into rather than a legislative requirement.

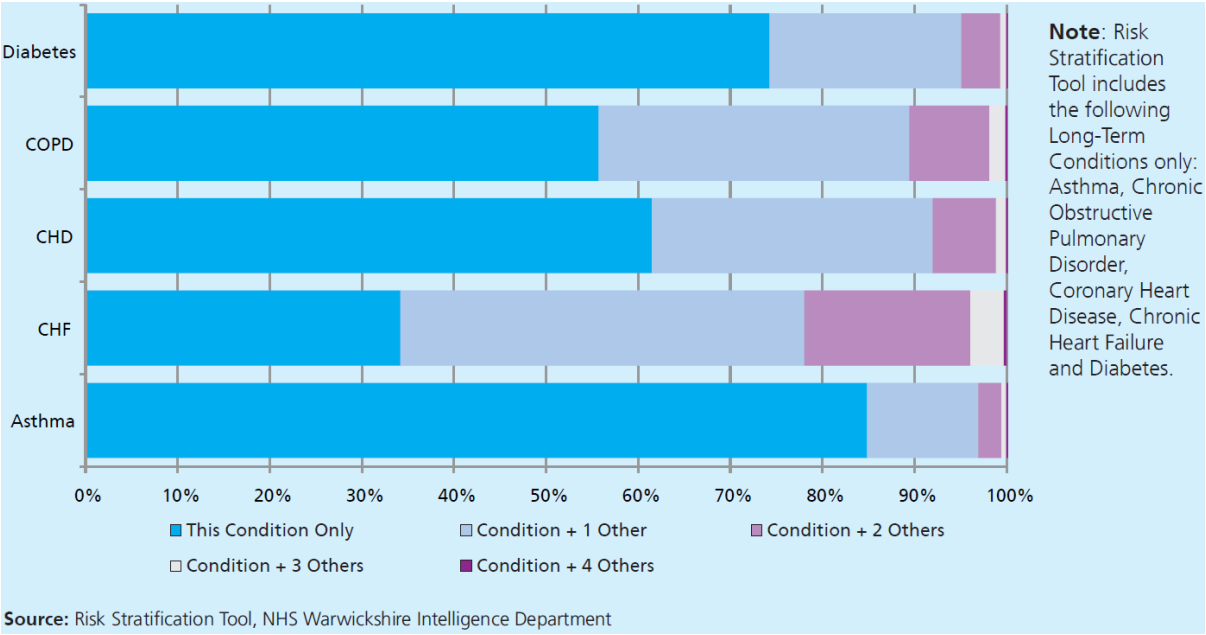
There is very little data on people with multiple health conditions in Warwickshire, however, data is currently collated on the five most common long term conditions through the risk stratification tool. Data from 59 out of 76 GP practices across Warwickshire shows that as of March 2012 there were 58,429 people diagnosed with one or more of these conditions. 49,362 people (84.5%) were diagnosed with a single condition, with 9,067 (15.5%) having two or more long-term conditions (multi-morbidities).

The most commonly diagnosed long-term condition in Warwickshire is asthma. Asthma patients were the least likely to be diagnosed with an additional disease – only 15% also had a further long-term condition. This is in contrast to heart failure patients, where nearly two thirds were living with an additional long-term condition, and over 20% had two or more further conditions.

Figure 5. The number of patients in Warwickshire with one or more long term conditions, 2012

Number of Long-Term Conditions	Number of Patients	Proportion of Total Patients
1	49,362	84.5%
2	7,673	13.1%
3	1,222	2.1%
4	162	0.3%
5	10	0.0%
Total	58,429	100.0%

Figure 6. Proportion of patients with one or more long term condition, by condition, Warwickshire, March 2012



Source: Risk Stratification Tool, NHS Warwickshire Intelligence Department

Health Inequalities

Health inequalities are preventable differences in health and wellbeing experienced by certain population groups. The causes of health inequality are complex but they do not arise by chance. The social, economic and environmental conditions in which people live are the biggest influences on their health.

Health inequalities are often measured by life expectancy, however there are other important drivers such as rates of smoking, employment, earnings potential and deprivation.

Deprivation in Warwickshire

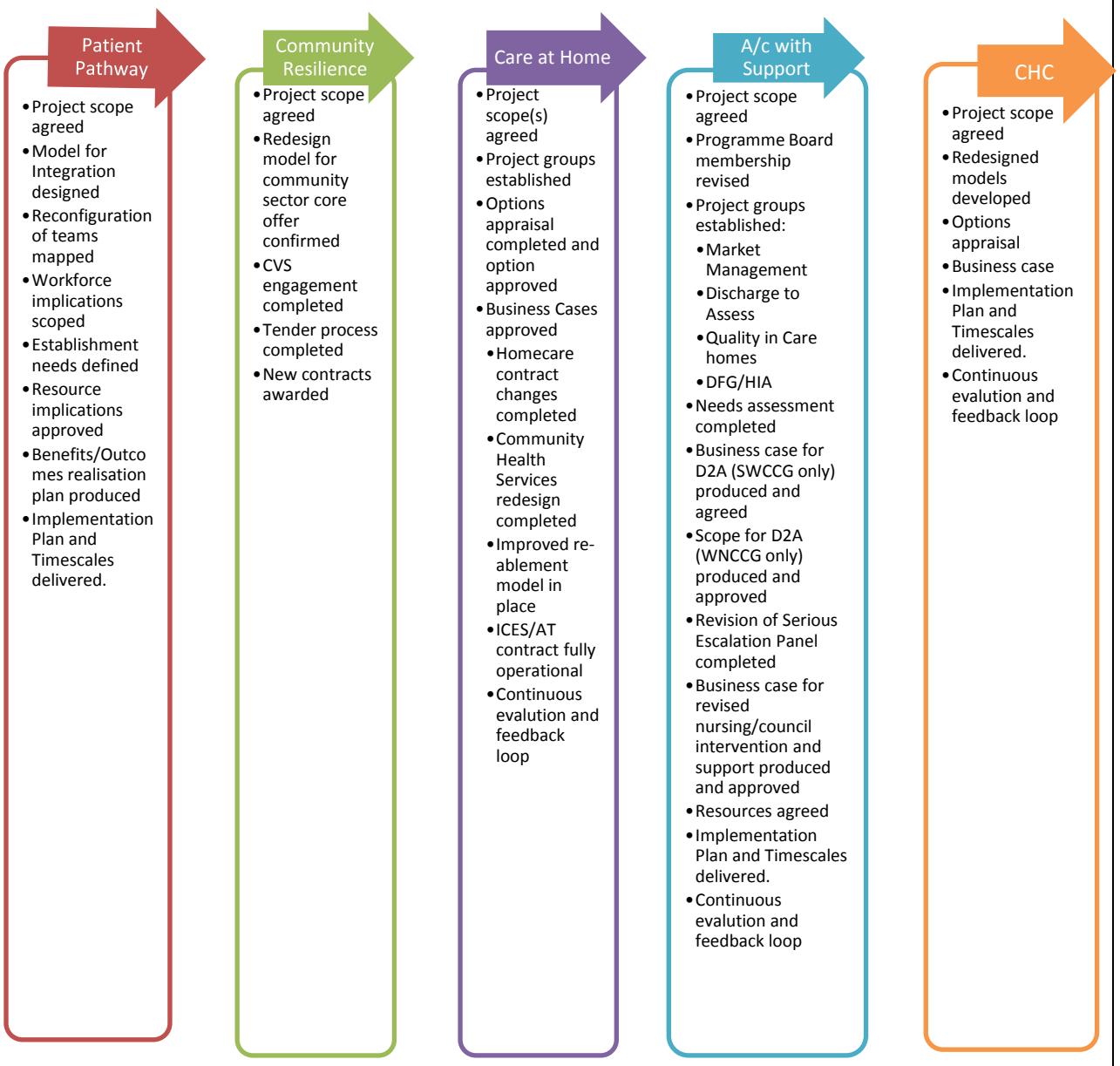
Overall, the 2010 Indices of Deprivation show that Warwickshire is not particularly deprived, however there is considerable variation in deprivation across the county, with various, distinct pockets of severe deprivation as well as a more general pattern of higher levels of deprivation in the north of the county.

Nuneaton & Bedworth has the highest levels of deprivation in the County, indicated by the highest average Super Output Area (SOA) score. In 2010 the Borough ranked as the 76th most deprived Local Authority District (out of the 326 Local Authorities in England). In comparison, Stratford-on-Avon District is the least deprived in Warwickshire with a national rank of 303.

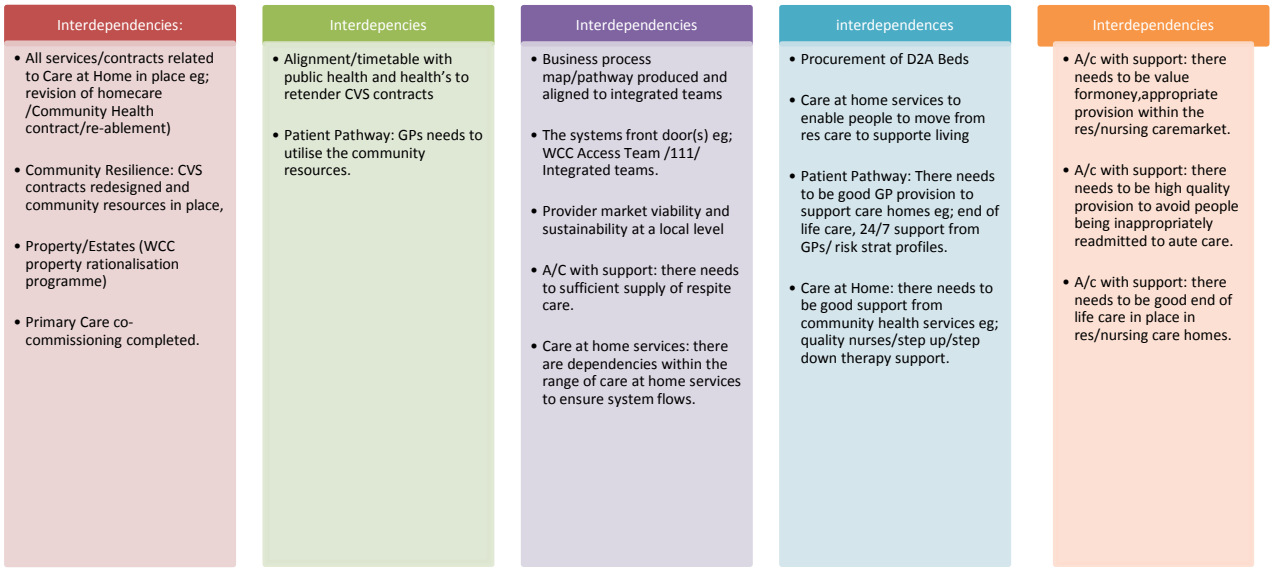
4) PLAN OF ACTION

- a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

KEY MILESTONES



INTERDEPENDENCIES



b) Please articulate the overarching governance arrangements for integrated care locally

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, Mental Health, Community Services, Pharmacy, and District and Borough Councils. 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 meets 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.

It has been agreed that the evolution of integration through the delivery of our BCF plans within Warwickshire, will be governed through the existing Joint Commissioning Board, which reports directly to the Integration Executive. Below illustrates the strength of the partnership within explanation of the core roles and responsibilities of each element of the governing structure for BCF:

The Health and Wellbeing Board (HWB) is accountable for:

- Ensuring a coordinated approach to health, social care and public health across Warwickshire
- Developing a countywide HWS, informed by the JSNA
- Receive and consider plans submitted by key partners.

The Integration Executive's membership exists of the Accountable Officers of the three Clinical Commissioning Groups (CCGs), the Strategic Director of People Group (Warwickshire County Council) and the Directors of Public Health.

- Are accountable for investment decisions
- Define the direction of the business/partnership; ensuring all work is aligned with strategic intent
- Approve programmes of work; ensuring that all areas of work proceed within the individual and collective restraints of corporate and political governance requirements
- Provide leadership to the programmes in order to achieve the intended transformational change across the health and social care system

The Joint Commissioning Board (JCB) has a membership including senior managers from agencies responsible for commissioning health and social care services across the county. The JCB is responsible for:

- Identifying, planning and seeking approval for initiating programmes of work that improve the efficiency, effectiveness and impact of the health and social care system within the county
- Managing interdependencies between programmes and resources across them
- Ensuring the ongoing viability of programmes of work and validate benefits' realisation

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

All programmes of work undertaken by the Joint Commissioning Board (JCB) adopt a programme and project management approach, supported by a dedicated programme manager.

The JCB will act as the BCF programme board and will be responsible for ensuring:

- Joint accountability is supported
- The programme delivers within agreed boundaries (including the fulfilment of national conditions) and that benefits are realised
- The programme clearly articulates the approach to be taken for managing resources, risk, quality, communications and planning and reporting, which will also be followed by any associated projects and activities
- The programme provides timely, succinct progress reports to all stakeholders and fulfils all national monitoring and reporting requirements
- Projects and activities have the requisite authorisations in place, receive clear direction and that any issues between them are resolved quickly and effectively
- Strategic issues are dealt with to ensure operational stability and effectiveness throughout the programme

As articulated previously Warwickshire has adopted a model for the Better Care Fund (BCF) including the following work streams:

- Customer / patient pathways (joint assessment & planning)
- Self-management and community resilience
- Care closer to home
- Accommodation with support
- Continuing healthcare

Each work stream has an allocated lead officer who, with the support of the programme manager, will:

- Coordinate and deliver all projects and activities within their work stream to the agreed time, cost, quality and scope
- Get the required authorisation for each new project or piece of work
- Adhere to the required management systems and processes as set by the programme
- Ensure operational issues are dealt with, and where necessary escalated to the JCB

The programme manager, on behalf of the JCB will:

- Secure and manage programme management resources so that strategies and plans are in place and implemented effectively and consistently across all programme activity and interdependencies are understood.

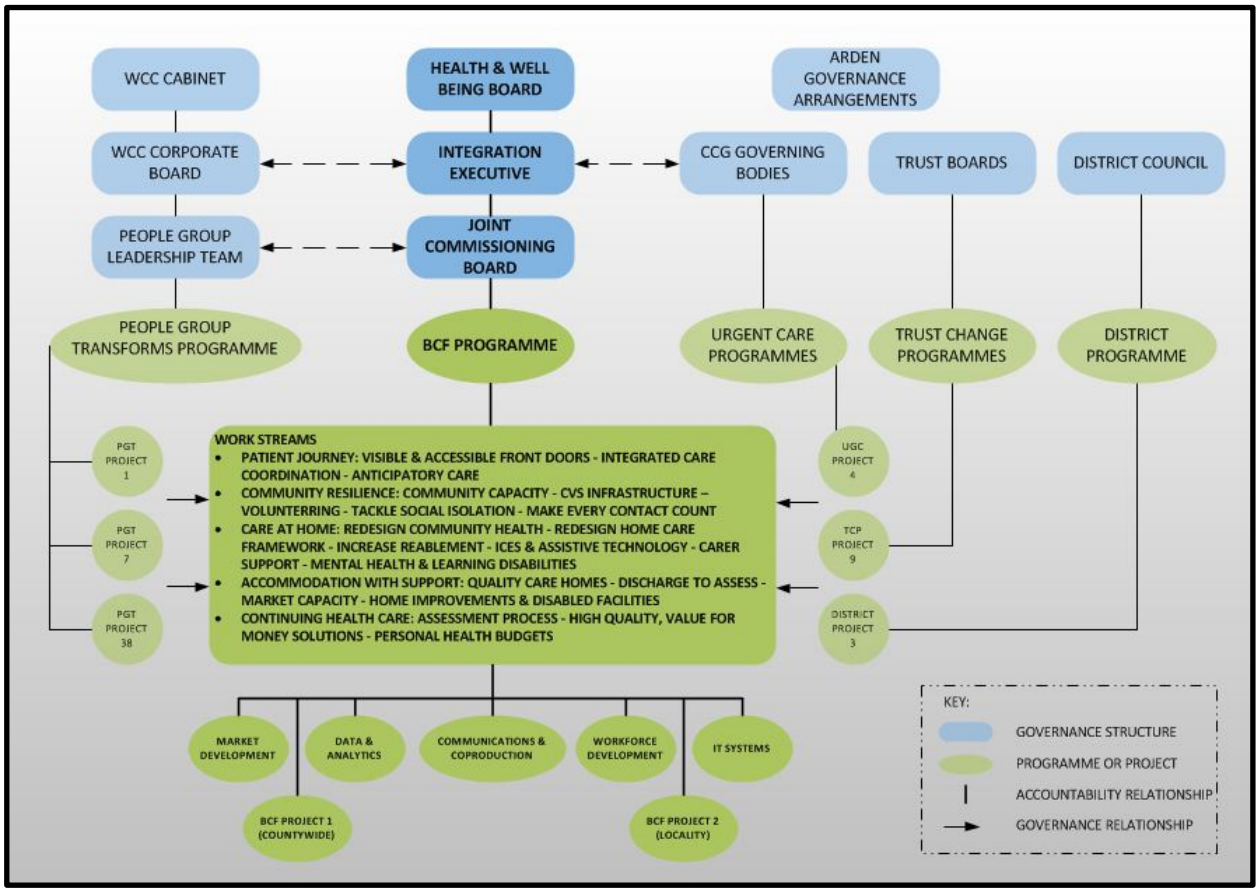
- Ensure that the programme's organisational design is managed through the programme life cycle and roles and responsibilities are clearly defined and articulated including temporary project management teams
- Provide technical project and programme management guidance to work streams, projects and activities within the programme
- Induct new members into the programme management team

Assurance for all programme and project management activity will be provided by the Governance and Assurance Team of the People Group (Warwickshire County Council).

All issues, risks, configuration management and contingency planning will be managed as per MSP and Prince2 methodologies by the JCB, supported by the programme manager.

Aligned to this activity the JCB will also be managing five foundations projects that will provide ongoing support to all work streams. These are:

- Communication and Co-production
- Market Management & Development
- Workforce Development
- IT infrastructure
- Data and Analytics



d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	Customer/Patient Pathway
2	Community Resilience
3	Care At Home
4	Accommodation with Support
5	Continuing Health Care
6	Foundation/Enabling Projects

5) RISKS AND CONTINGENCY

a) Risk log

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 and any financial risks for both the NHS and local government.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Leadership and continuity of transformation of whole system	3	5	15	Establish join programme office and joint posts for integration
Inability to meet financial challenges across the health and social care economy	5	5	25	We will be developing a local risk sharing agreement which will include the financial risks. Financial plans will be monitored through quarterly reporting to the BCF programme Board, any issues will be escalated to the JCB. Local partners will share their wider financial plans with each other.
Political and GP member buy in for proposed new service model	4	5	20	Establish strong brand and key message. Demonstrate financial viability across the economy. Evidence value for

				money and outcomes to be delivered for each scheme.
Introduction of the Care Act, 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	4	4	16	Align projects across the BCF with the Care Act implementation.
Moving resources to fund new joint interventions and schemes will destabilise current service providers, particularly the Acute Services.	4	5	20	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.
Access to data across the system	4	4	16	Secure Data Sharing Protocols that give access to data across the whole system.
Lack of understanding of the BCF function and intentions resulting in little change in behaviours/systems and outcomes for patients/users	4	5	20	Develop strong communication strategy and include people's stories of success.
Failure to secure capacity, capability and quality provision from the market	3	3	9	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
Public expectations remain static.	5	5	25	Robust communication Strategy. Public engagement and co-production of pathways and service reconfiguration.

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

Post submission further work will commence to produce a contingency plan and risk sharing protocols. This will include:

- A more detailed plan regarding how to manage the payment for performance.
- More detailed planning around the sharing of financial risks.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

The BCF aligns to the following projects and initiatives:

- Discharge to Assess Programme
- Care-Co-ordination (pilot for Integrated Team as GP level)
- ECAT/IT Infastructure project(s)
- Data Sharing Protocols (Phase 1)
- Retender of Community Services
- Review of Homecare Framework
- Quality of Care in Care Home
- MECC (Public Health)
- Implementation of Mental Health and Wellbeing Strategy (Public Health)
- Joint re-commissioning of ICES to include development of Assistive Technology

- Implementation of Dementia Strategy
- Individual Personalised Commissioning
- Implementation of Carers Strategy
- End of Life Care Strategy
- Market Management (Market Position Statements/Needs Assessment)
- Autism Strategy
- Winterbourne Action Plans

The Governance and Assurance Team in People Group hold all of the project management and governance support arrangements for all of the above initiatives. The BCF Programme Manager is part of this wider team and therefore has access to all current and future governance arrangements. It is this teams obligation to identify, understand and resolve interdependency issues.

The BCF Programme Manager supported by work stream lead officers will ensure the alignment between the BCF and the above initiatives is proactively managed through monthly reporting arrangements.

All new projects and activity generated through the BCF will be subject to the gateway processes established within People Group.

Where initiatives / projects are already underway that form part of the wider BCF plans their scope and governance will be reviewed to ensure that they are being managed by the most appropriate body and that the Joint Commissioning Board retain scrutiny and oversight of the work.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Warwickshire County Council have already agreed with each of the respective clinical commissioning groups that we will aim to be more strategic in how we deploy resources, which will require better collaboration and co-ordination across the council and the Clinical Commissioning Groups as well as with Districts and Boroughs.

Jointly we have agreed that we will:

- Develop mechanisms that enable people to manage their own care through self-assessment, information and advice and online resources.
- Create opportunities and initiatives to develop community based and preventative support services that deliver the health and social care outcomes that prevent, postpone and delay the need for formal support.
- Together identify, develop and implement opportunities to achieve financial savings and wider benefits through cooperation and working together around the key points of the health and social care inter-face, particularly, but not exclusively, in relation to older people and pathways out of hospital.
- Given the outcomes of Winterbourne and the Francis Report we will, and together, strive to deliver a vibrant competent workforce with quality at its core across all services including those that are commissioned and across the health and social care economy.

It is already well evidenced that there are many benefits for working together and aligning services and pathways. Together the council and the clinical commissioning groups have identified key areas of focus for integration that includes:

South Warwickshire Clinical Commissioning Group
Redesigning the voluntary sector offer
Discharge to Assess
Falls Services
Mental Health including CAMHS
Long Term Conditions eg; Dementia
Admission Avoidance
Care Home/End of Life Care.

Warwickshire North Clinical Commissioning Group
Redesigning the voluntary sector offer
Discharge to Assess (community based model)
Integrated Community Services
Long Term Conditions eg; CVD, Dementia
Care Homes/End of Life Care
Admission Avoidance (Redesign of A & E)
Redesigning children health services

Coventry & Rugby Clinical Commissioning Group
Redesigning the voluntary sector offer
Discharge to Assess (Community Based Model)
Long Term Conditions eg; Dementia
Mental Health including CAMHS
Integrated Community Services
Care Homes/End of Life Care
Vulnerable Children 0 -5 yrs eg; looked after childrens health

Coventry & Warwickshire CCGs Strategic Plan 2014 – 2019 is also well aligned to the BCF plan and provides good evidence of the synergies across the health and social care system for the delivery of an integrated system.

The principles of our approach to transformation are:

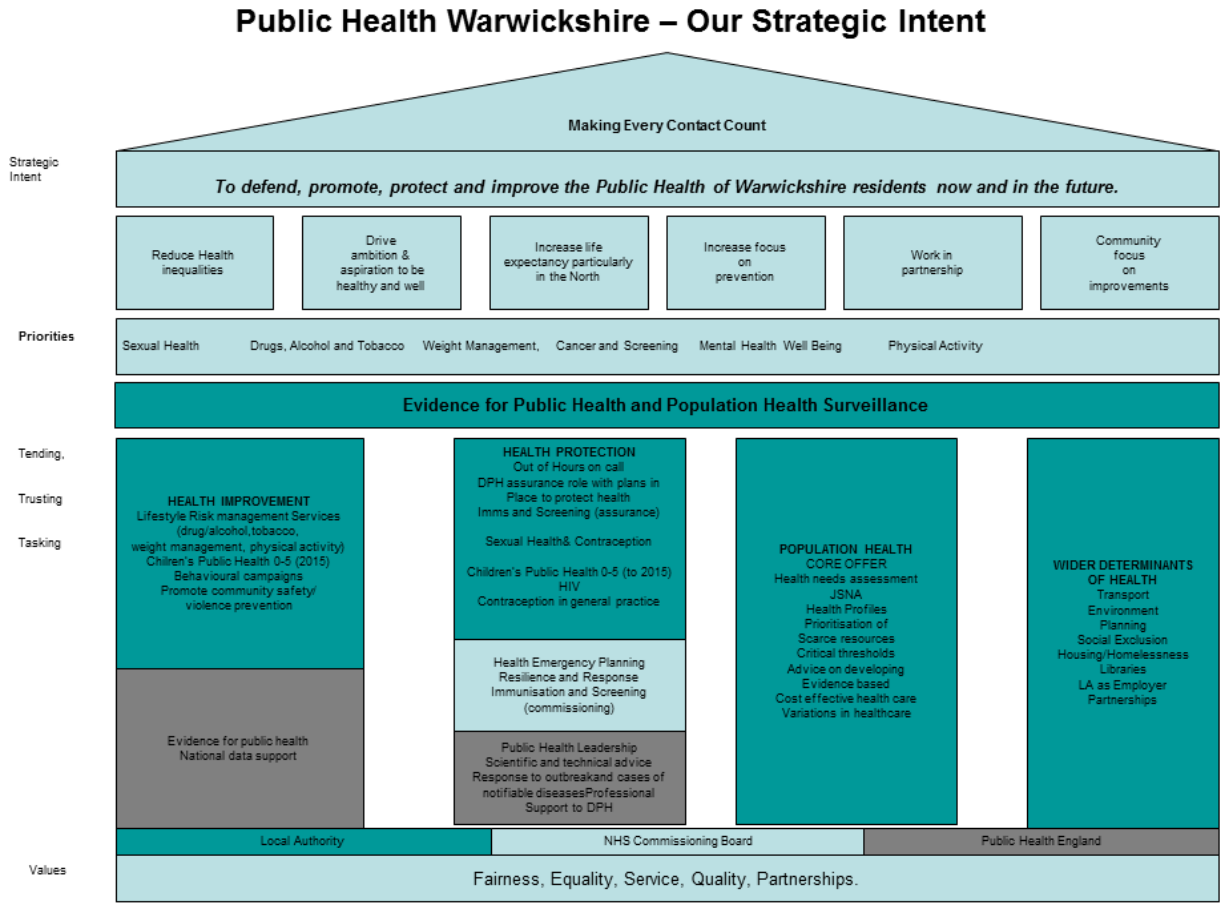
- Care closer to home
- Specialist care in the right place, at the right time
- Enable patients to live the lives they choose
- Clinicians from across health and care working together
- Use of innovative practice and technology to deliver care
- Care delivered within a financially sustainable system
- Mental disorders are treated on par with physical disorders.

With ambitions to:

- **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 strategic intent of Public Health Warwickshire, as outlined in the diagram below, has clear synergies with the BCF plans. Particularly aligned to BCF scheme 2 Self-Management and Community Resilience, through public healths focus on reducing health inequalities through lifestyle risk management services and driving aspirations to be healthy and well.



In addition ,the revision of the Health & Wellbeing Strategy is underway and is attached as an initial draft and provides a strong platform for the development of the BCF plans.

http://publichealth.warwickshire.gov.uk/

http://hwb.warwickshire.gov.uk/about-hwbb/consultation-hwbs/

Finally, there is strong correlation between the outcome frameworks measures defined for the 2 year operational plans for the CCGs and the Social Care Outcomes Framework.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

The CCGs 5 year plan sets out a strategy for integrated care delivery with the patient and GP at the centre. Co-commissioning will enable better join up between primary care and other services. We also recognise the importance of reducing variation in quality of primary care as key to improving efficiency and quality overall in our services. Co-commissioning will enable us to support targeted improvement through the sharing of intelligence and resources. Local co-commissioning will also enable better linkage to partner with local authority led initiative such as community asset and health living innovations, and support our local health and wellbeing boards with tackling health inequalities.

Joint responsibilities with the Area Team include:

- Working with the public and with health and wellbeing boards to assess need and decide strategic priorities.
- Jointly designing any local contracts such as PMS, APMS and any enhanced services commissioned by NHS England.
- Planning and decision making related to new GP premises to ensure join up with wider Arden system wide strategies.
- Deciding in what circumstances to bring new providers and managing associated procurement and making decisions on practice mergers.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

We have jointly agreed the following principles for the Better Care Fund:

1. Protecting Social Care
2. Supporting QIPP and OOPs savings
3. Investing to Save
4. Maximising the efficiency and effectiveness of the health and social care system as a whole

Protecting social care services has two equally important aims... that people with eligible social care needs will have them met and that the investment in social care and health is appropriately balanced so that health and social care can support each other in shifting the balance of spending more into the community, reducing demand on acute health care services.

Funding to be transferred for spending on social care services will be clearly set out in the better care fund plan. This funding may meet any of the following criteria: supporting existing services, meeting savings targets and covering reductions in funding, funding new demand pressures, funding new responsibilities (for example The Care Act), and funding spending pressures driven by changes in demand management across the whole health and social care system.

The paragraphs below set out the funding / protection that will be going to social care. However, there are a number of financial risks facing social care which are not protected in this BCF plan. They are:

- Future savings targets that may not be viable, or which may have a negative impact upon the health and social care system as a whole.
- Demand, inflation and other unavoidable adult social care spending pressures.
- Wider Care Act costs beyond the implementation costs.
- Double funding and other transitional costs.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Jointly we have agreed that

- The funding for this year 14/15 will continue (as defined within the S256)
- The minimum Care Act costs for 15/16 will be included (£1.3m)
- Protecting social care will include the funding for the Discharge to Assess (D2A) beds and the Moving on Beds across the County.

We will also be covering

- Some CHC related costs where through D2A we are generating savings overall in the whole system i.e.; Savings for health which creates a small cost for social care.
- We will be covering any investment costs required by business cases for the purpose of improving the health and social care system as a whole.

We will continue to invest the social care capital.

And we will be setting up a performance fund to protect social care from costs that it will bear from reductions in overall admissions activity.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The Care Act funding for Warwickshire equates to £1.3m and forma part of the allocation to social care.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

£1.3m will transfer to the local authority for the implementation of the Care Act. Key areas of spend are detailed below:

Personalisation	Create greater incentives for employment for disabled adults in residential care
Carers	Put carers on a par with users for assessment.
	Introduce a new duty to provide support for carers
Information advice and support	Link LA information portals to national portal
	Advice and support to access and plan care, including rights to advocacy
Quality	Provider quality profiles
Safe-guarding	Implement statutory Safeguarding Adults Boards
Assessment & eligibility	Set a national minimum eligibility threshold at substantial
	Ensure councils provide continuity of care for people moving into their areas until reassessment
	Clarify responsibility for assessment and provision of social care in prisons
Veterans	Disregard of armed forces GIPs from financial assessment
Law reform	Training social care staff in the new legal framework
	Savings from staff time and reduced complaints and litigation

v) Please specify the level of resource that will be dedicated to carer-specific support

These are indicative figures and further more detailed modelling is required pre and post Carer Act implementation.

Total Carers Additional Assessment Cost	**£134,791.79**
Total Carers Additional Package Cost	**£614,450.33**
Total Other Carers Provision Costs	**£30,000.00**

NB: Does not include any health related costs.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

- Reduced ambition for pooled budgets e.g. CHC – however this will be explored further as the projects progress and a robust risk strategy is in place.
- Reduction in element of funding to protect social care.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to 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 be 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, re-ablement, 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 teams 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 in some key areas of the health and social care system, for example within care homes so that people can be discharged back to the home over the weekends.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

The County Council has a specific NHS Number Sharing Project in place to address this. We have recently re-established a mechanism for retrieving NHS numbers for our clients through the use of the MACS system. This will mean that virtually all of our social care clients will have a valid NHS Number recorded on our system, enabling us to share information with local health colleagues more efficiently. We are now in the process of populating our system with NHS Numbers where there are currently missing records, and

all future data capture will include NHS Numbers by default.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

The use of Open APIs is being actively examined in a number of workstreams, For example, we will be considering how our new corporate Management Information system can utilise APIs such as the ones offered by LG Inform and the Office for National Statistics to populate our systems with national benchmarking data. The new social care system currently being implemented (Corelogic) also has considerable capacity to utilise APIs, with in terms of populating our databases but also for automating the process for surfacing our own data elsewhere.

We use the GCSX system for sending secure emails to colleagues in the NHS where appropriate. We also have access to the Egress Encrypted email system through our Google Chrome tools. We also have a corporate Information Security Policy covering all aspects of secure email procedures.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

At present, only our Public Health service is IG Toolkit compliant, and we are currently progressing towards the production of a WCC-wide submission. Our corporate Information Governance team is responsible for coordinating this and the expectation is make a compliant submission before March 2015. In the meantime, we able to exchange information with the local CSU via our Public Health team; this is operable on a short time basis but it is recognised the move to full organisation-wide compliance is required for a sustainable solution.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

The Risk Model

In Warwickshire we offer the Combined Predictive model1 which uses an algorithm developed by the Kings Fund, Health Dialog and New York University. It uses both

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

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 – 26/28 (93%)
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], Proactive Care Programme enhanced service.

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

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

Across all three CGs, practices are making plans for GPs to be accountable for co-ordinating patient-centred care for older people and those with complex needs. The work streams within the BCF (underpinned by the CCG £5 per head funding as per national guidelines) will support practices to play a key role in developing a joined-up approach to assessment and care planning. For example, in SWCCG practices are working with the voluntary sector and third sector providers to develop the Slivers Book with Public Health.. In WNCCG practices have identified a need to align community, social care, and voluntary care sector around the practices to support better care for this vulnerable

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

group. In CRCCG, Rugby GPs have identified a need to work more closely with the voluntary sector to provide support for vulnerable patients and are developing a social prescribing model.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

Further more detailed work will continue to better understand the risk stratification population and to determine where joint care plans exists.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

Service users and carers have been involved through specific projects and will include people from more identified vulnerable groups for example carers, people with mental health issues, learning disabilities, physical impairments and long term health conditions.

An Artist in Residence has been commissioned to:

1. Work directly with the public to visualise what good integrated services will look and feel like.
2. Will develop visual material to enable their message to be seen and heard across the health and social care system
3. Will work with Experts by Experience and co-produce methods of engagement across all of the projects linked to or specific to the Better Care agenda.

The project aims to gather the personal stories of the participants, creatively reflecting on their experiences on their journey so far through the health and social pathways, but also write new narratives, telling the story of how they envisage the future of their journey.

This commission is intended to support the wider rollout of the BCF by;

- Providing an effective and safe space for participants to express their views and aspirations through creative expression, in order to engage local people who would not ordinarily participate in projects like this.
- Raise public awareness.
- Generate a body of evidence, views and experiences through whichever artistic medium is used to positively influence and visually present the development of the new Customer Journey
- Offer a creative, but robust method of consultation.

In addition, the co-production team, within the council, will work with all project leads to ensure that the principle of putting customers at the heart of commissioning is a firm reality as Integration moves forward.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

This plan has been developed alongside the 2year and 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.

More specifically the three Acute providers and the Coventry Warwickshire Partnership Trust have all been actively engaged in scoping and designing the plans at a CCG level;

- CRCCG have held three days planning sessions with a range of key stakeholders including the four main providers.
- SWCCG engage with provider through the Urgent Care Board and have also engaged in a specific provider workshop to support the shape of the plans.
- WNCCG have held a stakeholder workshop and have also revised the scope of the Urgent Care Board to now include the BCF.

All stakeholders agree that existing forums and meetings should be used to drive the BCF forward with a particular preference to use the Urgent Care Board as the primary vehicle for provider engagement, where practical and relevant.

ii) primary care providers

- A series of workshops have included GP leads and other representatives.
- GP leads defined for hi level key projects and attend other relevant projects and link back to GP member councils and governing bodies.
- GP members are informed of progress through the Member newsletters
- Presentations have been completed across all 3 CCGs on some key areas eg; outcome of Home Truths project, Autism Strategy, Discharge to Assess.
- GPs leading some key projects eg; Quality in Care Homes (SWCCG).

iii) social care and providers from the voluntary and community sector

WCC Social Care have been leading the development of the submissions to NHS England and have played a key role in bringing together the three CCGs, public health and representation from the districts and boroughs, through the Joint Commissioning Board which is also chaired by the council.

Key leads within social care have also been instrumental in driving key projects that are central to the principles of the BCF, for example; the Discharge to Assess Programme is chaired by the Head of Social Care and Support. Additionally key staff from across the People Group; commissioners, operational service managers, officers with expertise in co-production have and will continue to have a significant contribution to make to the BCF plans.

The community and voluntary sector (CVS) have been engaged through individual

projects and service redesigns. For example, the CVS, have contributed to the shape of the community resilience scoping paper and have been instrumental in driving through the Mental Health and Wellbeing Strategy.

Key to the implementation of the BCF programme with be the co-production of our plans, not just with the public but with key providers and stakeholders.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

This will progressed by health colleagues post submission.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
1
Scheme name
Customer/Patient Pathway
What is the strategic objective of this scheme?
Improving: • **Visibility and accessibility of 'front doors' to support services to make the right choice the easiest choice.** • **Improved care co-ordination for high risk/high cost patients** • **Develop effective anticipatory care within a primary care setting.**
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
<u>Project 1: Improve accessibility and visibility of 'front doors' to support services, to make the 'right choice the easiest choice, informed by customer journey examples.</u> In Warwickshire, we have identified that it is not simply the quality of the services that produces good outcomes for patients / customers. It is how they aligned together, and whether they are easily accessible at the time they are really needed. Therefore a key focus of our integration work is looking at how current services 'fit together' and how easy (or not), they are to access when they are really needed. This will assist us to determine how to: 1. Improve timely accessibility and responsiveness. 2. Reduce duplicated or overlapping services, where work is needed on refining or merging those services. 3. Understand how the public perceive and interact with services and use this insight to improve information about and access points to services, to ensure the public get best use of the right services.* 4. Enable the workforce to make 'the right choices' from the suite of services available, when they need to refer on. **<u>Project 2: Integrated care co-ordination</u>** This scheme will deliver integrated community teams located around a group of practices. GPs will have access to a consistent set of individuals in the community that will be able deliver the full range of community services. This care and support will feature social care, community health and associated services. Integrated teams will be will be supported by the national condition for an accountable lead professional to oversee the coordination of care. IT will be premised upon case management which will coordinate a range of inputs to provide greater stability to people who may otherwise become overwhelmed by their circumstances and recourse to acute services. We recognise that there is potential for improved outcomes for patients if multi-agency care co-ordination is better developed. Research provides a mixed view as to whether

fully integrated health and care teams deliver sustainable cost and outcome improvements when done at scale. However, we have identified locally that for high risk/high cost patients/customers, there could be benefits from an integrated model, linked to GP practices. This would enable support for this cohort to be better co-ordinated and reduce the risk of admission, reduce speed of health deterioration and enable the professional team to better understand the suite of services to draw from, to maintain independence as much as possible. We will develop this by:

1. Establishing multi-agency project groups to scope the models that will best fit the local areas, based around an integrated team approach linked to GP practices. This is likely to happen separately in each CCG patch initially.
2. Accessing best practice research and national evidence to determine potential benefits and long term viability of proposed models.
3. Utilise appropriate engagement methods to assist with redesign, e.g. workshops / PDSI
4. Take into account the potential benefits of housing, technology and other targeted support solutions in the model.
5. Assuming viable model developed, develop delivery plan.
6. Reconfirm baseline measures and indicators of success.
7. Implement and review, probably via staged roll-out.
8. Incorporate the requirement to align the processes for accessing personal budget and personal health budget as part of this work.

The Clinical Commissioning Groups and Social Care recognise that to enable people to have the best possible experience of the care system, health and social care need to work together in a joined up, coordinated way. The care system should be easy to navigate and people should feel confident that they will be treated with dignity and respect at all times.

Project 3. Developing anticipatory care Working with GPs and using the risk stratification tools to determine high risk patients and anticipating care needs. And using evidence from the Home Truths project improve information and access for GPs and practices to local services as a viable alternative to residential and hospital admissions.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

CCGs are the lead commissioning working in partnership with social care and the local Acute provider.
Name:
Anna Hargrave – lead CCG Commissioner
Jenny Wood – Lead for Social Care
Jane Ives – Lead for South Warwickshire Foundation Trust

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme

- to drive assumptions about impact and outcomes

➡ Home Truths: This is possibly driven by the findings that:
- ➡ 53% of GPs believe that older peoples services are not working well
- ➡ 65% of GPs have struggled to access older people's services

Findings from the Home Truths project confirmed that:

Issue	Impact
GPs lack knowledge of key local services. The lack of knowledge can often result in good services being underused.	**Key preventative and community services are underutilised –** this has the twin risk of impacting on outcomes for older adults, and to generate negative perceptions of service performance and validity
Limited ownership of the community offer on a locality basis – e.g. 73% of GPs surveyed reported having a problem accessing services	**Effective locality working aligned to GP networks is undermined**– practitioners are more likely to signpost to broader borough service offers, rather then promote local specialist services
Practitioners are inconsistently updated regarding emerging diagnoses – e.g. dementia diagnoses	**Poor communications and information flows can undermine the services offered** – delayed updates on key diagnoses mean that the relevant services are not offered in a timely fashion, if offered at all
GPs are frustrated by service access routes and response times – particularly the requirement for all calls to go through the contact centre	**GPs do not follow the proper processes and seek workarounds –** this can lead to delays in mobilising the right resources and mean that records are not properly updated
Early intervention activity is not prioritised. Crisis response practitioner focus throughout the system	**Clients may not receive the support they need until crisis –** opportunities to support clients earlier in the pathway are missed, potentially leading to an accelerated deterioration in condition

➡

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

TBC via Joint Commissioning Board

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Reduction in non elective admissions
Reduction in delayed transfer of care.
Carer reported quality of life
Proportion of people feeling supported to manage their own long term condition

People feel more in control by being better informed and knowledgeable about the health and social care system.

Ensuring that people have a positive experience of care.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand

what is and is not working in terms of integrated care in your area?
% of people supported with their long terms conditions % of people cared for at home % of at risk patients supported by an integrated team (including local community services)
What are the key success factors for implementation of this scheme?
• Effective engagement with staff, patients and customers to gain maximum benefits from co-production • Commitment from providers and commissioners to change service delivery mechanisms • The ability to take a differentiated approach across the County to ensure that the needs of local communities are met. • People feel more in control at a time when they are most vulnerable

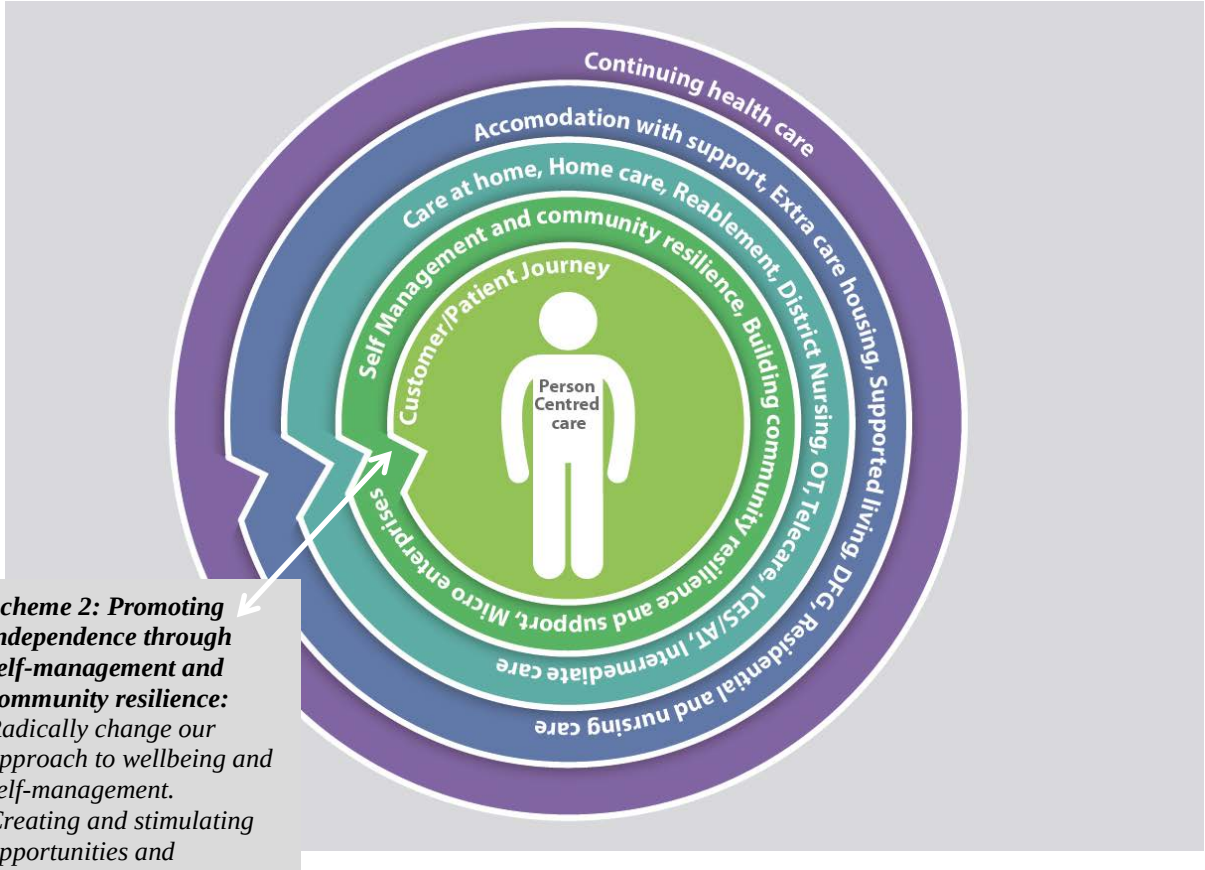
Scheme ref no.
2
Scheme name
Community Resilience
What is the strategic objective of this scheme?
• **Develop a community and voluntary sector support offer** that enables us to manage increasing demand by developing and building on existing community assets and community resources • **Promote wellbeing and social Inclusion** (includes promoting the New Economics' Foundation's Five Ways to Wellbeing, not just targeted at individuals, but including shaping existing services or providing new services in such a way that they encourage behaviours which promote the Five Ways. This work is already well underway in Warwickshire. Co-ordinated approach to social inclusion, economic inclusion and digital inclusion) • **Promote independence through self-management and community resilience** o **Building social / community capital** (relationships and social connections: includes targeted interventions to build social relationships amongst isolated groups, changes to the way existing services are run to facilitate social connections, peer support for people with similar experiences and the concept of neighbourliness) **support community and population groups to enable people collectively to 'feel good and function well** o **Building social / community capital** via; - **Community Facilitation** (co-ordinated approach to community development, community leadership, Town and Parish councils, and the use of community assets) - **Community Intelligence** (co-ordinated approach to, and best use of, community engagement, community consultation and analytics) **- Voluntary sector relationships** (managing relationships with the voluntary and community sector including funding relationships and strengthening Warwickshire's volunteer economy)
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Community resilience is about supporting population groups either within specific communities, or vulnerable groups within populations, or larger population groups, to enable people collectively to "feel good and function well". Incorporated into the concept of community resilience is the principle of developing personal and collective capacity to support local initiatives and forms of support, e.g. building local community enterprises, supporting the growth of voluntary activity for

example through time banking, peer support groups for carers, and information and advice, including financial advice, and developing self-management programmes, and expert patient programmes for people with long terms conditions.

Working with key partners with a joint 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 recognise that the success of this approach 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.

To achieve this the Council and its partners will develop a new approach to working with local communities that looks to build on the assets that individuals and communities have to ensure that people are able to live full and independent lives within their local communities. By 'assets' we mean facilities, capacity, skills, knowledge, connections and potentials.

This means a move towards a different dialogue and way of working with citizens, communities and the wider public to support the development of sustainable community-led initiatives and solutions. Creating and stimulating opportunities and initiatives to develop community based and preventative support services that prevent, postpone and delay the need for formal support.



Scheme 2: Promoting independence through self-management and community resilience: *Radically change our approach to wellbeing and self-management. Creating and stimulating opportunities and initiatives to develop community based and preventative support services that prevent, postpone and delay the need for formal support.*

The promotion of wellbeing and the building up of resilience in communities will take a multi-faceted approach that acknowledges the needs of residents and the environment they are living in. Each community is different as are its residents and needs. Therefore our response will be inclusive of the necessary services required to meet those needs from across the spectrum of the Local Authority and the Public Sector.

This means a move towards a different dialogue and way of working with citizens, communities and the wider public to support the development of sustainable community-led initiatives and solutions.

To achieve this we will:

- Work with the voluntary and community sector to develop a community and voluntary sector support offer that ensures people can maximise their independence within their local community, remain independent and to prevent escalation of need in to statutory services.

- Redesign our voluntary sector infrastructure support services to align with this approach and ensure they are positioned to support the local community and voluntary sector to respond to this agenda / approach.

- Build community capacity through targeted investment to stimulate individuals, local communities and small enterprises to develop / provide a range of support order to:
  - Promote health and wellbeing
  - Maximise independence
  - Reduce social isolation
  - Support and improve access to community resources
  - Prevent and delay people from accessing health and social care funded services

- Invest in services to support vulnerable adults and carers who are bordering on FACS eligibility, focussed on enabling them to remain independent and to prevent escalation of need in to statutory services by facilitating access to support and resources within their local community.

- Produce a robust voluntary strategy that will support new approaches to build community capacity, for example progressing “time banks” and “time credits” and other volunteering initiatives.

- Reduce Social Isolation and Loneliness by developing:
  - Targeted interventions to build social relationships among isolated groups
  - Changes to the way existing (non-wellbeing focussed) services and support are run to facilitate social connections
  - Interventions that encourage social connections between people with similar experiences to provide peer support

- Making Every Contact Count (MECC)
  All WCC and CCG Public Health contracts will have the requirement for Making Every Contact Counts (MECC) training to promote the health and wellbeing

agenda and ensure signposting to services as required. There is a sustained roll out of MECC across WCC staff and voluntary groups to ensure appropriate signposting/support by frontline staff.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

All community based contracts, commissioning activity and one-off funding will be reviewed and considered across the following organisations/partners:

- WCC People Group
- WCC Communities Group – Localities and Partnerships
- WCC Communities - Public Health
- WCC Resources – Libraries / Customer Services TBC
- South Warwickshire Clinical Commissioning Group
- Warwickshire North Clinical Commissioning Group
- Coventry & Rugby Clinical Commissioning Group
- Five District & Borough Councils.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Young Foundation Wellbeing and Resilience Measure (WARM) identifies three scales that contribute to community resilience:

- **Self**: the way people feel about their own lives
- **Support**: the quality of social supports and networks within the community
- **Structure and systems**: the strength of the infrastructure and environment to support people to achieve their aspirations and live a good life.

Each of the three levels interacts to influence community resilience in an area.

The Mental Health Foundation focus uses the five ways to wellbeing developed by the New Economics Foundation :

- **Connect** – feeling close to people and valued
- **Be Active** – physical activity improves the mental wellbeing
- **Take notice** - being aware of what is taking place in the present directly enhances your well-being and savouring 'the moment' can help to reaffirm your life priorities.
- **Learn –** Life-long learning enhances self-esteem and encourages a more active life
- **Give -** Individuals who report a greater interest in helping others are more likely to rate themselves as happy.

It is helpful to understand the current capacity and resilience within Warwickshire. The recent 'Living in Warwickshire' survey provides useful information on the views and perceptions of residents:

Engaged Communities

Only one in three residents across the County agreed that they could influence decisions affecting their local area. Even in areas where the largest proportion of residents felt they could play a part in affecting local decisions, the figure was only 50%.

The analysis also raises the issue of how do we empower communities and develop social capital locally. This is important as greater interaction between people generates a greater sense of community spirit and research has shown that higher levels of social capital are associated with better health, higher educational achievement, better employment outcomes, and lower crime rates.

Empowered Localities and Neighbourliness

Across Warwickshire, one in three people responded that they didn't know their neighbours. The results showed that nearly 39% of respondents felt that they didn't belong very strongly with their surrounding immediate area.

If residents struggle to identify with their local neighbourhood, it poses the question as to what is the best way to engage with these communities. It is clear that tailored approaches are required across the County given the notable geographic differences which exist, particularly between urban and rural areas.

Volunteering

Overall, across Warwickshire, 41% of respondents have been recently involved with a local community or voluntary organisation, but only 12% have been engaged in formal volunteering. However, this masks some huge variation within the County.

The Living In Warwickshire survey has been useful in clarifying where there are strengths in our communities, and also where WCC needs to focus its activities in developing resilient communities

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

TBC via Joint Commissioning Board

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Increased access to community resources
- Reduced reliance on GP practice and recourse to A & E
- Improved GP knowledge of local services and support
- Improved relationships between frontline health and social care staff
- Increased self management of long term conditions

- Improved decisions making around individual's care and support

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

This scheme aligns to the councils own community capacity strategy and the Public Health Mental Health and Wellbeing Strategy and forms a workstream of the Community Capacity Board. Through this governance we are able to measure the impact of the scheme through the recognised CVS infrastructure. The scheme will also use the metrics defined above to determines its impact on the system.

What are the key success factors for implementation of this scheme?

Communities themselves have the skills, resources and knowledge to support people to remain independent for as long as possible. Through building on community assets and garnering local help and support, in partnership with the voluntary and community sector, we anticipate that the following outcomes will be achieved

- reduced reliance on statutory services
- reduced or avoided admissions to hospital
- reduced or delayed admissions to residential care
- Patients/clients ability to remain independent sustained and/or increased.
- Patient/clients overall satisfaction increased eg; keeping active and social activity improved.
- Community resilience increased.

Scheme ref no.
3.
Scheme name
Care at Home
What is the strategic objective of this scheme?
• **To provide a sufficiency of supply within community based provision to enable people to remain at home for as long as possible.** • **Improve 7 day access for all community services within the system.** • **Reduce the % of admissions due to carer breakdown** • **Improve reported quality of life for carers** • **Reduce the need for crisis interventions** • **To support all people with mental health and/or learning disabilities to live full and independent lives.**
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Outcome based approaches requires whole system transformation and fundamental change in the way that services are delivered. Outcomes based approaches is about changing: "*the system away from the traditional service provision with its emphasis on inputs and processes towards a more flexible, efficient approach, which delivers the outcomes people want and need and promotes their independence, well-being and dignity*[3]". The three CCGs together with WCC are seeking to secure a long term future for community health services that moves away from bed based provision to more integrated community service (that ideally is wrapped around GPs and/or GP practice clusters.) and moves away from service specifications to an outcome based model. Joined up Care at Home services are at the centre of the BCF model to ensure that people remain independent for longer and prevent them from being unnecessarily admitted to or become stuck in inappropriate provision. All community based services across the health and social care system, including the community and voluntary sector will need to reviewed, redesigned, consolidated and coordinated. This will mean for some services a programme of modernisation and redesign that results in bringing together services into a single pathway that proactively avoid admissions and improves discharge. This will mean that people who are frail and become sick are managed at home with intensive community services, it will mean providing step down services to enable people to be discharged to their home as soon as possible and step up facilities to support people to stay out of hospital. It will mean providing services that support carers so that

[3] Department of Health LAC (DH) (2008) 1Transforming Social Care

people can remain at home for longer.

The key questions posed for Care at Home are:

- What is important to existing and potential customers in terms of the delivery of care at home.
- What demand requirements are there in relation to demographic changes within Warwickshire.
- What are the differing needs within Warwickshire, particularly the distinction between north and south need.
- What are the implications for the market and for health and social care staff in terms of the nature and delivery of the transformation.
- What is the evidence of good practice from elsewhere.
- What financial model will ensure sustainability and consistency can we achieve?

Key Projects:

Project 1: Review of the Community Health Contract

Project 2: Redesign of the Homecare Framework

Projects 3: Increase in re-ablement services

Project 4: Full implementation of the ICES/AT service.

Project 5: Support to Carers

Project 6: Mental Health and Learning Disabilities

Project 1: Review of the Community Health Contract

Coventry & Rugby CCG, North Warwickshire CCG and South Warwickshire CCG (CCG) are seeking to meet the requirements of the Warwickshire population and secure a long term future for integrated out of hospital services. The retender process has been scoped to:

- Deliver a services that will respond appropriately to the health needs of local people;
- it supports a move away from service based to outcome based services;
- ensure that service quality is maintained or improved and meets national standards at all times;
- long term financial viability is achieved;

Project 2: Redesign of the Home Care Framework.

The principles on which the redesigned model for home care services is built is that it will deliver:

- Positive outcomes for customers that can enable them to achieve a level of independence and support that can be maintained in a community setting of their

choice.

- Locally based services and opportunities to customers that will reduce the unnecessary admission to hospital or residential care.
- Consistent, flexible, safe support that is high in quality and can evidence its contribution to a customer's wellbeing.

The current domiciliary care market generally experiences:

- Increasing complexity with a range of provision.
- Growth in self-funders and those who individually purchase using state funds.
- A growing gap between what people want and what the state will fund.
- Overall commissioning and provision of home care that is fragmented and this fragmentation is costly and ineffective.
- Providers recognising the need for change but not being in a position to drive that change.

The model for Warwickshire includes key delivery factors such as:

- A revised outcome based specification enabling greater flexibility for providers to meet the outcomes desired by customers and their carers.
- Zoning (locality working) and sizes of teams and the number of hours worked by staff members.
- Approaches to evening, weekend and public holiday provision (7 day working)
- Systems for providing cover for staff illness, holidays or job changes.
- System for managing times of peak demand (eg around getting clients up in the morning, meal times and bed times) as well as responding to sudden increases in demand for support from individual clients.

Project 3: Increase in the use of re-ablement

The Reablement Strategy will focus on key priorities of development that are all influenced by the changing social care landscape locally and nationally. These are set out below:

- **Deliver cost efficiencies in order to meet current and future demand within existing resources**. Within the current and future financial and political climate, both health and social care economies are tasked to provide best value services for the local population, within agreed budgetary constraints.
- **Improve quality and maximise independent living.** Maximise people's potential to live independently in their chosen community by giving them access to the Reablement Service.
- **Decrease the number of people unnecessarily admitted to long term care following a hospital stay.** Assessment and decision making about peoples long-term care needs will only be made only after they have had the opportunity for rehabilitation, recuperation and recovery.
- **Prevent hospital admissions and support timely discharges**. Individuals will receive their care in the right place, at the right time.
- **Improve the skills and competencies of the reablement work force.** Investing in workforce development will ensure reablement has the right skill mix of staff. This in turn will maximise throughput, volume and quality within the reablement Service. Performance management. Monitor and evaluate quality, provide accurate reporting data and to inform future commissioning intentions

This project is built on a successful re-ablement service and will provide additional value to the system through a re-abling model that is reinforced by the redesigned Homecare Framework. This project will be the foundations of the Care at Home model by providing the route to independence for all services. The project scope includes:

- Reviewing existing pathways and services
- Redesigning to align to the pathways for community health provision
- Align to ICES and Assistive Technology so that any IT solutions considered first.
- Act as the champion for independence.

Project 4: ICES and Assistive Technology

The ICES and AT project will be responsible for bringing innovation and technological solutions to the health and social care market. It will build on the recently retendered specification that seeks to deliver outcome based solutions and will, with the new provider, include cost effective solutions, using technology, as viable alternatives to traditional forms of care and support.

This will be a priority area of development for integration across the partnership and will link to other technological solutions being taken forward through our Foundation Projects. This project will deliver:

- A centre for independent living
- Customer led Community Equipment service delivery
- Time appropriate equipment delivery to aid people's discharge from hospital
- Drive technological solutions as the alternative to traditional forms of support.

Project 5: Support to Carers

We know that a % of admissions to acute care is due to breakdown. We also know that a % of these carers have not had a package of support prior to admission. We also know that post an episode of acute care some carers are not able to continue to care and people are transferred to residential or nursing care on a permanent basis.

National and local research confirms that better access to support ie; respite during the day and night is a significant factor to enable people to remain at home for as long as possible. We also know, through national evidence that providing good support to carers delays or avoids admission into an acute setting or into residential care.

This project will review the type and range of support provided to carers to enable them to care at home. The primary objective of this project is to secure breaks for carers during the day, evening and at weekend. This will be a key joint project that flows across the system and removes the barriers to good and timely access to support for all carers irrespective of the agencies involved.

Project 6: Mental Health and Learning Disabilities

The concept of parity of esteem underpins all of the work of the BCF. WCC and CCGs recognise the disjoint between mainstream health and social care services and specialist provision and with an increasing population with long term conditions this needs to be jointly co-ordinated to move to a community based model. We have recognised that there are many benefits to customers and carers and ourselves as commissioners of these services to work together to secure services that are of high quality and deliver person centred care that ensures people's own outcomes are the driver for change.

To do this, services will need to be redefined and redesigned. And together through the joint project groups there are clear moves towards a joint commissioning approach of integrated provision. One example of this is the personalised commissioning for people with learning disability. This model lends itself well towards an integrated model.

We will continue to build on the individual personalised commissioning approach with the intention of embedding this across the health and social care system. We have begun discussions with health colleagues.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

These projects will be governed by the Joint Commissioning Board. There are already lead commissioners and project groups established for some of these projects:

Project 1: Review of the Community Health Contract – **Anna Hargraves Director for Strategy and Innovation SWCCG**

Project 2: Redesign of the Homecare Framework – **Zoe Bogg Service Manager for Older People Commissioning**

Projects 3: Increase in re-ablement services – **Hugh Disley Head of Service for Early Intervention and Prevention**

Project 4: Full implementation of the ICES/AT service **Becky Hale Service Manager for All Age Disabilities.**

Project 5: Support to Carers – **Claire Hall Lead Commissioner for Care at Home.**

Project 6: Mental Health/Learning Disabilities: **Becky Hale Service Manager for All Age Disabilities.**

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Community Health Services

Community based rehabilitation requires a multi professional approach to care and can have a number of benefits. It can reduce the time spent in hospital, moves the patient either nearer home or indeed back home, has the potential for improved morale, increased visitors and reduced hazards from remaining in hospital[4]. The impact and intensity of rehabilitation provided can vary depending on the need for such services.

There are 4 main types of rehabilitation service[5]:

Acute: To treat acute illness and get patients medically stable.

Intensive: Concentrated, focused, intensive rehabilitation with specialist medical and nursing support in the hospital setting.

Intermediate: These meet a range of needs for the medically stable with a focus on 'confidence building'. Can be used post-discharge (step-down) or as a halfway house between home and hospital (step-up).

Community based: Multidisciplinary teams working in patients' own homes and providing wider specialist support to intermediate settings.

Home Care

The delivery of specialist home care will require the provision of care for individuals outside of normal working hours. Furthermore, in order to provide a flexible domiciliary service which offers individuals choice and flexibility will require a service that can operate when required, and not just provide care between set hours. Almost half of providers of home care services offer night sitting, day sitting and respite for carers, though some local authorities retain this element of domiciliary care for in-house services[6].

[4] British Geriatrics Society (2009). Rehabilitation of older people. BGS Best Practice Guide 1.4.

[5] Audit Commission (2000). The way to go home: rehabilitation and remedial services for older people. London, Audit Commission.

[6] Matosevic T et al (2001). Domiciliary care providers in the independent sector. PSSRU.

The most important organisational factors contributing to the effectiveness of home care re-ablement have been described by research as[7]:

- Commitment, enthusiasm, knowledge and skills of front-line staff. This requires thorough initial training and regular on-going supervision and peer support.
- High quality initial assessments by senior re-ablement staff; clear goals negotiated with users; regular reassessment throughout the re-ablement process; and flexibility to adapt the timing, duration and content of visits as users' needs and capabilities altered.
- Rapid assessment and delivery of equipment. Having quick access to occupational therapy skills and equipment may be more important than having occupational therapists employed as members of the re-ablement team.
- A strong and shared vision of the service to ensure appropriate referrals and discharges.
- Staff commitment, attitude and skills to encourage and motivate service users.
- Adequate capacity within long-term home care services to maintain the level of turnover required by re-ablement services.

Re-ablement

Research suggests[8] that following re-ablement people's need for social care services is reduced by 60% compared to if they had used conventional home care. Other studies[9] have shown that up to 63% of reablement users no longer need the service after six to 12 weeks, and that 26% had a reduced requirement for home care hours. Reablement also significantly improves people's wellbeing, particularly in terms of restoring their ability to perform usual activities and increasing their perceived quality of life[10].

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

TBC via the Joint Commissioning Board

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Outcome focused approaches – focusing on the impact of the service on an individual's quality of life, in contrast to services whose content and/or forms of delivery are standardised or are determined solely by those who deliver them.
- Targeted and early intervention/prevention approaches – for example those which provide a 'rapid response' and those that use a 'turnaround' approach in that the attempt is both to turn people around from their health and well being deteriorating and that the interdisciplinary, inter-conditions approach represents a turnaround in

[7] CSED (2010). Homecare reablement prospective longitudinal study: Final report summary. Department of Health.
[8] SCIE (2011). Reablement: Emerging practice messages.
[9] SCIE (2011). Reablement: Emerging practice messages.
[10] SCIE (2011). Reablement: Emerging practice messages.

terms of thinking about service provision.

- Integrated health and social care approaches – those which cut across professional disciplines providing seamless care for individuals.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

In terms of the overall delivery of services, a review which investigated the views of a range of service users and other organisations suggested there were ten broad outcomes to be achieved from social care and related services[11]

Outcomes from social care and related services	
Maintaining independence.	Keeping active and alert.
Keeping clean and comfortable.	Living healthier and longer lives.
Clean and orderly environment.	An adequate income.
Being safe.	Opportunities to contribute to the community.
Access to social contact and company.	Feeling valued.

More specifically in terms of home care, a survey (of service users and relatives, providers, care workers, and council staff) considered the top 3 priorities most important in delivering good homecare were[12]:

Sufficient time for care.

Friendly, respectful, capable care workers.

Choice about services eg when visits happen, who visits and what care workers do.

What are the key success factors for implementation of this scheme?

1. **Avoidable admission**
2. **Increased client/carer satisfaction rates**
3. **Improved delivery of standards of care within the community.**

[11] Social Policy Research Unit (2004). A new vision for adults social care: scoping service users views.

[12] Guardian Professional and DH (2013). Attitudes to home care in England.

Scheme ref no.
4
Scheme name:
Accommodation with Support
What is the strategic objective of this scheme?
• **<u>Priority 1: Quality of Care -</u> To improve the quality of care within residential care to reduce inappropriate admissions to acute care (Includes End of Life Care)** • **<u>Priority 2:</u> <u>Discharge to Assess</u>. To improve the flow of people from acute care back into the community and/or the most appropriate destination.** • **<u>Priority 3: Market Capacity</u>: To stimulate the market to provide the capacity and market shape to reflect the changing needs through our transformation from acute to community and demographic pressures to improve hospital flow back into the community.** • **<u>Priority 4: Home Improvements.</u> Increase and improve home adaptations to reduce delays in transfer of care.**
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Warwickshire Headlines: • Increase in the very elderly population is predicted to be higher in Warwickshire than the national average • This increase is most marked in the South of the County • The number of people living with dementia will increase by 34% by 2021 • The highest predicted rate of increase • There was a significant increase in permanent admissions to residential care between 2011 and 2013. A significant amount of this increase was attributable to dementia needs. • The profile of care home customers (with and without nursing) is generally older and more dependent on admission. There are **key strategic themes** that are relevant to all partners. These are: • Collaboration at the key points of the health and social care interface such as care home provision and pathways into and out of hospital, will deliver financial savings and wider benefits • Promote quality of service delivery through the development of a competent workforce across commissioned services • Support the voluntary sector to ensure that services are able to respond effectively

to partner priorities

- Develop person-centred services that are responsive to individual and population needs
- Support customer choice where appropriate and within a finite budget
- Driving down demand and driving up innovation through effective market management

These translate into specific **commissioning intentions** for accommodation with care for older people:

- Implement the outcomes of the Home Truths project to reduce the utilisation of residential care by 5%
- Increase the specialist residential and nursing care provision within Warwickshire by 10% - with at least 5% of these in Intermediate Care and 5% in Dementia Care. Review all contracts relating to elderly care across the residential and nursing care market to continually drive up quality including End of Life care to avoid unnecessary admissions to acute care
- Over the next four years commission in excess of 1500 Extra Care Housing with support. Ensuring provision for people who are frail as a suitable alternative to residential care.
- Improve the overall standards and performance in residential and nursing care homes to avoid people having to go into hospital unnecessarily.
- For people who choose to enter residential care, work with providers to
    - Develop personalised support arrangements (including understanding and responding to the proposed introduction of direct payments for residential care in April 2016)
    - Reduce unplanned hospital admissions and ensure that staff can support people to remain in the care home until their death in accordance with their advance care plan (if this is their choice)
- Expand the person centred care training for residential and nursing care staff to improve the quality of care across the County. Link this to quality premium payments where appropriate.
- Work with relevant stakeholders to improve the availability of appropriate accommodation for vulnerable people across the County.
- With partners develop a relevant statement of intention for accommodation with support, so to ensure aims and outcomes are shared across Warwickshire.
- Review the Home Improvement Agency service with housing partners to ensure it achieves measurable outcomes for the elderly population of Warwickshire

Project 1: Improving the Quality in Care Homes

-

This model is the first step on the journey to full joint commissioning in this sector – **the agreed vision**.

1. **Fully joined up (lead commissioner) model for quality improvement by15/16**

The standard of care and service delivery within nursing homes remains a key concern for health and WCC commissioners. As demand on these services increases, it is vital that the offer to customers and their families is one that meets expectations and outcomes.

One team across Health and WCC commissioning that has the responsibility of lead commissioning quality in care within nursing homes. This will include all aspects of the commissioning cycle: needs analysis, strategic planning, market management, contracting and procurement, quality improvement and management, and performance management. There would be a requirement that this team was made up of clinical posts and social care posts, to ensure the nursing care element and the holistic social care element of care standards were appropriately set and monitored.

To compliment this, our community based peer audit team will be strengthened to work across the health and social care market. Peer audits are user led and developed from an expert by experience perspective and will complement and not duplicate CQC regulations (that are subject to change from October 2014). The audits would be developed by using the 'my mum' test, which requires the auditor to assess elements of care that they would like to see present if it was their own parent that was being cared for within the nursing home environment.

In addition the Quality team would be responsible for commissioning a training programme that is accredited for all providers to undertake. The training focus would be on the practical and holistic elements of care giving; personalised care, respect, dignity and safety would underpin this training programme. If successful, this could generate a charter marked care programme that sees nursing care being 'rubber stamped' with the charter if they fully sign up to (and pass the 'my mum's test) that reflects quality standards. This will include the expansion of person-centred training for residential and nursing staff to improve the quality of care across the County. This will be linked to Quality Payments where appropriate.

GPs will have allocated time to visit care homes on a regular basis. Residents will be able to build relationship with their GP. The outcome expected is that long term conditions such as heart disease will be better managed, early interventions will prevent existing health conditions becoming worse and unplanned admissions will be reduced.

Review all contracts across the elderly care residential and nursing market to continually drive up quality and establish an agreed standard of service quality. We will dis-invest in services that do not meet the agreed standard and promote continuous service improvement.

Work with residential care providers to develop personalised support arrangements that will reduce unplanned admissions and ensure that staff can support people to remain in their care home until death in accordance with their advanced care plan.

Priority 2: Discharge to Assess.

D2A give patients an opportunity for further rehabilitation in a 24 hour care environment, and crucially allows for an assessment to take place outside of an acute setting over a longer period. Evidence shows that frail elderly patients do not always make the right decision about their future long term care when in an acute setting and still recovering

from an acute illness or accident.

D2A is a transformation project that builds on local developments designed to move care closer to home and reduce unnecessarily prolonged acute hospital stay. It is a multi-agency project working with the Local Authority and the CCG including Continuing Health Care.

In South Warwickshire we have been piloting the D2A model, beds are commissioned by the Local Authority from 2 nursing homes. Nursing care is provided by the home and medical cover is provided by a commissioned GP practice. Assessment for rehabilitation and ongoing therapy is provided by the CERT team, Case management and CHC assessments are provided by SWFT Discharge Coordinators and Social Care Support is provided by the Hospital Social Care team.

Through the BCF we will develop and adapt the Discharge to Assess (D2A) model across the county to improve the flow of people from acute care back into the community and/or the most appropriate destination, and reduce delayed transfers of care.

Project 3: Market Capacity

A comprehensive needs assessment of the residential and nursing care market has been completed an informs the next steps, which are to develop an Accommodation with Support model that will illustrate the market requirements for the next five years understood and published to the market (MPS) to:

- Support joint working with health partners to reduce the number of people entering residential and nursing care directly from hospital. We will develop appropriate 'step down' services to enable people to live independently at home following a stay in hospital. The model will be relevant to local needs.
- Develop robust accommodation options to support the need to reduce hospital admissions. We will work to prevent avoidable hospital admissions through working with the care home market to:
    - Support 7 day working so that discharge from hospital can be across weekends.
    - improve the links between primary care and the care home market to ensure that care is co-ordinated in the community
    - improve end of life care and advanced care planning to enable more people to die in their usual place of residence and thus avoid admission to hospitals.
    - improve overall standards and performance across the care market by having an agreed quality standard that all providers adhere to; securing a more person-centred approach; and developing a robust de-commissioning policy for those services that do not meet agreed quality standards.
    - Develop a 'step up' service model that is relevant to local needs.
    - Work to incorporate a Trusted Assessment model that improves the pathway between hospital and care home (residential and/or nursing) into the agreed care home model.
    - Commission therapy input into Step up and Step Down beds to reduce admissions and improve discharge flow.
    - Strategy with clearly quantified dementia nursing requirements developed

and authorised

o

- Develop a Shared Lives scheme through a sub-regional partnership that will support accommodation with support choices for people with a learning disability and people living with dementia.
- Encourage new providers to the local AwS market through the development of an on-line tendering process for commissioning
- Deliver AwS solutions as part of a wider range of solutions for 16-17 year olds likely to meet FACS criteria.
- Support the commissioning of specialist housing and support for people with disabilities, Autism and/or mental health – focusing on moving people out of residential care and repatriate home to Warwickshire.
- Increase specialist residential and nursing care provision in Warwickshire to ensure sustainable and affordable provision to meet the projected need of people living with dementia.
- Increase the provision of Extra Care Housing with Support ensuring provision for people who are frail as a suitable alternative to residential care. In addition, we will develop the current model to support people living with dementia.

Project 4: Home Improvements and Disabled Facilities.

- Secure the development of a Home Improvement Service (including major Disabled Facilities Grant) with housing partners that achieves improved timely and measurable outcomes for people and supports them to return and/or remain at home longer.
- Work with providers of Home Improvement and Adaptations to fully utilise the Making Every Contact Count to prevent people's needs escalating and requiring admission to residential or acute care.
-

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

WCC Strategic Commissioning Business Unit
Clinical Commissioning Groups and their associated Commissioning Support Unit/s George Eliot NHS Trust, South Warwickshire Foundation Trust and University Hospital Coventry & Warwickshire Trust

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Warwickshire's Transformation Programme has seen a focus shift towards rehabilitation and reablement services which have had the effect of reducing those who require long-term packages of care/ support. Evidence suggests those receiving permanent social care services through Warwickshire may have a higher-level of need and require a higher level of support.

Self-Funding Market

Due to the increases in the levels of personal wealth amongst Warwickshire's population, it is expected that there will be a continued growth in the self-funding market in the coming years, which is of particular significance to the Older People's care sector. The Personal Social Services Research Unit (PSSRU) estimates that 13.2% of all Older People receive social care services, of which a quarter fully self-funds their care [3]. In Warwickshire 8.4% (8,396 individuals) of the 65+ population are supported by Warwickshire which, extrapolating from the PSSRU research, means that a further 4.8% (4,844 individuals) of Older People self-fund their care.

Demographic pressure – including ageing population; increase in numbers of people living with dementia and other long term conditions
market pressures around affordability and sustainability of traditional residential and nursing services
Market Position Statement for Older People and Adults with Disabilities
Care Home for Older People market assessment

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

TBC via the Joint Commissioning Board

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Discharge to Assess:

- Referral rates eg; refusals to scheme (refusal reasons)/acceptance levels
- Duration of acute spells eg; average length of stay for accepters and refusers
- Duration of spell in D2A bed
- Patient destination post D2A
- Council number of care packages (post D2A)
- Total cost to health
- Total cost to social care
- Patient and carer experience

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The discharge to assess project is governed through the D2A Programme Board.

All other projects will be governed through the Accommodation with Support Programme Board.

What are the key success factors for implementation of this scheme?

Joint working between health, housing and social care to deliver integrated working, a wide range of accommodation with care options, improved quality and person-centred services.
Positive engagement of the care home market to deliver 7 day working, workforce

development, Trusted Assessment model and End of Life Care.
Positive engagement of primary care professionals to increase knowledge of accommodation with support options available across the County.

Scheme ref no.
7
Scheme name
Foundation/Enabling Projects
What is the strategic objective of these schemes?
1. To create an IT infrastructure that enables people to have more control and greater choice about how their health and social care needs are managed and delivered. 2. To create a transformed workforce that owns the changes required for the health and social care system to be financially viable and operationally robust and deliver the vision for the BCF. 3. To produce a systemic communications plan that generates enthusiasm and innovation to transform behaviours and attidues to the health and social care system from the public, from frontline staff, from senior managers and politicians and from the provider market. 4. To build a data intelligence, second to none, that secures our commissioning decisions and practice in strong evidence. 5. To ensure 7 day services are threaded through all key projects. These projects will underpin the BCF. Further scoping work is required to understand the status of each of these projects in terms of scope and levels of ambitions to ensure that they each accord with the principles and vision of the BCF.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Warwickshire Health and Wellbeing Board
Name of Provider organisation	
Name of Provider CEO	
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	
	2014/15 Plan	
	2015/16 Plan	
	14/15 Change compared to 13/14 outturn	
	15/16 Change compared to planned 14/15 outturn	
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	