Health and Wellbeing Board
North Yorkshire

The Better Care Fund

A New Era for Health and Social Care in North Yorkshire

Final Submission

NHS Airedale, Wharfedale and Craven Clinical Commissioning Group

NHS England

North Yorkshire County Council

NHS Vale of York Clinical Commissioning Group

NHS Harrogate and Rural District Clinical Commissioning Group

NHS Scarborough and Ryedale Clinical Commissioning Group

NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group

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INTRODUCTION

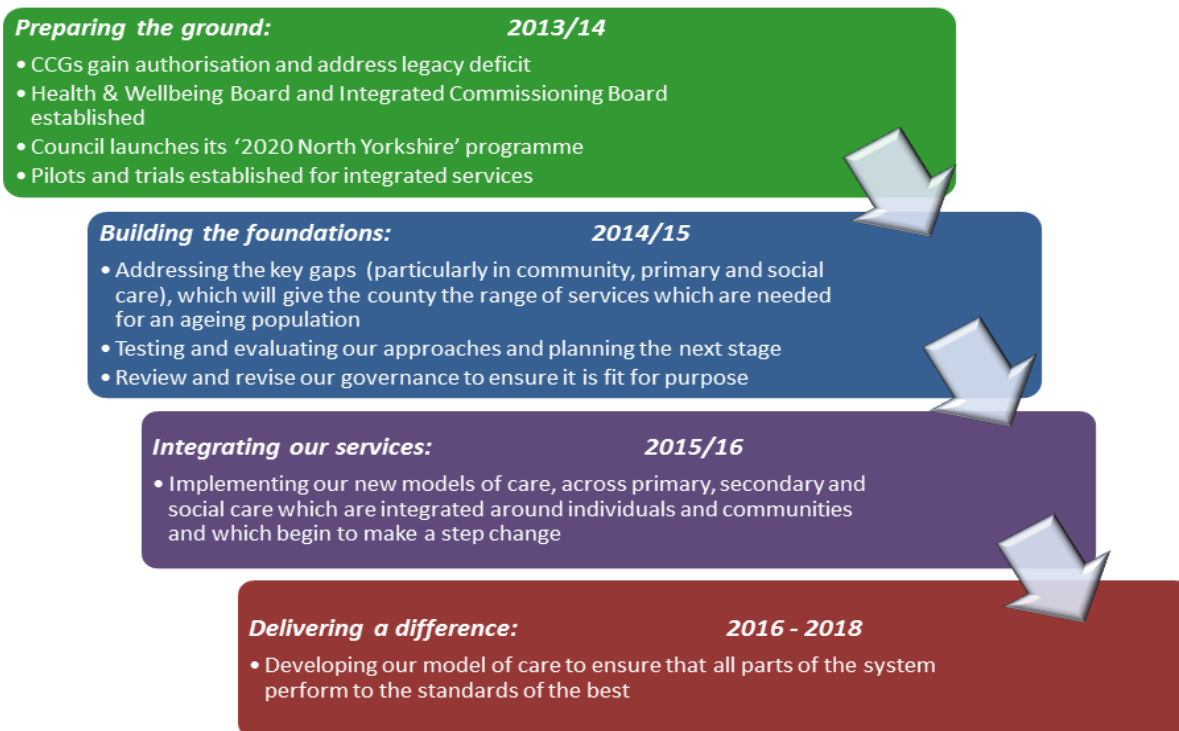Health and Social Care in North Yorkshire is at the start of a new era.

The Better Care Fund is providing the impetus for the NHS and local government in the county to set out a shared vision, underpinned by practical actions and joint investment, which breaks the cycle of the past. As a public services economy, we know we face the challenges that come with rurality, geography and system complexity. Our biggest challenge, and our biggest opportunity, is to learn from our history and to look to the future. For the first time, we are united in our ambition to make the county an exemplar for how a complex, rural health and social care system can deliver health improvement and social gain.

This plan describes how our shared investment will:

- Improve self-help and independence for North Yorkshire people;
- Invest in Primary Care and Community Services;
- Create a sustainable system by protecting Adult Social Care and by working with Secondary Care to secure the hospital, mental health and community services needed in North Yorkshire.

Building on work already started, we will approach our ambitions in three further stages:

Staging the journey – towards a
New Era for Health & Social Care in North Yorkshire

Preparing the ground: 2013/14
- CCGs gain authorisation and address legacy deficit
- Health & Wellbeing Board and Integrated Commissioning Board established
- Council launches its '2020 North Yorkshire' programme
- Pilots and trials established for integrated services

Building the foundations: 2014/15
- Addressing the key gaps (particularly in community, primary and social care), which will give the county the range of services which are needed for an ageing population
- Testing and evaluating our approaches and planning the next stage
- Review and revise our governance to ensure it is fit for purpose

Integrating our services: 2015/16
- Implementing our new models of care, across primary, secondary and social care which are integrated around individuals and communities and which begin to make a step change

Delivering a difference: 2016 - 2018
- Developing our model of care to ensure that all parts of the system perform to the standards of the best

We will not complete this journey alone. As a system, we will welcome learning and support from outside the county, to help us achieve our ambitions. We will also develop the strengths and assets which exist within the county.

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

The plan explains how Clinical Commissioning Groups (CCGs), NHS Trusts, Councils and the Voluntary and Independent Sectors will work together, how we have and will continue to engage with communities and patients and how we will promote good mental and physical health and responsive services as part of our shared vision and investment for the future.

Each CCG and the County Council has produced 2 to 5 year plans setting out local priorities, financial targets and outcomes and we see the Better Care Fund as the mechanism to add value to these plans and knit them together to create even greater value. Thus the submission includes a wide range of schemes, some large, some small, but all evaluated by local clinicians and professionals as important to the whole system, as evidenced within CCG Strategic Plans, the County Council Plan and the County-wide agreement on integration.

North Yorkshire has a complex health and social care economy, including 6 Clinical Commissioning Groups including Cumbria and three of which also operate in Bradford, City of York, East Riding of Yorkshire, 6 acute hospital trusts and 3 Mental Health Trusts. The area is also served by 2 NHS Area Teams and 2 Commissioning Support Units. The County Council relates to 7 District Councils and has close economic and transport links with the conurbations of West and South Yorkshire and Teesside. There is limited co-terminosity between agency boundaries.

As a health and care economy and as partners delivering public services across this county, we have three overarching priorities:
- Integrated locality services
- Prevention and community resilience
- High impact interventions

We recognise in our plans that by the nature of our complex and diverse county, we have a wide range of public, strategic and organisational perspectives that need to be reflected, while also achieving consistency of direction and flexibility to define the appropriate approach at a local or even at times a micro level. We have a common ambition to invest in new, jointly defined and locally owned schemes and our plan includes over £10m of new scheme investments, demonstrating that we are prepared to invest and operate at some risk to develop new ways of working. We have achieved a balance between county-wide and local approaches and the specific schemes are grouped within the priorities under our 5 core thematic areas as follows:

Integrated locality services	1. Community / Intermediate Care / Reablement / Multi-Disciplinary Case Management Teams
Prevention and community resilience	2. Public Health / Prevention
	3. Voluntary Sector
High impact interventions	4. Mental Health and Dementia
	5. Care Home Support

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North Yorkshire is committed to integrated working and to a locality based model. The local authority, as a part of its current restructure, is reconfiguring its Health and Adult Services leadership to strengthen its locality footprint. This will increase capacity and leadership of local plans and investment and is part of new governance arrangements to support implementation. The diversity and complexity drives us to manage the schemes on a local basis in order to meet the specific needs of the population. The number of schemes reflects the local management, and by grouping the schemes into themes, a high degree of consistency can be seen. The local authority role and that of the Integrated Commissioning Board is to ensure that these local approaches together deliver the outcomes the aims of our Health and Wellbeing Board.
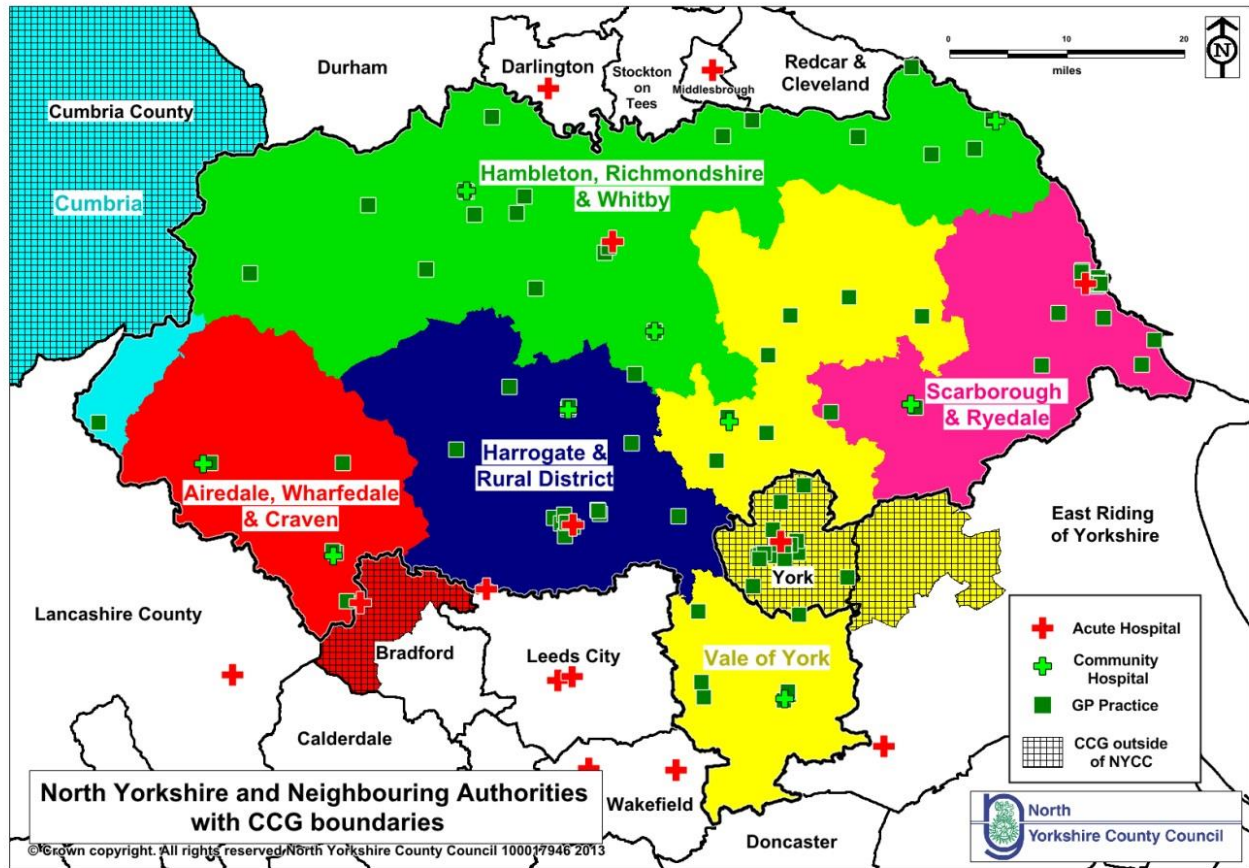
North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

1. PLAN DETAILS
a) Summary of Plan

Local Authority	North Yorkshire County Council
Clinical Commissioning Groups	Airedale, Wharfedale and Craven Clinical Commissioning Group
	Hambleton, Richmondshire and Whitby Clinical Commissioning Group
	Harrogate and Rural District Clinical Commissioning Group
	Scarborough & Ryedale Clinical Commissioning Group
	Vale of York Clinical Commissioning Group

Boundary Differences

This submission details the plans of the North Yorkshire Health & Wellbeing Board. As previously described, the territory of North Yorkshire is complex and crosses local authority, CCG and NHS provider boundaries. North Yorkshire County Council has seven district councils within its boundary and six Clinical Commissioning Groups.

This plan wholly encompasses the CCG footprints of Harrogate and Rural District, Hambleton Richmond and Whitby, and Scarborough and Ryedale; the footprint of Airedale, Wharfedale and Craven CCG crosses into the Health and Wellbeing Board coverage of Bradford Metropolitan District Council and the Vale of York CCG covers the City of York and the East Riding of Yorkshire. Finally, to the extreme west of North Yorkshire, the general practices of Low and High Bentham fall into Cumbria CCG. The Cumbria Health & Wellbeing Board BCF plan will cover this area.

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Date agreed at Health and Well-Being Board:	**19th September 2014** By delegated authority granted 25th July 2014, Ratified at HWB 26th September 2014
Date submitted: Date Re-submitted:	**19th September 2014** **28th November 2014**
Minimum required value of pooled budget: 2014/15	**£11,109,000**
2015/16	**£39,795,000**
Total agreed value of pooled budget: 2014/15	**£20,121,000**
2015/16	**£46,727,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Airedale, Wharfedale and Craven Clinical Commissioning Group
By	Dr Phil Pue
Position	Chief Clinical Officer
Date	19th September 2014

Signed on behalf of the Clinical Commissioning Group	Hambleton, Richmondshire and Whitby Clinical Commissioning Group
By	Dr Vicky Pleydell
Position	Clinical Chief Officer
Date	19th September 2014

Signed on behalf of the Clinical Commissioning Group	Harrogate and Rural District Clinical Commissioning Group
By	Amanda Bloor
Position	Chief Officer
Date	19th September 2014

Signed on behalf of the Clinical Commissioning Group	Scarborough & Ryedale Clinical Commissioning Group
By	Simon Cox
Position	Chief Officer
Date	19th September 2014

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Signed on behalf of the Clinical Commissioning Group	Vale of York Clinical Commissioning Group
By	Dr Mark Hayes
Position	Chief Clinical Officer
Date	19th September 2014

Signed on behalf of the Council	North Yorkshire County Council
By	Richard Flinton
Position	Chief Executive
Date	19th September 2014

Signed on behalf of the Health and Wellbeing Board	North Yorkshire Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Cllr Clare Wood
Date	19th September 2014

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 links	Document or information title Synopsis
Joint Health and Wellbeing Strategy NY-JHWBS 13-18.pdf	The JHWS sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out in the period 2013 to 2016.
Terms of Reference ICB June 2013.doc	Terms of Reference for North Yorkshire Integrated Commissioning Board. This sets the strategic environment in which our plans are being developed and managed
NY PH Report sept2013.pdf	North Yorkshire Public Health Report The report highlights some of our key priority areas, provides a snapshot of where we are now and celebrates the wide variety of actions currently being carried out to improve the health of the population in North Yorkshire.
http://www.northyorks.gov.uk/media/29056/Care-and-support-where-I-live-strategy/pdf/14_07_17_Appendix_1_Care_and_Support_Where_I_Live_Strategy_(2).pdf	"2020 North Yorkshire Care and Support Where I Live Strategy" (Currently out for public consultation until November '14)

http://www.airedalewharfedalecraven ccg.nhs.uk/wp-content/uploads/2014/08/Bradford-and-Craven-five-year-forward-view.pdf	AWC CCG 5yr Forward View
http://www.hambletonrichmondshire andwhitbyccg.nhs.uk /data/uploads/hrw-strategic-plan-final-v1.0-september-2012_20121029.pdf	HRW CCG 5yr Strategic Plan
http://www.harrogateandruraldistrict ccg.nhs.uk/data/uploads/publications/ hard_strat_plan_final_june2014.pdf	HaRD CCG 5yr Strategic Plan
http://www.scarboroughryedaleccg.nhs.uk/data/uploads /publications/integrated-plan-srccg-with-appendices-25.06.14.pdf	SR CCG 2yr Operational Plan and 5yr Strategic Plan
http://www.valeofyorkccg.nhs.uk/data/uploads/current-work/strategic-planning/voy-strategic-plan_v5.pdf	VoY CCG 5yr Strategic Plan
http://www.nypartnerships.org.uk/CHttpHandler.ashx?id =18685&p=0	North Yorkshire Joint Strategic Needs Assessment 2012
http://www.northyorks.gov.uk/media/24275/North-Yorkshire-carers-strategy/pdf/North_Yorkshire_carers_strategy_-_supporting_unpaid_carers_in_North_Yorkshire_20 12-15.pdf	North Yorkshire Carers Strategy
http://lawcommission.justice.gov.uk/docs/lc351_data-sharing.pdf	Law Commission Report on Data Sharing – see Section 7c) iii

Throughout this document, there is frequent use of the following acronyms:

AWC CCG	Airedale, Wharfedale and Craven Clinical Commissioning Group
HaRD CCG	Harrogate and Rural District Clinical Commissioning Group
HRW CCG	Hambleton, Richmondshire and Whitby Clinical Commissioning Group
SR CCG	Scarborough and Ryedale Clinical Commissioning Group
VOY CCG	Vale of York Clinical Commissioning Group
HAS	Health and Adult Services (Directorate of NYCC, including Adult Social Care and Public Health)
NYCC	North Yorkshire County Council
DES	Direct Enhanced Service
GMS	General Medical Services – Contract between GPs and NHS England
ICB	Integrated Commissioning Board (see section 4b for details)
LES	Local Enhanced Service
LTC	Long-Term Condition
MDT	Multi-Disciplinary Teams
NY HWB	North Yorkshire Health & Wellbeing Board
START	Short Term Assessment and Reablement Team

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

The Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS) referenced in Section 1 are currently undergoing review and refresh by a sub-group of the Health & Wellbeing Board and are due to be completed by December 2014.

The current JHWS was prepared in 2012 and signed off in 2013, and while the broad direction is unlikely to change, there are several areas of focus which might be expected to be raised in priority in light of the increased expectations of both integrated health and care services and the need to ensure that key policy areas such as Mental Health are properly prioritised.

The current versions of both have been used where necessary and with cognisance of the detail that is emerging in the refresh.

All our consultations with communities and patients point in the same direction. People understand the financial climate. They say they want to be supported to live at home and use services that are safe and as near to home as possible. They want to be active participants in their communities and families and only tell their story once.

Therefore, our collective vision is for:

Care centred on the needs of the individual and their carers, empowering people to take control of their health and independence

The Council and CCGs are committed to the following principles for how people should experience services:
- Promoting health and wellbeing
- Care is integrated around people rather than organisations
- Treating the patient's home as the main focus of care and services
- No health without mental health
- No decision about me without me

The Better Care Fund provides an opportunity and perhaps even compels us to undergo a transformation together that will require all the involved key players – Councils, CCGs, NHS Trusts, Primary Care, NHS England and HealthWatch – to take ownership together, to plan together and to transform our current models into a single model of care for the future. We will use this opportunity on a local level through Local Transformation / Integration Boards and at a County level through the Integrated Commissioning Board to support providers to develop their service models to accommodate the changes proposed.

This means that in five years' time, as a result of the Better Care Fund and broader investment and service transformation, North Yorkshire people will benefit from:

- an integrated, locality driven Prevention Service which supports them and their

- carers to improve their lifestyle, improve health, reduce social isolation and use digital and personal-contact channels to obtain advice and information on how they can manage their situation
- a 24/7 fast response to assess their needs and wherever possible avoid a hospital admission should they become ill, and an integrated team approach to helping them get home again if they do go to hospital
- a joined up service to prevent and manage falls
- support for people and families living with dementia
- improved access to psychological therapies, fast response services and in-reach community services for people with mental health needs
- specialist support from community staff, good liaison between care staff and health staff, care at home for people living in a care home if they become ill
- support by a multi-disciplinary team for people with complex needs who know them well, they will have a named care coordinator and will be supported to avoid the need to go to or stay in hospital, to manage their conditions and to maintain social activity and contacts

Our joint vision is not altered by the revision of the strategy. Our plans seek to ensure that people in North Yorkshire will be empowered to take control of their health and independence supported by a sustainable health and social care system which promotes health and wellbeing, provides timely access to joined-up services and responds to the distinctive rural and coastal features of North Yorkshire.

The vision is consistent with, and supported by, the Joint Health and Wellbeing Strategy, CCG Strategic plans, the North Yorkshire 2020 Vision and the Annual Public Health Report.

Our vision for integrated services combines a county-wide vision and principles with locally tailored services and approaches. We have a county-wide commitment to ensure everyone has access to core services for prevention, reablement, integrated health and social care teams. However, we also recognise that needs differ, existing community services are variable and local teams wish to innovate and evaluate new ways of doing things.

All developments are in line with our shared Statement of Principles for Integration. In addition we have taken the call for 'Parity of Esteem for Mental Health' very seriously and are embedding this in our plans, both for prevention and for reablement, as well as for specialist mental health services and for integrated community services. We believe in the principle that there can be 'No Health without Mental Health'.

The key point with the BCF schemes is the added value they bring, both to coordinating services locally and to accelerating how the NHS and Local Authority integrate budgets and people. The BCF is a small percentage of our collective resources and in most cases the specific schemes are designed to address gaps or support coordination in ways which can demonstrate additionality.

Next steps
Having repaid the Primary Care Trust legacy deficit and built new clinically led organisations the CCGs are working with NYCC and health providers during 2014-15 to develop and test out some new approaches. We fully expect that some will be more successful than others and we will share learning and evidence and make decisions

about what to continue in 2015-16. We have therefore begun to deliver against our overarching priorities for joint work, which are:

Integrated locality services
- extending current work to roll out integrated teams in localities
- testing out models of GP led Community Health and Care Hubs
- developing a blue print for the future of Health and Social Care Services in each CCG area

Prevention and community resilience
- integrating approaches to Prevention and Reablement
- completing, launching and implementing our Prevention Strategy
- reviewing community equipment services to secure a highly efficient service offering the best value for money

High impact interventions
- developing a county-wide Dementia Strategy to be implemented locally
- reviewing falls services and commissioning services to ensure we have a comprehensive service accessible to all patients
- collaboration on the re-design of mental health services
- starting the process of aligning the work of the County Council and NHS on Mental Health and Learning Disability Services with a view to developing an integrated approach to commissioning in these areas

System Wide
- using learning from the above to develop the detailed implementation plans for 2015-16 and beyond

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

We aim to improve outcomes for customers, patients and carers, improving their experience of services as well as improving our use of resources and meeting national and local performance targets. Improvements will be achieved for range of different types of outcomes:
- Choice and control – patients will feel more involved in designing care services and being in control of care when they need it
- Experience of care – patients and service users will experience a more joined-up approach to care supported by sharing information and more integrated working between staff
- Safety of care – people should experience fewer incidences of poor quality care or adverse incidents through higher quality services and less hand-overs between different services
- Outcomes of care – people's health will be improved leading to, for examples, fewer years of life lost due to conditions amenable to healthcare, fewer falls, and improved management of long term conditions

These improved outcomes will be achieved across a breadth of clinical and service areas, as defined within our core aims set out on page 3:

Improve health, self-help and independence for North Yorkshire people by:
- Implementing integrated Prevention Services across all localities

- Supporting Carers
- Improving access to housing based solutions including adaptations, equipment and assistive technology and extending our flagship Extra Care Strategy
- Ensuring everyone can access a comprehensive falls service

**Invest in Primary Care and Community Services**
- Creating an integrated health and social care reablement and intermediate care service in each area
- Investing in core community health services to increase capacity
- Creating and growing integrated health and social care multi-disciplinary teams in each area
- Developing mental health in-reach services to support people in acute care and in community settings
- Investing in dementia services
- Better support to care homes

Create a sustainable system
- Protecting Adult Social Care, maintaining and growing the effectiveness of social care reablement
- Developing more alternatives to long term care for older people and those with learning disability and mental health needs
- Investing in support to carers
- Implementing the Care Act and ensuring that all customers, however funded, get improved information and advice
- Increasing the reach of assistive technologies to support people at home and in care homes
- Working with Secondary Care to secure the hospital, mental health and community services needed in North Yorkshire

As described in the introduction, the activity within our plan is grouped thematically.

Unsurprisingly, the major area of investment is in Community Health and Care services where over £23.5m or 50% of the BCF is invested. This is mostly new scheme activity which sits alongside the existing START (reablement) service in HAS, funded from the Protection of Social Care money. A further 21% of the fund is directed to Protection of Social Care.
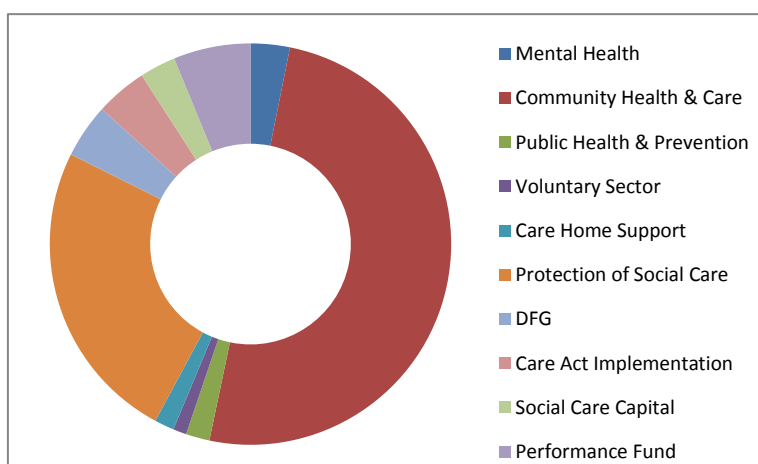
This demonstrates that we are investing the biggest share of the BCF in services which should reduce the use of secondary and institutional care.

These are integrated reablement/intermediate care services, case management teams, mental health in-reach and dementia services. This in turn will enable the delivery of the BCF supporting metrics of reducing avoidable admissions, reducing care home placements and reducing delayed transfers of care.

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We can evidence that we are placing initial resources in services which deal with the immediate and pressing challenges of increased demand and balancing this with the need to invest in ways which prevent or delay people needing formal services. This includes Social Prescribing, Care Navigators, Falls Prevention, Carers Services, and Assistive Technology.

Investment £000	NYCC	County Wide	AWC	HaRD	HRW	SR	VOY	TOTAL
Community Health & Care	5,600	11,425	769	1,895	1,984	1,000	850	**23,523**
Mental Health				426	518	400	125	**1,469**
Care Home Support			105	251	175	208		**739**
Public Health & Prevention					355	535		**890**
Voluntary Sector				200	40	92	170	**502**
Protection of Social Care	11,400							**11,400**
DFG		2,033						**2,033**
Capital	1,350							**1,350**
Care Act	1,932							**1,932**
TOTAL *	**20,282**	**13,458**	**874**	**2,772**	**3,072**	**2,235**	**1,145**	**43,838**

* This excludes £2.89m pending release via the Payment for Performance process

This position can be seen as 'stage one' and as the system develops and confidence increases in our ability to continue to invest 'up-stream' in prevention and early intervention, we will be able to reduce the intensity of service spend and reduce costs at the acute end still further. Work will be required to ensure this is factored into planning and commissioning of services in the future and to increase the certainty for providers to enable them to plan effectively. This in effect signals a longer term planning cycle for an integrated system.

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?

Over the next five years we expect to see:
- **A transformed landscape for Primary Care** with GPs working collaboratively with hospital colleagues and with social and community care to deliver more clinical services in local communities, reducing the numbers of people attending or being admitted to hospital and making optimum use of NHS and Social Care facilities in the community. We plan to see a reduction in the numbers of acute and mental health beds and an increase in community based services. We have confidence in our ability to do this because:
  - In all CCGs we are already supporting the emerging development of networks of GPs (in some areas these are already known as Federations), some more formal than others to increase clinical capacity and skills and enable more integration and shared care with secondary care and social care
  - We are actively modelling to see how the 'protecting social care' element of BCF should be used to maintain and grow the existing Social Care

- reablement service which will be strengthened by integration with health professionals and be able to support higher numbers and higher risk people
  - o We are piloting models of integrated multi-disciplinary teams with all CCGs and BCF will build on this, extending the approach to more Practices and patients, embedding the use of shared assessments and shared data and a shared approach to risk stratification
  - o Extensive consultation is underway on a range of new models of community services. For example, in Whitby we are consulting on a future model of care which includes appropriate use of hospital beds, integrated health and care teams and development of extra care housing, in Ripon we are creating a new community approach, Scarborough and Ryedale CCG are consulting on the future of Urgent Care and this may lead to new improved usage of Community Hospitals, Vale of York CCG are consulting the public on the development of Community Health hubs which could serve between 50,000 and 100,000 people
  - o All CCGs are working with Trusts to re-design Community Services and these will be transformed in the next year and this will be done in collaboration with Social Care
- **An integrated approach** between NHS, County Council, District Councils and the Voluntary and Community Sector to creating sustainable communities with a local network of prevention services available to people who may be at risk of needing social and health care. We have confidence in this because:
  - o We are investing Public Health Resources in Community Capacity building and in a new Prevention Strategy
  - o The County Council is investing in a 'Stronger Communities Programme' with a focus on building community capacity and maximising the use of local assets
  - o We have identified additional social care resources to pump-prime prevention services in response to the recent FACs consultation
  - o CCGs are committed to working with local authorities to develop this approach and we have early success for example in Hambleton the CCG and District Council run "exercise on prescription" schemes, Harrogate and Rural District CCG fund "Social Prescribing" pilots and are rolling this out further, in Selby DC there are Community Development staff who work with communities to maintain health and reduce isolation, Airedale Wharfedale and Craven CCG are funding Community Navigators to work in rural villages
- **A sustainable system across health and social care** where we have protected social care to support implementation of the Care Act, maintain and improve reablement, manage increased demands and maintain essential services in the community. We are confident we can do this because:
  - o We already have very good performance on delayed transfers of care, reablement and placing low numbers of people in residential care, supported by an ambitious Extra Care programme
  - o Social Care has a long track record of managing within its budget
  - o The County Council has embarked on a transformation programme for Adult Social Care which focuses on self-help, prevention, independence and integrated services
  - o The CCGs have collectively agreed to invest £17m from the BCF to protect Social Care Services, recognising how critical social care services are to the overall system
  - o We have agreed that all investments in Social Care will be transparent and

that CCGs will be able to influence and shape local service delivery in line with local strategies

o We will work with Secondary Care providers to secure the hospital, mental health and community services needed in North Yorkshire, underpinned by a network of modern community hubs delivering a new generation of health and social care services

o The Council and NHS are working together to support the development of personal budgets for health, to start to share contracting and commissioning capacity and to explore Integrated Personal Care Commissioning

While the Better Care Fund is not the only means by which these jointly set ambitions will be delivered, it provides an opportunity to review how reconfiguring our health and social care services, and developing our workforce, can more effectively deliver these ambitions and it is clear that BCF is woven through all of this work.

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.

Increasing challenges, driven by changes in demography, rising public expectations of high quality care and an increased access to and use of technology are key factors in our thinking as we have developed our approach to integration, set within the context of a difficult financial climate.

In addition to these factors and using data from the JSNA, Director of Public Health Annual Report and NHS, Social Care and Public Health Profiles point towards the following as issues for North Yorkshire:

- The geography is large with only small centres of population
- The population is already, on average, older than the English population
- The population is ageing at a quicker pace to that of England
- Although, on average, the NY population is relatively affluent there are significant populations of deprivation, largely clustered in Scarborough and Whitby with smaller pockets in Selby, Harrogate and Skipton. In sheer number terms, the size of the deprived population in Scarborough is similar to that of Harrogate due to Harrogate having a greater population density
- North Yorkshire has issues with smoking, obesity and alcohol use particularly linked to deprivation. These pockets also related to illness in the population
- With an ageing population comes increasing numbers of people with one or more long-term conditions, and increasing numbers of people who are frail. Both of these issues lead to increased service usage, reduced quality of life and early mortality
- Mental health problems are significantly associated with long-term conditions and multiple morbidities and they are a cause and consequence of episodes of ill health
- Cancers and cardiovascular diseases are the main drivers of early death
- The top 10% most deprived areas account for 25% of all potential years of life lost due to pneumonia
- Emergency admissions in NY continue to rise over time. Emergency admissions for acute conditions that should not usually require a hospital admission in particular are on the rise. The main drivers of these admissions are urinary tract infections (25%), gastroenteritis (19%) and influenza/pneumonia (18%)

The system of care locally must adjust to meet the challenges presented by an increasingly ageing, and therefore frailer, population. The system must also recognise the importance of deprivation and related common needs presented by mental health problems.

The emphasis in the system - the culture, the strategy, the priorities, the structures, the care models – must be redefined to keep people generally more healthy, more informed, and better supported – with the *right* care (emergency or long-term) available to people when they need it – particularly those with mental health problems. Providing the right system will ensure that more costly and less suitable institution-based care is reserved for those occasions when it is appropriate and right.
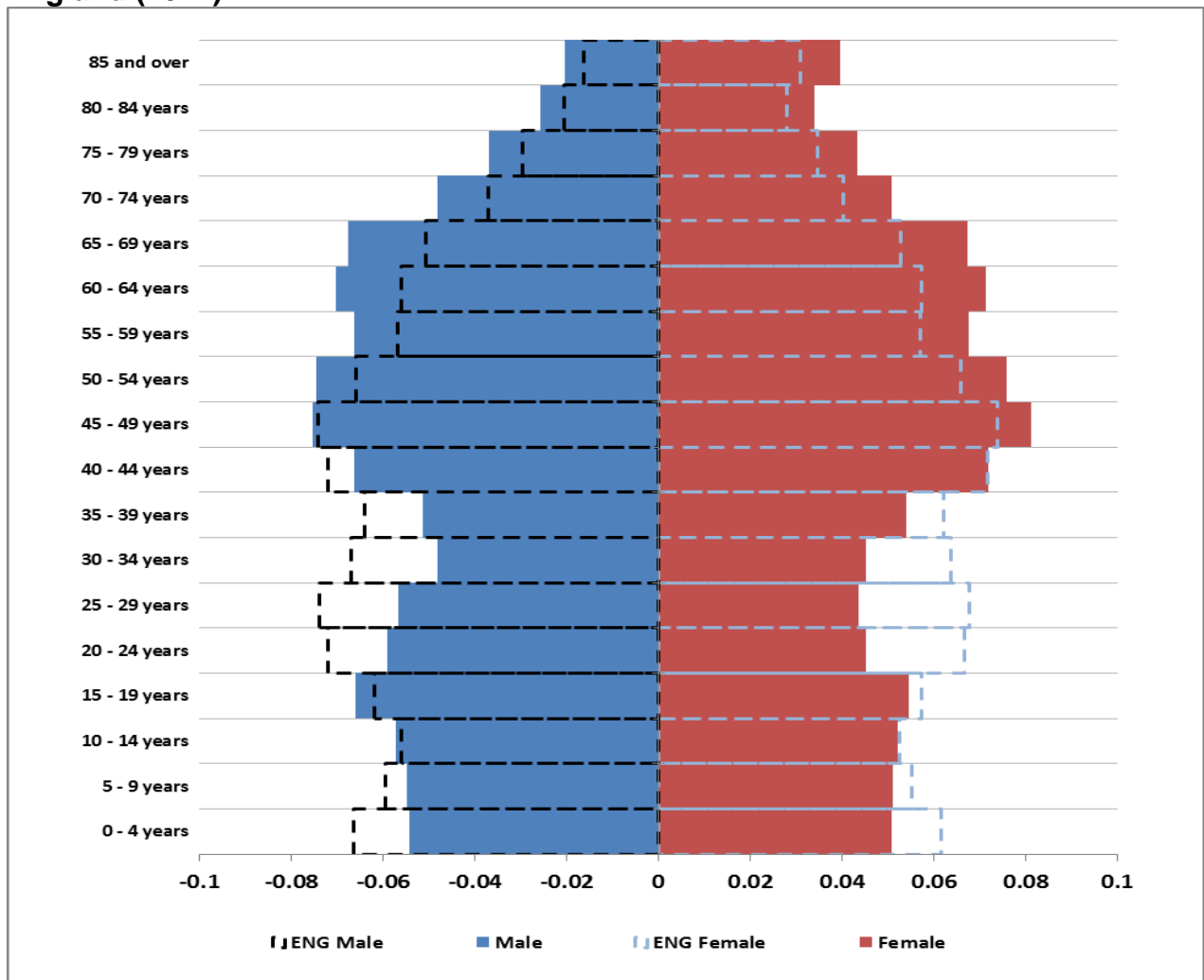
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The North Yorkshire Joint Strategic Needs Assessment (2012) points towards common issues and challenges facing the county.

Population and geography
Primarily the county is geographically very large at 3,000 square miles, thus making the coverage of preventative, health and social care services very difficult to achieve at the same cost as urban or metropolitan areas. Not only is the county the biggest in England but it is also one of the most rural. There are only two towns in North Yorkshire with a population of over 50,000 – Harrogate and Scarborough. There is one city – Ripon – with a population of 17,000.

Outside of urban centres and market towns North Yorkshire is sparsely populated with 16.9% of the population living in areas which are defined as super sparse (less than 50 persons/km). The issues of rurality and access are not only apparent to commissioners and providers, but they form a common theme identified by North Yorkshire's citizens and it is one of the most common public challenges levied at the system by the public.
The sheer scale of North Yorkshire means that often well publicised positive health indicators for the county mask significant variations, examples of which are illustrated below.

Figure 1: Population Pyramid showing North Yorkshire's age make up compared to England (2012)


On average the current population is older than that of England. The current North

Yorkshire population structure indicates that proportionally there are more people at each of the 5 year age groups from 45 years and older when compared with England (fig 1). Conversely North Yorkshire has a smaller population at each of the 5 year age bands under 45 years when compared with England except in 10-19 year old males.

Overall, the population of North Yorkshire is becoming older with a predicted increase in people aged over 65 from 133,000 in 2013 to 211,000 by 2037, and a predicted increase in people aged over 85 from 17,500 to 47,000 (fig 2).

Figure 2: Population Pyramid showing North Yorkshire population change between 2014 and 2037
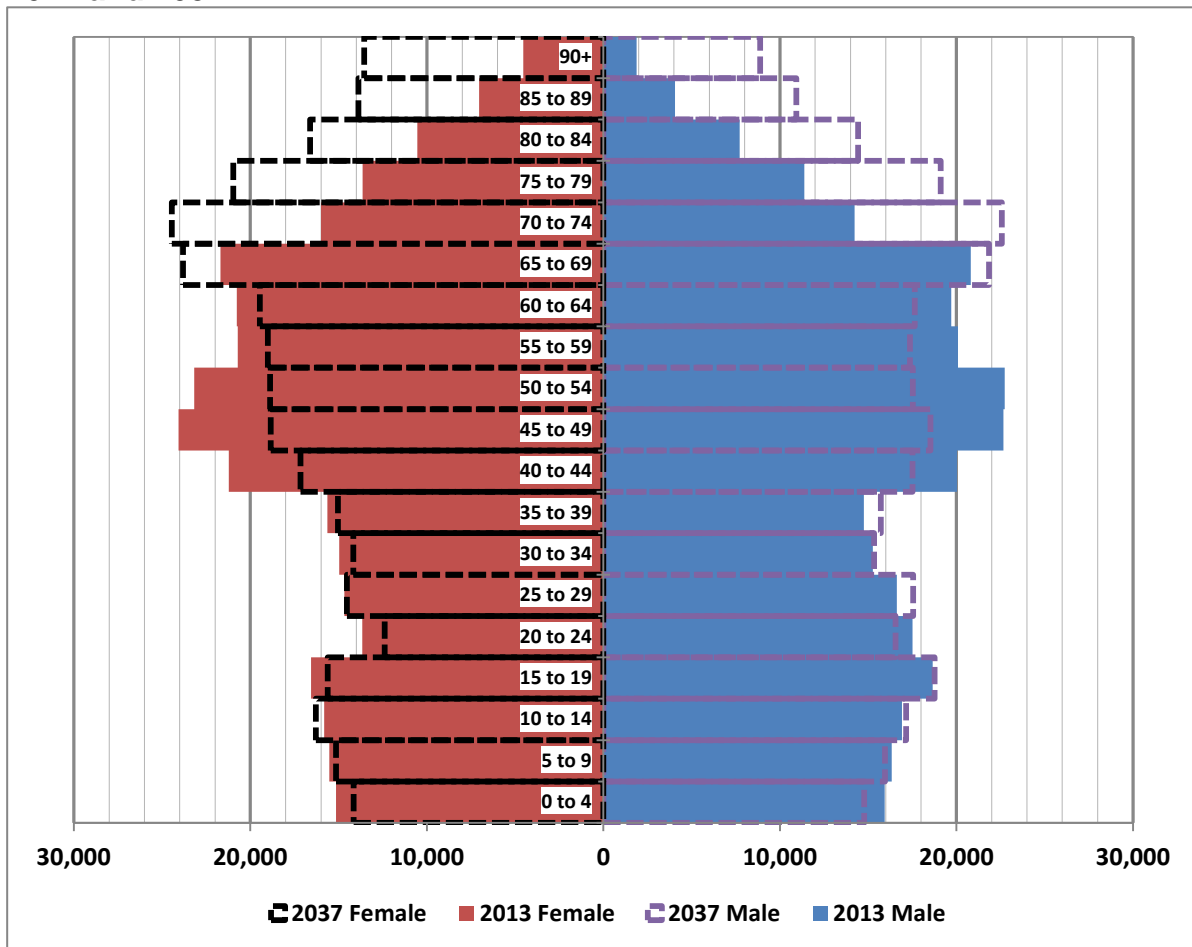
Compared to other upper tier local authorities, North Yorkshire had a 2% higher proportion of people aged over 65 in 2013; a gap that will widen to 4% by 2037. The corresponding 2% increase is the equivalent of an additional 13,000 people aged over 65.

The 2010 Index of Multiple Deprivation (IMD) identifies eighteen Lower Super Output Areas (LSOAs; out of 370 in total within North Yorkshire) which are amongst the 20% most deprived in England. Fourteen of these LSOAs are in Scarborough district (around Scarborough and Whitby), two in Craven district (around Skipton), one in Selby district and one in Harrogate district.

Risks to health
The risks to health also vary significantly from area to area, with the major risk factors clearly associated with the greatest burdens of disease in North Yorkshire. Again, on

average North Yorkshire performs at around the national average for these indicators, but in absolute terms they offer a huge challenge to the county:

- Smoking – the over 18 year old prevalence in North Yorkshire sits below the national average at 18.9% however it is higher in Scarborough and Ryedale and still equates to 91,500 smokers. The inequalities in smoking prevalence is more of a concern with North Yorkshire sitting above the national average for smoking prevalence in routine and manual group. Harrogate has the highest prevalence amongst routine and manual labourers over aged 18 (41.8%, significantly higher than the England average) with Ryedale, Scarborough, Selby and Hambleton all sitting above the national average. In the Public Health Outcomes Framework North Yorkshire ranks 24 out of 27 shire counties.
- Obesity – in North Yorkshire it is estimated that there are between 398,000 and 419,000 adults who are either overweight or obese – some 67% of the adult population. North Yorkshire also ranks 24 out of 27 shire counties for this indicator.
- Alcohol – there are an estimated 125,000 people in North Yorkshire who regularly drink over recommended safe limits. This presents a significant challenge to the long term health of the population as well as the acute health and social consequences of alcohol.

Living with illness and disability
The link between health risk factors and illness are clear. These risk factors, among others, lead to lives lived with disability and illness that place a strain on the health and care economy. Nationally, the major causes of years lived with disability in 2010:

- Mental and behavioural disorders (including substance abuse; 21.5%; 17.2-26.3%),
- Musculoskeletal disorders (30.5%; 25.5-35.7%),

These are two of the major long-term conditions (LTCs). A LTC is defined as a condition that cannot, at present be cured; but can be controlled by medication and other therapies. Other examples of LTCs are diabetes, heart disease and chronic obstructive pulmonary disease.

People with long-term conditions account for (General Lifestyle Survey, 2009):

- 30% of the population
- 50% of all GP appointments,
- 64% of outpatient appointments,
- 70% of all inpatient bed days,

In total around 70% of the total health and care spend in England (£7 in every £10) is attributed to caring for people with LTCs, this means 30% of the population accounts for 70% of spend. North Yorkshire has a significantly higher proportion of people in the county (32.3%) who have one long-term condition than the national average (30.7) – this places North Yorkshire in the bottom quartile nationally (GP Patient Survey, 2011).

The care of individual LTCs is often the focus of healthcare delivery, research and training. However, increasingly, as the population in the UK ages, there are people with multiple morbidity – that those with two or more LTCs. This poses a big challenge to health, and indeed social care, delivery; particularly in an area such as North Yorkshire where the population is ageing rapidly.

Barnett et al. (2012) conducted a cross sectional study on 1.75million people registered

at 314 medical practices in Scotland as of March 2007. The purpose was to examine the distribution of multiple morbidity, and of comorbidity of physical and mental health disorders in relation to age and socioeconomic status.

The key findings were:
- 42.2% of all patients had one or more morbidities,
- 23.2% of all patients were multi-morbid,
- Relative proportions of the population with multiple morbidities increase with age as might be expected,
- However, the largest absolute numbers of people with multiple morbidities were found in those aged under 65 years – this is due to the relative size of the populations under and over 65,
- Onset of multiple morbidity occurred 10-15 years earlier in those living in the most deprived areas compared with those in the most affluent areas,
- Socioeconomic deprivation was particularly associated with multiple morbidity that included mental health disorders,
  - Prevalence of both physical and mental health disorder:
    - 11.0% (95%CI: 9-11.2%) in most deprived areas
    - 5.9% (95%CI: 5.8-6%) in least deprived areas
- The presence of a mental health disorder increased with the number of physical morbidities:
  - 6.74% (95%CI: 6.59-6.90) for five or more disorders
  - 1.95% (95%CI: 1.93-1.98) for one disorder

Multiple morbidity becomes progressively more common with age. Fig. 3 below illustrates how morbidities accumulate with age which places a particular challenge on the North Yorkshire system. The current system in North Yorkshire is not designed to cope with this level of complexity, in particular the complexity of managing mental health disorders.

The most problematic expression of population ageing is the clinical condition of frailty. Frailty develops as a consequence of age-related decline in many physiological systems, which collectively results in vulnerability to sudden health status changes triggered by minor stressor events. Between a quarter and half of people older than 85 years are estimated to be frail, and these people have a substantially increased risk of falls, disability, long-term care, and death.

Fig.3: Number of Chronic Disorders by Age
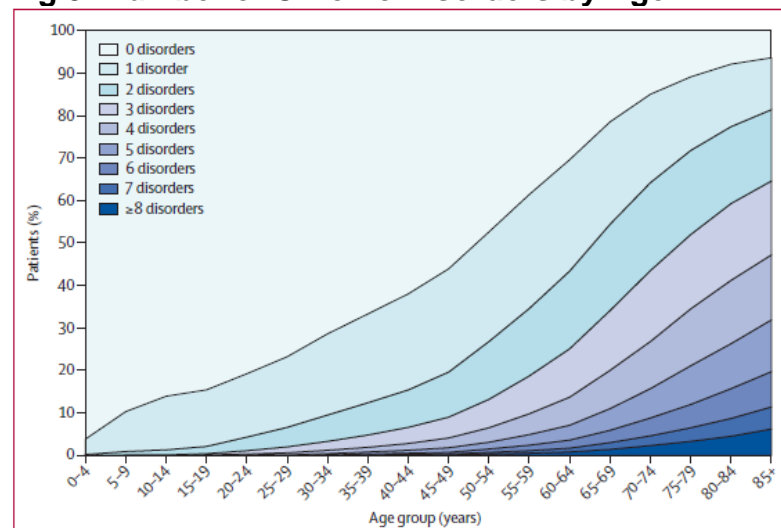
Mortality and early mortality

Like many parts of the UK, circulatory disease (including heart disease and stroke) and cancers account for the greatest proportion of deaths in North Yorkshire. Cancers are the most common cause of death under the age of 75 years, however the number of years of life lost vary significantly from district to district, often in line with deprivation. Figure 4 shows the inter district variation in potential years of life lost from causes considered amenable to healthcare. Scarborough, an area with higher deprivation, is a statistical outlier for coronary heart disease and stroke.

Figure 4: Potential years of life lost per 100,000 population by district and cause of death, directly age/sex standardised 2013
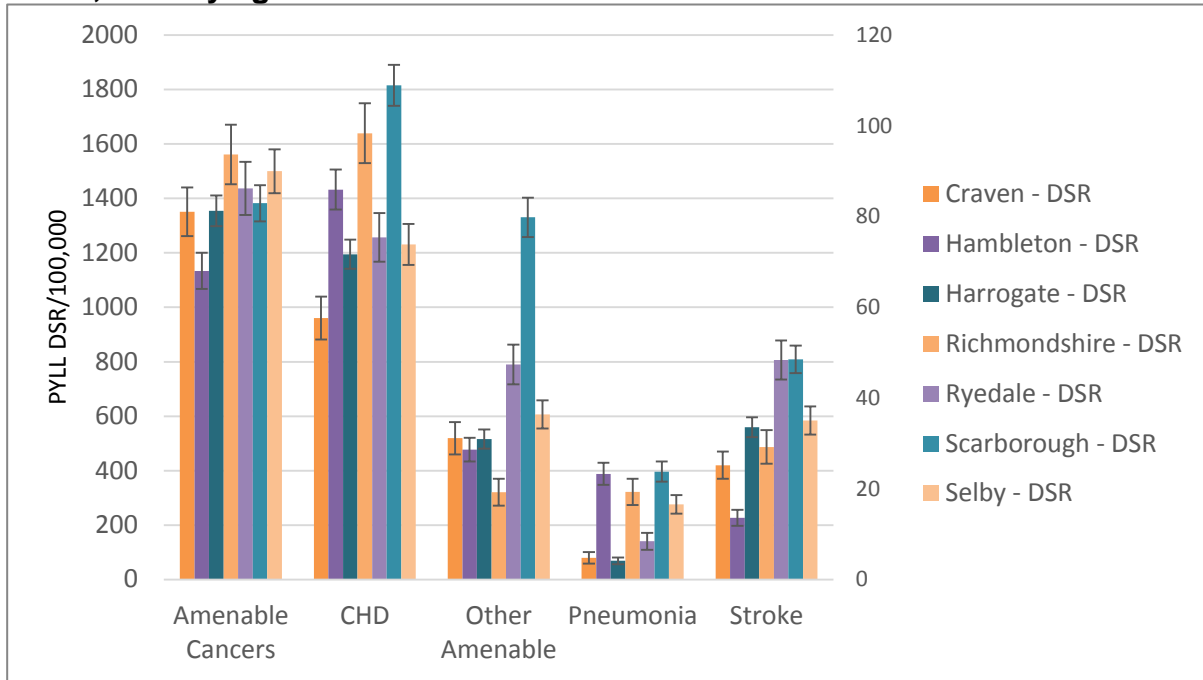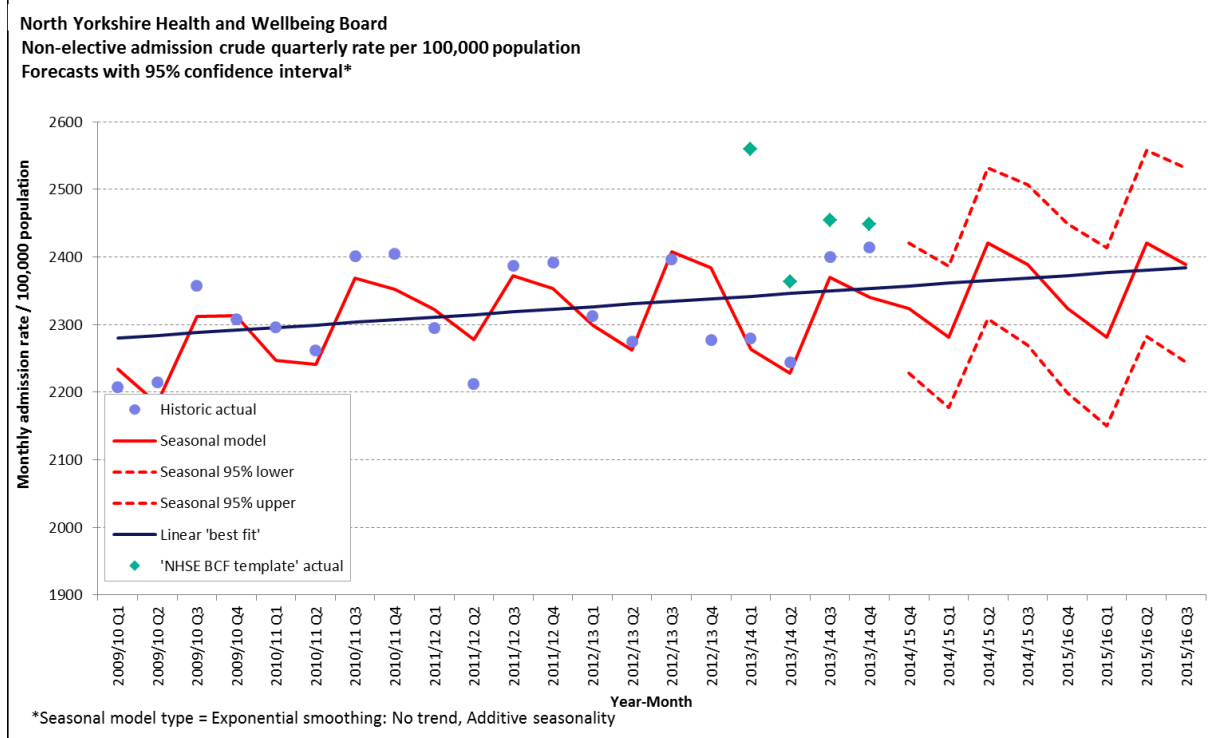

Service delivery

Service delivery is a challenge across the county especially as the funding settlements across public health, social care and health are significantly lower than other areas in the region. According to the Public Health England Spend and Outcomes Tool (2014) North Yorkshire spends £32 per head on Public Health in comparison to £57 nationally, £54 regionally and £38 by ONS cluster group. Similarly, North Yorkshire spends £245 per head on Adult Social Care compared with £281 nationally, £259 regionally and £264 by ONS cluster group.

Non-Elective Admissions (Acute and General)

This indicator is the primary performance metric in the BCF and a focus for the North Yorkshire system. In line with the national picture, North Yorkshire has a rising standardised trend of NEAs (Fig.5). This rising trend, when coupled with an ageing population makes the challenge even greater to achieve an absolute reduction in the number of NEAs.

Fig. 5 Non Elective Admissions

North Yorkshire Health and Wellbeing Board
Non-elective admission crude quarterly rate per 100,000 population
Forecasts with 95% confidence interval*

*Seasonal model type = Exponential smoothing: No trend, Additive seasonality
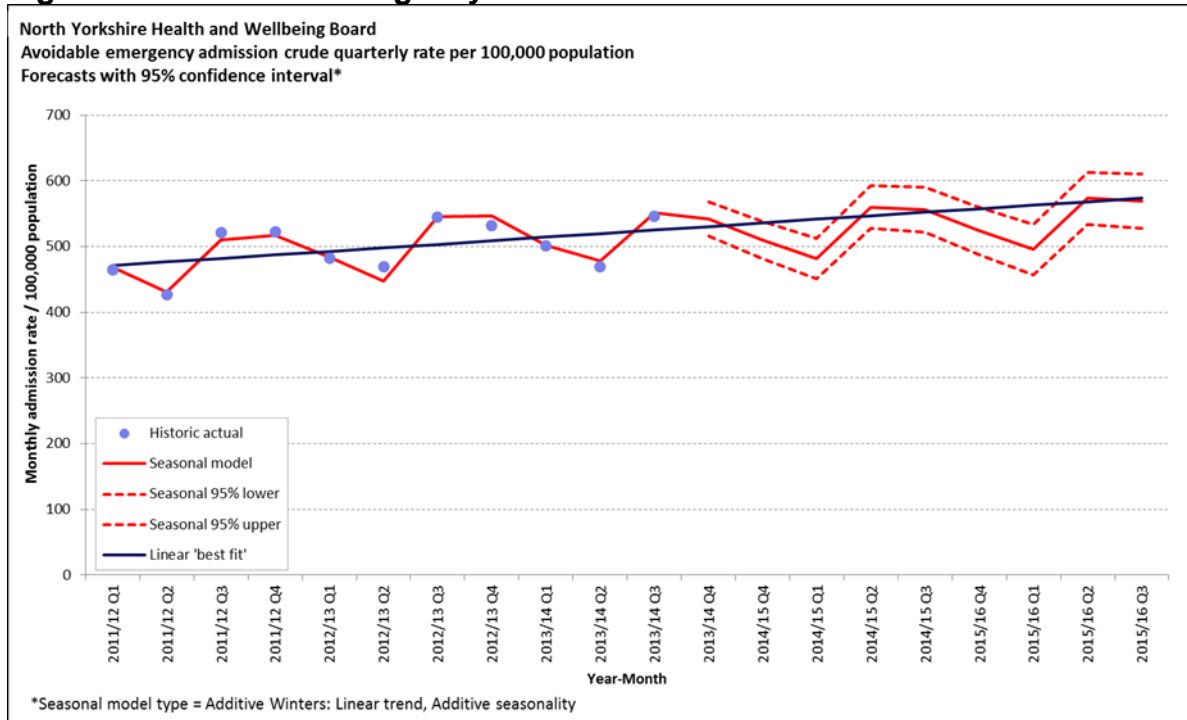
It is important to define the key features of these admissions to truly understand where change needs to happen. Not all NEAs are realistically avoidable. Approximately 25% of NEAs can be considered as "avoidable emergency admissions".

As with NEAs, North Yorkshire has an increasing rate of avoidable emergency admissions (as per previous BCF metric). The North Yorkshire rate appears to be increasing more rapidly than the national rate.

Figure 6: Avoidable Emergency Admissions

North Yorkshire Health and Wellbeing Board
Avoidable emergency admission crude quarterly rate per 100,000 population
Forecasts with 95% confidence interval*

*Seasonal model type = Additive Winters: Linear trend, Additive seasonality

Breaking down the 'avoidable emergency admissions' indicator into its four constituent parts highlights where the greatest opportunity for change in North Yorkshire lies:

'ambulatory care sensitive conditions'
Ambulatory care sensitive conditions (ACSCs) are conditions where effective community care and case management can help prevent the need for hospital admission. Even if the ACSC episode itself is managed well, an emergency admission for an ACSC is often a sign of the poor overall quality of primary and community care.

North Yorkshire already starts from a good position on this indicator with a generally declining rate in chronic ACSC admissions. The current local rate sits in the second best quintile nationally at around the 22nd percentile.

Around half of all ACS condition admissions in North Yorkshire relate to 5 conditions – this mirrors the national picture:
- Atrial fibrillation
- Angina
- Asthma
- Heart Failure
- COPD

The long-term trend in improvement on this indicator appears to be slowing locally, when compared to the national trend. Therefore there are still opportunities to improve long-term condition management and this is a key tenet of our integration approach.

'unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s'
Locally and nationally there is a declining trend in this indicator. North Yorkshire currently has a rate similar to that of the national average, showing that there is room for improvement on this indicator. However the number of admissions that make up this indicator are relatively small so sensitive to natural variation.

'emergency admissions for acute conditions that should not usually require hospital admission'
These emergency admissions to hospital are for acute conditions such as:
- Ear, nose and throat infections
- Kidney and urinary tract infections
- Heart failure etc

These are acute conditions that usually could have been avoided through better management in primary care.

This indicator is showing an increasing trend both locally and nationally. North Yorkshire currently sits in the top 40% of performers nationally, but this still illustrates that there is potential scope for local improvement, particularly against a rising upward trend. The main local drivers of this indicator are urinary tract infections (25%), gastroenteritis (19%) and influenza/pneumonia (18%). Greater support in primary care, improving the general health of the population, and providing specific self-care support to more vulnerable individuals such as people with long-term conditions needs to be the focus of local integration efforts.

'emergency admissions for children with lower respiratory tract infections'
These admissions make up a small proportion of the overall avoidable emergency admissions, however they are still a good marker of a well-functioning system. In North Yorkshire there is an upward trend, albeit with large seasonal fluctuations. North Yorkshire currently sits in the bottom quintile nationally for this indicator so there is scope for improvement.

Practicalities of service delivery
The very rural nature of much of the County has profound implications for the delivery of services and creates associated additional costs for both NHS and Council partners, which are not always addressed within national funding formulae. Some standardised policy solutions often require different approaches. For example:

- Market development looks very different in a large rural area, in which there are many different market economies, ranging from areas with a competitive supply of providers to other areas where significant effort has to be made to stimulate a provider market

- The crucial importance of sustaining several medium sized, high quality, general hospitals because of the distances that people have to travel to access services

The County Council would like to see national policy and funding formulae take much greater account of population sparsity and the delivery costs associated with it. Moreover, policy approaches, designed with unitary or metropolitan authorities in mind, often work very differently in two-tier local government areas.

Over the past few years in response to reducing funding settlements and demographic growth, North Yorkshire County Council (NYCC) has worked hard to protect front line services whilst seeking efficiencies and new ways of working and progressing with integration. The County Council and its partners continue to innovate to achieve value for money:

- Our flagship Extra Care home programme, as a part of the draft "2020 North Yorkshire Care and Support Where I Live Strategy" (Currently out for consultation until November '14), has already provided 666 homes for people over the past 5 years and will deliver another 2134 over the next 5 years

- Prevention is at the heart of the County Council transformation programme: we have a strong track-record on Developing Stronger Families; our Innovation Fund, delivered in partnership with the voluntary sector, is encouraging innovative local approaches to issues such as tackling loneliness and addressing bereavement with the use of time bank initiatives and an ambition to maximise the use of local assets for local communities

- Helping people to lead independent, healthy lives and be able to do more for themselves through a digital model of service delivery is a key feature of our transformation programme. This means we will develop a strong and effective front door, built upon better web content, self-service processes and telephone support. This will ensure people can access the most appropriate services to meet their needs

Aside from issues about an ageing population, and pockets of hidden rural and urban deprivation, Catterick Garrison, with a military population of over 17,000, along with other

military bases in North Yorkshire, has major economic, health and social implications for the County.

Growth in demand for Social Care is exacerbated in North Yorkshire by its size and rurality. Services are expensive to deliver, commercial providers are unable to attract sufficient staffing and efficiencies to make provision attractive / economic and so the County faces high delivery costs. NYCC's average hourly rate for domiciliary care is higher than most authorities in our region. To address these issues, we are, for example, using extra care developments as potential incubator units for new local care providers, and are exploring options around staff mutuals.

The approach to be taken to achieve whole-system collaborative gain will include:
- Integrating care around people rather than organisations
- Greater proportion of care deliver outside acute settings with seamless working across primary and secondary care to keep people at home
- Services promoting the patient's home as the default for care delivery
- Commissioned services with the underpinning ethos of "No health without mental health"
- Common procedures for individual care needs assessment
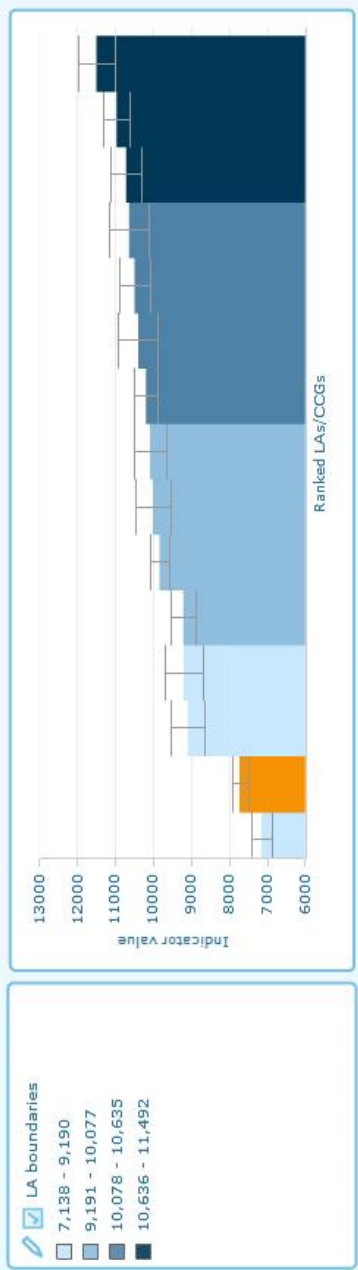- Pooled resources across health and social care wherever possible to support joint care delivery

As required, this plan sets out a series of metrics in Part 2 and these are summarised below. The targets detailed reflect a staged approach, based on our strong belief that there is significant work to be done before the system can perform to the level of ambition and transformation we expect. Clearly we would expect wherever possible to exceed targets, but we believe that setting unachievable targets gives no benefit. We would expect any external assessment to give this context due consideration.

This plan provides clear reasons why we believe this staged approach to be necessary and appropriate:
- As illustrated below in data extracted from the Better Care Atlas, we already perform highly in many targeted areas, ranking second in the region for our performance Age 75+ Avoidable Admissions per 100,000. Within this data, it is also clear that we are best quartile or better than median in 8 of the 13 metrics
- We are complex, not just because of boundaries and the number of organisations and service providers, but also because of the deeply rural nature of the county, the persistently low levels of funding over many years and the culture of our people
- The evidence for financial integration benefits is weak but the incentive is strong. We know we need to transform, not just change our services and we know we need to do that together. We need to try things that might not work, to find and build on what does work

Broader metrics of integrated care >> Age75+ Avoidable Emergency Admissions per 100,000 >> 2013/14 provisional >> Filter: GORs >> Yorkshire and The Humber

Targets for the residential care admissions and the reablement metrics are set in accordance and in line with those which are in place in the County Council's 2020 North Yorkshire Transformation Programme. For this reason, there is no specified scheme or activity noted in this plan or in the Part 2 template as to do so would risk duplication of targets. It should be noted that performance in both these areas is already comparatively high.

North Yorkshire already places 25% fewer people into care than its equivalent shire council peer group and has the lowest rate in this group of 27 councils. Reductions have already been 10%, 10% and 15% over the last 3 years, partly due to the introduction of 15 Extra Care schemes around the county.

For reablement, North Yorkshire is a top quartile performing shire council in this metric. The highest performing shire county achieves 91%, the lowest 62%. High performance in this indicator can be seen as a counter balance to the low numbers of permanent admissions to residential and nursing care for the same age group. This high level of performance is achieved despite the deeply rural nature of the county which often has an impact on the availability of suitable home-based care provision due to transport, staffing and relative paucity of options for community-based support.

Our metrics and targets are as follows:

Metric	2014/15 Target	2015/16 Target
Non Elective Admissions reduction		4,908 (8.5%)
Residential Care Admission reduction	19 (2.8%)	31 (4.7%)
Reablement Volume increase	105 (18.6%)	105 (15.7%)
Delayed Transfers of Care reduction	229 (1.9%)	647 (5.5%)
Patient / Service User Experience	33 (20%)	21 (11%)
Injuries due to Falls reduction	55 (2.4%)	152 (6.7%)

The target for the Reduction of Non-Elective Admissions metric is set relatively, but necessarily, high at 8.5%. This equates to 4,908 fewer admissions based on the current level of 57,409. As described in the Risk Log in section 5 and in the Part 2 template, the basis of calculation of the metrics is subject to external change and will impact upon the Payment for Performance process. This is particularly relevant to services such as the Community Assessment Team, where activity is currently locally defined and is not deemed as "Non Elective Admissions". In a change to the reporting framework, the coding and counting of this activity will shortly fall under national definition which does deem it as an admission and therefore will require a full baseline shift and will change the target accordingly. The main impact will be for HaRD CCG whose baseline will shift upwards by c1,800 admissions. Detailed work on this will need to be coordinated as a part of the Risk Sharing agreement and in conjunction with the Local Area Team.

In North Yorkshire, there have been historic agreements which have affected the tariff actually paid. Over and above a threshold, significantly lower than the current levels, a marginal rate is paid to acute providers, representing only 30% of the full tariff. Consequently, the savings expected across the majority of the NY system are calculated on the basis of a £570 tariff – being 30% of the full £1,900. The exception to this has been AWC CCG whose savings are calculated at the full rate. This consequently affects the average saving applied to the reduction and causes the average rate in our

submission to be £589 per admission.

In order to find funds to invest into the new BCF schemes, CCGs and Trusts have to stop or change services. It has always been expected that achieving the funding balance would need to be through reductions in acute costs. The scale of reduction in admissions in North Yorkshire has been required to be set at the 8.5% level because the volume of reductions needs to be high enough to enable acute costs to be cut – without sufficient volume, cost reduction would only be at the margin and not on a sufficient scale to impact significantly.

The detail has been worked from the bottom-up, scheme by scheme and as far as is possible, cohorts of included groups within each of the 20 or so schemes have been tested to minimise duplication or double counting.

The following table sets out the local targets for each area:

CCG North Yorkshire Only	Current (planned) 2014 out-turn Per CCGs operational plans	15/16 Reduction identified through BCF Schemes	% reduction	Cumulative reduction	Cumulative %
Airedale, Wharfedale and Craven	5,145	163	3.2		3.2
Hambleton, Richmondshire and Whitby	13,070	1,201	9.2	1,364	7.5
Harrogate and Rural District	13,821	1,457	10.5	2,821	8.8
Scarborough and Ryedale	11,888	782	6.6	3,603	8.2
Vale of York	10,468	1,075	10.3	4,678	8.6
Sub Total	**54,392**	**4,678**	**8.6**		
Joint / Existing Schemes		**543**	10.0	5221	9.6
Other CCGs	3,017				
Total	**57,409**	**5,221**			**9.1**
Performance Year	**57,409**	**4,908**	**8.5%**		

In additional to the schemes in place, further pieces of work underway which will also address the issue of non-elective admissions, for example:
1) CCGs are looking at the reasons for admissions for those admissions where length of stay is one day or less to determine whether the reason is one of:
   a. insufficient understanding of the alternative approaches available
   b. lack of alternative options which might be addressed
   Example and unverified data suggests that in the Vale of York area around 25% (3,800) of NEL admissions for over 65's resulted in a LOS<1 day
2) ICB has reviewed System Resilience planning and in particular Winter Planning around Excess Winter Deaths and determined that there might be significant advantage in addressing this issue with increased home and housing support, increased emphasis on vaccination
   Example and unverified data suggests that there are hundreds of excess winter deaths (EWD) each year, with each one on average preceded by an average of 8 NEAs. Tackling 25% of those deaths might give rise to 1,600 – 2,000 avoided admissions.

These examples are not described as schemes in this plan as the likely implication would be to increase further the target, which would be counter-productive. However, these examples should provide an assurance that this is a significant area of focus for us and

that activity is not confined to that which is in the focus of the BCF.

Further work is required and planned as part of the risk sharing agreement and the IMT programme which will include the undertaking of a detailed modelling exercise to enhance our understanding of the impact of our changes on the providers. This will enable Trusts to plan their contributions to the changes within the health and social care system. This will also provide a baseline for our evaluation and on-going measurement of the impact of the BCF. We have also been collaborating with a consultancy working with AWC CCG to test and deliver a multi-organisational risk stratification tool.

North Yorkshire HWB would welcome support in this area.

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

The schemes developed across North Yorkshire will lay the foundations for a much more integrated system. All schemes will be initiated in 2014-15 and will be subject to active learning and evaluation during the year so that we can be sure of entering 2015-16 with confidence in being able to adjust contracted levels of service and profile resources to new models of care.

A detailed implementation plan will follow this BCF submission and the subsequent assurance process, to be reviewed at ICB in December, but the headline activity can be summarised at present as follows:

By the end of September 2014
- New Psychiatric Liaison schemes will be in place across HRW and HARD areas
- The top 2% identified as being at risk of admission will be identified
- BCF Pooled Fund will have been agreed, signed and ratified at full HWB
- Craven Care Home Improvement Scheme will be underway
- The 'Improving Access to Psychological Therapies' clinical referral process will be launched across Scarborough & Ryedale

By the end of October 2014
- Whitby 'FAST' team will be launched
- Harrogate & Rural District's Care Home Support scheme will be launched
- Harrogate & Rural District's Clinical Assessment Team will have been expanded
- We will use feedback from the assurance process to develop the implementation plan

By the end of November 2014
- A Care Act Implementation plan will be in place

By the end of December 2014
- All Admission Avoidance schemes will have been initiated
- A full Implementation plan will have been agreed by ICB
- An evaluation process will be agreed for all BCF Schemes at a Locality level
- Information Governance protocols will be in place that will support data sharing between relevant partners including, consent principles and arrangements are in place including policy and process that will enable assessments are able to be shared
- Craven Collaborative Care Team – extension of Intermediate Care operational

By the end of January 2015
- Information Management and Technology programme will be scoped and incorporate early work on Integrated Digital Care Record and Risk Segmentation
- Scarborough & Ryedale Palliative Care Pathway will be launched
- North Yorkshire 'Model of Care' will be operational
- Scarborough & Ryedale Nutrition in Care Homes scheme operational
- New Psychiatric Liaison schemes will be launched across Scarborough & Ryedale

By the end of February 2015
- 2015/16 Section 75 Agreement will be in place
- The new "Model of Care" will go live across North Yorkshire
- A Governance Review of HWB arrangements will have been presented at HWB with a plan for implementation

By the end of March 2015
- a revised 'Risk Share' approach will be in place
- Vale Of York will open new 'Care Hubs' in Malton and Selby, in partnership with Scarborough & Ryedale and the YFT
- Locality Board arrangements will be reviewed and updated
- Craven Specialist Community Nursing (Intermediate Care) will be fully operational
- Craven Assistive Technology – Telemedicine expected to be fully operational

By the end of Quarter 1, 2015
- The 'Improving Access to Psychological Therapies' Self-Referral process will be launched across Scarborough & Ryedale
- An evaluation process will be in place and reporting first quarter progress across all BCF schemes an activity

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

Health and Wellbeing Board (HWB) sets, and is accountable for, the strategic direction and the delivery of the BCF ambitions. HWB is member led and vice-chaired by a CCG Chief Officer, with representation from the County Council, each of the CCGs, Public Health, mental health and acute trusts, Districts, HealthWatch, NHS England and the Voluntary Sector. Delivery of the BCF will be overseen by the Integrated Commissioning Board (ICB), underpinned by a network of local transformation / integration boards.

The ICB is a HWB sub-group with representation from the Chief Officer level of CCGs, North Yorkshire County Council Health and Adult Services and Children's Services, and the Director of Public Health. The ICB also includes representation from the main NHS Trusts and the City of York Council is also an active participant.

The make-up of these Local Transformation Boards varies around the same core agenda; in some CCG areas, these are Systems Resilience Groups, in others a Locality Board dealing with wider transformation across the health and care system. These local boards will have joint health and social care senior leadership and will be accountable for the implementation and delivery of local BCF plans, including reviews of progress and risk management. Regular progress reports will be shared with the ICB who in turn will provide assurance to the HWB and escalate risk where required

This model is currently being developed through a wider governance review that is underway to ensure that the HWB and key partners have a clear grip and focus throughout implementation and beyond. The diagram below shows how these groups relate to each other.

- Project and Scheme management
- Delivery of target results
- Accountable for local delivery

- Responsible for Local Delivery
- Issue resolution
- Accountable to CCG Governing Bodies and ICB

- Advising Strategic Direction
- Commissioning Activity and Directing Operations
- Delivery Assurance of BCF
- Programme Board for countywide/ Infrastructure

- Strategic Direction
- Overall Accountability

There remain clear lines of organisational accountability for progress implementing BCF plans through CCG governing bodies and NYCC Corporate Management Board.

d) 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

Five 'Local Delivery Teams' will cover the county, reporting through the Local Transformation Boards. These teams will comprise representation from Social Care Operations, commissioning, delivery capacity and be co-led by a CCG lead and an Assistant Director from NYCC.

Delivery Support Team
This local delivery capacity will be underpinned by support from a range of specialists across contracting and procurement, analysis and performance insight as well as delivery capacity. In order to maximise the efficiency and value for money, the support will be centralised.
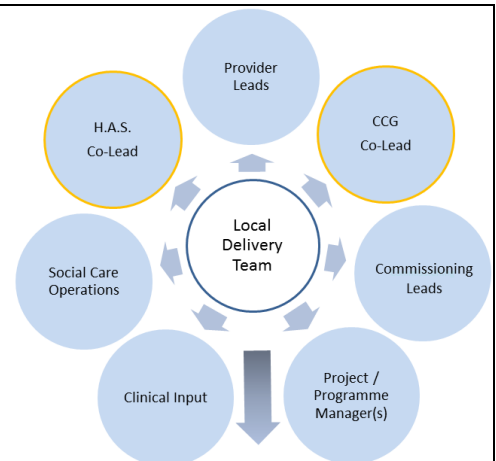
This central team will also include some over-arching capacity and back-up from the BCF Pool Manager and the HWB Programme Manage and must tie in with the Commissioning Support Unit(s) as well as the Public Health and HAS Performance teams to ensure consistency of data and information reported.

The **BCF Pool Manager** is a finance professional, responsible for ensuring that the BCF pooled fund operates effectively, that the payment processing and scheme accountability to ICB / HWB is reported and clear. Responsible for the collation of the various performance and metrics data and the analysis of activity. This individual has the responsibility of ensuring adequate reporting and monitoring arrangements are in place across the county and will ensure that appropriate evaluation is taking place on schemes with a view to recommendation of schemes for further investment or disinvestment, reflecting relative performance.
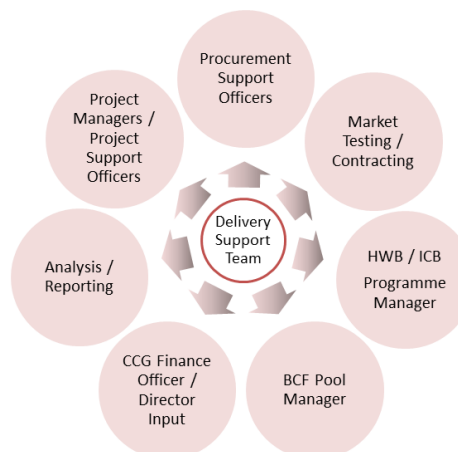
The Pool Manager reports to the Finance and Performance Sub-Group of ICB.

HWB / ICB Programme Manager, employed by the NYCC, is a senior programme manager, responsible for managing the work programme for HWB and ICB. They will ensure that a clear and planned forward plan is operated, and will provide the support to the various programmes of work.

Working together, the Pool Manager and the HWB / ICB Programme Manager will ensure that appropriate monitoring and understanding of the progress, issues and delivery of the schemes and activity across the county will be reported and managed through the ICB and HWB. They will ensure appropriate risk/issues management, change control and reporting processes are in place and are escalated appropriately.

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

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.

Mental Health	HRW_001_MH	Psychiatric Liaison
	HRW_002_MH	Dementia strategy
	S&R_003_MH	Psychiatric Liaison
	HaRD_001_MH	Psychiatric Liaison
	VOY_003_MH	Street Triage
	VOY_005 _MH	Psychiatric Liaison

Community/Intermediate Care/Reablement	HRW_003_CIR	H&R integrated START / intermediate care / FRT
	HRW_004_CIR	Whitby overnight nursing service
	HRW_005_CIR	Hospital case management
	HRW_006_CIR	H&R district nursing capacity
	HRW_007_CIR	Risk profiling and long term conditions
	HRW_008_CIR	Community-focused acute care
	S&R_001_CIR	Malton Care Hub
	AWC_001_CIR	Assistive Technologies - Telemedicine
	HaRD_003_CIR	Intermediate Care & Clinical Assessment Team
	AWC_003_CIR	Specialist Community Nursing Service
	AWC_004_CIR	Craven Collaborative Care Team Expansion
	VOY_002_CIR	Selby Care Hub
	VOY_004_CIR	Urgent Care Practitioners

Public Health / Prevention	HRW_009_PHP	Lifestyle referral
	HRW_010_PHP	Prevention Officers (aka Community Navigators)
	HRW_011_PHP	IAPT (prevention initiative)
	S&R_002_PHP	Health Trainers / Self Help
	S&R_004_PHP	Mental Health in the Community (IAPT)
	S&R_005_PHP	Smoking Cessation

Voluntary Sector	HRW_012_VS	Carer sitting services and training
	HaRD_002_VS	Voluntary Sector Projects
	S&R_008_VS	Palliative Care Pathway
	VOY_001_VS	St Leonard's 'Hospice at Home'

Support in Care Homes	HRW_013_CH	Clinical skills educator
	HRW_014_CH	Telemedicine in care homes
	S&R_006_CH	Nutrition in care homes
	AWC_002_CH	Care Home Quality Improvement Support Service
	HaRD_004_CH	Named GP per care home
	S&R_007_CH	Care home link nurse

Countywide	ALL_001_RC	Reablement and Carers
	ALL_002_CS	Community Services
	ALL_003_PHP	Falls Prevention

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	Risk Owner / Timeline
Plans may not deliver financial savings necessary to make them sustainable	4	5	20	• Each element of our planning has an identified exit strategy, should it be necessary to decommission them	• HWB, • Managed through monthly reporting to ICB by Finance & Performance sub-group
Non Elective Admissions do not reduce in line with expectations	4	5 £2.9m Acute Costs	20	• Monitoring of activity and metrics to seek early signs of 'failure' • Engage staff, GPs, providers and public • Communication process to inform of alternatives to admission	• HWB • Managed through monthly reporting to ICB by Finance & Performance sub-group
Delayed Transfers do not reduce in line with expectations	3	4	12	• Develop alternative models of care that provide clear alternatives to admission	
Admissions to Care Homes do not reduce in line with expectations	4	4	20	• Clear procedures and training • Monitoring of process effectiveness • On-going leadership from the ICB	
Continued intervention at a national level continues to divert attention from delivering the plans and inhibits progress	4	5	20	• Political representation to manage any further impact • Treat any further changes under change control, without suspending implementation	• HWB • On-going

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There is a lack of availability of providers of support for carers	4	4	16	• Market development including with voluntary sector providers • Monitoring through survey and analysis	• HAS Commissioning Team • On-going
Data analysis, segmentation and benchmarking are constrained by perceived and actual restrictions on data and information governance	4	4	16	• Define and engage support / expertise • Seek legal clarification of acceptability of proposed approaches	• ICB Finance & Reporting Sub-Group
Financial allocation is inadequate to meet new duties from Government, resulting in • additional pressure on NYCC and Health budgets • duties not being met in full • reputational damage and negative impact on performance targets	4	4	16	• Modelling and analysis • Careful monitoring of volumes of new case-loads • Representation to government	• HAS Leadership Team • Monitoring of new guidance and allocation announcements October / November 2014
Agreed system changes between partners are not realised	3	5	15	• Monitoring and reporting processes in place with reporting to ICB and NYHWB	• HWB • Managed through monthly reporting to ICB
Commissioners not being able to agree clear common objectives with each other that can translate into workable commercial agreements.	3	5	15	• Escalation through ICB and NYHWB if required.	• ICB • On-going
There might be double counting in the estimates for scheme achievement	4	3	12	• Scheme planning with clear cohorts identified for each scheme • Evaluation of results on a regular basis • Adoption of Improved data segmentation and analysis tools	• ICB • Managed through monthly reporting by Finance & Performance sub-group
Baseline data for the Metrics change, over the course of the fund's operation and measurement of outcomes is challenging, and open to subjectivity. Example – "Community Assessment Team" coding changes will increase the baseline and activity levels	5	2	10	• Clear statement of changes • Impact analysis as part of the risk share agreement process • Discussion with NHS England Local Area Team • Reporting process to be clear on change and impact	• HaRD CCG to lead • Managed through monthly reporting by Finance & Performance sub-group
Differing Information Governance regimes prevent opportunities for co-location.	3	3	9	• Organisations will achieve separate compliance for local purposes. • Local agreements will be needed to achieve cross-organisational compliance. • Workaround is to delivery separate systems on separate devices in the same location.	• ICB sponsored Information Management and Technology Programme • On-going

Each partner's sovereign transformation programmes / operational plan might pull the organisation in a different direction to that set out in this document or not deliver the required enablers / elements.	3	3	9	• Integrated Care Board responsible for managing the conflicts of local directional 'pull' • ICB will monitor delivery • Stakeholder engagement • Programme reporting and evaluation of metrics/data	• ICB through monitoring / reporting • On-going
Existing systems not able to support the chosen model of recording and managing consent.	3	3	9	• Some systems may need additional manual workarounds to be applied if the consent model can't be supported.	• ICB sponsored Information Management and Technology Programme • On-going
Financial envelope may not be sufficient to support plans, even with savings identified.	3	3	9	• Local Transformation Groups will continue to monitor delivery, as will ICB, and changes can be made as required	• Locality Boards • On-going
Political leadership at both national and local level may change at elections in this plan's lifespan and cause significant change of policy and purpose of the Better Care Fund	3	3	9	• Fundamentally, the requirement and rationale for integration is not at risk; specific changes can be managed by the partnership	• HWB / ICB • Monitoring of policies / manifestos ahead of elections
Regulations yet to be finalised for Care Act will divert or change the current plans	3	3	9	• Close monitoring of regulations as they emerge and embed in the service redesign and changes	• HAS Leadership Team • Monitoring of new guidance October / November 2014
The contractual mechanisms necessary to provide the legal and financial framework to allow new and existing services to be commissioned in partnership may not work effectively enough to enable service change to progress in a timely manner and for providers to be sufficiently confident to properly engage with the process.	3	3	9	• A proper contracting function is established, clearly directed by the ICB, and whose responsiveness and performance is monitored by the ICB	• ICB • On-going
Public may not welcome all changes to system.	4	2	8	• There has been early patient and public engagement, and it is intended that this will grow as plans develop further	• All partner organisations • HWB oversight • On-going
There is a lack of joint working between partners, resulting in duplication of effort	2	4	8	• Locality Boards and ICB monitoring the implementation and management of on-going services	• Locality Boards / ICB • On-going

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Automated matching of NHS Numbers is not done in a timely manner.	2	3	6	• Plans will be in place to manually populate NHS Numbers from current correspondence.	• ICB sponsored Information Management and Technology Programme • On-going
ITK standards are not sufficiently developed to meet the timetable of integration work.	3	2	6	• Local standards will be developed and applied through agreement across all partners affected.	• ICB sponsored Information Management and Technology Programme • On-going
Legacy systems may not have suitable Open API's published.	3	2	6	• Most likely to affect the social care system. Other methods for exchanging data already exist.	• ICB sponsored Information Management and Technology Programme • On-going
NHS Number is not used for communication between organisations.	2	3	6	• Organisational development plans including staff training will be monitored.	• Locality Boards • On-going
The outcome of the National ADASS work on Data Sharing / Matching may recommend a different approach.	2	3	6	• The existing DBS tracing service will continue to be used.	• ICB sponsored Information Management and Technology Programme • On-going
IM&T baseline activity not completed on time. IM&T work programme not developed.	2	2	4	• Resources identified for the work will be increased.	• ICB / Information Management and Technology Programme • On-going
The return on investment from carer-specific support is not properly recognised	2	2	4	• Proper communications, engagement and information available to all organisations	• Locality Boards • On-going
The CCG Allocation (£319,000) for Cumbria CCG may not be transferred to this BCF Pooled Fund	4	1	4	• Further work is to be completed to agree how the investment might be made in this area of the county and understand what Cumbria CCG are planning already	• HWB, managed through ICB

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

This plan and the attached template sets out a target for avoidance of Non Elective Admissions of 8.5%, or 4,908 avoided admissions. The financial return is calculated on the basis of the saving made at the average actual cost of those admissions which is substantially lower than national assumptions as it reflects a threshold level set in 2008 over which all admissions are charged at 30% of the normal tariff. Therefore, the risk at the 8.5% level equates to £2,888,505.

In following the principles of the Payment for Performance (P4P) process described in the guidance, we have not defined any spend against the performance pool. Should the expected quarterly performance be achieved, the funds will be released to the BCF pooled fund as they arise, to create a contingency fund against future issues, or to further invest in any scheme showing superior performance or as otherwise deemed appropriate.

There is a total of £10.1m of BCF Pooled Funds being invested in new schemes across the county which to greater or lesser extent might be deemed discretionary; given the number of schemes within this pool, the individual risk invested in these schemes is relatively low. This approach offers some shelter from investing in large projects which would risk significant portions of the Pooled Fund, while also offering the benefit of trialling approaches and determining opportunity for further investment where it is proven to be effective.

The remaining risk in the plan is that schemes do not deliver the expected returns which would cause all partners to examine likely cause and to prescribe remedial action at a local level.

Both NY HWB and ICB have BCF as a standing agenda item, with reports and progress evaluation reported at each meeting. ICB meets monthly and receives reports from the Finance and Performance sub-group which in turn monitors progress and out-turn via the BCF Pool Manager and each organisation's own financial returns.

It is assumed that, aside from the P4P amounts, funds will transfer to the pool on a monthly "12ths" basis as required, and will be managed under a Section 75 agreement which extends the pool from the similar agreement set in place for 2014/15.

We have an ambition to support our system with an innovative risk share approach to underpin our approach to delivery. Alongside our Section 75 agreement we recognise that as the systems develops further, we will need to develop in further stages around our locality-based management approach. Within our overarching countywide BCF we will develop a framework that allows the locality boards to assess and manage risk, to deal with any under-performing schemes and to agree how best to share or reinvest where performance is on or ahead of plan.

As a part of this approach, we will develop a Risk Sharing Agreement which will include

the County Council and CCGs and potentially the Providers. The intention will be to meet, as a minimum, the following:

- Quantified pooled funding amount deemed to be 'at risk'
- Calculation and modelling of risk amounts for the schemes and the 'payment for performance' (P4P)
- Agreement of the principles for investment of released P4P funds
- Modelling of the impact on the wider system as a result of any failure to meet targets set within this plan
- Mitigating actions defined for the risks identified above and contingency arrangements as required
- Articulation of the approach to be taken to sharing the risks appropriately across the system, including differential performance against targets in the plan and delivery at organisation versus HWB level.

The high-level timeline in place to deliver this agreement is as follows:

Milestone	Date
Principles and scope agreed with partners	28 November 2014
Finalise principles and scope, and agree the action plan and responsibilities	8 December 2014
Draft agreement developed through a Task & Finish Group	1 December 2014 to 13 February 2015
Legal team review and edit process	12 January 2015 to 13 February 2015
Final edits and incorporation to Section 75 Agreement	16 February 2015 to 4 March 2015
Agreement reviewed and agreed by ICB	12 March 2015
Finalised and signed agreement, by	31 March 2015

The draft high level principles expected to form that basis of the agreement are as follows:

The Local Health & Social Care Economy
- The BCF represents only a proportion of the local care economy. Risks associated with the Better Care Fund should not lead to pressures on individual organisational budgets outside the scope of the BCF
- BCF operates on the principles of affordability and equity to ensure a sustainable and resilient care economy
- Organisations will act in the best interest of the overall care economy. This includes gain sharing where necessary and elimination of cost 'shunting';

Developing of Plans
- Changes to service, including investment and decommissioning will be based on robust evidence demonstrating net impact across organisations
- Partners will be involved in the development of organisational plans including and beyond the elements contained within the BCF
- Plans and budgetary provisions/contingencies in each area are agreed by all partners at the beginning of financial year
- Decisions are based on the medium to long term impact not short term wins

Governance & Risk
- Responsibility for the management of the Better Care Fund that is the pooled budget is split between the CCGs and the Local Authority by mutual agreement
- Overall financial management continues to be the responsibility of individual organisations (the statutory body) and cannot be abdicated to the BCF. Parties to the BCF remain responsible and accountable for delivery of their own financial performance
- Each party to the BCF remains responsible for their contracted expenditure and contribution to the pooled budget
- Financial risks, mitigation plans and contingencies are developed by the responsible organisation in conjunction with BCF partners
- Where the impact is so financially significant that individual bodies could be at financial risk, the parties need to work together to mitigate the impact
- There will be flexibility to add to the arrangement subject to agreement by all parties and by approval of the Health and Well Being Board

Financial Risk
- Financial governance on each element of the BCF scheme are the responsibility of the authorising organisation
- Financial overspends will not be funded through the BCF, unless agreed by all parties
- Partners to the pooled budget will need to identify contingencies within their overall financial plans commensurate to the level of risk associated with delivery of the budget and achievement of savings/efficiencies
- Financial risks will be considered as part of the overall risk management process and documented within Risk Register
- Accounting arrangements will follow those incumbent on the host and appropriate accounting standards will apply.

This is an area that we recognise we could benefit from support, particularly with examples from complex systems like ours.

6. ALIGNMENT

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

The individual Operational and Strategic Plans in our area are entirely aligned with the ambitions set out earlier in is submission.

For example, Hambleton, Richmondshire and Whitby (HRW) CCG's over-arching priority to transform the local community system has found common cause with North Yorkshire County Council's (NYCC) ambition to ensure a clearer focus on partnership working and prevention. HRW CCG and NYCC jointly serve a population of 142,000 people, living in three distinct super-sparse rural localities - Hambleton, Richmondshire and Whitby – each with their own complex pattern of providers. Our shared vision was a properly integrated health and social care system, capable of meeting the challenges of a rising elderly population, estimated as increasing by 30% by 2021.

In **Harrogate and Rural District CCG**, the system resilience scheme monies 2014-15 provide for additional GP and nurse appointments through winter, additional Consultants in A&E on weekday evenings and weekends and additional acute elderly care consultant during peak periods on Acute Medical Unit. Alongside this, the DES is targeted at Care Planning for top 4% of at risk patients. A jointly funded 12 month scheme is in place to reduce avoidable hospital admissions by GPs providing care plans to top 4% high risk patients by Dec14. There is also a planned development of GP-provided local enhanced services and 'GMS plus'.

We recognise that delivering integrated services, built around the needs of patients, underpinned by high trust between staff and organisations, is an iterative process and continuing challenge. However, we believe we have delivered a breadth of work that shows our local health and social care system has made massive strides in improving how it works in partnership. Through united ambition, underpinned by a shared vision, real action and joint investment, in a complex, rural, health and social care system we will deliver real health improvement and social gain for our community.

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

Our BCF, 5 year forward view, and 2 year operational plans across the CCGs have been developed collaboratively across health and care commissioners and providers, with each of the schemes ensuring alignment to improved outcomes for our local citizens.

This approach ensures that our BCF plan aligns with the CCGs and local authority commissioning plans and that of health and care providers in the district, who have each been equally integral to the development of the 5 year forward view and are all fully signed up to its priorities.

At present, we are currently developing the narrative to our 2 year operational plans to ensure we can fully commit to the intended outcomes within our 5 year forward view. The local authority will be considering these commitments and intentions as part of its current budget and planning cycle.

There is joined-up responsibility between the individuals accountable for the delivery of the plans and of the wider strategic framework. Any risks that emerge as we progress in the delivery of the BCF and our operational plans will be managed via the governance structure outlined in section 4. We are also currently developing a governance framework to manage the alignment of CCG strategic plans and local authority strategic intentions. We have committed to sharing our plans with the local authority prior to the commencement of their budgeting and planning cycle.

Each CCG has planned to deliver a breadth of work across a wide range of strategic aspirations. Plans included within the BCF are entirely consistent with this breadth of endeavour and have been woven into each overall CCG strategic approach. Particularly, the BCF is supporting initiatives relating to the transformation of each local community system, the development of mental health services, and the longer-term prevention of ill-health. These are common priorities across all CCGs, although solutions may vary according to local patterns of service providers.

The priorities set out in the Introduction above are threaded through each of the CCG 2 year and 5 year plans. All of the CCG 5 year plans are included within the bibliography in section 1.

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.

CCGs have been given the opportunity to co-commission primary care with NHS England. Three different levels are possible, but even at the most basic level, CCGs still have increasing powers and responsibilities to influence and develop the local commissioning of primary care. For example, all CCGs are able to commission out-of-hospital services which are above and beyond the basic NHS contract. CCGs are starting to take these opportunities, for example in HRWCCG a single NHS contract has been developed covering a range of out-of-hospital services (most of which were previously Local Enhanced Services) which are most practicably delivered through GP practices. As the level of responsibility taken on increases, so CCGs increasingly take a role in assuring delivery of independent contracts in their fullest extents.

All the CCGs are working to commission work from their GP practices that compliments the delivery of BCF plans. Examples include:

- The North Yorkshire CCGs, NHS England and the Yorkshire and Humber CSU are working together to deliver the Directed Enhanced service for avoidable admissions. This is a national contract, the detail of which is to be delivered locally. The partnership of health organisations has been instrumental in delivering also universal take-up of the DES by practices, supported by the procurement and implementation of a county-wide risk stratification tool. This DES is key to ensuring practices are included within the growing partnership of integrated services in each locality and that vulnerable patients are identified and have a personalised care plan.
- GP practices are busy implementing the revised contract requirements to ensure

all over 75s, whether identified as at-risk or not, have a named GP
- The North Yorkshire CCGs are also working with their GP colleagues to consider additional local schemes in support of the over 75 population, through the creation of local £5 per head funds for suitable projects.
- 'GMS plus' – working on an enhanced basket of services to replace and enhance LES
- Additional investment available to reduce admissions in over 75s
- Working with GPs/Practices, to identify opportunity to provide services in primary care, and to understand where services can transfer from hospital to primary care
- Utilising the 'resilience funding' to increase primary care resilience and capacity

An underpinning element of the BCF plan is a transformed landscape for Primary Care with GPs working collaboratively with hospital colleagues and with social and community care to deliver more clinical services in local communities, reducing the numbers of people attending or being admitted to hospital and making optimum use of NHS and Social Care facilities in the community. We plan to see a reduction in the numbers of acute and mental health beds and an increase in community based services. We have confidence in our ability to do this because we are:
- supporting the emerging development of the Yorkshire Health Network
- piloting models of integrated multi-disciplinary teams, extending the approach to more Practices and patients
- embedding the use of shared assessments and shared data and a shared approach to risk stratification
- improving the quality of care within Care Homes

At its July '14 meeting, the Health and Wellbeing Board gave confirmation of its support for the CCGs in their expressions of interest.

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)

Protecting adult social care services recognises that people's health and wellbeing are generally managed best where people live, with very occasional admissions to acute hospital settings. Without the full range of adult social care services being available, including those enabling services for people below the local authority's eligibility criteria for support, the local Health system would quickly become unsustainable. Adult social care services are fundamental to the delivery of our ambition to deliver the right care and support, in the right place, first time. Protecting adult social care will allow the local health economy to deliver 'care closer to home' and, whenever possible, in people's own homes.

This protection of social care is against a backdrop of an ambitious transformation programme (known as '2020 North Yorkshire') being undertaken by the County Council. The social care budget is already profiled to reduce by £21.5m from its 2013/14 level of c£138m having reduced by £27m in the four years to 2015. NYCC has prioritised the protection of Adult Social Care within its budget savings programme however the County has had historically low levels of national funding allocations for social care. Adult Social Care spend per capita in North Yorkshire is lowest of all its peer group of 27 Shire counties – some 18% lower than the average and 30% lower than the highest.

This transformation programme also involves corporate activity to strengthen local community resilience, invest in a digital and telephone Customer Resolution Service, support self-help and increase the Council's ability to generate income via commercial solutions. The programme requires us to substantially change the way people receive information and advice and the ways in which they manage their own health and well-being. This will require substantial numbers of people to have their route through the social care system changed – for example, improving and promoting people's use of digital channels, reducing the number of long term placements to the lowest nationally and investing Public Health resources in Prevention schemes to ensure we can divert or delay demand.

Specifically within the Health and Adult Services directorate transformation programme are activities including:
- Reducing demand, investing in prevention and diverting people to self-help and community solutions;
- Promoting independence by improving reablement, integration with the NHS, extending the use of Assistive Technology and improving equipment services;
- Developing a wider range of Accommodation and Care and building on our flagship programme of Extra Care to support more groups of customers to live independently;
- Developing a distinctive NY Public Health agenda and in particular linking this to the rural nature of the County and the challenges of reducing social isolation and

loneliness, affordable warmth and the challenges posed by garrisons and coastal communities;

- Developing our current and future capacity to develop the market, developing our own and the independent sector workforce and prepare for greater public service integration.

North Yorkshire County Council has recently consulted on eligibility and as a result moved the criteria from 'Moderate' to 'Critical and Substantial', in line with the expectations of the Care Act. With the transfer monies in place, this FACS criteria will remain unchanged.

We are clear that this protection to Social Care is critical to ensuring that the wider systems changes can occur within a safe environment where support is available to those people who do not need acute care but do need support. Without this support Adult Social Care services would need to find additional savings and this would place the whole system in jeopardy.

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

The transfer of £17m to protect social care is not in itself investing in a discrete set of defined services or schemes that can be measured or reported in isolation. Within the overall operational services budget, there are a range of service areas that contribute to the wider health and care system, underpinning the services offered by both the NHS and other parts of Social Care.

Service Area	Approximate Budget £m	Number of people supported
Reablement / START	10.7	3,648
Assessment Team	11.6	6,590
Elderly People's Homes proportion of costs attributable to use by Step-Down / Intermediate Care services	1.4	229
LD Day Centres	4.3	698
LD Respite	1.5	102
Carers Support	2.3	5,075
Mental Health Services	6.7	2,497
	38.5	

On top of this, demographic growth is projected to add approximately £1.9m to Social Care costs in 14/15. The implications of the Care Act will be to potentially increase this further in 15/16. The nationally recognised growth in demand for Social Care is exacerbated in North Yorkshire by its size (c2m acres) and rurality with a limited number of large towns (only 3 with a population >15,000). Therefore, services are expensive to deliver, commercial providers are unable to attract sufficient staffing and efficiencies to make provision attractive / economic and so the County faces high delivery costs.

Our priorities in protecting Adult Social Services are to ensure continuity of current levels of service which support the NHS and to provide sufficient funding to support the transformation programme which aims to reduce and delay demand, focus on prevention,

self-help and independence and maintain current good performance on delayed transfers of care and customer satisfaction. The funds will be used to ensure that Social Services can respond to existing and new service users in the context of a known increase in older people and younger adults with very complex needs.

The Council and CCGs are committed to the following principles for how people should experience services:
- Promoting health and wellbeing
- Care is integrated around people rather than organisations
- Treating the patient's home as the main focus of care and services
- No health without mental health
- No decision about me without me

As described in our Introduction and in section 2c, our intention is that in five years' time, as a result of the Better Care Fund and broader investment and service transformation, North Yorkshire people will benefit from:

- an integrated, locality driven Prevention Service which supports them and their carers to improve their lifestyle, improve health, reduce social isolation and use digital and personal-contact channels to obtain advice and information on how they can manage their situation
- a 24/7 fast response to assess their needs and wherever possible avoid a hospital admission should they become ill, and an integrated team approach to helping them get home again if they do go to hospital
- a joined up service to prevent and manage falls
- support for people and families living with dementia
- improved access to psychological therapies, fast response services and in-reach community services for people with mental health needs
- specialist support from community staff, good liaison between care staff and health staff, care at home for people living in a care home if they become ill
- support by a multi-disciplinary team for people with complex needs who know them well, they will have a named care coordinator and will be supported to avoid the need to go to or stay in hospital, to manage their conditions and to maintain social activity and contacts

The activity within our plan is grouped thematically. Unsurprisingly, the major area of investment is in Community Health and Care services where over £23.5m or 50% of the BCF is invested. This is mostly new scheme activity which sits alongside the existing START (reablement) service in HAS, funded from the Protection of Social Care money. A further 21% of the fund is directed to Protection of Social Care.

This demonstrates that we are investing the biggest

Legend:
- Mental Health
- Community Health & Care
- Public Health & Prevention
- Voluntary Sector
- Care Home Support
- Protection of Social Care
- DFG
- Care Act Implementation
- Social Care Capital
- Performance Fund

share of the BCF in services which should reduce the use of secondary and institutional care.

These are integrated reablement/intermediate care services, case management teams, mental health in-reach and dementia services. This in turn will enable the delivery of the BCF supporting metrics of reducing avoidable admissions, reducing care home placements and reducing delayed transfers of care.

We can evidence that we are placing initial resources in services which deal with the immediate and pressing challenges of increased demand and balancing this with the need to invest in ways which prevent or delay people needing formal services. This includes Social Prescribing, Care Navigators, Falls Prevention, Carers Services, and Assistive Technology.

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 North Yorkshire plan includes £7m in 2014/15 and £17m in 2015/16 to protect Social Care. The County Council is, however, to contribute an additional one-off £5m in 2015/16 in order to bridge funding pressures and to stabilise the system (i.e. net £12m protection of adult social care). It has been recognised that adult social care is an area of high priority and there is agreement that the North Yorkshire plan will work towards providing a net contribution of £17m to protect adult social care in future years.

In 2015/16, additionally, the prescribed £1.432m of Care Act Preparation monies and £527k of IT system capital costs have been allocated from the fund, as well as the £1.35m Social Care Capital Grant which underpins the Council's investment in Extra Care Housing.

For 2014/15, NYCC has invested an additional £4.7m to the fund in order to stimulate the creation of the new schemes, kick-starting the ability to generate the shift in the community based services required to deliver the BCF.

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

The introduction of the Care Act will mean changes in the way HAS works across a range of areas. These include:
- The way we provide information and advice, including financial advice
- Increased focus on preventing and delaying needs
- Integration and partnership working is reinforced
- Carers placed on same footing as those they care for
- Working differently with increased numbers of people who fund their own care

Some of these changes will be funded through BCF monies, as well as reviewing our arrangements for Safeguarding, assessment and eligibility, what is taken into account in financial assessment, and independent advocacy. Staff will need to be aware of these changes through a training programme.

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The Lead for the Care Act implementation programme reports regularly to the HAS Leadership Team, and to the Care Act Steering Group, which has NYCC Corporate Management Board representation as well as from the NHS Partnership Commissioning Unit, and is accountable for the implementation of the duties of the Care Act. Reports are also made to the NYCC Executive, and the Executive Member for HAS is regularly updated.

Actions to meet the new duties around Carers are being taken forward by the Carers Strategy Group, whose membership includes NYCC, each of the CCGs and Providers.

Regular meetings are held between the NYCC Care Act Lead and the Director of the Partnership Commissioning Unit and reports have been made to individual CCG meetings. The Care Act is a standing item on the monthly Integrated Commissioning Board, the officer- led multi-agency group that reports into the Health and Wellbeing Board, which is ultimately accountable for expenditure of the BCF monies allocated to meet the requirements of the Care Act. ICB will have Care Act as a standing item and will oversee the progress of the preparation process and agree any spend from the BCF pooled fund.

The interdependencies between this work stream and the delivery of the BCF are as follows:
- Increased integration and improved partnership and co-operation across services
- Joint assessment
- Joint care plans (including carer plans)
- In common with the Care Act implementation, BCF schemes are addressing needs and services for carers, information and advice, operation of Safeguarding arrangements and advocacy provision

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

Investment in specific carer support schemes funded from the BCF totals £1.447m.

Within the Care Act allocation, further BCF allocations for carers assessment is £232k and £499k for package costs. These are being modelled at present and on first examination are likely to be higher, but met from other resources.

This funding will be used to support improved outcomes for carers as follows:
- Provide improved information and advice for carers, both generally about local support/services available to them, and specific to their personal circumstances
- Improved assessment process in terms of speed and accessibility and efficiency (joint assessments)
- Offer a wider range of high quality services and support that include supporting the prevention, reduction or delaying of needs for carers, and enable them to maintain their caring role
- Increased number of carers being able to access support as a result of better identification of "hidden" carers

The risks relating to the delivery of carer-specific support include:
- Inadequate financial allocation to meet new duties from Government, resulting in

> o additional pressure on NYCC and Health budgets and
> o duties not being met in full – reputational damage and negative impact on performance targets
> - Lack of availability of providers of support for carers,
> - Lack of joint working between HAS and Health, resulting in duplication of effort
> - Lack of recognition by partners of return on investment from carer-specific support

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

> The proposals within the BCF are that protection of Adult Services will be at the same level as the original submission, £17m. As stated the Council is investing a further one off sum of £5m into the BCF for 2015/16 to reflect the additional pressures and investment opportunities available to the CCGs and to facilitate further avoidable admissions and integration work.

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

> North Yorkshire already has some 7 day services in place but these are not consistent and a priority will be for all areas to have a consistent level of service, even if the local models differ.
>
> **NHS Commissioned Contracts between CCG and providers ensure delivery of clinical standards for 7 day services**
>
> **HaRD CCG**
>
> HaRD CCG has an agreement in principle with Harrogate District Foundation Trust (HDFT) for this year's contract that includes the following provisions to ensure that clinical standards relating to 7 day working are achieved:
> - Expansion of the Clinical Assessment Team (CAT) services to 7 days/week, 12 hours per day. The CAT service is available to all GPs to refer patients needing immediate assessment and investigation with the intent to avoid hospital admission.
> - Ensuring that hospital support services such as radiology, pathology, and laboratory have sufficient capacity 7 days to support prompt investigations and discharge.
>
> In addition, HaRD has expanded its Mental Health Liaison services through BCF to 7 days, 10 hours per day to ensure that HDFT has sufficient support to make decisions quickly and effectively regarding patients with mental health co-morbidities. This will help achieve standard 7 (mental health).
> The CCG has funded two additional initiatives aimed at reducing unnecessary hospital admissions and meeting standard 9 (transfer to community, primary, and social care):

- "One GP per Care Home" with practices taking responsibility for care home patients, and pro-actively reviewing patients with a view to preventing unplanned admissions. This program is supported by in-reach from both the Rapid Response team, and Mental Health.
- An expanded national "Avoiding Unplanned Admissions" Enhanced Service to include the top 4% of patients at risk of admission, and to implement the Royal College of GPs "Two Visit Model" for implementation and co-creation of Care Plans, again with a view to preventing unnecessary admissions.

This means that local contracts include a local action plan to deliver the clinical standards required in 2014/15.

HaRD CCG endorses the national standard contract and welcomes the inclusion of the clinical standards that have an impact move into national quality requirements in 2015/16.

In 2016/17 it is HaRD CCG's intention that all clinical standards will be incorporated into the national quality requirements section of the NHS Standard contract.

HRW CCG
HRW CCG is actively working with STHFT as its main acute provider to ensure the clinical standards relating to 7 day working are achieved. A CQUIN covering Clinical Standard 2, Time to first consultant review, is included within the Trust contract. This will provide baseline information to identify if patients are addressed by a consultant within the required timescales at Friarage Hospital Northallerton Clinical Decisions Unit (CDU) and other areas receiving direct emergency admissions. This will help to ensure that patients who do not need a full admission to hospital can be returned home with support more quickly and also short-stay patients are discharged more quickly.

Through the BCF, additional capacity is being invested within community therapy and liaison psychiatry, which will help achieve standards 7 (mental health) and 9 (transfer to community, primary and social care) respectively. The acute Trust has done a high level analysis of their position across all the clinical standards for 7 day working and are now in the process of establishing a programme board to oversee delivery of all the standards.

AWC CCG
For **Airedale Foundation Trust**, in accordance with the NHS standard contract technical guidance, AWC CCG in their role of lead commissioner have included a service development improvement plan (SDIP) as part of the overall contract. This sets out actions that the provider will take during 14/15 to commence implementation of the recommendations of the review into 7 day services and the associated clinical standards. An action plan has been developed and is monitored as part of the SDIP through the service development groups at both acute providers.

SRCCG
SR CCG has an agreement in principle with York Teaching Hospital NHS Foundation Trust (YFT) for the Implementation of Clinical Standards set out in NHS Services, Seven Days a Week. The agreement details the development of review and baseline of current service, the development of an action and implementation plan within the contract.

The BCF is being used as a driver for change within the locality with the development of Psychiatric Liaison service and investments in the Malton community hub and

intermediate care/reablement. This will be a significant enabler in the achievement of standards 7 (mental health) and 9 (transfer to community, primary and social care). YFT is developing a high level analysis of their position across all the clinical standards for 7 day working and is in the process of establishing an action and implementation plan for delivery of the standards.

VoY CCG

The VoY CCG is actively working with YFT, as its main acute provider, to fully understand the requirements and implications of 7 Day Working. For 2014/15 7 Day Working forms a specific element of the contractual agreement between both parties within the Service Development and Improvement Plan (SDIP).

The SDIP is used to detail any service changes or developments that will impact materially on the contract. Progress against the SDIP will be monitored via the Contract Management Board (CMB) as appropriate during the year with quarterly review the minimum expectation. The SDIP is a live document which will continue to be developed and jointly agreed between both parties.

The expected outputs and the consequences for not achieving these outputs will be agreed once the working groups are established. The default consequence is subject to General Condition 9 (Contract Management).

The working groups will be responsible for identifying and cross referencing schemes to the relevant national and local Key Performance Indicators, CQUIN schemes, and quality premium indicators for which achievement will be supported through implementation.

The SDIP includes the following contractual expectations:

A national condition of the Better Care Fund is the requirement to "provide 7 day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends." The CCG wishes to work with the Trust, through the proposed Care Hub models, to identify where changes to current service delivery models are required to support this requirement. It is expected improvements will be required in (but not limited to) areas such as access to diagnostics (including interpretation and resulting care plans), clinical decision making at weekends to support admissions avoidance and discharge, increased liaison with social services and better overall discharge planning.

The progress towards the above and the impact of delivery/non delivery will be measured through the Partnership Delivery Board and existing contract management arrangements.

So far this progress has been made in establishing a working group with Trust and CCG representatives to agree implementation plan and milestones and identifying high priority services, specialties and diagnostics for 7 day working. Further work plans and timescales are now being agreed by the relevant groups.

North Yorkshire's system-wide approach to 7 day working

Local acute Trusts are in the process of implementing plans to support seven day services across a wider range of standards. Plans through the Better Care Fund will particularly impact on their ability to discharge patients over a 7 day period.

North Yorkshire already has some 7 day services in place but these are not consistent

and a priority will be for all areas to have a consistent level of service, even if the local models differ. As a minimum the intention would be to have services in place from 8 AM to 8 PM 7 days a week. However, the models in each CCG locality will be designed to respond to local determinants e.g. geography, community hubs. Some extended seven day services will be available to provide additional support from 8pm to 8am, including 24/7 fast response services, home night services and community hospitals, where possible. These models will be evaluated and learning shared across the County. Key to the success of this model is clear communications and handover at discharge between acute sector and community services ensuring that the person and their carer is fully aware of the discharge arrangements.

NYCC and the CCGs are developing a new model of Joint Reablement/Intermediate Care to be rolled out locally across North Yorkshire during 2014/15. The first step is the functional integration of the Reablement and Intermediate Care teams with a view to jointly commissioning this model of care with CCG partners. This model of care reflects the Better Care Fund national conditions of protecting social care services, providing 7 day services to support discharge, enabling data sharing – using the NHS number as a primary identifier plus other data sharing requirements, enabling joint health and social care assessments with an accountable lead professional and agreed impact on the acute sector

Priority Actions

1. The Integrated Commissioning Board has identified the need for a short term project to map provision and support each area to undertake a gap analysis, along with capacity and demand profiling. This will enable each CCG along with Social Care to identify how the existing resources can be better coordinated as well as how new investment should be targeted. This will be undertaken in 2014/15 to allow for service improvements during the year. This work will also feed into the work underway with all CCGs to re-commission Community Health Services. The PCU have established a Dementia Commissioning Intelligence task group (Health and Social Care). This group will use relevant NICE tools to gather information which will feed into service improvements.

2. In the short term in some areas where there is significant pressure, additional capacity has been created through the identification of short term step-up/step-down beds within the care home sector and the flagship Extra Care provision, through increasing Occupational/ Physiotherapy capacity in the longer term and increased support for carers.

3. The establishment of **Joint Rapid Response** in each CCG locality which will provide a 4 hour/same day service to respond to community crisis and avoid admission into hospital. The rapid response teams would also partner up with Acute front of house teams to avoid preventable admission, also within a 4 hour response time,

4. The establishment of **Joint Reablement/ Intermediate Care** in each CCG locality which will provide a range of first intervention services. This would include enabling and supporting people in the community identified at risk of deteriorating need, supporting in-reach into hospitals, facilitating hospital discharge and facilitating rehabilitation for up to 42 days. This service will be extended for up to 84 days to meet the needs of people with dementia, Learning Disability and

Mental Health needs. This will be shaped subject to stakeholder engagement as part of the Dementia strategy and implementation process.

Impact upon hospital admission prevention and hospital discharge

a. Rapid Response will be part of the core joint reablement/intermediate care and will provide crisis intervention to stabilise an individual at home and prevent hospital admission. It will provide alternative responses for GPs rather than using Yorkshire Ambulance Service and A&E. It will provide a service within 4 hours/same day service in the CCG locality for up to a period of 72 hours. The service will feed into the joint assessment and joint care plan for reablement and intermediate care, if this is required.

b. We are ensuring that all patients are discharged from hospital via a pathway that's appropriate to their presenting needs, which for many patients could mean discharge home without reablement/intermediate care support. For those patients requiring a planned discharge there will be evidence of a presenting reablement/rehabilitation need. Acute discharge will be on the basis that the assessment undertaken in the hospital will be the 'trusted assessment'. The Reablement/Intermediate Care team will then use this assessment to put a care and support plan put in place. The Care and Support plan will then be reviewed by the team with the individual against their goals and targets. Confidence and improved working between acute and community services is a key component of early, well planned and organised care and support post discharge, with consultants being able to refer into 7 day services working. This will reduce the duplication of assessment and will ensure that services are wrapped around the individual promoting personalisation in meet their presenting needs. This will improve early discharge from hospital and reduce length of stay in hospital.

People in hospital or as part of their discharge will be supported as appropriate by an enhanced hospital liaison service in place supported with new funding from the CCGs to provide specialist mental health assessment and advice for treatment and management where there are clinical issues relating to Mental Health need specific to acute hospital setting. This service is operational in hospital sites in Harrogate, Northallerton and being introduced in Scarborough.

c. By aligning professionals in one service there will be better co-ordinated assessment and planning and delivery of care through joint assessment and joint care plans. This will avoid duplication and a fragmented approach to support arrangements, therefore improving outcomes for the person and delivering both cashable and non-cashable efficiencies for NYCC and the CCGs. The care co-ordination function carried out by the lead accountable professional will be pivotal to the success of this approach. The lead professional will ensure that the individual is supported in a seamless and timely way. They will ensure that the relevant care workers and specialists provide their input at the right time and in the right environment. They will also ensure that all communications with referrers, e.g. GPs, take place in an appropriate fashion. The new Dementia Support Services jointly funded by NYCC and the CCGs has a care navigation/advice role which will contribute to more holistic and joined up care planning approaches for the individual.

The diagram below shows the model of Integrated Intermediate Care and Reablement Service we are developing. It is very different to our current service which is more heavily focused on post hospital services. This new model has the added capacity and capability to avoid admissions and maintaining people at home with multi-disciplinary teams.
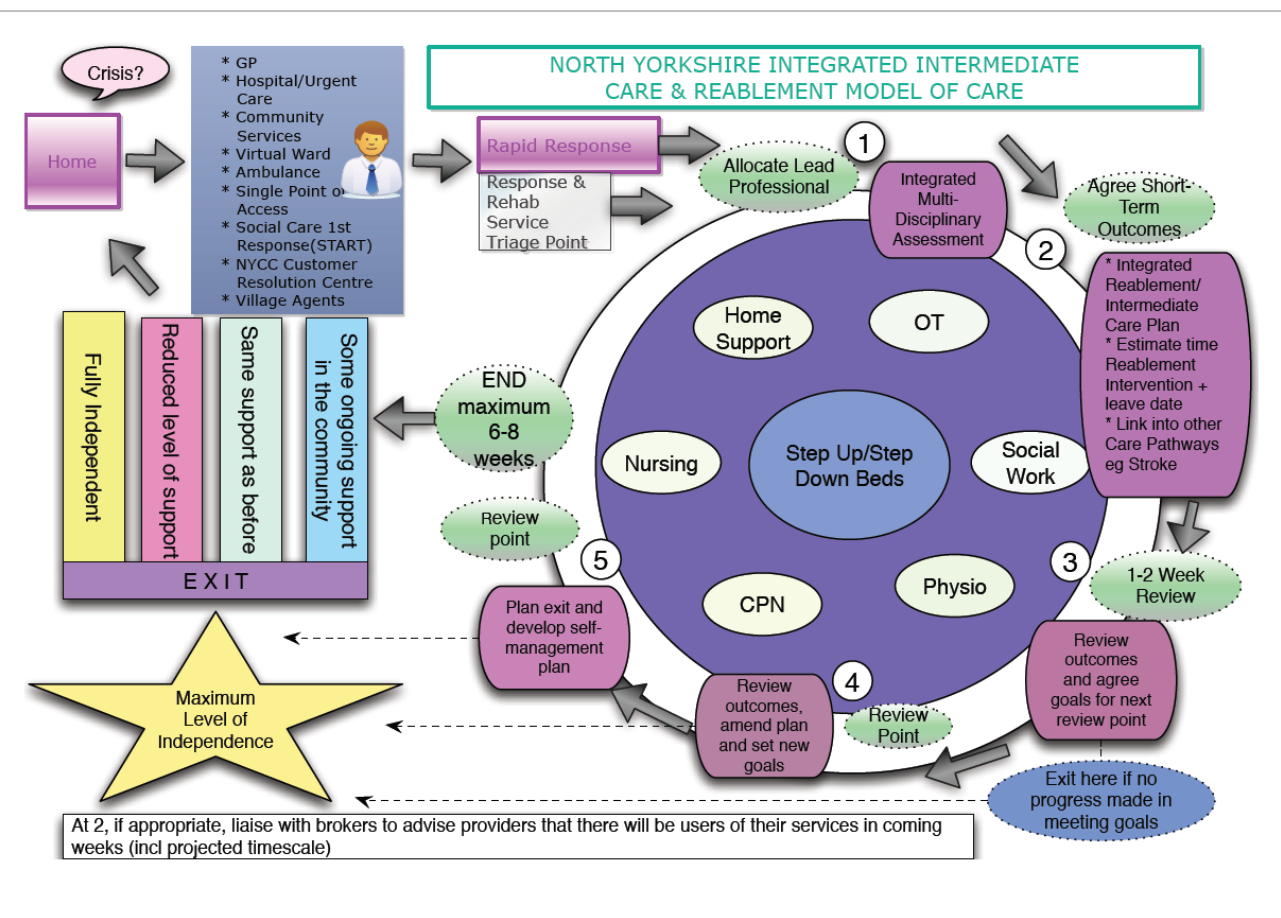
Key next steps

1. Establish Joint Reablement/Intermediate Care including Rapid Response in each CCG locality by January – February 2015.
2. Development and implement an organisational development plan which introduced new ways of working, culture change and tests out new types of worker role e.g. 'generic worker' role to deliver a combination of both health and social care elements in the care and support plan. The plan will also reflect the plans of the Multi-agency Dementia Workforce Development Group which is focussing on later stage dementia and End of Life Care.
3. Monitor and evaluate the new model by CCG locality in Q 3 and 4 in 2015/16 to ensure sufficient community resources in place which can respond quickly to hospital admission avoidance and pick up hospital discharge referrals quickly.

Key risks

1. Not all areas will have the right service for their local population
2. Clinical governance to enable joint working needs to be agreed between the County Council, Acute Trust and Community Health services.
3. Agreement regarding joint assessment and joint care plan tool/documentation that is consistent across North Yorkshire

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

Key Milestones			
Ref	**Milestones**	**CCG area**	**Timescales**
1.0	**Milestone 1 : Model of care**		
1.1	Local model developed and agreed in each locality which reflects County wide blue print and principles	All	October 2014
1.2	Capacity and demand analysis to inform workforce planning	All	October- November 2014
1.3	Implementation of model 'go live'	All	January – February 2015
2.0	**Milestone 2: Recruitment**		
2.1	Ensure sufficient capacity within reablement and intermediate care services	HRW CCG VoY CCG S&R CCG	September to December 2014
3.0	**Milestone 3: Organisational and Workforce development**		
3.1	Develop and agree organisational and workforce development plan which includes: • New ways of working – joint assessment/joint care planning • Culture change (Trusted assessor) • Supporting management arrangements so teams know where to go for permissions and advice when needed to ensure smooth transition	All	November 2014
4.0	**Milestone 4: revise arrangements to facilitate 7 day services**		
4.1	Ensure clinical standards for 7 day working are reflected in NHS contracts between CCGs and providers for 2014/15, 2015/16 and 2016/17	All	October 2014
4.2	Impact clarified of new joint reablement / intermediate care model of care to ensuring 7 day discharge arrangements	All	November 2014
5.0	**Milestone 5: Communication and Engagement**		
5.1	Identify stakeholders by CCG locality	All	October 2014
5.2	Stakeholder management plan by CCG locality	All	October 2014
5.3	Communications and engagement plan by CCG locality	All	October 2014
6.0	**Milestone 6: Governance and Assurance**		
6.1	Agree clinical governance arrangements	All	November 2014
7.0	**Milestone 7 : Evaluation**		
7.1	Agree evaluation criteria for North Yorkshire	All	November 2014
7.2	Monitoring and report system in place for each CCG locality Transformation Board reporting into County wide ICB	All	December 2014
8. 0	**Milestone 8: IM&T support**		
8.1	Ensure new working arrangements are supported by effective underpinning IM&T processes, including: • Consent principles and arrangements are finalised • Policy and process for sharing assessments through safe and secure e-mails • Technical solution to enable access to both health and social care systems at the same location to facilitate hot desking and MDT meetings	All	December 2014 – March 2015
8.2	Project agreed to establish long-term solution for integrated records through IM&T workstream	All	October 2014

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

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All health and care systems will use the NHS Number as the primary identifier supporting communication with other providers of health & care services for the purpose of direct patient care. Key systems already have the capability to store NHS Numbers.

NHS Number matching rates within the main provider services are already over 99% and processes are well established for maintaining that.

NHS Number matching rates within social care are currently just over 80%. This has been based on an initial overnight DBS trace of all known active service users. Research shows that other LA's have achieved matching rates of around 95%.

Development work has started on an automated process for extracting records from the social care case management system and uploading them to the overnight DBS service via the Councils N3 link. NHS Numbers returned are then quality checked and entered into the case management system. This process will operate on a weekly basis and provide the NHS Number at an early stage in the care pathway.

There will still need to be a manual process for dealing with those records that do not return a positive match. Work is already underway to estimate the volume of unmatched records affected this way. Contact with referring organisations and/or patients will be needed to source the NHS Number from existing documentation.

Further improvements to matching rates could be achieved through a direct PDS linked trace from within the social care case management system. However, it has been noted that there is already work underway in this area led by ADASS nationally. The outcome of the work is to recommend the most appropriate methods of obtaining NHS Numbers in social care together with the respective risks and benefits of each approach.

Use of the NHS Number as a primary identifier has also been amplified in a collaborative bid to the Integrated Digital Care Fund, the outcome of that is expected to be known during October 2014. More detail on that bid is shown in the following sub-section.

Milestone	Area	Date
Outcome of bid to the Integrated Digital Care Fund confirmed	HRW CCG NYCC	October 2014
Agreed manual processes for resolving unmatched traces	NYCC	November 2014
Completion of development work on automated DBS traces	NYCC	December 2014
Outcome of ADASS National work of methods of obtaining NHS Numbers in social care	NYCC	December 2014
Automated DBS traces operational	NYCC	January 2015
Organisational development plans to reflect use of NHS Number will be dovetailed in with the overall BCF OD programme	All	April 2015 to March 2016
Business case produced for direct PDS integration of social care case management system	NYCC	March 2015

The key risks relating to the use of NHS Number are shown in the main risk log :

Risk	Likelihood	Impact	Overall	Mitigation
Automated matching of NHS Numbers is not done in a timely manner.	Low (2)	Medium (3)	6	Plans will be in place to manually populate NHS Numbers from current correspondence.
NHS Number is not used for communication between organisations.	Low (2)	Medium (3)	6	Organisational development plans including staff training will be monitored.
The outcome of the National ADASS work may recommend a different approach.	Low (2)	Medium (3)	6	The existing DBS tracing service will continue to be used.

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))

Not all health and care systems use Open APIs and Open Standards but will be expected to in the future. This does represent a challenge, and therefore a risk, due to the ability of some legacy systems, or indeed their suppliers, to deliver Open API's from within the technologies used to develop those systems. It will be necessary to establish alternative methods of accessing data from those legacy systems if delivery of Open API's is not possible.

A joint bid to the NHS England Integrated Digital Care Fund was made covering the HRW CCG area as well as the neighbouring authorities of, Middlesbrough Borough Council, Redcar & Cleveland Council. This bid was in conjunction with North Yorkshire County Council, South Tees CCG, North East Commissioning Support Unit, Yorkshire & Humber Commissioning Support Unit, South Tees Hospital Trust and sought support to create a shared care record across multiple partners by provision of open-source, Open-API integration engine.

The bid was not successful. Further feedback is being obtained to identify areas that could be improved in subsequent bids to new funding streams as they become available. However, all the organisations involved in pulling the bid together have confirmed their agreement to continue working towards achieving an integrated digital care record. The bid group will meet in January 2015 to review the original scope and timescale with a view to producing a revised plan and cost model.

The concept of the approach is illustrated through the schematic below:
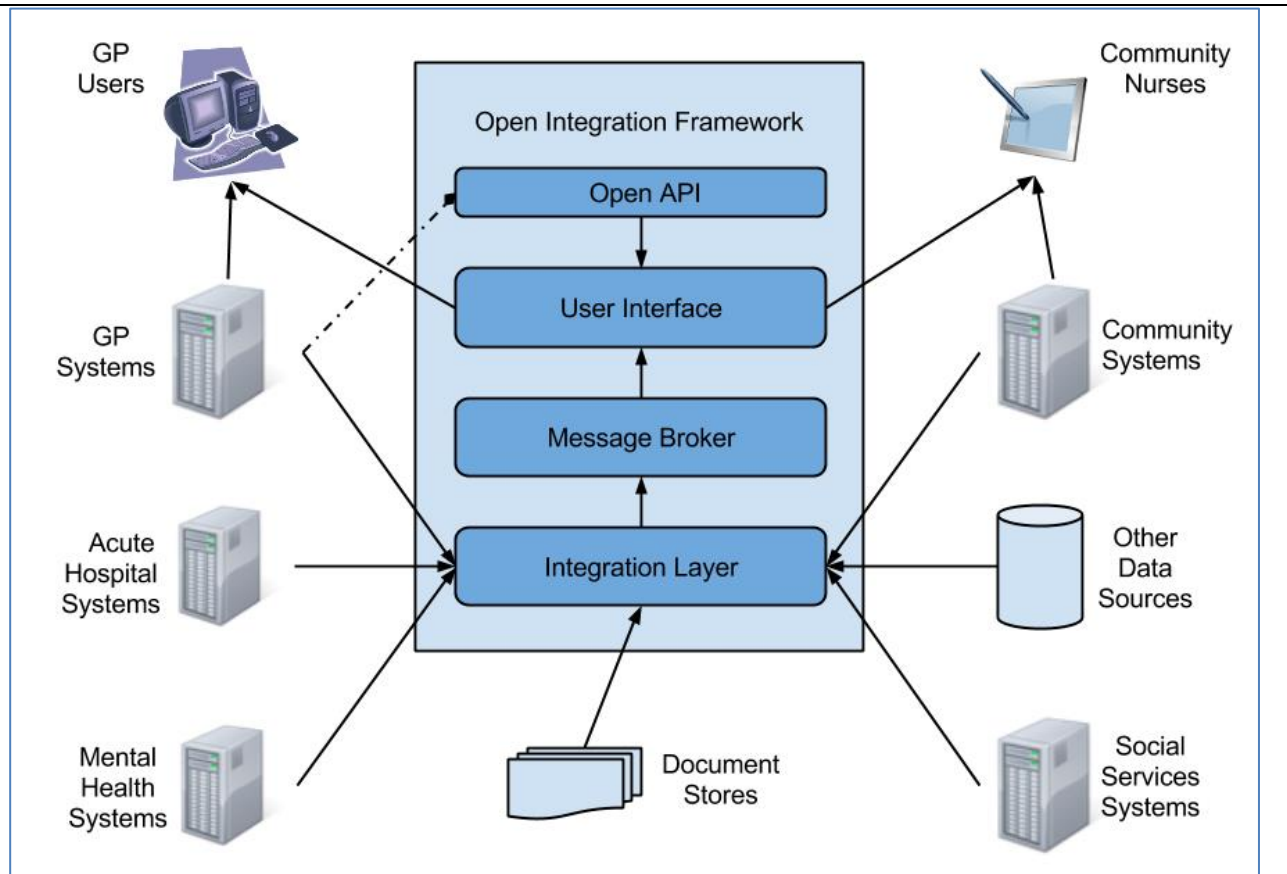
A new joint health and care record is being developed by a community of organisations in the Airedale, Wharfedale and Craven CCG area. It will be based on the shared use of TPP SystmOne across all those organisations. The Craven area of NYCC sits within this HWB area while the remainder of the CCG area falls across other authorities' plans, so there is a complex array of different systems in use. There will need to be some integration with the NYCC Liquidlogic case management system.

Part of the work to deliver both these projects is an assessment of the current systems and the availability of Open API's now, or the likelihood of them in the future. This work will become part of the wider IM&T baseline activity for the BCF programme.

The current Interoperability Toolkit (ITK) is light in terms of standards to support extensive integration across the health & care service providers, though it is recognised that the position will improve as a result of national initiatives around the Integrated Digital Care Fund and the integration pioneers programme. Those ITK standards that do exist, and apply to the areas of integration envisaged within this BCF plan, will be used.

Within NYCC, a council-wide transformation programme is under way called North Yorkshire 2020. As part of the programme, development work is planned to create a single customer view for citizens accessing the services of the council and its partners. Solutions are likely to be built on Open Source using Open-API's wherever possible. This will naturally join up with any integrated care records developed by those partner organisations working with the same citizens.

Milestone	Area	Date
Outcome of bid to the Integrated Digital Care Fund confirmed.	HRW CCG NYCC	October 2014
IM&T Baseline activity completed.	All	December 2014

Detailed implementation plan for the IDCF project produced – subject to outcome of bid.	HRW CCG NYCC	April 2015
Detailed implementation plan for the AWC CCG shared care record produced.	AWC CCG	April 2015
IM&T work programme devised and project/s agreed to support BCF outcomes	All	April 2014 to October 2014

The key risks relating to the Open-API's and open Standards are shown in the main risk log :

Risk	Likelihood	Impact	Overall	Mitigation
Legacy systems may not have suitable Open API's published.	Medium (3)	Low (2)	6	Most likely to affect the social care system. Other methods for exchanging data already exist.
IM&T baseline activity not completed on time. IM&T work programme not developed.	Low (2)	Low (2)	4	Resources identified for the work will be increased.
ITK standards are not sufficiently developed to meet the timetable of integration work.	Medium (3)	Low (2)	6	Local standards will be developed and applied through agreement across all partners affected.

iii) 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.

NYCC already uses a secure email solution for communicating with the NHS and other Public Sector organisations. It is provided through the GCSx infrastructure and is deemed to be compatible with NHSMail. In addition, NYCC uses another secure email solution for communicating with non-Public Sector organisations. This is a product called eGress Switch.

NYCC has a current IGT V11 assessment. This supports an existing N3 connection direct into the NYCC corporate data centre. In addition, NYCC achieved PSN compliance in May 2013, ISO27001 in November 2012 and ISO20000 in February 2013.

Work to align the different technical compliance regimes covering the local authority and NHS organisations is understood to be taking place nationally through the integration pioneers. The most recent NHS IG Toolkit (V12) recognises the compliance levels of local authorities who have already reached PSN Code Of Connection. All organisations are committed to reaching and maintaining compliance with their respective regimes. However, there is duplication of effort in this area and this has been recognised as a risk. Feasibility work has started within the HRW CCG area to explore how co-location of staff from different organisations can be achieved, safely and securely, through the delivery of multiple systems over multiple networks into the same building. This will enhance and improve multi-disciplinary case conferences leading to better outcomes for patients. Because of the separate IG regimes this is expected to challenge the ability of each organisation involved to deliver their systems into locations they are not able to govern.

Assistance from the Commissioning Support Unit IM&T service has been requested.

Caldicott Guardians are in place across the system. All Statutory and Legislative requirements are understood. The recent report from the Law Commission *Data Sharing Between Public Bodies A Scoping Report* [1] also suggests a need for progress to be driven nationally on resolving information sharing challenges within the current legal framework.

Within the AWC CCG area, as part of their accelerator project, work has been taking place with Oliver Wyman Co to test the theory that a USA style of processing people through the health & care systems could work across the wider North Yorkshire and partners. For the secure sharing of information to take place in support of this work, a series of information and data sharing protocols were completed by all parties involved. This highlighted a lack of standardised protocols across the community of organisations covered by this plan.

The current DH Social Care Informatics Strategy Work Programme (for the period July 2014 to March 2015) highlights the need for a "system wide IG strategy". As a result, the work of the integration pioneers is expected to explore this area further. We await the outcome of this work and representatives from NYCC are already in contact with the pioneers working in this area.

Milestone	Area	Date
Outcome of pioneers developments around IG, including re-aligned compliance regimes expected.	All	March 2015
Complete feasibility work into co-location of staff from different organisations and develop plan for roll-out to other CCG areas.	HRW CCG NYCC	March 2015
Reach agreement on a standard approach to information and data sharing protocols.	All	October 2015
Development of revised approach to IG including new models for consent management.	All	March 2016

The key risks relating to IG controls are shown in the main risk log :

Risk	Likelihood	Impact	Overall	Mitigation
No multi-agency forum for progressing IG matters	Medium (3)	Medium (3)	9	Escalation to Integrated Commissioning Board for executive mandate.
Delay in delivering the outcome/s from the integration pioneer work	Medium (3)	Medium (3)	9	Work will have to continue locally and duplication of effort expected.
Existing systems not able to support the chosen model of recording and managing consent.	Medium (3)	Medium (3)	9	Some systems may need additional manual workarounds to be applied if the consent model can't be supported.

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[1] http://lawcommission.justice.gov.uk/docs/lc351_data-sharing.pdf

Differing IG regimes prevents opportunities for co-location.	Low (3)	Medium(3)	9	Organisations will achieve separate compliance for local purposes. Local agreements will be needed to achieve cross-organisational compliance. Workaround is to delivery separate systems on separate devices in the same location.

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 national 'Pro-active Care' enhanced services instructs primary care to identify the top 2% of patients at risk of admission. Although this is being used as a baseline across the County, there are some variations in each CCG locality. For example, HARD CCG has expanded this to the top 4% with additional funding to practices to support the use of the Royal College of GPs "Two Visit Model" to ensure true co-production of joint care plans. AWC CCG have invested the equivalent of £5 per head of population in an 'enhanced primary care scheme' and have agreed a CQUIN scheme with acute and community providers so all partners are incentivised to undertake an increased number of joint assessments and agree integrated care plans, which will be used to support delivery of the pro-active care enhanced service. As a result a greater number of people most at risk of acute admission (identified through predictive risk stratification tool) are being targeted with more pro-active care and the number of those being assessed and with care plans in place will significantly increase from 2%.

GP practices across North Yorkshire are currently able to utilise a risk stratification approach through a system called RAIDR. RAIDR's risk stratification module uses the Combined Predictive Model (CPM) algorithm to process acute secondary care and primary care records. This produces a list of patients within each practice, ranked by their risk of hospital admission. The RAIDR tool also provides some condition specific risks e.g. COPD, AF (CHADs), and fracture (osteoporosis risk factors). RAIDR is very flexible tool that allows users to easily navigate a wide variety of information and intelligence from high level trends to detailed patient level data. These patient lists carry each patient's NHS number, allowing practices to import them directly into their own practice management systems or utilise them in case management/ Multi-Disciplinary Team (MDT) working to improve and personalise individual care plans.

The RAIDR tool is refreshed monthly, allowing new cases to be quickly identified and changes to existing patient risk status to be effectively monitored. The CCG will shortly have access to aggregated information about each patient's risk scores which can then be monitored over time to help assess the impact of its service improvement programme, and help to ensure the efficient allocation of resources, both organisationally and geographically.

Patient consent is sought so MDT meetings can discuss their case.

Criteria for access into the service is for those people aged over the age of 18 estimated by the RAIDR tool to be at risk of hospital admission.

The benefits of active care planning are:

- Hospital admission avoidance – reducing the risk of admission
- Reduce emergency admissions
- Reduction in frequent visits to GP Practice
- Prevent A&E attendance
- Reduce delay/need for long term care
- Optimise level of care to enable person to stay at home
- Maximise level of care and self-care to enable patients to stay at home
- Prevent and manage crisis
- Reduce deterioration
- Long term condition management

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

Joint process to assess risk

The North Yorkshire Integrated response for high risk populations is detailed in the diagram below.
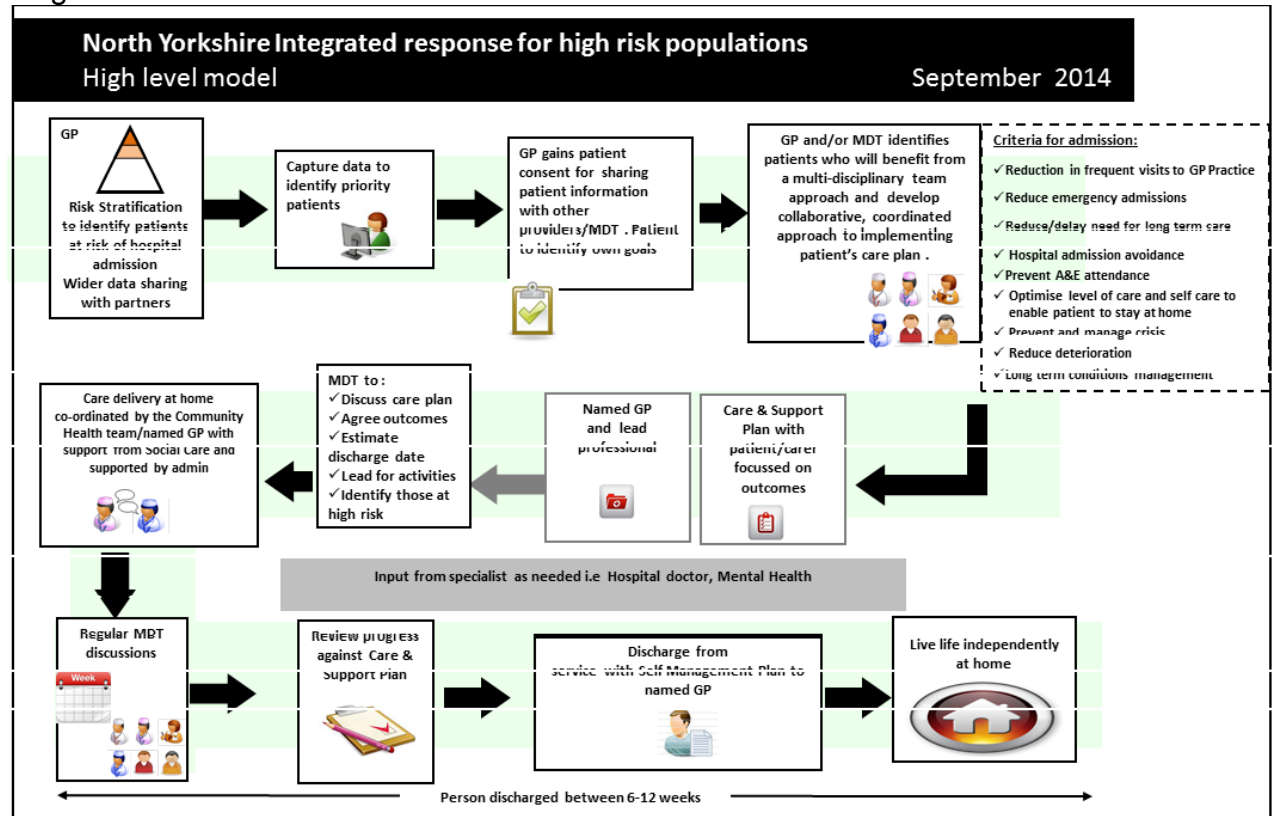
The GP will request the consent of each patient identified to discuss their care needs with other providers. Some GPs will meet with their at-risk patients to discuss referral to MDT, and in these instances, will ask for input on their goals and concerns regarding their health and well-being. Upon obtaining that consent, the GP will work with an appropriate MDT representative or MDT to triage which patients will benefit from a full MDT approach to their care. Each patient will be identified through this triage process as one of the following:

1. *Patient will benefit from referral to MDT for discussion and follow up*
2. *Patient to be referred a service but does not need MDT approach at this time*
3. *Current package of care and support is sufficient - the GP will continue as the lead professional monitoring this patients' progress*

The lead GP in each practice facilitates the MDT meetings and discussions. The MDT would typically consist of a Community Nurse, Social Worker and a Community Psychiatric Nurse. *The purpose of the meetings and discussion are to discuss the patient's own goals and concerns about their care (where known), agree the recommended lead professional for each patient,* agree the **outline outcome** for each patient, agree **urgency** and **estimated date of discharge** (EDD, where applicable) and agree **patient prioritisation** into the service.

Role of accountable lead professional and joint process for care planning and support to GPs

The team will identity and recommend the lead accountable professional who will work with the named GP to coordinate care. The recommended accountable lead professional will then meet with the patient (and their carers if appropriate) to conduct a joint assessment and develop a joint care plan with the patient in their home. The patient and carers personal goals and objectives will be discussed and reflected in the care and support plan agreed with the patient and their carers. The recommended lead professional for their care plan will also be discussed and agreed with the patient/carers. Evidence shows that meaningful engagement on the part of the patient in their care plan leads to better outcomes.

The lead GP in each practice facilitates the MDT meetings and discussions. The MDT may include a Community Nurse, Community Matron, Social Worker, Community Psychiatric Nurse, MacMillan Nurse, or other appropriate professional. Where any attendees have concerns regarding the care or risks to any patient registered with that practice they may be discussed – irrespective of their calculated risk. These meetings offer an opportunity to discuss complex cases, plan care and desired outcomes, address and assess risk, and reflect upon wishes expressed by the individual as part of the care planning process. The lead GP or designated MDT meeting organiser will establish an agenda of patients to be discussed at each MDT. To ensure that each patient receives equal consideration and that the MDTs discussions are focused and productive, the team will establish a standard set of information to be available for the MDT and how it will be presented.

The lead accountable professional would be the most appropriate professional to support the personalised goals for example Community Nurse, Social Worker or Community Psychiatric Nurse. The lead accountable professional can bring specialist help and

advice into the joint assessment and the joint care and support planning process.

There will be a single joint care plan in the person's home. Ultimately a single IT system, (with a patient facing shared portal) is the ideal solution but this is unlikely to emerge in the short term but should not stand in the way of progress towards joint care planning. The degree to which people are prepared to have their information shared will be addressed through agreed consent protocols.

Following the joint assessment and joint care plan the person is reviewed at the regular MDT meetings lead by the named GP and the outline outcomes are confirmed along with the detailed outcomes and Estimated Date of Discharge (EDD). The MDT agrees the patient plan and allocates tasks and goals to members of the team. The MDT identifies who will lead on each of the tasks including:

- Carers assessment
- Carers health check
- Mental Health screening/Health and wellbeing assessment

People are then discharged to their named GP when their outcomes and goals have been reviewed and determined if these have been achieved. The estimated discharge date is reviewed in light of this. Upon discharge from the service the person has a self-management plan to support them at home.

There will be a single joint care plan in the person's home. Ultimately a single IT system,(with a patient facing shared portal) is the ideal solution but this is unlikely to emerge in the short term but should not stand in the way of progress towards joint care planning. The degree to which people are prepared to have their information shared will be addressed through agreed consent protocols. (The ability for the patient to own their care plan also inherently allows them some control over how this is shared.)

Action being taken to remove barriers

1. <u>GP involvement in MDT meetings for high risk populations</u>

There is already an expectation for General Practice to work as part of multi-disciplinary teams as part of the national risk profiling Directed Enhanced Services (DES) to enable General Practices to work with Community Health and Social Care services to improve patient hospital admission avoidance. Currently the GP is rarely the named care coordinator. With the 2014/15 GMS Contract change, this will change and we will ensure that all patients with a certain risk level are assigned to an accountable GP who will ensure they are receiving coordinated care. This will be supported by members of the multi-disciplinary team.

2. <u>Currently no single IM&T system for assessment and care planning in place</u>

IM&T is an enabler for and will help to address the challenges of consent, data sharing and interagency protocols in line with National Guidance e.g. General Medical Council, NHS England.

3. <u>Ensuring Joint Assessment and Joint Care planning in practice</u>

An organisational development plan is being developed which will address the change management requirements for multi-disciplinary working to deliver joint assessment and joint care planning including culture change, 'trusted assessor'.

Impact of these systems for people with Dementia and Mental Health

Specialist Health and Well Being screening along with access to specialist support for dementia and mental health will promote independence and enable people to remain at home. Liaison psychiatry services have been developed in response to this and have shown to improve care and enable discharge earlier if a patients mental health needs are addressed, also reducing readmission rates. The initial aim is to develop a mental health liaison service with a strong development approach allowing an enhanced quality of care for patients who are older with dementia, delirium and/or depression.

IAPT services will work more closely with Social Care to deliver services that are wrapped around the individual and deliver a seamless service. This will provide additional support for GPs for older people and those people who have complex needs.

This should enable people to recover their independence and remain safe at home for longer.

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

NHS England have commissioned a direct enhanced service (DES) designed by the NHS Commissioning Board (NHS CB) to identify and case manage patients identified as seriously ill or at risk of non-elective hospital admission. This 'pro-active care' enhanced service involves encouraging GP practices to:

- undertake risk profiling and stratification of their registered patients on at least a quarterly basis, following an holistic approach embracing physical and mental health problems
- work within a local multidisciplinary approach to identify those who are seriously ill or at risk of non-elective hospital admission
- co-ordinate with other professionals the care management of those patients who would benefit from more active case management.

All practices are participating in the 'pro-active care' enhanced service. A predictive risk stratification tool is in place which is used to identify those most at risk of hospital admission, the top 2% of these are targeted and discussed in multidisciplinary, multi-agency team meetings and have integrated care plans agreed and put in place. A review of 'read' codes has been undertaken and 42% of those most at risk of admission have codes assigned to their records to indicate care plans are in place. The nature of the pro-active care enhanced service incentivises GP practices to ensure care plans are in place for all of the top 2% hence we have confidence that as a minimum the top 2% of those at risk of admission will have plans in place by the end of September 2014.

In addition some CCGs have invested the equivalent of £5 per head of population in an 'enhanced primary care scheme' and have agreed a CQUIN scheme with acute and community providers so all partners are incentivised to undertake an increased number of joint assessments and agree integrated care plans. This will support delivery of the pro-active care enhanced service and as a result a greater number of people most at risk

of acute admission will be targeted with more pro-active care and the number of those being assessed and with care plans in place will significantly increase from 2%.

For example, AWC CCG and SR CCG have implemented further Local Enhanced Services (LES) specifically for the over 75s practice population where each practice is expected to deliver an implementation plan for specified outcomes. The practices are requested to achieve a minimum of 35% of their over 75s registered list over the course of the year. They must also monitor their unplanned/emergency admissions, A&E attendances and GP Out of Hours. The specified outcomes include:

- Practices must be signed up to the NHS England 'Avoiding Unplanned Admissions Enhanced Service as a pre-requisite
- All appropriate patients will receive a tailored plan including opportunistic anticipatory care planning for less vulnerable over 75 years of age (Min. 35% of practice population)
- All patients or their carer will know where their care plan is and will understand the content in relation to their treatment and what to do if their condition changes
- GP practices will be monitored for reductions of Inappropriate 'Out of Hours' call outs for the GP, as well as 'In-' and 'Out-' of Hours unplanned admissions and A&E attendances

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

The NHS and the County Council have engaged in significant local consultation over the last year. A number of key themes have emerged from all areas. These are that:
- People want to be supported to live at home for as long as possible
- People want to be given help to be independent
- People want access to good quality primary care and GP Services
- People understand that they may have to travel further for specialist services and to secure the best outcomes
- Support for carers is a priority
- People believe that we should invest in prevention

All CCGs have Patient Engagement mechanisms and representatives on their Governing Bodies and all schemes have been approved by the Governing Bodies which have assessed how the schemes fit not only the BCF criteria but also the CCGs Strategic Plans.

Active engagement with HealthWatch is progressing and well-attended launch events have been conducted. HealthWatch have presented a timetable of events that they are involved with across the County, which includes active participation in many CCG public and patient consultations.

Some specific examples are given below; this is not an exhaustive list.

Hambleton Richmondshire and Whitby CCG have consulted widely on their 'Fit 4 The Future' model in Whitby and this is now being extended with a programme of events in Hambleton and Richmondshire. A programme of more traditional engagement events has been undertaken. The CCG is now following this up with a more informal approach, designed as a fun, interactive game 'vision or no vision', which is being played with a range of community groups and stakeholder gatherings.

Airedale Wharfedale and Craven CCG produce regular 'Grassroots' patient experience reports which are reported to the CCG Clinical Quality and Governance Committee on a quarterly basis. They have also held extensive consultations on priorities across all their local districts.

Harrogate and District CCG has held 2 large public engagement events in the last 10 months with the local population. Responses and feedback from both these have helped shaped the local plans and long term strategy, this is reflected in 'you said, we did' approach detailed in the plans, not least the priority which the public gave to Mental Health. In addition the CCG have engaged with the local leaders from the voluntary and community sector to influence and shape how the statutory organisations work with the sector.

Vale of York CCG are currently consulting on their new approach to Community Hubs in all of their localities and are co-producing the model with local clinicians and the public.

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Scarborough and Ryedale CCG are currently consulting widely on Urgent Care and working with the District Councils and NYCC to develop approaches to combatting health inequalities.

North Yorkshire County Council has regular meetings with Partnership Boards for Older People, Physically Disabled People and People with Learning Disabilities.

The County Council undertook a major consultation on Fair Access to Care and Charging for Care as well as Prevention late in 2013. In total over 450 people attended 13 meetings, and 1575 people responded to questionnaires and online and the issues were the subject of numerous radio and newspaper reports. The consultation asked people where they felt the priority for investment should lie in the current financial climate. Over 80% of people said that the biggest priority for the Council should be to focus on Prevention. In addition, the vast majority of respondents wanted to be supported to remain in their own homes rather than be admitted to care homes. These results give us a strong mandate for the Prevention and Reablement elements of the BCF.

At a district level, there are regular cross county meetings such as the District Chief Executives Forum at which public sector reform is discussed and there are newly emerging Public Sector Leadership Boards in place in Harrogate and Scarborough. Integrated Commissioning Board is planning to hold a workshop with Districts to deal specifically with the opportunities presented by BCF to work together as a system.

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

NHS provider Trusts, building on long-standing involvement with CCGs and their local Transformation / Integration Boards as well as their representation at Health and Wellbeing Board, are key participants in the Integrated Commissioning Board.

Basic modelling of the impacts on providers has been carried out and shared as a part of the engagement process before seeking sign-off. Further modelling is required now to support the risk sharing agreement and indeed to provide the basis for further decisions about schemes and future investment. This will enable Trusts to plan their contributions to the changes within the health and social care system. This will also provide a baseline for our evaluation and on-going measurement of the impact of the BCF.

The recently submitted System Resilience plans for all CCGs reflect clearly the BCF plan of work and approach described in this plan. Providers have demonstrably been a part of this planning process and submission.

Each CCG area has a combination of formal contract monitoring arrangements and associated supporting groups with appropriate service development and transformation forums for partnership working. Generally BCF schemes have been worked up in partnership with colleagues across CCGs, acute and community trusts and the local

authority, as a minimum. The financial and activity impacts of these schemes are then processed through the appropriate supporting contract arrangements. Acute and community trusts will then reflect the impacts of these plans within their own submissions to Monitor.

Discussions have also been had across each of the Contract Monitoring Boards between CCGs and their respective providers in recent weeks.

ii) primary care providers

Engagement with GPs across the NY area has been on-going for a number of months through a wide range of means – for example:

In Harrogate, GP providers are regularly updated via Council of Members which meets every two months with representatives from each practice. In addition, the CCG arranged twice monthly "Practice Cluster" meetings allowing for more detailed exploration of how plans may affect local issues.

In AWC all practices are members of the CCG. Within the constitution member practices have delegated authority to the CCG executive group which is made up of six executive GPs, Chief Operating Officer, Chief Financial Officer and Executive Nurse. It is this group which has had more detailed involvement in development and monitoring of the BCF and will 'sign off' on behalf of their members the final plan. In addition, primary care providers through their CCG member representation are engaged through membership meetings and through broader meetings such as the Integrated Service Development Group which includes a broad range of stakeholders. The areas of development undertaken through these forums all contribute to delivery of the programmes of work which form part of the BCF plan.

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

North Yorkshire County Council undertook a major consultation in 2013. The main focus was on Fair Access to Care but the consultation was extended to obtain views on Prevention. In total over 450 people attended 13 meetings, and 1575 people responded to questionnaires and online and the issues were the subject of numerous radio and newspaper reports. This included direct contact with over 120 Independent Sector Social Care Providers who are all aware that the Council intends to further reduce long term placements and to develop the market for Personal Budgets, reablement and rehabilitation services as well as for support to carers. These themes are also reflected in the Council's latest Market Position Statement.

In addition the Council holds regular Provider Forum meetings with the Independent Care Group, a membership organisation representing residential, nursing and home care providers.

Direct engagement about BCF has been somewhat limited so far as the impacts on providers will mostly manifest through NYCC's Transformation Programme which has its own engagement process. There has been and will continue to be use of the Market Development Group – a cross marketplace provider forum and the Independent Care Group's Newsletter. Specific other fora such as the Carer's Strategy Group and the sub-

groups leading on the refresh of the JSNA have also supported to ensure provider's interest, especially the voluntary Sector are met.

The Voluntary Sector is represented across the Local Transformation Boards and within the engagement events described in 10a), as well as at NY HWB where the BCF has been discussed regularly.

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?

Our plans indicate that the total volume of avoided non-elective admissions is forecast to be 5,221 in 15/16 giving rise to a reduction in General and Acute non-elective costs of £3.072m. Further reductions through reducing Delayed Transfers and other community services based reductions are shown in Part 2 to total £ 1.459m giving a total reduction in spend of £4.5m.

	2014/15	2015/16
Reduction in delayed transfers of care	(134)	(576)
Reduction in non-elective (general + acute only)	(1,493)	(3,072)
Other	(255)	(883)
Total	**(1,882)**	**(4,531)**

Summarising the Provider statements in Annex 2, the following totals impact is described in these plans, which have been developed with providers and agreed as demonstrated in Annex2 by all NHS Acute providers

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	59,547
	2014/15 Plan	56,521
	2015/16 Plan	51,300
	14/15 Change compared to 13/14 outturn	1,180
	15/16 Change compared to planned 14/15 outturn	2,000
	How many non-elective admissions is the BCF planned to prevent in 14-15?	2,353
	How many non-elective admissions is the BCF planned to prevent in 15-16?	4,678

As has been described throughout this plan with its annexes, we have taken the call for 'Parity of Esteem for Mental Health' very seriously and have ensured that this is embedded in our plans, both for prevention and for reablement, as well as for specialist

mental health services and for integrated community services. We believe in the principle that there can be 'No Health without Mental Health'.

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 Descriptions
Scheme index

Mental Health	HRW_001_MH	Psychiatric Liaison
	HRW_002_MH	Dementia strategy
	S&R_003_MH	Psychiatric Liaison
	HaRD_001_MH	Psychiatric Liaison
	VOY_003_MH	Street Triage
	VOY_005 _MH	Psychiatric Liaison

Community/Intermediate Care/Reablement	HRW_003_CIR	H&R integrated START / intermediate care / FRT
	HRW_004_CIR	Whitby overnight nursing service
	HRW_005_CIR	Hospital case management
	HRW_006_CIR	H&R district nursing capacity
	HRW_007_CIR	Risk profiling and long term conditions
	HRW_008_CIR	Community-focused acute care
	S&R_001_CIR	Malton Care Hub
	AWC_001_CIR	Assistive Technologies - Telemedicine
	HaRD_003_CIR	Intermediate Care & Clinical Assessment Team
	AWC_003_CIR	Specialist Community Nursing Service
	AWC_004_CIR	Craven Collaborative Care Team Expansion
	VOY_002_CIR	Selby Care Hub
	VOY_004_CIR	Urgent Care Practitioners

Public Health / Prevention	HRW_009_PHP	Lifestyle referral
	HRW_010_PHP	Prevention Officers (aka Community Navigators)
	HRW_011_PHP	IAPT (prevention initiative)
	S&R_002_PHP	Health Trainers / Self Help
	S&R_004_PHP	Mental Health in the Community (IAPT)
	S&R_005_PHP	Smoking Cessation

Voluntary Sector	HRW_012_VS	Carer sitting services and training
	HaRD_002_VS	Voluntary Sector Projects
	S&R_008_VS	Palliative Care Pathway
	VOY_001_VS	St Leonard's 'Hospice at Home'

Support in Care Homes	HRW_013_CH	Clinical skills educator
	HRW_014_CH	Telemedicine in care homes
	S&R_006_CH	Nutrition in care homes
	AWC_002_CH	Care Home Quality Improvement Support Service
	HaRD_004_CH	Named GP per care home
	S&R_007_CH	Care home link nurse

Countywide	ALL_001_RC	Reablement and Carers
	ALL_002_CS	Community Services
	ALL_003_PHP	Falls Prevention

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ANNEX 1a - MENTAL HEALTH

Scheme ref no.
HRW_001_MH

Scheme name
Psychiatric Liaison (RAID)

What is the strategic objective of this scheme?

To provide a comprehensive enhanced Liaison Service for Adult Mental Health Services (AMHS) and Older Peoples Services (MHOPS) based on the RAID model (Rapid Assessment, Interface and Discharge) which will help to direct patients to the most appropriate mental health service at the hospital front-of-house and prevent unnecessary hospital admissions.

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?

New model of care

This is based on the provision of liaison services 7 days per week, 8am-8pm, ensuring a liaison approach rather than current consultation only approach (these hours will be assessed over time against demand / need).

This approach would enhance the quality of care for patients by ensuring the appropriate patients are referred into the service, assessments are undertaken on admission therefore reducing the number of bed days and there are no delays in identifying the appropriate pathway of care.

This new model of service would ensure appropriate detection of mental illness, signposting of specialist mental health services, working to avoid re-admissions and up-skilling of ward staff. Development of liaison psychiatry would also support other local initiatives to establish parity of esteem for patients with mental health problems, particularly the establishment of Section 136 places of safety. Overtime the scope of the service would be extended to include outreach support to Nursing Homes and GP Liaison in the community.

The service model will be delivered by increasing the number of existing liaison nurses working into the acute wards and A&E within the Friarage Hospital, Northallerton, and increasing the specialist roles including medical (consultant Psychiatrist) and psychology to enable rapid intensive support which includes multidisciplinary assessments, which essential to support appropriate and safe discharge.

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

For the HRW CCG area, the lead commissioner for the project is HRWCCG, while the main provider is TEWV (Tees, Esk and Wear Valleys NHS Trust). A business case has already been finalised outlining the service requirements.

It should be noted that parallel services are being commissioned in neighbouring CCGs. A project board will therefore be established by the North Yorkshire Partnership Commissioning Unit to provide some overarching countywide economies of scale and strategic direction to the Liaison project, although it is recognised that local models of delivery are imperative, there is scope for the Board to develop shared learning and support around governance, evaluation and monitoring.

Implementation of this model requires project management support to recruit and establish a liaison team. The provider (TEWV) has already identified a project manager and additional project support will be provided by the CCG.

To achieve the objectives it is also essential that links are developed and maintained with Adult Social Care, Acute Community Services, Mental Health Community Services, START Team and HIT.

Timescales and Milestones
- Agreement with provider to develop Raid/Liaison model – March 2014
- Service Design co-produced with providers and commissioners – April 2014
- Devise service specification and KPI's – October 2014
- Contract Variation – October 2014
- Additional staff recruitment (provider) - October 2014
- Service go live – September 2014

The development is being principally taken forward through the CCG's Mental Health Service Improvement Group which meets monthly, with co-reporting through the partnership Service Delivery and Improvement Group for unplanned care and community services (also monthly).

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

National evidence
The model is based upon the principles of Birmingham & Solihull Mental Health NHS FT's Rapid Assessment Interface & Discharge (RAID) Project, which has received accreditation from the Psychiatric Liaison Accreditation Network of the Royal College of Psychiatrists and also won a Health Service Journal Award for innovation in mental health in 2010.

The economic evaluation study of RAID concluded that the RAID service is good value for money, particularly as the benefits included in the assessment are over and above

any improvements in health and quality of life which are the fundamental justification for health spending.

An economic evaluation has been undertaken by LSE, this evaluation has been reviewed internally in order to make assumptions on cost and potential savings. National benchmarking statistics provide evidence for a much higher cost saving. However with other schemes potentially impacting on non-electives a more realistic saving of 5% - 20% saving would generate a cost saving of approx. £220k-£800k

The model will ensure patients mental health needs are addressed when they are in an acute hospital for treatment for their physical health needs. It would also enable earlier discharge and reduce readmission rates. It would increase the number of people receiving appropriate care and support and reduce the number of people developing mental illness within an acute hospital setting. Liaison services can reduce the risk of self-harm and suicide while also addressing the long-term conditions and medically unexplained symptoms with which many patients present.

The Government's Mental Health Strategy *No Health Without Mental Health 2011*, emphasises the importance of improved services that interface between mental and physical health where co-morbidities exist.

Current operational situation
Current limited liaison service provision provides a consultation only approach to urgent patients presenting in A&E. This service is only operational during office hours and there are no cover arrangements in place. The current model provides a piecemeal service operating on a part time basis. There is an unmet demand which cannot be quantified at the present time, and the quality of this model is therefore compromised as it is not available to some individuals whom may benefit. The new model of service would provide more streamlined approach to care with appropriate medical input from clinical teams.

Specific details are as follows:

- The current hospital liaison team operates a very limited service into the CDU, 1 B7 Nurse (30 hours), 8am-9pm Monday, Tuesday & Thursday and 1 B6 Nurse (20 hours), 8am-6pm, Tuesday & Friday.
- There is no out-of-hours in-reach into the acute wards.
- Medical input is provided through 1 session per week from a Consultant Psychiatrist however this is not formally commissioned and is dependent on pressure from other commitments.
- An adult mental health Crisis worker also provides dedicated input into A&E. (1 WTE B6 Nurse, 9am-5pm, Monday to Friday).
- The Crisis Team provides an out of hour's response to those patients who present to A&E in crisis but this service excludes those presenting with dementia, memory problems and / or delirium.
- The Crisis Team aims to respond within 4 hours, as per the nationally defined standard, though the liaison service, being based on site can usually achieve a 1 hour response time for urgent referrals during working hours.

Needs Analysis
A needs analysis of local mental-health related admissions was undertaken of the year 2012/13.

Inpatient emergency admissions

All age summary:

	No of Spells	No of Patients	No of Patients with multiple admissions	Average Length of Stay
All Inpatients	18,185	11,594	3,060	2.5
Mental Health	3,081	2,249	449	3.5
MH Admissions where MH is main cause	73	71	2	5.1

- 19% of all inpatient admissions costs to the Friarage are from admissions which have a mental health diagnosis.
- Mental health is coded as a secondary diagnosis in 98% of the mental health admissions
- 20% of patients admitted with a mental health diagnosis have had more than 1 mental health admission in 2012/13.
- The average cost of an admission in 12/13 at the Friarage was £1,292. The average cost of an admission including a mental health diagnosis was £1,460
- The average length of stay for an admission in 12/13 at the Friarage was 2.5 days. The average length of stay for an admission including a mental health diagnosis was 3.5 days.
- The average number of excess bed days for an admission in 12/13 at the Friarage was 0.2 days. The average number of excess bed days for an admission including a mental health diagnosis was 0.3 days.

Patients 65+:

Patients aged 65+ account for 38% of the mental health admissions and 51% of the costs. The majority of activity is emergency non-elective. For older patients:

- 25% of emergency admissions costs to the Friarage are from admissions which have a mental health diagnosis
- Mental health is coded as a secondary diagnosis in 95% of the mental health emergency admissions
- 19% of patients admitted with a mental health diagnosis have had more than 1 mental health emergency admission in 2012/13
- The average cost of an emergency admission in 12/13 at the Friarage was £1,646. The average cost of an emergency admission including a mental health diagnosis was £1,814
- The average length of stay for an emergency admission in 12/13 at the Friarage was 4.5 days. The average length of stay for an emergency admission including a mental health diagnosis was 5.5 days.
- The average number of excess bed days for an emergency admission in 12/13 at the Friarage was 0.4 days. The average number of excess bed days for an emergency admission including a mental health diagnosis was 0.6 days.

Referrals from A&E and MAU to the crisis team and hospital liaison

- *Referrals made:* In September 2013, a total of 123 referrals were made to Crisis/Liaison from A&E and MAU, of which 83 were Monday to Friday, and 40 were at the weekend.

Total	Mon-Fri (9-5)	Sat-Sun	Total OOH
123	83	40	92

- *Referrals accepted:* On average there were 33 referrals a month accepted by Crisis and the Hospital Liaison Team from A&E and MAU for the period April 2013 to September 2013. In September just 24 referrals were accepted.
- During this same period (September 2013) there were 9 referrals from Police/S136.

	Apr	May	Jun	Jul	Aug	Sep	Average
Total Referrals	39	24	25	46	38	24	33

Conclusion

- This information clearly shows that there is a significant gap in capacity to meet demand at the front-of-house of the Friarage Hospital, Northallerton.
- There is a significant level of admissions with a mental health diagnosis that potentially can be impacted upon with improved front door arrangements for mental health through the 'liaison psychiatry' service
- It is believed that current activity data generated via coding provides an under-representation of activity/need. It is anticipated that a more accurate picture will emerge as the service is operational. It is therefore important to ensure that there is regular monitoring in partnership with the Commissioners as this will shape the development of the next phase.

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

14/15 £285,000   15/16 £473,000

The model commissioned is a full liaison service for both Older People and Adults, which is a significant extension of the current model.

The total recurrent cost is £472,880. The costs are based on the following staffing model:

- 1x B7 (WTE) (increasing existing establishment to WTE, Monday-Friday))
- 2x B6 (WTE) Rota over 7 days (8am-6pm)
- 0.2 WTE Consultant Psychiatrist
- 0.5 WTE B8a Psychologist
- 1x B3 WTE Admin support

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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

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The additional benefits of the scheme are:

Improved Quality
- Enhance quality of care for patients
- Ensure appropriate patients are referred into the service
- Increased rates of diagnosis
- Appropriate clinical input from medical staff
- Reduced repeat attendance at A&E through early diagnosis and intervention
- Improved patient clinical outcomes
- Reduction in time patients spend waiting in Emergency Department
- Reduction in ED admissions to acute medical assessment unit
- Increased number of patients returned to address recorded at admission with no change in status
- No delays in identifying appropriate pathways of care
- Improved patient or staff safety, e.g. reduce the number of people prescribed anti-psychotic medication
- Improved patient Experience / Carer of people in acute wards with accompanying MH needs
- Support crisis services and Section 136 work-stream

Reduced Costs
- Bed occupancy and length of stay
- Reduced inappropriate investigations
- Reduced reduplication and avoiding wasting of clinical time and resource
- Reduced waste / increased productivity – reduce number of attendees at A&E

Secondary Benefits
- Reduced hospital acquired infections
- Reduced falls with better drug use
- Increased dementia detection
- Reduced readmissions
- Reduced admissions to care homes
-

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?

Engagement will be required with the Commissioning Support Unit Business Intelligence Team and provider's performance management team to develop and implement performance management measures. This will involve:

- Working closely with the provider to continuously monitor and review the service
- Conducting regular analysis of performance and quality data
- Attend monthly quality meetings with the provider.
- Reduction in admissions to medical wards
- Early diagnosis of dementia

- Reduced admission to residential care following discharge from hospital
- Patient supported in the community for longer
- Improved patient satisfaction

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

- Effective leadership by Partnership Commissioning Unit.
- Effective communication between the two key providers, TEWV and South Tees Hospitals NHS Foundation Trust.
- Effective care pathway between Liaison Psychiatry and intermediate care service in the community for appropriate patients
- Working more effectively across services boundaries
- Effective and useful partnership(s) which leads to improved patient experience due to partnership working
- Improved workforce competency, behaviours and well-being which build effective and useful partnership(s) for an increased positive staff experience
- Robust links with Adult Social Care, Acute Community Services, Mental Health Community Services, START Team and HIT.

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

Scheme ref no.
HRW_002_MH

Scheme name
Development and Implementation of a Dementia Strategy

What is the strategic objective of this scheme?

Development and implementation of a Dementia Strategy to increase the early diagnosis of patients and improve outcomes for patients and carers. The intention would be to increase the number of people receiving appropriate care and support and reduce the number of people developing mental illness within an acute hospital 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?

Patients currently experience a lack of holistic, person-centred care that meets their physical, mental and social needs. Current services are unable to meet present demand and future growth.

The strategic aim is by working with service users and carers and other agencies we will develop services for people with dementia that:

- Are sensitive to each person's individual circumstances
- Support people to live independent, productive, fulfilling and active lives for as long as possible
- Encourage people and their carers to be actively involved in the decisions made about their care.
- Support people in negotiating along the care pathway as and when they choose as appropriate
- Provide information in a way that is understood and helps to support the person and their carer's in the options available from diagnosis to end of life.
- Are in line with best practice and wherever possible good evidence based practice and are cost effective.

North Yorkshire does not currently have a Dementia Strategy in place, the proposal is therefore to recruit a suitable qualified project lead for HRW CCG to undertake the following:

- Research the work already being undertaken by South Tees Acute Trust in collaboration with North Tees to improve service and pathways for dementia patients providing a platform to further develop this work into the Friarage Hospital, Northallerton. This is a priority for the CCG/LA and is highlighted within

the JSNA.
- Gain an understanding of current dementia service capacity in particular memory clinics and the impact this is having on dementia diagnosis rates and quality of care for patients
- Map current service provision in both acute and community settings (including voluntary sector resource) in order to identify gaps and areas for priority
- Develop an action plan to improve service for patients, ensuring there is adequate advice and support for carers and family members and also giving some focus to enhancing dementia friendly communities
- Implement this action plan with specialist seconded support, using an appropriate methodology to make service improvements and improve outcomes for patients and carers.

To support this work, additional capacity will also be provided within our main acute provider, STHFT, to improve the experience of dementia care both in hospital and in the community for patients, family and staff involved in providing care. This capacity will be in the form of a clinical educator post, which will provide training and education for staff across the organisation and carers. This will help to create a more seamless pathway for patients with dementia, where staff across the organisation help to ensure patients are diagnosed sooner.

Expected outcomes include establishing user-focused services able to meet the needs of an aging population, service quality improvements through large scale cross-organisational change, increased inter-agency working, increasing the early diagnosis of patients through shorter waiting times for memory services, and better communication with care homes to reduce admissions.

The whole project will include working with local communities to instil a better understanding of dementia and the constraints that this may pose to the sufferer and carer and will also support better signposting of patients to appropriate services. Supports a move towards dementia friendly communities and better integration between health and social care.

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

Commissioner / provider
Staff from a range of organisations will be required to support the project in order to ensure success of the implementation. In particular, the project would require support from NYCC, provider organisations (STHFT and TEWV) and CCGs as colleagues.

- The lead commissioner for this project is HRWCCG
- The principles provider are STHFT and HRWCCG

Timescales and milestones
This is a 1 year non-recurrent project.

- Recruit project leads / clinical educators – August - October 2014
- Undertake research on work undertaken in other areas – November –December 2014

- Develop strategy identifying gaps in service and improvement requirements – January-March 2015
- Develop and implement action plan – March 2015 onwards

Stakeholder Groups/ Engagement & Frequency
- Service provider and relevant staff groups
- Acute Trust and relevant staff groups
- Community Teams and GPs
- Feedback to be obtained on proposed new service specification

The development is being principally taken forward through the CCG's Mental Health Service Improvement Group which meets monthly, with co-reporting through the partnership Service Delivery and Improvement Group for unplanned care and community services (also monthly).

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 National Dementia Strategy, Living Well with Dementia (2009) highlighted this disease as one of the greatest challenges facing our aging society. A five-year strategy was set out to make improvements to benefit people with Dementia by improving awareness across our communities, providing earlier diagnosis and interventions and providing a higher quality of care.

A national study undertaken by the Alzheimer's Society found that at any one time, a quarter of hospital beds are taken by people over the age of 65 with dementia, 86% of nurse managers said that people with dementia are hospitalised for longer periods than those admitted for similar medical conditions without dementia, the report predicts that supporting people with dementia to leave hospital 1 week earlier could result in national savings of at least £80million a year.

The newly published Dementia Map reports HRW CCG area as having longer than average lengths of inpatient stay and more than average re-admissions for patients with dementia.

A demographic profile of dementia across the Yorkshire & Humber region commissioned by the Yorkshire & Humber Improvement Partnership showed that for NY&Y the levels of dementia are predicted as:

	2008	Predicted for 2025
Early onset dementia	175	200
Late onset dementia	8,264	13,876

Collaboratives have been established in other areas of the Country showing success. Successes in the Harrogate Collaborative Project include 62% reduction in waiting times for diagnosis, improved value for money, better signposting of services (31% reduction in waiting times for patients needing second service) increased productivity, reduced hospital admission rate (indicative figures show 50% reduction), 9% reduction in hospital stays, leading to improved quality of care and a reduction in lengths of stay for patients with dementia. They also demonstrated a quality impact in terms of dignity and personal

care which is difficult to quantify.

The local provider (STHFT) has experience in developing collaboratives in other areas and can demonstrate the achievement of positive outcomes for patients and streamlining of pathways providing efficiency savings. The intention would be to build on this work already undertaken for Hambleton, Richmondshire and Whitby.

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

14/15 £45,000   15/16 £45,000

The costs for the scheme (£90K) will go towards funding two posts, each for 12 months:
- A clinical development lead for dementia services at band 8A hosted by HRWCCG (£53,908 2nd from top-of-scale with on-costs)
- A clinical educator role within STHFT to train and develop staff internally within the organisation at band 6 (£36,220 mid-point of scale with on-costs)

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

Ultimately, we would anticipate a saving in terms of unplanned admissions and reduced length of stay however this requires further analysis to quantify as the project progresses.

Additional benefits include:

- A clear picture of research evidence and needs
- Improved assessment and regulation of health and social care services and of how systems are working for people with dementia and their carer's.
- Reduced waiting times for diagnosis
- Good quality early diagnosis and intervention for all.
- Enabling easy access to care, support and advice following diagnosis
- Implementing the Carers' Strategy
- Improved quality of care for people with dementia in general hospitals
- Improved intermediate care for people with dementia
- Improved end of life care
- Increased productivity
- Reduce repeat attendance at A&E through early diagnosis and clinical intervention
- Improved community personal support services
- Improving public and professional awareness and understanding
- Good quality information for those with diagnosed dementia and their carers
- Development of structured peer support and learning networks
- An informed and effective workforce for people with dementia
- Effective national and regional support for implementation of the strategy

| **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? |

HRWCCG would work closely with NYCC, TEWV and STHFT in the delivery of the project, covering the following:

- Research and strategy would define relevant projects
- Monitoring and reviewing systems will be in pace to identify
- Establish clear action plans
- Working closely with the provider to continuously monitor and review the services and projects
- Conduct regular analysis of performance and quality data
- Attend monthly quality meetings with the provider.

We would also start to track the following specific KPIs:

- Hospital admission rates for patients with dementia
- Diagnosis rates (in line with CCG operational Plan requirements) at CCG and practice level
- Activity through key services, e.g. local memory clinic

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

- Effective working links between acute and community services and intermediate care
- Effective leadership from CCG Dementia lead
- Improved public & professional awareness and understanding
- An informed and effective workforce for people with dementia.

Scheme ref no.
S&R_003_MH
Scheme name
Psychiatric Liaison

What is the strategic objective of this scheme?

- Reduce non-elective admissions into hospital for patients with dementia
- Reduce risk of readmission into hospital
- Reduce numbers of older people admitted from hospital into care home settings
- To positively promote mental health in acute hospital settings.
- Improved service user experience and care outcomes
- Reduced risk of adverse events
- Enhanced knowledge and skills of acute hospital clinicians
- Improved access to psychiatric services for patients with high morbidity outside of "normal" working hours.
- To reduce waiting times for psychiatric assessment and support for patients within acute hospital settings.
- Improved ambulatory care pathway for service users with a mental health difficulty or following an episode of self-harm.
- improved compliance of acute trusts with legal requirements under the Mental Health Act (2007) and Mental Capacity Act (2005)
- improved compliance with NHS Litigation Authority Risk Management Standards and the Clinical Negligence Scheme for Trusts (CNST)

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?

The psychiatric liaison service commissioned by CCG's in North Yorkshire will focus on the following objectives within service design:

1. To collaborate with acute Hospital Trust colleagues to facilitate prompt assessment avoiding duplicate contacts ensuring fluent and timely progression through the care pathway.

2. For patients with a physical health problem and a mental health need attending ED and/or admitted to hospital wards: assess, advise and recommend treatment plans, including advice on management of risk and behaviours.

3. Signpost/refer to other services as appropriate and for those with complex needs who are admitted into hospital, provide ongoing advice and support for staff coordinating care through their stay.

4. Provide regular visits to general wards, providing advice and answering queries as

well as reviewing known complex cases and case finding new patients who would benefit from liaison input.

5. Assist hospital staff in developing appropriate discharge plans for identified patients.

6. To provide an advocacy role for the service user and carers within the general hospital.

7. To provide education and training to the staff in key inpatient areas with specific objectives to :
- Promote an understanding of the roles of mental health services that interface with ED.
- Promote an understanding of common mental health problems and the nature of psychosocial crisis and distress.
- Promote an understanding of suicidal ideation and behaviour and self-harm in the context of tension relief.
- Provide an insight into mental health risk assessment and risk management.
- Develop communication skills within hospital teams in asking questions pertaining to an individual's mental health.
- Develop skills in identifying mental health problems in service users who may have presented with a physical disorder.

The service will be available to all adults over 16, and will provide an all-age pathway for psychiatric care for patients with physical health care needs in general and district hospitals. The team will liaise with children's services to meet the needs of young people presenting in acute hospitals with physical and mental health needs. All patients with physical health need and a mental health need presenting to ED or admitted to the hospital (16Yrs upwards). Service users will not be excluded from psychiatric liaison services due to further disabilities, such as autism, ADHD, and learning difficulties. Or on basis of age for adults.

Services will include staff who have two specialisms:
a) specialist knowledge of older people's mental health issues and be able to work proactively with other disciplines e.g. geriatricians, ED consultants, old age psychiatrists, to assess complex cases.

b) crisis care for adults with all mental health issues, including first episode psychosis, self-harm and dual diagnosis of substance misuse. The team will seek to include an overview of all specialisms including learning disability, autism, ADHD and eating disorders.

The **New model of care**
This is based on the provision of liaison services 5 days per week, 8am-8pm, ensuring a liaison approach to patients and staff (these hours will be assessed over time against demand / need).

This approach would enhance the quality of care for patients by ensuring the appropriate patients are referred into the service, assessments are undertaken on admission therefore reducing the number of bed days and there are no delays in identifying the appropriate pathway of care.

This new model of service would ensure appropriate detection of mental illness, signposting of specialist mental health services, working to avoid re-admissions and up-skilling of ward staff. Development of liaison psychiatry would also support other local initiatives to establish parity of esteem for patients with mental health problems, particularly the establishment of Section 136 places of safety. Overtime the scope of the service would be extended to include outreach support to Nursing Homes and GP Liaison in the community.

The service model will be delivered by increasing the number of existing liaison nurses working into the acute wards and A&E within York Foundation Trust Scarborough Hospital site, and increasing the specialist roles including medical (consultant Psychiatrist) and psychology to enable rapid intensive support which includes multidisciplinary assessments, which essential to support appropriate and safe discharge.

The model commissioned is a 5 days a week liaison service for both Older People and Adults.
The total recurrent cost is £292,794.

Timescales and Milestones
- Agreement with provider (TEWV) to cost service – May 2014
- Service Design co-produced with providers and commissioners – June 2014
- Agreement with provider implementation process –September/ Oct 2014
- Service delivering patient contact - Jan 2015.
- Review of first quarter and development of service spec in the community – April 2015

The delivery chain

The service will be delivered on behalf of the following Clinical Commissioning Groups by the mental health provider Tees, Esk and Wear Valley NHS Foundation Trust:
- Harrogate and Rural Clinical Commissioning Group
- Scarborough and Ryedale Clinical Commissioning Group
- NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group

Development of existing liaison services is taking place in 2013-2014 through negotiation between the four NHS organisations, with support from NHS Partnership Commissioning Unit Mental Health commissioning team to share and coordinate resources.

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

There is a well-established policy and evidence base about the value of psychiatric liaison services. Several recent reviews of the evidence and models developed to deliver psychiatric liaison services highlight the importance of focusing on older people in general hospital settings. The key reasons that psychiatric in-reach is important in acute hospitals are that the prevalence of co-morbid mental health problems among patients in general and acute hospitals is extremely high and many of these problems typically go undiagnosed and untreated. In the absence of effective intervention, mental health co-

morbidities lead to poorer health outcomes and significantly increased costs of care; and improvements in the identification, management and treatment of mental health conditions in hospital can significantly reduce the scale and cost of these problems.

The prevalence of mental illness is higher in general hospital than the community for some conditions:

	% in hospital	% in the community
Dementia	31	5
Depression	29	12
Delirium	20	1-2
Anxiety	8	3
Alcoholism	3	2
Schizophrenia	0.4	0.5

Evidence suggests liaison psychiatry has the potential to improve length of stay, discharge disposition and costs. Core elements of the service included educating non-psychiatric staff; regular ward rounds identifying patients who would benefit from psychiatric consultation; weekly multidisciplinary team meetings; appropriate follow-up; and attendance at other ward rounds. Additional benefits have been identified around the management of working age adults, including self-harm, waiting times in ED, and management of mental health crises in an acute hospital setting. The focus on liaison services requires acute trusts working in partnership with Mental Health Services to provide 24/7 psychiatric services.

Three conditions – the three Ds of dementia, depression and delirium – account for the majority of cases and the prevalence of dementia and delirium in particular is markedly higher in hospital than in the community at large. The diagnostic case mix in older people is very different compared with younger patients. Dementia and delirium are largely conditions of older age, while among younger adults there is relatively higher prevalence of such problems as self-harm, alcohol and drug misuse and medically unexplained symptoms.

Evidence reviewed by the Royal College of Psychiatrists (2005) shows that mental health problems in older inpatients are associated with a wide range of adverse consequences. These include:

• poorer health outcomes, including a two- to three-fold increase in mortality rates in hospital, after controlling for age and severity of physical illness;
• Longer lengths of stay, typically increasing the time spent in hospital by 5-10 days per case;
• increased rates of re-admission to hospital after the initial episode; and
• increased rates of discharge to institutional care rather than the patient's own home, reflecting higher levels of morbidity, dependence and functional impairment.

Self-harm:

Self-harm is one of the 49 Ambulatory Emergency Care pathways identified by the NHS Institute of Innovation and Improvement. The Institute suggested that service users

attending A&E who had deliberately self-harmed but did not have a medical need to be in hospital should usually not need to be admitted to a bed and could be treated on an ambulatory protocol. A recent audit of mental health presentations in ED in York hospital showed that 216 patients of a total of 7132 had been confirmed as presenting with mental health issues. Of the mental health presentations, 105 involved alcohol, 12 were for people under 18 and the mean age was 33 years old.

There is evidence that service users who present with mental health difficulties to the Emergency Department experience delays, due to problems accessing psychiatric support. Whilst patients are waiting for assessment, the hospital may experience difficulties "detaining" a patient who is psychiatrically unwell, in an Emergency Department. This can increase the risk of someone with self-harm being routinely admitted to an assessment bed on a self-harm protocol and pathway. Service users experience an inequitable service depending on the time and day they presented and the availability of provision of psychiatric assessment.

Liaison services based in ED ensure that mental health staff are part of the triage process, and assess service users with psychiatric needs promptly and move them onto the most appropriate service or discharge them, in a timely manner. Presentation rates vary immensely with no evidence of patterns or trends, which means that the team is required to be responsive on a 24 7 basis.

RAID

The majority of liaison services have been developed to focus on the acute hospital population, rather than those at risk of admission to hospital. For example the RAID model was first introduced into the City Hospital, an inner city hospital with 600 beds in Birmingham, in December 2009, and offers comprehensive mental health support, available 24/7, to all people aged over 16 within the hospital. The service offers consultation and liaison to A & E, the medical assessment unit and the medical maternity and surgical wards with response targets of 1 hour for A & E and 24 hours for inpatients. RAID builds on existing liaison services adding health and social care capacity to the liaison team plus specialist skills in older adults and addictions – as such it is a complete, all age mental health service with an acute trust.

The London School of Economics independent economic evaluation of this service, highlights significant cost savings. The incremental cost was £0.8m versus the incremental benefit, based on conservative assumptions, of £3.55m. These savings relate to a reduction in acute in-patient bed days in terms of reductions in LOS (1.5m), admission avoidance (0.3m) and reduction in readmissions (1.5m). LOS cost savings are derived from annual bed day savings multiplied by the cost of a bed day, estimated to be £200.

The cost of implementing a liaison service based on the RAID model is approximately £1.3 million for an 800 bed acute hospital. These costs however increase investment in acute settings, and focus more on the reduction of length of stay in hospital than admission avoidance. This can lead to reductions in the number of older people being admitted from hospital into institutional care, by up to 50%.

Primary care liaison:

Nationally primary care liaison services vary between providing education and awareness

sessions for GPs, to providing specialist assessment and screening services, or sign-posting patients to local community services. Mental health care in primary care is often managed through the IAPT service, and can include significant waiting times locally for services. In the future, liaison services will be developed to ensure psychiatric assessment and advice is available regardless of setting, for example by linking the development of psychiatric liaison services in acute settings to primary care and through out of hours services.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
14/15 £ 200,000   15/16 £400,000
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

Admission avoidance:
Analysis of costs of in-patient care in 2012-2013 at the three acute hospitals within the North Yorkshire area, (Harrogate, Friarage Northallerton and Scarborough Hospital), shows that a 3.5% reduction in the overall cost of mental health non-elective admissions would lead to savings of £391,334 across the three acute hospital sites.

Reducing length of stay/improving quality outcomes:
Currently the cost of hospital admission is higher for patients with mental health needs, the liaison teams can work concurrently with care teams providing physical healthcare to improve the holistic outcomes for patients and their families, and bring "parity of esteem" for the hospital experience. If mental health admissions cost the same as other non-elective admissions, NHS commissioners would have saved a total of £1.8 million in 2012-2013.

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 service will engage with the Commissioning Support Unit Business Intelligence Team and provider's (TEWV) performance management team to monitor KPI's and evaluate performance management measures. Further work will be untaken on a formal evaluation of this work by a University research department in a similar structure to the on-going evaluation of the Teesside service by the University of Durham. This will involve:

- Working closely with the provider to continuously monitor and review the service
  - Waiting times for patients with mental health conditions in acute settings
  - Length of stay for patients with mental health conditions
  - Cost per admission
  - Numbers of mental health patients presenting at ED
  - Numbers of non-elective admissions where mental health was a factor
  - Quality outcomes for patients presenting with self-harm and dual diagnosis e.g. reduction in self-harm
  - Number of patients readmitted with mental illness in presentation
- Conducting regular analysis of performance and quality data

- Formal assessment of the service through associated University research department.

Regular quality meetings with the provider.

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

- Reduction in admissions to medical wards
- Early diagnosis of dementia
- Reduced admission to residential care following discharge from hospital
- Patient supported in the community for longer
- Reduced length of stay – where appropriate
- Reduced repeat attendance at A&E through early diagnosis and intervention
- Improved patient satisfaction

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

Scheme ref no.
HaRD_001_MH

Scheme name
Psychiatric Liaison (Rapid Assessment Interface Discharge - RAID)

What is the strategic objective of this scheme?

The strategic objective is to address the mental health needs of patients treated for physical health conditions in both A & E and on the acute wards at Harrogate District Foundation Trust (HDFT), and thus improving patient care and patient outcomes as well as avoid unnecessary hospital admissions.

Overview of the scheme

The mental health liaison service is already in place in HDFT. This Better Care Fund (BCF) scheme has allowed the Harrogate and Rural District CCG to expand the service from Monday through Friday from 9 to 5 p.m. to a comprehensive service available 7 days per week from 8 a.m. to 8 p.m.

The service is available to all adult patients over the age of 16. The primary goals of the service are to provide the following services within A & E and on the acute wards at HDFT:

- Assess, advise, and recommend treatment plans, including advice on management of risk and behaviours,
- Signpost/refer to other services as needed
- Follow patients admitted during their stay
- Assist with discharge planning
- Rapid response to crisis in ED within 1 hour
- Daily visits to general wards
- Advice service on mental health issues for all areas of the acute hospital

Services will be delivered by a complement of mental health liaison nurses supported and complemented by specialists including Psychiatrists and Psychologists. These staff will have the following experience and background:

a) specialist knowledge of older people's mental health issues and be able to work proactively with other disciplines e.g. geriatricians, ED consultants, old age psychiatrists, to assess complex cases.

b) crisis care for adults with all mental health issues, including first episode psychosis, self-harm and dual diagnosis of substance misuse. The team will seek to include an overview of all specialisms including learning disability, autism, ADHD and eating disorders.

The mental health liaison service will improve the quality of care for patients by ensuring that their mental health needs are promptly identified and addressed when they are in the acute hospital, whether A & E or inpatient. Discharge planning will also be more thorough and effective through addressing the patient's mental health needs.

In addition, HDFT and the CCG expect that this availability of this service will expand and enhance the mental health awareness, knowledge and skills of all HDFT clinical staff over time. Again this enhanced knowledge and awareness will improve detection and support to all patients with mild to serious mental health needs. If successful, the CCGs plan to expand the scope of the service to include outreach support to care homes and primary care.

Patient cohort: Adult patients over 16 years of age with physical health conditions and mental health co-morbidities.

Timescales and Milestones
- HaRD CCG commissioned mental health liaison services to commence at HDFT – December 2013
- HaRD CCG with HDFT and TEWV proposed to expand the days/hours of mental health services through BCF in February 2014
- Three CCGs meet to coordinate and standardise the approach to this service by TEWV in June 2014
- HaRD CCG and TEWV agreed to expand hours of operation to 7 days/10 hours per day starting in September 2014
- Begin monitoring data on length of stay and non-elective admission rates for patients with mental health co-morbidities in November 2014
- Evaluate first year of operation in January 2015 to inform future commissioning decisions and possible expansion of the service to care homes and primary care.
- Modify contracts, care pathways, and the service delivery model based on lessons learned in 2014 – April 2015

The delivery chain

The Tees, Esk, and Wear Valley (TEWV) NHS Foundation Trust has been commissioned as the provider of mental health services across North Yorkshire serving three CCGs in the area: Harrogate and Rural District, Hambledon Richmond and Whitby as well as Scarborough/Ryedale, under contract to the Partnership Commissioning Unit. TEWV began providing these services in 2013/14 and BCF funding is enabling Harrogate and Rural District CCG to expand these services to 7 days per week, 10 hours per day.

Development of existing liaison services is taking place in 2013-2014 through negotiation between the four NHS organisations, with support from NHS Partnership Commissioning Unit Mental Health commissioning team to share and coordinate resources.

The evidence base

Assessment of public health needs in HaRD

In March 2013, HaRD did an analysis of benchmarked data to determine where HaRD compared poorly with its cluster CCGs. The indicators where HaRD was in the lowest quartile or quintile related to hospital admissions and length of stay for patients with a secondary diagnosis of dementia, the prevalence of dementia in the population, prescribing costs for dementia, hypnotics, and anxiolytics, and binge drinking (considered a risk factor for mental health.) It is therefore clear that addressing the needs of patients

with dementia and other mental health risk factors is an area for improvement in HaRD. Anecdotal information from our providers coincided with our conclusions that providers in acute settings and in the community need more support in addressing patient's mental health needs. Increasingly, our patients health issues are complicated by or inextricably linked to their mental health needs. Therefore, patient's health and mental health issues need to be addressed in a holistic, coordinated way to keep patients independent and in the community as much and as long as possible.

Mental Health Needs of Patients in Hospital

Several recent reviews of the evidence and models developed to deliver psychiatric liaison services highlight the importance of focusing on older people in general hospital settings. The key reasons that psychiatric in-reach is important in acute hospitals are that the prevalence of co-morbid mental health problems among patients in general and acute hospitals is extremely high and many of these problems typically go undiagnosed and untreated. In the absence of effective intervention, mental health co-morbidities lead to poorer health outcomes and significantly increased costs of care; and improvements in the identification, management and treatment of mental health conditions in hospital can significantly reduce the scale and cost of these problems. In order to address these issues effectively, three CCGs in North Yorkshire turned to TEWV to develop and deliver a model of mental health services based on the RAID model developed and successfully implemented in Birmingham.

RAID – Rapid Assessment Interface Discharge

This mental health liaison service is based on the RAID model implemented and evaluated at Birmingham. The RAID model offers consultation and liaison to A & E, the medical assessment unit and the medical maternity and surgical wards with response targets of 1 hour for A & E and 24 hours for inpatients. RAID builds on existing liaison services adding health and social care capacity to the liaison team plus specialist skills in older adults and addictions – as such it is a complete, all age mental health service with an acute trust.

The London School of Economics' independent economic evaluation of this service, highlights significant cost savings. The incremental cost was £0.8m versus the incremental benefit, based on conservative assumptions, of £3.55m. These savings relate to a reduction in acute in-patient bed days in terms of reductions in LOS (1.5m), admission avoidance (0.3m) and reduction in readmissions (1.5m). LOS cost savings are derived from annual bed day savings multiplied by the cost of a bed day, estimated to be £200.

The cost of implementing a liaison service based on the RAID model is approximately £1.3 million for an 800 bed acute hospital. These costs however increase investment in acute settings, and focus more on the reduction of length of stay in hospital than admission avoidance. This can lead to reductions in the number of older people being admitted from hospital into institutional care, by up to 50%.

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
2014/15 £425,928   2015/16 £425,928

Investment in the Mental Health Service for Older People team providing support to the acute wards at HDFT includes:

> 1 x Band 7 (WTE)
> 1 x Band 6 rotating on a 7 day schedule
> 0.5 WTE Psychiatrist Consultant
> 0.5 WTE B8b Psychologist
> 0.5 x B4 Admin Support
>
> Total Cost: £210,821

Investment in the Adult Mental Health Services providing support and response to A & E includes:

> 1 x Band 6 rotating on a 7 day schedule
> 0.2 WTE Psychiatrist Consultant
> 0.2 WTE B8b Psychologist
> 0.5 WTE B4 Admin
>
> Total Cost: £215,107

Impact of scheme

Like several of the other CCGs in North Yorkshire, HaRD CCG is investing in this Mental Health Liaison Service in order to reduce the number of non-elective admissions for patients with Mental Health co-morbidities and reduce the length of stay of admitted patients with Mental Health co-morbidities. Research has shown that investment in the "RAID" model has a positive impact on these indicators and our service provider, TEWV, is aware of the expectation to deliver on these improvements to the current level of performance.

We believe that making mental health services more readily available to patients in A & E, and on the wards, will also improve patient care and patient experience. Below is a list of quality improvement expected as a result of this investment in MH services:

- Enhance quality of care for patients
- Ensure appropriate patients are referred into the service
- Increased rates of diagnosis
- Appropriate clinical input from medical staff
- Reduced repeat attendance at A&E through early diagnosis and intervention
- Improved patient clinical outcomes
- Reduction in time patients spend waiting in Emergency Department
- Reduction in ED admissions to acute medical assessment unit
- Increased number of patients returned to address recorded at admission with no change in status
- No delays in identifying appropriate pathways of care
- Improved patient or staff safety, e.g. reduce the number of people prescribed anti-

psychotic medication
- Improved patient Experience / Carer of people in acute wards with accompanying MH needs
- Support crisis services and Section 136 work-stream

Since all of our BCF schemes are aimed at reducing reliance on A & E and hospital admission (as well as improving patient care), it is difficult to assess the specific financail impact of an individual scheme. The overall impact of our BCF schemes has been estimated and documented in Annex 2 of this document.

Feedback loop

The CCG will be monitoring the following indicators to determine the outcome of this scheme:
# of non-elective admissions for patients with MH co-morbidities
# of bed days for patients with MH co-morbidities

In addition, TEWV will be reporting performance indicators of activity as part of the CCG's contract monitoring.

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

TEWV must hire a competent team of professionals and ensure that referral and communication systems between the MH liaison staff and HDFT staff are well understood and working effectively. Since this is an expansion of an existing service to 7 days/week, 10 hours a day, communication and referral systems are already in place and working well. TEWV has an excellent track record of hiring competent and knowledgeable staff.

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

Scheme ref no.
VOY_003_MH
Scheme name
Street Triage
What is the strategic objective of this scheme?

The proposed Mental Health Street Triage Scheme is intended to enable timely and appropriate interventions to individuals at their point of contact with police. It has been successfully trialled in Leicestershire and Cleveland, and other pilots are currently being rolled-out across the country. Leeds Street Triage service has been operational since December 2013 and has seen significant results in relation to increased patient experience and reduced detentions under the Mental Health Act 1983.

Working in partnership with the police, community mental health services, City of York Council and the Third Sector to offer an assertive outreach and follow up service to those difficult to engage following initial contact with the police

Key Objectives –

- Reduce the burden on Crisis Teams, police and health staff, and hence reducing costs
- Mitigate risk and reduce the potential for vulnerable people escalating into crisis
- Significantly enhance inter-agency working in addressing the issues of vulnerable people at the earliest opportunity, with the lowest level of intervention
- Improve the outcomes for those who are detained and also those who are dealt with in the community
- Increased accessibility to Mental Health Service staff beyond normal working hours, seven days a week.
- Reduce the number of inappropriate detentions to both hospital and custody
- Support North Yorkshire Police experiential learning through multi-agency teamwork, leading to greater understanding of the roles of other professionals within mental health service and a greater understanding of mental illness and pathways to support vulnerable people
- Reduce the number of expensive call-outs for Forensic Medical Examiners and Approved Mental Health Professionals within police custody
- Actively contribute to reducing future demand upon services through pre-emptive engagement and action
- Reduce S136 detentions, evidence around the UK with other Pilots is a minimum 25%-30% reduction
- Reduced Emergency Department (ED) admissions (no figures available however above reductions could be replicated with mental health presentations through the ED).

The scheme will achieve this by adding skilled mental health professionals into the existing Crisis Assessment Service in York, the service that currently manages the Cities

Health-Based Place of Safety for Section 136 detentions under the Mental Health Act. The team will be available to be deployed by the police to provide an initial assessment of the individual. With various interventions the Mental Health professionals will provide officers with advice, signposting to relevant support packages of care. It will also facilitate information-sharing between agencies at the interface of mental health and service provision, and help to address the subjects issues that lead to the revolving-door cycle of service use. By effective intervention and advice, the scheme will complement the recent investment in the creation of a Health-Based Place of Safety (HBPoS) for MHA detainees in York, and help avoid unnecessary detentions under the Act, thereby improving the patient experience for these individuals and achieving a substantial cost saving for those services.

It is envisaged that the Street Triage Team will see a Registered Mental Nurse (RMN) or an equivalent trained Allied Health Professional and a nursing assistant, on duty between 14:00hrs and 0.00hrs, 7 days a week. Following the model developed for implementation in Scarborough, it is proposed that they will utilise an unmarked vehicle suitable for the discreet assessment of vulnerable people at the scene of incidents in support of the police.

The focus of the service will be directed towards improving the patient experience, with an emphasis on providing a prompt, effective and efficient response to the Police. While not in itself a panacea, the scheme will assist in providing the lowest appropriate level of intervention at the earliest possible juncture.

Purpose of Street Triage
This Service is open and accessible to people of all ages, where it is believed that they may have a mental illness, learning disability, personality disorder or misuse substances, who come into contact with the police outside of custody. The team assesses their mental state in a face to face contact and advises if detention under the Mental Health Act is necessary. The object being to divert people from the Criminal Justice System when appropriate and provide access to community based services thereby ensuring that their health and social care needs are known and provided for by appropriate services.

If the person does need to be detained in a place of safety then the team follows the vehicle being used to transport the person, and once at the place of safety ensures that their health needs are known by staff at the receiving point. The team also where appropriate, provides signposting for all other persons who do not meet the criteria for detention.
The focus of the service is very much towards the front end of the criminal justice pathway, with an emphasis on providing a prompt response to incidents.

The team offers advice, assessment and access to services. They achieve this by offering advice and support to Criminal Justice Staff, checking where appropriate whether someone is known to mental health services and offering advice and signposting to other services.

A face to face triage screening assessment is carried out on persons outside of a custodial setting and risk assessments are completed on all persons seen.

The team also facilitate access to appropriate services in the community where this is appropriate.

Philosophy of Care
The Street Triage team seeks to provide an inclusive service to ensure that persons coming into contact with the criminal justice system receive a high quality, competent and effective range of interventions. The service delivery includes liaison, prevention and ultimately if needed, equitable access to mental health services across the trust.

The service promotes social inclusion and acceptance of service users within mental health provision who may have offended, or are likely to offend or re-offend to enable them to live a more productive, positive and fulfilling life.

The Street Triage service is an integrated part of mainstream services ensuring access to mental health assessment and advice, and creating robust multi-agency working.

The Street Triage service promotes prevention and reduction of offending by working in a flexible, mobile and timely manner with all agencies in the locality.

• The Street Triage team completes follow-up work to promote mental well being and encourage access to appropriate services and offer support.

• The Street Triage team works in partnership with Cleveland Police to provide mental health advice and guidance in an effort to assist the police in their decision making process around managing risk.

The service's values are:

To recognise that mentally disordered persons who may also be offenders have the same right to assessment and treatment as any other person. Each person will be treated as a unique individual with dignity and mutual respect, whilst promoting a non-discriminatory service to all. The service will strive to be flexible and responsive to individual needs, responding to requests in a timely manner. Our aim is to establish a therapeutic relationship built on trust and respect. Confidentiality will be maintained within the boundaries of our environment. The service will integrate with the individual's existing systems of support.

Service Definitions
The service is open to persons of all ages with recognition that it will only provide triage screening. There are agreed referral pathways to Child and Adolescent Mental Health Services for persons under 18 years of age and for adults and older adults via the agreed pathways for Adult Services and Mental Health Services for Older People.

If during the triage process a learning disability is suspected then although the team do not have specialist skills in this area they do have a general awareness and would signpost to the most appropriate service.

As part of the triage process Drug and Alcohol Issues will be screened for and help and advice on what services are available will be offered.

The service ensures that the care they provide is culturally sensitive and recognises that cultural differences will not exclude anyone from the service.

North Yorkshire Health and Wellbeing Board
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The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

A memorandum of understanding, in parallel with commissioning governance and assurance, supports definition of the delivery chain.

An accountable lead provider model has been adopted for the development of Street Triage, initially as a pilot. The accountable lead provider, Leeds and York Partnership NHS Foundation Trust (LYPFT), is commissioned through the better care fund partners and process, monitored through a joint health and social care delivery group. The memorandum of understanding defines the overall engagement and principles of this arrangement between NHS Vale of York CCG (commissioner), City of York Council (commissioner) and LYPFT (provider). The lead provider is accountable for the effective delivery of the Pilot however LYPFT works with North Yorkshire Police and other stakeholders to deliver all the objectives and deliverables.

Well-established LYPFT Clinical Governance structures will support Street Triage and existing supervision within the Crisis and Access Service will ensure continued delivery of safe and effective high quality Mental Health care to all patients seen on Street Triage.

The accountable lead provider is held to account against defined objectives and metrics and a defined plan for the agreed budget, however, there is flexibility for provider innovation and adaptation to ensure the model is as effective as possible in delivering the aims and objectives sought.

Street Triage development, progress and metrics are reported monthly.

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

Existing schemes around the UK have been consulted; findings are consistent with reports highlighting their impact on reduced Section 136 Mental Health Act 1983 detentions by Police. There are also reports highlighting the reduced attendance of mental health presentations in custody areas.

Anecdotal reports highlight increased patient experience and describe improvements in working relationships between Health providers and Police Constabularies.

Investment Requirements

Financial resource required to recruit to the following posts:
(The following costs are based on a 12 month secondment or temporary contract)

2.31 Whole Time Equivalents (WTE) Band 6 Mental Health professional
working 7 days a week between the hours of
14.00 and Midnight: £100,809.22

2.31 WTE Band 3 Health Support Worker
working 7 days a week between the hours of
14.00 and Midnight: £60,358.27

Staffing total resource   **£161,167.49**

Financial resource other:

Vehicle :
£4,000 Qty 1 Vauxhall Zafira people carrier, with privacy glass and annualised running costs (tax, insurance) for 12 months
£1500 fuel for above
£237 Qty 1 SRH Cradle Car Kit
£20 Qty 1 T Bar Radio Antenna
£17 Qty 1 Fist Mic
£160 Qty 1 Bury 9068 Blue Tooth Kit
£590 Qty 2 days Installation / Resource Costs. (Install of original S Max plus De Install and Re Install into new Zafira @ £295 per day)
Total : £6524

Hand Held :
£1116.20 Qty 2 SRH3900 GPS Radio including all Ancillaries @ £558.10 per radio
£450 Qty 1 Radio Battery Charger
£210 Qty 6 additional Batteries
Total : £1776.20

Security :
£650 Qty 1 CPNI Approved Airwave Radio Safe
£85 Qty 1 Safe Delivery
Total £735

Airwave Access Agreements Revenue:
£2628.32 Qty 2 per year @ £1314.16 each terminal per year
Total £2628.32 per year

Accessories:
£26.80 x4 duty belts
£7.18 First Aid vehicle kit
Total £33.98

Other financial costs   **£11,697.50**

Margin   **£25,930.00**

Total Costs for 12 month Pilot   **£198,795**

This investment is being shared by North Yorkshire and City of York Council HWBs – therefore investment = 14/15 £100,000 15/16 £125,000

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

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

14/15 A&E 444 = £48k
15/16 A&E 1329 = £144k

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?

Outcomes of the scheme are measured and/or to be measured through the following methods;

- Daily Police meetings are planned to support feedback and enable growth in the service
- The pilot will collect data following each Street Triage intervention, this will support the completion of the Department of Health's Incident Pro-forma (see below)
- Formal monthly data evaluation will be sent to all parties including the joint delivery group

Mental Health Triage Pilot Incident Pro-forma

Date of encounter	DD / MM / YYYY
Response officer time on incident prior to triage	HH / MM
Start time of triage involvement	HH / MM
Ref number for individual	
Location of encounter	

What type of issue lead to triage involvement
Nature of triage engagement
Gender of person encountered
Age of person encountered
Date of birth   DD / MM / YYYY

Ethnicity of person encountered

What mental health issue triggered triage involvement? (tick as many as appropriate)

if unusual behaviour, please elaborate in open box below

First contact with triage car

Action taken by triage

Conveyed to **1st** place of safety by

If other, please specify
Detainee taken to

Length of time detained in **1st** place of safety   HH / MM

If taken to **2nd** place of safety, conveyed by
If other, please specify

Detainee taken to

Length of time detained in **2nd** place of safety   HH / MM

If taken to **3rd** place of safety, conveyed by

If other, please specify
Detainee taken to
Length of time detained in **3rd** place of safety   HH / MM

Clinical assessment started within what length of time since start of encounter   HH / MM

End time of encounter   HH / MM

Previous conviction
Known to mental health services
Known to CAMHS
Active care plan
Open to services
Previously detained under S136
Engagement with and uptake of

services Subsequently sectioned under Menta Health Act Subsequent informal admission	
Please note any problems, obstacles, observations or other outcomes (Please capture here any feedback/user experience)	

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

A range of broad and recognised factors consistent with any programme delivery are recognised, such as addressing barriers to change and ensuring a clear structure and approach for implementation.

Specifically related to findings in other Street Triage services and the National Pilot the defined scheme key success factors relate to;

- Ongoing provider engagement in delivery
- Allowing time (for model development and scale amongst other areas), in parallel with the evidence from other Street Triage schemes.
- Monitoring and adapting scheme delivery though real-time and scheme-sensitive metrics (recognising external influences such as population growth, demographic changes and other influences on change)
- To ensure sustainability of the scheme through ongoing adaptation and learning

Scheme ref no.
VOY_005_MH - Psychiatric Liaison

Scheme name
Psychiatric Liaison – Emergency Department Liaison Service

What is the strategic objective of this scheme?

To provide a 24/7 Psychiatric Liaison service within the Emergency Department (ED) at York Hospital to manage patients presenting with psychiatric requirements safely and effectively.

Strategic Aims:
1. To provide rapid bio-psychosocial and risk assessment of individuals who present to the ED with deliberate self-harm and acute mental health problems.
2. To collaborate with York Teaching Hospital Foundation Trust (YTHFT) colleagues to facilitate prompt assessment avoiding duplicate contacts ensuring fluent and timely progression through the care pathway.
3. To screen referrals and prioritise them according to urgency.
4. To provide an advocacy role for the service user and carers within the general hospital.
5. Discussing treatment and management options with the service user and safely signposting them to the most appropriate service(s) to meet their individual needs.
6. To facilitate prompt access to mental health intervention for those individuals who have an identified mental illness working closely with the acute care pathway to access in-patient psychiatric admission and intensive community services.
7. To facilitate prompt access to appropriate physical health/emergency intervention for service users where it is identified they have compromised their physical health.
8. To liaise with other services in York, including GP's and primary care workers, community mental health teams, specialist mental health teams, addiction services, crisis services and voluntary organisations.
9. To provide a resource to general hospital colleagues for information and advice on mental health issues.
10. To positively promote mental health in York Hospital.
11. To collaborate with YTHFT in adhering to the Emergency Care standard and auditing adherence outcomes against targets.
12. To provide education and training to the ED and medical inpatient areas with specific objectives to :
    - Promote an understanding of the roles of mental health services in York and the roles of mental health services that interface with York Hospital.
    - Promote an understanding of common mental health problems and the nature of psychosocial crisis and distress.
    - Promote an understanding of suicidal ideation and behaviour and self-harm in the context of tension relief.
    - Provide an insight into mental health risk assessment and risk management.
    - Develop communication skills within the ED in asking questions pertaining an individual's mental health.
    - Develop skills in identifying mental health problems in service users who may have presented with a physical disorder.

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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?

Individuals attend the ED of York Hospital with mental health difficulties and following acts of self-harm. They present with a diverse range of issues and presentation. The Emergency Department Liaison Service (EDLS) team will provide a comprehensive bio-psychosocial assessment.

The EDLS will work in close collaboration with YTHFT on building established working relationships through the Crisis and Access Service (CAS) and link into wider mental health services provided by Leeds and York Partnership Foundation Trust (LYFPT) as the gatekeepers of the mental health acute care pathway.

This interface is seamless in respect of shared assessment format. To manage the transition in implementing the ED service, staff from the CAS will be rotated into the EDLS team. This is to optimise the clinical expertise of the ED team and support the induction of the newly appointed staff.

Service users will be provided with a thorough bio-psychosocial assessment. This assessment should take place within three hours of arriving in the ED of York Hospital for the initial six months of the service. From 1 April 2015 the assessment should take place within two hours. Once their assessment is completed, they will be signposted to the most appropriate service to manage their current mental health and bio-psychosocial difficulties.

There will be an improved patient experience through the ambulatory care pathway for service users with a mental health difficulty or following an episode of self-harm.

Service user groups covered

The service provides mental health and self-harm assessment to individuals age 18 and over who present to the ED department of York Hospital. Service users with mild to moderate learning difficulties can access the services if it is thought that they may benefit from doing so. It may be necessary, to work jointly with Learning Disability or Adult Mental Health Services, on occasions to ensure the best outcomes for the service user.

Exclusion criteria

-   Service users under the influence of alcohol or illicit substances should be referred when sober enough to effectively and safely engage in the assessment process. The EDLS team should be informed of these service users at the earliest appropriate time to allow planning of the assessment at the earliest opportunity.
-   Service users who are not medically fit for assessment.
-   Service users detained under Section 136 of the Mental Health Act.

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

The driver to provide the EDLS is to improve the quality of service to people who present to the ED with mental health problems, and to reduce the number of admissions to the

Acute Medical Unit (AMU) within York Hospital.

From April 2013 – February 2014 there were 1,057 mental health attendance (based on a primary diagnosis of anxiety, bipolar affective disorder, depression, overdose, personality disorder, psychiatric/behavioural, psychosis or schizophrenia).

14% of these attendances breached the 4 hour target, suggesting that mental health related attendances are more likely to breach than attendances for a physical health problem. We expect the rate of ED breaches for patients with a mental health need to reduce as a result of this service.

The table below shows the volumes and costs of non-elective admissions to York Hospital in 2013/14 relating to serious and enduring mental illnesses (SMIs), common mental health disorders (CMDs) and self-harm admissions:

Category	Primary Diagnosis Spells	Final £	Secondary Diagnosis Spells	Final £	Total Spells	Total Final £
SMIs	56	£101,394	261	£422,970	317	£524,364
CMDs	61	£121,197	1,010	£1,961,674	1,071	£2,082,871
Self Harm	767	£445,710	143	£345,244	910	£790,954
Grand Total	**884**	**£668,301**	**1,414**	**£2,729,888**	**2,298**	**£3,398,189**

It is anticipated that these figures will fall as a result of the introduction of the EDLS.

The EDLS will be operational 24/7 seven days a week providing a mental health assessment to the ED department. The target group are service users who have presented with self-harm and acute medical management and interventions are not indicated. It is also anticipated that the service model will provide more timely assessment of those admitted to medical inpatient area of York Hospital, a consequence of which will be a reduced length of stay.

The EDLS will advise YTHFT colleagues on the management of individuals with mental health difficulties who frequently present to the ED. This, where appropriate, will include working with both LYPFT and YTHFT colleagues to devise individually tailored care plans, for implementation to the ED. This is aimed at supporting this group of service users with a consistent approach.

These individuals could be suffering from the range of mental health conditions, commonly described as common mental health disorders and serious mental illnesses. Effective liaison has been shown to be successful in significantly reducing repeat attendances from individuals within these groups by promptly signposting patients to the most appropriate services. Evidence and data will be recorded to ensure the EDLS is meeting the needs of these groups.

The EDLS, as part of CAS, will have well established relationships with a range of community services including home treatment, Community Mental Health Teams (CMHTs) and Section 136 services. They also regularly link with and refer to Social Services, GPs and other voluntary and statutory services, including housing, employment and education agencies.

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| **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 report '*Managing Urgent Health Care In The Acute Trust*', 2008, is a guide developed by practitioners for managers and commissioners in England and Wales. This report was prepared by the Royal College of Psychiatrists, working in partnership with representatives from the Royal College of Physicians of London, the Royal College of Nursing and the College of Emergency Medicine.

The executive summary highlights that the current provision of mental health services to people attending the emergency departments of general hospitals are extremely variable across the country. These departments have high levels of activity and encounter some of the most seriously ill people at greatest risk. The summary describes this variability in service provision situation as unacceptable.

The summary of the report recommends that liaison services should coordinate the front line responses for psychiatric support to the emergency department and acute wards. This would mean acute trusts working in partnership with mental health services to provide 24/7 services.

This report and the report '*High Quality for all*', (Department of Health, 2008) both send a strong message about developing care pathways that are easily accessible, and provide timely assessment and high quality care. This translates into a clear single point of access for emergency department staff to refer to mental health services 24/7, seven days a week.

This is also supported within the document '*Healthy Ambitions*' (NHS Yorkshire and Humber) describing of critical importance is single point of access to services which are accessible 24/7.

The need for mental health nurses in emergency departments (ED) is highlighted in the Royal College of Psychiatrists and the British Association for Accident and Emergency Medicine report *CR118* (February 2004). This report recommends that '…mental health nurses should provide the first point of contact from mental health services. Where such professionals are employed they generally develop a close working relationship with the A&E department, and have a role in training and staff support.'

The *National Service Framework for Mental Health* (Department of Health 1999) does acknowledge that EDs can make a valuable contribution when providing access to mental health services particularly for service users who have self-harmed, rough sleepers and those who have not registered with a GP.

The RAID model was first introduced into the City Hospital, an inner city hospital with 600 beds in Birmingham, in December 2009, and offers comprehensive mental health support, available 24/7, to all people aged over 16 within the hospital. The service offers consultation and liaison to the ED, the medical assessment unit and the medical maternity and surgical wards with response targets of 1 hour for the ED and 24 hours for inpatients. RAID builds on existing liaison services adding health and social care capacity to the liaison team plus specialist skills in older adults and addictions – as such it is a complete, all age mental health service with an acute trust.

The London School of Economics have recently published an independent economic evaluation of this service, based mainly on a critical scrutiny and re-analysis of data collected by the hospital. The publication concludes that the service generates significant cost savings and is excellent value for money. The incremental cost was £0.8m versus the incremental benefit, based on conservative assumptions, of £3.55m. These savings relate to a reduction in acute in-patient bed days in terms of reductions in length of stay (LOS) (1.5m), admission avoidance (0.3m) and reduction in readmissions (1.5m). LOS cost savings are derived from annual bed day savings multiplied by the cost of a bed day, purported to be £200.

Admission avoidance and readmission savings multiply the avoided admissions by the marginal rate of an acute admission. The savings are therefore both provider and commissioner related and the London School of Economics report has demonstrated that it can achieve the following outcomes, over and above traditional liaison services:

- Reduce admissions, leading to a reduction in daily bed requirement
- Reduce discharges to institutional care for elderly people by 50%
- Produce a cost-to-return ratio of £1 to £4
- Good service user feedback on holistic care in acute settings
- Staff feedback of improved confidence and capacity in managing service users with mental health issues with improved staff morale
- Waiting times for service users time in A & E has reduced by 70%

The Emergency Department Liaison Service (EDLS) will be a precursor to developing and implementing the RAID model in York hospital from 2015-2017.

References and an evidence-base being used to inform the model and above statements are highlighted below.

References

Applicable national standards (e.g. NICE)

- NICE CG16. *Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care*

Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- RCPsych report, CR158, 2010: *Self-harm, suicide and risk: helping people who self-harm*
- CEM report 6883, 2013, *Mental health in Emergency Department*

Associated policy documents

- Department of Health (2012) *Preventing suicide in England – a cross-government outcomes strategy to save lives*.
- Department of Health (2011) *No health without mental health: a cross-government mental health outcomes strategy for people of all ages*.

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Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
14/15 £25,000
North Yorkshire BCF and York BCF are each providing £25,000 to fund the pilot in 2014/15. 15/16 to be part of the new mental health tender.

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
It is anticipated that the EDLS will improve the level of service provided to patients presenting to ED with a mental health need, and reduce the proportion of patients that breach the 4 hour ED target from this cohort.

When the service is fully running we expect it, in conjunction with the other BCF schemes, to enable more efficient management of patients with a mental health need, providing effective alternatives to ED attendances and in-patient admissions.

This scheme is a whole system enabler and is supporting the BCF schemes, therefore no benefits have been specifically identified against this scheme. It is anticipated that as part of the mental health tender in 15/16 this service will be embedded. |

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 service is being launched in a phased approach, and the first shifts were introduced into the Emergency Department of York Hospital in October 2014.

Outcomes of the scheme are measured and/or to be measured through the following methods;

- Regular informal discussion between stakeholders from the three main organisations: LYPFT, YTHFT and Vale of York CCG.
- Formal monthly data evaluation using agreed metrics against agreed KPI's, reported to main stakeholders and the Partnership Commissioning Unit.
- Formal evaluation through an academic partner currently being developed for formal, mixed methods (quantitative and qualitative) evaluation to understand what is working well, staff and service user evaluation, evidence that could inform development and evaluation of impact. |

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

NHS Outcomes Framework Domains & Indicators:

Domain 4	Ensuring people have a positive experience of care	X
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	X

Reporting specific to this scheme:

Info id	Information to be reported	Frequency of reporting
1.	Number of people referred to EDLS	Monthly
2.	Number of people assessed by EDLS	Monthly
3.	Time taken from booking into ED reception to referral to EDLS	Monthly
4.	a) Number of people assessed by EDLS within the set target. b) Number of people assessed by EDLS outside of the set target. When the target has been missed, reasons should be recorded.	Monthly
5.	Number of EDLS assessments delayed because the service user was intoxicated from alcohol or illicit substance misuse	Monthly
6.	Number of people assessed requiring MHA assessment	Monthly
7.	Number of people referred to EDLS who meet the 4 hour ED target	Monthly
8.	Number of people referred who self-discharge prior to assessment	Monthly
9.	Number of people assessed who self-discharge prior to completion of EDLS involvement	Monthly
10.	Destination following assessment and treatment. Number of people assessed who are: ▪ Admitted to AMU ▪ Admitted to inpatient bed within York Hospital ▪ Admitted to inpatient bed within LYPFT ▪ Referred to community based MH services ▪ Referred to primary care ▪ Discharged back home ▪ Self-discharge	Monthly
11.	Number of patients who attend community based mental health services when referred from ED	Monthly
12.	Length of stay for patients: ▪ Admitted to AMU ▪ Admitted to inpatient bed within York Hospital	Monthly
13.	Number and % of re-attendance within: ▪ 7 days ▪ 28 days	Monthly
14.	Number of ED staff who have received appropriate training to equip them to understand and care for people who have self-harmed or who present with mental health needs	Monthly
15.	Service User Experience data	TBC
16.	Staff experience data	TBC

ANNEX 1b - COMMUNITY, INTERMEDIATE CARE AND REABLEMENT

Scheme ref no.
HRW_003_CIR

Scheme name
Integrated START, Fast Response and Intermediate Care in Hambleton and Richmondshire

What is the strategic objective of this scheme?

To build capacity in intermediate care and reablement services and establish an integrated service combining existing and additional START (Short Term Reablement and Assessment Team), FRT (Fast Response and Intermediate Care), and intermediate care, supported by an integrated delivery model to manage people within the community, prevent hospital admission and long-term care home placement, and reduce length of stay.

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?

Underpinning BCF investment and service development
This project builds upon two recent service developments from April 2013 onwards through the original health and social care monies. The investment for which is also being included within the Better Care Fund. These are:

- *Additional therapy capacity in Hambleton and Richmondshire* (£142K recurrently) – This was intended to enable a basic level of community therapy provision within the intermediate care team to support Fast Response and community hospital services
- *Integrated health and social care night service* (£165K nursing / £258K social care) – This includes two key elements to create the most efficient and effective 'whole system' across a 24/7 period of service delivery:

    a) Overnight, scheduled visits to known patients/service users who require planned visits to maintain them in their own homes. Generic workers can deliver both Health and Social Care interventions, under the same processes currently delivered in the existing working hours generic service.
    b) Responder visits to Out of Hour GP calls. The new service envisages a professional assessment of an individual's need by either a GP or qualified nurse. Where the professional staff assess that a hospital admission is not necessary, generic workers would support the individual until normal day time services are available.

Next phase project service model

The over-arching aim will be to create an effective, sustainable community team that provides person-centred fast response and rehabilitation services as close to home as possible. This team will provide goal-directed rehabilitation focused on restoration of function / independence and therapeutic intervention for patients with a wide range of conditions to prevent admission and support timely hospital discharge. The team will enable patients to remain in their own homes in the longer term by encouraging independence and reintegration into local community. This team will be locality-based but managed as one service ensuring that maximum capacity can be maintained at all times. To support a fully integrated approach, work will be undertaken during the period of the BCF to pool the budgets for FRT, intermediate care and START.

Element 1. Integrating existing services

Currently three services that work closely together (FRT, START and intermediate care). Feedback from the services shows that there are inefficiencies in hand-overs, referrals and co-ordination between the teams that could be improved if these services were combined as a single integrated team, which is free at the point of delivery. The intention would be to enable smoother referral and transition from acute care, reducing unproductive assessment and speeding up response, possibly dispensing with section 2s and 5s in favour of a single access point, and allow more flexible working between health and social care. This would enable to receive care within their own homes and communities and retain function and independence for a longer period. This would be supported by:

- An OD / service improvement plan to support the integration and remodelling of the service funded from slippage in the first year
- An integrated capacity and demand modelling exercise, establishing a new service model, then delivering this supported by a programme of organisational development.

Element 2. Ensuring there is sufficient capacity in the system

Currently the collective capacity within the three services is insufficient to meet the full demand, including facilitating discharge and proactively supporting people in the community. To properly establish an integrated team, the current capacity in START, intermediate care and overnight FRT (all funded through Health and Social Care monies would need to continue) and additional therapy capacity would need to be identified. This would need to include a mixture of specialist and generalist expertise, for example supporting stroke survivors. Investment at the outset will focus on capacity within intermediate care and the 'twilight period' for the Fast Response Service and small investment in START / generic workers. The inclusion of dietetic staff will ensure nutritional support is consistently available at the right time in treatment and goal planning following the patient home. This additional capacity will help to promote 7 day working, by ensuring that generic therapy workers are available on a 7 day basis.

Element 3. Flexibility to support patients beyond 6 weeks

A small number of patients with health-related problems, e.g. those requiring medication support, hosiery, simple dressings / leg care, are able to receive support through generic workers which currently stops at six weeks. As part of creating a more integrated service, flexible arrangements will be agreed so that for patients with no other form of personal or professional support (e.g. carer, neighbour, family, social care package, district nurse support), they can continue to receive the service for an extended period. This will be done with the ethos of working with partners and the patient's family to identify a longer-

term solution. The activity will be quantified during the year to assess true demand

Element 4. Dietetics
This investment also would free up existing community dietetics time to implement the nutritional screening pathway. The nutritional screening pathway makes sure that any patients who are discharged particularly into care homes are taken off prescribed nutritional supplements where appropriate and supported in identifying alternatives more suitable to their needs. Cost efficiencies could also be expected from the implementation of the pathway.

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

Commissioner / provider
Commissioning the service will be a joint endeavour between North Yorkshire County Council and HRWCCG. This will involve a local service model in line with county-wide principles and high-level aspirations.
The principle service providers will be:
- STHFT – current providers of intermediate care and fast response services
- NYCC – current provider of the START service

Delivery plan
The high level plan (timescales revised from original submission) would be:
- Agreement from providers to work to an integrated service model – March 2014
- Health (FRT and intermediate) to produce a combined capacity and demand plan - March 2014
- Recruitment plan to be agreed and commenced – June 2014
- Clarify how far additional investment and remodelled ways of working takes us towards comprehensive 7 day working – By July 2014
- START, HIT and social care assessment base-line capacity and demand to be quantified – September 2014
- Integrated capacity and demand modelling jointly undertaken between health and social care – Starting from September
- Additional staff all recruited by service – October 2014
- Integrated service design co-produced with commissioners and providers – November 2014
- Base-line core budgets for intermediate care, START, FRT to be quantified with view to creating pooled budget in Better Care – By November 2014
- Pooled budget arrangements baseline for 13.14 to be clarified (spend and what spent on) – By December 2014
- Process and criteria for allowing post-6 weeks care for patients with no other form of support – By December 2014
- OD plan for service development and remodelling – by December 2014
- Combined service specification and standards developed – December 2014
- Contract changes agreed by Commissioning organisations – December 2014
- Remodelled service goes live 1st April 2015

Project enablers
- Joint assessment systems and processes with social care and health
- IM&T supporting infrastructure
- Data-sharing agreements and processes

These would all be taken forward as part of the wider BCF.

Stakeholders group/ Engagement & frequency
The development is being principally taken forward through the partnership Service Delivery and Improvement Group for unplanned care and community services (monthly), which includes HRWCCG, NYCC, STHFT and other providers.

Engagement would be required for the following groups as part of establishing the revised service arrangements:
- Service providers (staff in services)
- Stakeholders (referrers to service, e.g. GPs)
- Patients and service users

The scheme is being developed through a local project group with representation from:

- NYCC BCF central team (as commissioners)
- HRWCCG
- NYCC service provider representatives
- STHFT service provider representatives

Work is being progressed through a regular workshop approach to create the service model supported by specific task and finish groups to look at service modelling.

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

Selection and design
When HRW CCG was established, we recognised through the JSNA that services in the community were not sufficient to meet the challenge of rising numbers of elderly people over the coming years. Our intention from the start was to strengthen and remodel local community services so that they were available round the clock, seven days a week, delivered in partnership by integrated teams working across the community system, and embraced new technologies and ways of working.

The emerging system-wide vision is based on supporting people to live at home and use services delivered at home or as near as is possible and safe. We intend to make the 'National Voices' narrative – "I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me" – central to the delivery and commissioning of care.

The CCG, NYCC and LA have also undertaken a substantial organisational project to consider how functionally integrated teams can be created locally. These were based on a bottom-up prototyping approach facilitated by the Centre for Innovation in Health Management (part of Leeds University Business School). The project identified a

consensus amongst staff delivering the services that FRT, START and intermediate care should be better integrated.

Evidence from the King's Fund also suggests that integrated approaches are also important in helping to prevent unnecessary hospital admissions and discharge people home faster.

Scheme assumptions

Savings generated for 2013/14 from the integrated night service and initial therapy capacity are assumed to be included within the 13/14 base-line for the purposes of BCF.

The over-arching expectation for the next phase of investment is a 1 to 1.5 (approx.) return on.

Admissions savings
- Savings calculated based on an additional 7.9 hospital admissions prevented per week, i.e. 410 per annum, at £1900 an admission. Assume 50% achievement in first year.
- Savings are calculated at 100% level
- Total saving in 14/15 = £390K
- Total saving in 15/16 = £780K

Context for "410 extra admissions" saved per annum:
- Current H&R FRT referral levels (based on 53 referrals in January 2014) on equate to 636 referrals per annum
- Latest 12 months admissions for ambulatory care admissions in over 65s (HRW-wide) is 756 (November 2012 to October 2013)
- Latest 12 months admissions for avoidable admissions in over 65s ((HRW-wide) is 985 (November 2012 to October 2013)
- Latest 12 months admissions for all other emergency admissions in over 65s (HRW-wide) is 4,626 (November 2012 to October 2013)
- H&R locality is 80% of HRW

Excess bed days savings
Based on 2014/15 YTD, use 300 XS bed days per month for NEL admissions. Assume that 7.5% of these can be saved and use a tariff of £220 per day. This equates to 270 excess bed days saved per year. This equates to a saving of £59,400. (50% in 2014/15).
Total annualised saving would be: £840K

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

14/15 £816,000 15/16 £1,067,000
Costs
The full-year effect costs include:

- Occupational Therapy (2.0 WTE Band 6 / 1.5 WTE Band 5)
- Physiotherapy (1.0 WTE Band 6 / 1.0 WTE Band 5)

- Generic Therapy Assistant (5.0 WTE Band 3)
- Dietetics (stroke) (0.6 WTE Band 6)
- Additional FRT (Fast Response Team) staff to cover the period 2 – 10PM, 24/7

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

The intention is to enable many more patients to be cared for in their own homes or communities, to be actively reabled faster, and hence to remain within their own homes for as long as possible, without being admitted either back to acute care or long-term residential care.

- Reduction in volume of ongoing social care packages
- Reduction in non-elective admissions to hospital
- Reduction in length of stay / acute bed days in acute hospital
- Reduction in the volume of (unproductive) assessments across the health and social care system
- Increase the proportion of older people living independently at home following discharge from hospital
- Reduction in long-term nursing and residential home placements including those directly from hospital
- Rehabilitation for stroke survivors discharged from JCUH or the Rutson at home to reduce current length of stay

Demographic growth is being built into contracts with acute Trusts, but part of the overall savings will be to prevent these additional emergency admissions from materialising and hence to manage the rise in numbers of older people.

Savings will also be made on lengths of stay below trim points. These will be of benefit to the acute trust which may enable acute hospitals to reduce operating costs. This may facilitate the Friarage hospital operating on a lower bed base.

Social care will also make additional savings based on reduced costs of ongoing social care packages and long-term admission to care homes.

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?

Regular performance reports are received the SDIP Group for unplanned care and community services covering activity through intermediate care, fast response and START services. Within the same report data is received on emergency admissions and excess bed days. These separate data-sources are compared to help to ascertain whether the services are having an impact.

As the project to integrate these services and increase capacity and flow-through is taken forward so an observed change in these various metrics will be looked for. In addition, regular milestone reports will be received by the SDIP2 from the project group to verify delivery is occurring to plan.

The group will track the following metrics:

Quantity and volume of the service
- Activity through service / new referrals / numbers of assessments / numbers receiving a treatment programme

Quality of service
- Patients completing care packages / complaints
- Patient / service user experience

'Better care metrics'
- Permanent admissions of older people (aged 65 and over) to residential and nursing homes per 100,000 population
- Proportion of older people who were still at home 91 days after discharge from hospital into rehabilitation / reablement services
- Delayed transfer of care from hospital per 100,00 population
- Avoidable emergency admissions
- Injuries due to falls in people aged 65 and over

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

- High level senior leadership buy-in to give permissions for a joint service model between START, intermediate care and fast response services
- Changing clinical behaviour to take increased risks and care for more patients in a home environment
- Establishing an effective and robust clinical front door into the service
- Ensuring IM&T systems and processes are ability to facilitate currently disparate teams joining up and working in an integrated way
- Developing a viable operational triage model to direct referrals to the most appropriate clinical or professional provider
- Effective business intelligence information that allows the capacity and demand for the new service to be modelled successfully

Scheme ref no.
HRW_004_CIR
Scheme name
Whitby overnight nursing service

What is the strategic objective of this scheme?
Extending the Fast Response service with nursing cover overnight to provide a 24/7 services for Whitby and surrounding area

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?

The CCG in conjunction with the local community are leading the transformation and reconfiguration of community health and social care services in Whitby. An extensive public and stakeholder engagement exercise has been undertaken and a procurement process is being undertaken to commission a provider of community and out of hours services aligned to the new vision. This proposal for an extended 24/7 fast response service will support this.

The fast response service in the community not only helps facilitate discharge from hospital but also to prevent unnecessary admission to acute care by:

- Providing short-term interventions (up to six weeks) of overnight care for people aged 18 and over living in Whitby and surrounding area
- Supporting individuals in a crisis; and
- Supporting people in need of re-ablement for a period of up to six weeks.

The current Fast response service for Whitby and surrounding area provides cover between 8am -10pm, with limited night service from HSA and OOH. This limited cover diminishes the opportunity in achieving the most effective solution for those people that require care and service across 24/7 period.

The proposal is to extend the fast response cover with nursing and to make it a 24 / 7 service for Whitby and surrounding area.

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

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

Commissioner / provider:

The lead commissioner is HRW CCG.

This service development is being implemented with the current service provider, irrespective of the outcome of the procurement process to establish the future provider for 15/16 onwards. The lead provider for 2014/15 is York Hospitals NHS Foundation Trust.

Implementation of the model will require close working between health and social care. The social care department covers Scarborough, Whitby and Ryedale and is a separate team to the Hambleton and Richmondshire area.

Action plan:

- Agreeing with providers to work to an extended 24/7 community nursing model – February 2014

- Model co-produced between CCG, NYCC, providers and staff – April 2014

- Agreement of Service description, standards and Performance Management Schedule - April 2014

- Recruitment commenced – August 2014

- Joint Induction/ Training for staff - October 2014

- Service commenced – October 2014

- Driving through clinical change by case review, publicising service, learning lessons from early provision – November 2014 onwards

| **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 principle drive for the selection of this scheme comes from 3 main areas:

1. Gap analysis through the Whitby Steering Group
As part of remodelling services in the Whitby area, the CCG has held stakeholder events with the public, partners, the voluntary sector, patients and service users. These have focused on establishing new required care pathways, supported by case studies and patient personas. This work has identified the lack of overnight services as a major gap in terms of pathways and clearly showed that patients are experiencing a more acute approach to care as a result.

2. Observed impact in other areas of the CCG
A key emphasis for the CCG is on ensuring equality across the whole CCG area. The overnight fast response model has been previously successfully rolled out in Hambleton and Richmondshire. The CCG recognises that establishing night services that maintain people at home successfully requires cultural as well as operational change. As a result patterns of care delivery require sustained change over time. Approximately 5 years ago

a limited service was put in place in Hambleton and Richmondshire consisting of a single nurse and health care assistant. This service gradually built its credibility and case-loads as patients started to be cared for at home, rather than being admitted to hospital. By 2012, the model was at capacity and having to reject suitable patients because the staff didn't have sufficient capacity to manage the volume of patients across the wide geographic area. From April 2013, the model was considerably expanded (see previous scheme) to include additional nursing capacity overnight and accompanying social care support.

3. Feedback from local clinicians

Local feedback from GPs in the Whitby locality indicates that they see the lack of 24/7 services as a significant gap in the over-arching network of community and social care services needed to keep people out of hospital. There are identified cases when local clinicians have had to send patients into hospital (either the local Whitby Hospital or Scarborough District General Hospital) due to lack of overnight cover for patients to be supported in the community, which can be avoided through this proposal. The patients' outcomes would be better with access to care closer to home and overnight. The local clinical consensus is this would prove very beneficial to the local population by supporting individuals at home. There will be reduced dependency on hospitals, emergency services and nursing homes with support available 24/7 in the community.

Savings assumptions

The assumptions for this scheme recognise that the key success factor for the scheme will be changing clinical behaviour. The challenge will be for the new services to work together to take an increased clinical risk and manage patients through alternate pathways. It is therefore difficult to quantify precisely how many patients will be successfully redirected into the new service arrangements.

However, the savings assumptions for the model are broadly based on a conservative assumption of saving 2.9 admissions per week, i.e. just one admission approximately every other day. It is assumed that the principle benefit in the early stages will be on providing better care for palliative care patients, including enabling them to remain in their own home.

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

14/15 £94,000   15/16 £188,000

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

In addition to the reductions in NEL admissions, it is likely that there will also be an impact on the following areas:

- Reduced inappropriate 999 callouts
- Reduced inappropriate A&E attendances
- Increase the support for patients on EOLC Pathway

- Reduced length of stay at both community hospital and acute hospital
- Reduction in emergency admissions to and from Residential care and Nursing Homes
- Preventing readmissions
- Better response times
- Increased flow of older people, moving from acute hospitals, to community hospitals to home
- Support increased numbers of patients and carers in crisis to remain at home.
- Enabling early discharges from Hospital/Residential/Nursing Care
- Reduce risk of falls, incl.- avoiding A&E attendance, potential admission

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 progress with the new service will be tracked through the Whitby Steering Group. This is a local partnership group responsible for the development of community services, which is chaired by Healthwatch. It also includes membership from NYCC, CCG, YHFT, CSU, Voluntary Sector. This Group will seek to confirm that the service is delivered effectively by tracking the following:

Project delivery:
- All staff recruited in line with project milestones
- Operational arrangements in place

Service delivery
- Referrals to the service, including by referral source
- Patients taken on by the service
- Length of time within the service
- Service outcome, i.e. return home, acute hospital, care home, death

Service impact
- Reduction in NEL admissions
- Reduction in out of hours admissions to care/nursing homes
- Reduction in readmissions
- Reduced out of hours A&E attendances

Service quality
- Increased patient and carer satisfaction
- Increase in % of home deaths for EOLC

There will also be with co-reporting through the CCG's partnership Service Delivery and Improvement Group for unplanned care and community services (also monthly) to demonstrate that the headline requirements of the scheme are delivered and the project is progressing satisfactorily.

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

- Changing clinical behaviour to take increased risks and care for more patients in a home environment
- Effective recruitment for the new service given a background of recruitment difficulties for nurses in the area
- Effective publicity and promotion of the new scheme to clinicians and professionals
- Effective patient and service user information and promotion about the new service
- Effective clinical pathways between community and acute services
- Structured discharge planning and personalised health care programmes are effective at reducing re-admissions
- The ability of the model to support the existing clinical pathways of; Dementia, Falls, Continence Management, Skin Integrity, End of Life, Long Term Conditions

Scheme ref no.
HRW_005_CIR

Scheme name
Hospital Case Management

What is the strategic objective of this scheme?

Hospital Case Managers will provide expertise through comprehensive assessment, planning, implementation and overall evaluation of individual patients, resulting in the transfer of the patient to the most appropriate level 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?

Model and patient cohorts
Detail of the model is described in a Standard Operating Procedure, designed to provide instruction to the case management team, divisional managers and the multi-disciplinary team, about the processes and responsibilities of the case management team. Broadly, three hospital case managers are based at the Friarage hospital, covering FHN, the Lambert Hospital and the Friary Hospital (with additional support at JCUH), during weekday working hours, to support the overall process of discharge of patients. They will:

- Review all newly admitted patients within the given case load to begin to assess the patients need for ongoing co-ordination.
- Undertake an average of 25 reviews per day
- Early identification of patients with complex needs.
- In collaboration with the multidisciplinary team ensure all patients have a planned date of discharge.
- To review all allocated patients, every day regarding the necessity to stay in hospital against the clinical transfer criteria.
- Resolve issues for those patients who do not clinically require inpatient care
- Support the daily board rounds and identify any barriers or gaps for delays to diagnostics, treatments or discharge.
- Provide expertise within the multidisciplinary team around management plans to consider alternative methods and venues for completing interventions out of hospital where clinically appropriate whilst also minimising length of stay.
- Liaise with social care and community services to enable discharge into a safe and adapted environment
- Provide post transfer / discharge follow up during the first 72hrs.
- Promote appropriate use of assistive technology, including use of life-line
- Develop and promote a broad knowledge base of the range of services and facilities available within the community, social care, voluntary sector and mental health services, including the dementia champions project and services for carers

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

Commissioner / provider:
The main commissioner for the service is HRW CCG.
The main service provider is STHFT.

The service was established from January 2013 as part of an earlier tranche of reablement support through health and social care monies. There are no set-up milestones to achieve. Instead the focus of the project is on maintaining delivery and improving performance.

Milestones:

- Deliver access to MEDWORXX data to explain impact of the project and identify where patients are still remaining within an acute setting for two long – by end November 2014
- Review progress with service delivery objectives - on a quarterly basis
- Extend model for winter 2014/15 to include an additional social care hospital case manager (to be funded from System Resilience Funding)
- Ensure hospital case managers play pivotal role in signposting appropriate patients into the new integrated START / FRT and intermediate care service once established – December 2014

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 drive to develop the scheme comes from work undertaken in 2011/12 which analysed the actual clinical need for patients at different levels of care in the Friarage Hospital, Northallerton, and the Lambert, Rutson, and Friary Community Hospitals. The Levels of Care clinical audit was undertaken using the Medworxx approach and categorised patients as to whether at the time of the audit they were in the correct place of care.

The results showed that a significant percentage of patients in each of these hospitals did not need to be there and, if the correct services were in place, the patients could be cared for at a less intense level of care.

One of the main conclusions was that the systems and processes to expedite the care of complex patients within the acute hospital setting simply did not exist. A new service model was sought which could more effectively ensure that patients were quickly and proactively transferred to the appropriate level of care.

The hospital case management model was researched from the evidence (key papers listed below) and a local version was established for South Tees Hospitals NHS Trust. The intention of the model as designed is to:

- Proactively facilitate discharge of more complex patients
- Through rapid improvement programmes or other organisational development methodology, skill up ward nurses and staff to more effectively plan and manage discharges
- Provide a point of contact across multiple organisations and services

Academic references for the model:
Terra, S. M. (2007) An Evidence Based Approach to Case Management Model Selection for an Acute Care Facility. *Professional Case Management 12 (3), 147 – 157*

Nutt, M & Hungerford, C (2010) Nurse Care Coordinators: Definitions and Scope of Practice.
Contemporary Nurse 36 (1–2), 71–81.

Shermont, H et al (2008) Meeting of the Minds.
Nursing Management 39 (8), 38-44

The evidence from the other published schemes suggested the following should be achievable for the STHFT-wide scheme. The scheme aims to prove that a productivity and efficiency opportunity exists of between £2m (1 day reduction on the AvLOS for pts with a current LOS >7 days) and £8m (2 day reduction on the AvLOS for pts with a current LOS >3 days). This equates to between 32 and 130 beds combining both acute sites (the Friarage Hospital and James Cook University Hospital). It should be noted that these savings take no account of the potential investment required to address changes in case mix/acuity and the associated requirement for a richer skill mix.

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

14/15 £126,000   15/16 £126,000

The scheme costs are based on employing 3 WTE Band 6 nurses @ c. £42K each. The total costs of the three posts are £126K.

 [Note – additional costs for the James Cook University Hospital site as a whole are not included within this scheme and are funded by Tees area commissioners.]

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

The project is designed to reduce the length of time patients spend inappropriately in hospital, facilitate quicker discharge home, reduce inappropriate outlying on hospital wards, and improve outcomes. This will specifically impact on the following:

- Maintaining or improving on lower lengths of stay (as for 13/14 base-line)
- Maintaining or improving on rates of excess bed days (as for 13/14 base-line)

For information, no specific savings have been set against the project as part of the BCF refresh, as the benefits have already been incorporated into the 2013/14 base-line.

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?

Progress with the project and the impact of the hospital case managers is tracked through a monthly Discharge Steering Group, which includes representatives of community services, acute medicine, social care, START and intermediate care, and the CCG. The following areas will be tracked:

Quantity and volume
- Number of WTE hospital case managers in post

Quality of service
- Number of patients meeting PDD (predicted date of discharge)
- Number of delayed discharges
- Number of patients remaining in hospital inappropriately despite being medically fit for discharge

Impact of service
- Overall bed days and lengths of stay
- Readmission levels
- Number of patients recorded as being at an appropriate level of care through the Medworxx monitoring system

The Discharge Steering Group reports into the over-arching Service Delivery and Improvement Group for unplanned care and community services (SDIP2). There, overall delivery of the project is tracked alongside all the other BCF schemes. Multi-agency partnership to agree policy and unblock obstacles.

On a more operational basis, conference calls occur weekly to facilitate liaison between the acute Trust and community services and social care.

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

- Buy-in by partners to faster discharge arrangements
- Confirming hospital case managers as trusted assessors for social care services
- Effective communication between the hospital ward staff and the hospital case managers
- Improved communication between the hospital case management teams at the Friarage Hospital, Northallerton and the James Cook University Hospital in Middlesbrough
- Effective systems for learning from poor and delayed discharges and disseminating these through the wider system
- Putting in place an ongoing Medworxx levels of care monitoring system to validate scheme impact

Scheme ref no.
HRW_006_CIR

Scheme name
District nursing capacity in Hambleton & Richmondshire

What is the strategic objective of this scheme?
The aim of the initiative is to strengthen community nursing services in Hambleton and Richmondshire and enable them to work in more integrated and holistic ways in partnership with social and intermediate 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?

During 2013/14, additional investment was placed in three district nursing teams in the Hambleton area because they were below safe levels of working. This had previously led to a more task-based approach to care than would be desirable and a lack of capacity to work in a more integrated approach with social care. This additional investment enabled the teams to participate in the integrated teams project during 2013/14. This brought together health and social care teams as part of a programme of facilitated organisational development.

The improvement initiative for 2014/15 onwards comprises the following elements:

Element 1: Securing continued investment in district nursing
The business case agreed in 2012/13 was to invest an additional £333K from health and social care monies into 3 of the 6 teams that were below a reasonable capacity to provide safe services. This funding would be made sustainable on a recurrent basis,

Element 2: Undertaking a productivity analysis of community staff
The longer-term aim is to move district nursing and social care teams away from a task-based approach to a more holistic approach, where the wider needs of patients and service users are more proactively considered. The intention will also be to establish more efficient ways of working and therefore have a greater impact on reducing emergency admissions and the size of ongoing social care packages. To facilitate this, we will work with service providers to understand the current capacity and demand through the service and how it is delivered, with a view to establishing more efficient models of service provision.

Element 3: Continued integration and team development
During 2013/14, the CCG, STHFT and NYCC undertook an integration project to establish closer working arrangements. These teams are built up from social care assessment, district nursing and social care therapies. At the moment six geographical teams have been identified within the community, although this requires further clarification. The project for 2013/14 would be to continue the work of the integration

project, focusing on properly implementing and embedding the issues and prototypes created, to maximise the benefits of integrated working, achieve efficiencies through reduced assessments and wasted journeys, and improve outcomes for patients and service users based on a more holistic approach. This work would need to include:

- Further discussion on how to better align teams with each other and ideally co-locate or facilitate hot-desk capability
- Access to both IM&T systems at common bases or hot-desk locations
- Shared consent policy, with exchange of patient identifiable information including assessments based on NHS number occurring through safe + secure e-mail addresses
- Flexibility between team members to reduce travel in rural locations
- Effective hand-overs between these teams & integrated intermediate care
- Clarity on access routes into the service
- Clarification of team roles and responsibilities, directories, contact details
- Sustained operation of multi-agency meetings

Element 4: Holistic care, focusing on falls, leg care and referrals for caring support
A holistic approach to care would be strengthened for falls prevention and leg care, with staff encourage to more comprehensively assess risk and need and then target patients and service users into prevention services or care, where appropriate. This would be supported by the latest clinical evidence and a programme of training and development. We will also work with community nurses to significantly increase referrals for carer support services and assessment. Holistic approach to leg and falls assessment is based on national best practice. Whole system integrated approaches and effective home access to health and social care are identified generally have lower rates of emergency bed use and readmission rates.

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

The lead commissioner is HRWCCG.

The lead provider is STHFT.

Project plan:

The high level plan would be:

- Team leader and manager workshop to agree how integration can be taken forward – May 2014
- Over-arching service / pathway description and standards developed for falls – June 2014
- Pathways for falls rolled out with staff in H&R – July 2014
- Learning rom integration project consolidated in the form of a newsletter for staff and patients – October 2014
- Description of health and social care services – October 2014
- Supporting IM&T arrangements implemented for better integrated district nursing and social care teams – November 2014
- County-wide agreement on best practice for falls – October 2014

- Review reporting arrangements for community nursing services and more accurately quantify activity levels – by December 2014
- Review of clinical way forward for more holistic leg care – December 2014
- Review of progress with integration and prototypes – quarterly / on-going

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

Evidence for scheme
Previous analysis of the community nursing teams in Hambleton and Richmondshire has identified that the ratio of community nurses per 10,000 populations over the age of 65 years is significantly lower than other localities within the South Tees Hospitals NHS FT and other SHA areas when benchmarked with previous research. This analysis of community services within Hambleton and Richmondshire was shared with the CCG in April 2102.

The following is an excerpt from this paper.

"The major challenge with implementing the levels of care concept within H&R is the _number_ of community staff available within an area that has a higher than average elderly population and that is geographically challenging.

For example the ratio of community nurses per 10,000 population over the age of 65 is low when compared with populations in other areas."

Area	Estimated wte community nursing to 10,000 population over 65 years
North East SHA	57 wte
Middlesbrough	42.1 wte
Redcar & Cleveland	30.2 wte
South West/South Central SHA	28 wte
Hambleton	14.9wte
Richmondshire	26.5wte

Assumptions on impact and outcomes
No specific savings have been included within the BCF refresh because they will already have been incurred during 2013/14 and therefore be built into the base-line. Continued delivery of the scheme will be necessary to maintain the base-line. It is possible that the capacity and demand work will model further savings, which can therefore be built into QIPP at a later stage.

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

14/15 £333,000   15/16 £333,000

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The total amount of annual investment is £333K. The breakdown of this investment for individual district nursing teams is as follows:

Team	WTE/Band	FYE Cost based on weekend working of 1:4
Bedale	1.0wte Band 6 (based on top incremental point)	£ 47,715
	2.0wte Band 5 (based on mid incremental point)	£67,992
Total	*3.0wte*	*£ 115,707*
Thirsk	1.0wte Band 6 (based on top incremental point)	£ 47,715
	2.0wte Band 5 (based on mid incremental point)	£67,992
Total	*3.0wte*	*£ 115,707*
Northallerton	3.5wte Band 5 (based on mid incremental point)	£ 101,988
Total	*3.5wte*	*£101,988*
Combined Total for Bedale, Thirsk and Northallerton Teams	**2.0wte Band 6's** **7.5wte Band 5's**	**Total expenditure: £333,402**

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

- Improved relationships both within team and with GP practices, older people's mental health services, housing, and voluntary sector partners
- Greater proactive identification of at-risk individuals through proactive risk-profiling in conjunction with GP practices
- Reduced (re)assessments due to greater sharing of soft intelligence and proactive multi-intervention planning
- Improved patient experience, through joint visits, clear care plan and clarity on who is providing care
- Greater holistic care, to prevent deterioration and proactively address risk factors
- Reduced emergency admissions, particularly for general and elderly medicine
- Reduction in falls admissions
- Reduced sizes of ongoing social care packages and reduced demand on reablement and rehabilitation services.

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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?

Regular performance reports are received the partnership SDIP Group for unplanned care and community services covering community service activity. Within the same report data is received on emergency admissions and excess bed days. These separate data-sources are compared to help to ascertain whether the services are having an impact.

The following performance metrics will be tracked through the SDIP2 Group or bespoke analysis will be commissioned:

Quantity and volume
Core central activity reports for district nursing / LTC team, including:
- Referrals – by source
- Activity – number of patients receiving service / new contacts / review contacts / non-face-to-face contacts
- Discharge arrangements – to alternative provider, self-care, death, etc.

Quality of service
- Audit of leg and falls assessments to confirm quality
- Patient satisfaction

Whether the service has made a difference
- Reduction in non-elective admissions
- Reduction in admissions for falls (Better care metric)
- Reduction in lengths of stay
- Reduction in size of ongoing social care packages
- Reduction in assessments that don't lead to social care packages

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

- Maintaining successful recruitment of district nursing staff
- Staff development programme to re-emphasise the skills required for holistic care, following a prolonged period of urgent task-based work
- Continued programme of organisational development to facilitate integration with social care teams and continue to develop shared IM&T approaches, a shared approach to assessment and review, effective multi-disciplinary team meetings (including with GP practices) and effective communication generally
- Developing a system-wide clinical and professional consensus about which patients can be managed in the community as opposed to in a more intensive setting
- Establishing effective links to projects to risk stratify and case manage at-risk patients as part of a sustained approach to proactive care in the elderly
- Effective care plans for frail elderly and patients with long term conditions

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Scheme ref no.
HRW_007_CIR
Scheme name
Risk profiling and long term conditions

What is the strategic objective of this scheme?

The aim is to put systems and criteria in place at practice level to systematically identify those patients who are at-risk for a crisis or avoidable admission through effective risk profiling and to ensure that patients, once identified, are successfully navigated through the health and social care system and have their care needs addressed proactively. Prioritised vulnerable patients would have their care plans completed and implemented on behalf of GP practices by the long term conditions team. This risk stratification and care planning work is to be supported by additional capacity within case management services to ensure sufficient patients can receive appropriate support.

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?

Element 1: Establishing a fully effective risk profiling tool through the CSU to support practices to identify vulnerable patients
In the first year of this scheme, vulnerable patients were identified through subjective practice criteria. Ultimately, the intention is for a far more scientific and robust methodology to be used to identify vulnerable patients using proper risk profiling software and algorithms using data extracted from secondary care and GP practices.

During 2014/15, the intention will be to work with the CSU to properly implement and embed a risk profiling system as part of the overall Business Intelligence service. This tool will systematically provide practices with data on at least a quarterly basis (or at a frequency directed by NHS England or GP practices themselves). The tool will also enable outcomes for patients identified to be systematically tracked so that the service overall can be evaluated. Feedback from the CSU team at this stage suggests costs of the basic risk profiling software are already included within the CSU contract. However, if the quality of the technical solution is increased at a later stage, then the costs may increase.

Element 2: Supporting practices to deliver their objectives under the Avoidable Admissions DES
The GMS contract is currently being revised to include a new DES in relation to risk profiling yand care management. The CCG will need make sure that practices are aware of their requirements under the DES and implement these accordingly. The CCG will then need to monitor compliance and impact. In particular the CCG will need to ensure that arrangements exist to enable them to work in a more integrated way with the wider health and social care community team.

Element 3: Increasing capacity within the H&R community long-term conditions team.

GP practices will identify 2% of their population through the avoidable admissions DES. This equates to 2,300 patients at any one time.

The capacity for the long term conditions team in H&R from June 2014, is: 2.8 WTE community matrons (of which 1.0 WTE is theoretically commissioned to provide support and training to Nursing Homes and will be reprovided through a separate Care Homes proposal), and 2.8 WTE case managers. This equates to 5.6 WTE capacity (split into 3 geographical areas) to meet the needs of 115,000 population.

Estimated current referral capacity: Using an average case-load of 40 patients, refreshed once a quarter, 1 WTE case manager could indicatively care for 160 patients per year. A community matron can indicatively have an active case-load of 50 patients, refreshed every six months (due to the more complex nature of the clients), i.e. 100 per year. This means the current capacity can manage only: 448 patients (case managers) and 162 patients (community matrons), i.e. 610 patients in total. This doesn't provide sufficient capacity to manage the expected volume of patients currently being identified by GP practices.

While not every patient identified will be appropriate to be managed through the long term conditions team (some may require support from the practice or social care, for example), there is a capacity gap if risk profiling is to be implemented successfully. The proposal would be to create additional capacity in the long term conditions team by:

- Releasing community matron time from Care Home support – This would increase their capacity by 20%, i.e. 40 extra patients per annum (as they currently spend approximately 80-90% of their time on LTC care).
- Additional capacity equivalent to 2.0 WTE additional case managers (a cost of c. £100K). This would support approximately 320 patients extra per annum.

This would mean the total estimated referrals that could be managed by the team would be 970. This is more in line with the protential numbers being referred by GP practices.

Element 4: Develop a Neighbourhood Care Team to support the transformation of community services in Whitby augmented by the creation of a new Care Navigator role.

This initiative intends to provide an integrated response and a personalised care plan for high risk patients with a Care Coordinator to support people at home and provide care out of hospital and in communities and in people's home where they can access safe and convenient care. Care coordinators will be drawn from existing community service provision and the new care navigator, piloted through social care, that takes a less clinical approach.

The proposed new model of service is a Neighbourhood Care Team approach, where a care coordinator along with a multi-disciplinary team (including GPs, professionals from health and social care) will support to keep people at home and to be cared for at home with a personalised care plan and appropriate services intervening at the right time. This model is being delivered across Scarborough, Whitby and Ryedale localities in partnership with Scarborough and Ryedale CCG and North Yorkshire County Council.

In particular, the development of the NCT is being supported by a new role – the Care Navigator. This is pivotal to the successful achievement of local integration with health and social care teams and in facilitating through the effective management of service users within the community, leading to a reduction in unnecessary admissions to hospital and improved clinical outcomes. Care navigator(s) will help service users access help and services to take more control of their own lives.

The Care Navigator will be responsible for three key areas:

- Work closely with the service users to ensure that the personalised collaborative care plan is adhered to by the assigned care team members
- To be an advocate for the individual and help them to navigate through the providers of care to ensure they obtain the best for them. To motivate them to adopt a healthier lifestyle and take responsibility for their condition (as much as they are able to)
- Help service users understand their condition better, the impact of choices they make and help them take more control of their own situation and condition

Element 5: establishing an integrated case management function
Case management occurs within community teams, social care assessment and continuing healthcare. The aim will be to integrate these services over time so that each person is case managed just the once. This work will be initiated by an analysis of capacity and demand, particularly focusing for an average practice on how many people are case managed and by whom. This will then be developed through discussion with the Local Authority and providers into proposals for a remodelled, integrated case management function.

Element 6: Championing new technologies
As part of this extended capacity within the long term conditions team, the community matrons / case managers would be expected undertake a specific role in championing new technologies to GP Practices and Community Services Teams. This would include:

- An understanding of the use and benefits of risk profiling to help practices identify suitable patients using the predictive risk tool itself
- An ability to sign-post and ensure uptake of local opportunities related to telecare to better enable patients to self-manage
- Clinical expertise to support the deployment of technological aids to support patients to self-care, for example smartphone use and appropriate NHS apps to better enable them to self-manage. Areas include: COPD, CHF, hypertension and hypotension, diabetes types 1 and 2, retinopathy, medication compliance and titration, orthopaedic, smoking cessation, speech therapy, carers wellbeing, mental health behaviour, adult asthma, alcohol support, weight management etc.

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

Commissioners

- Case management capacity is commissioned by HRWCCG.
- The avoidable admissions DES is commissioned by NHS England, with aspects of local implementation undertaken by HREWCCG and North Yorkshire and Humber

CSU.

- The care navigator project is a partnership between HRW CCG and SR CCG.

Providers

- Community matrons, case managers are provided by STHFT
- In Whitby the case management function is provided by District Nurses working for YHFT
- GP practices provide the DES for avoidable admissions
- The provider for the care navigator pilot phase will be NYCC. However, over time other provider models could be considered, including the Voluntary Sector.

Project plan

- Agreement with provider to work to a NCT service Model in Whitby – February 2014
- NCT model and pathfinder sites identified for Whitby - March 2014
- Agreement with providers on the final service model for the long term condition team – March 2014
- H&R Community matrons released to case manage from care home responsibilities – April 2014
- NCT post-holder for Whitby identified – April 2014
- Commissioning plan agreed with CSU for provision of robust and effective risk profiling tool to underpin the scheme as a whole – May 2014
- Details of new risk profiling DES established based on national requirements and local implementation plan agreed with practices – May 2014
- Demand and capacity analysis of all case management services as part of agreeing additional capacity for H&R and confirming what support is available in Whitby – June 2014
- Rollout of NCTs across Whitby and surrounding area – June 2014
- Additional case management staff recruited and in post – End September 2014
- GP practices identify named GPs for all patients and agree delegated responsibility for care co-ordination to case managers where possible / appropriate – End September 2014
- Quarterly monitoring of care plan delivery and identification of key commissioning and service issues commences – from October 2014
- Long term condition team training and development to be able to undertake technology champion responsibilities, including understanding RAIDR in order to support practices – October 2014
- Qualitative evaluation of the care navigator pilot – October / November 2014
- Proposal for wider integrated case management – March 2015
- Monitor final delivery of new DES by GP practices – March 2015

Enablers
The following developments and services also link to and support the delivery of this scheme:
- Avoidable admissions DES
- County-wide strategy through NYCC for the prevention of ill-health
- Out-of-hospital Service for Multi-Disciplinary Case Conferences
- Remote care monitoring DES (or equivalent)
- GMS contract requirement for all over 75s to have a named GP

- Implementation of care planning for all patients with long term conditions
- Services commissioned and implemented through £5.00 per patient fund to enable GP practices to better prevent avoidable admission and support vulnerable patients
- County-wide improvements in IM&T through the Better Care Fund

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

Whole system integrated approaches and effective home access to health and social care are identified generally have lower rates of emergency bed use and readmission rates, e.g. King's Fund publications.. The service would be focused on supporting those patients scientifically identified as being at-risk through risk profiling software to enable care to be accurately targeted to those in greatest need.

RAIDR
GP practices across North Yorkshire have access to risk stratification through a system called RAIDR. RAIDR's risk stratification module uses the CPM (Combined Predictive Model) algorithm to process acute secondary care and primary care records to produce a list of patients within each practice, ranked by their risk of admission. In addition to this the RAIDR tool provides some condition specific risks e.g. COPD, AF (CHADs), and fracture (osteoporosis risk factors). RAIDR is very flexible, allowing users to navigate, select, and drill down to gain intelligence in a wide variety of ways, from high level trends to detailed patient level data. The patient lists from these tools carry the NHS number allowing practices to load them directly into their own practice management systems, or use in case management work to improve individual care.

The RAIDR tool is refreshed monthly, allowing new cases to be quickly identified, and changes to existing patients monitored. The CCG will shortly have access to aggregated information about patients' risk scores which can be monitored over time to help assess the impact of its service improvement programme, but can also help ensure efficient allocation of resources, both organisationally, and geographically.

H&R case management Savings assumptions
Assume the additional capacity (2 WTE) manages 360 patients per annum who are new to the case management service. Assume approximately 25% of the new patients have at least one admission saved in the following 12 months. (For 2014/15, assume only savings in final quarter).

This equates to 1.8 admissions saved per week, i.e. 95 per year, with a total saving of £180K per annum (assuming £1,900 per admission).

Care navigator role
The Neighbourhood Care Team (NCT) Model is being developed which involves working across Health, Social Care and Voluntary Sector boundaries to deliver more a support network that will enable people at risk of inappropriate or unnecessary hospital admissions, to stay at home safely. A single NCT will cover a number of GP surgeries across a population of around 25,000. To make the model work efficiently and consistently, it has been identified that we need a specific role to be commissioned for

each NCT to support its running and ensure continual delivery.

- Work with the Practices and be part of the Multi-Disciplinary Team
- Work closely with the service users to ensure that the collaborative care plan is adhered to the assigned care team members in an advocacy role.

The post will sit at around AfC Band 3 – 4 or NYCC Band 6 – 7 and will be based on experience and skills. It is envisaged that it will attract from a wide range of care and health based organisations

Need for the Role
- Care Navigators will give some extra capacity to help the practices and community services coordinate their activities around an individual
- The Care Navigator will help pull together the both historic and current activity data around an individual to monitor the effect of the NCT.
- The Care Navigators will do a holistic assessment of the individual (The SWR MIND Outcomes Wheel) and take the desired outcomes to the MDT.
- The individual will have a role to see that the Collaborative care plan is being adhered to
- They will be a single point of contact for the patient (unless another professional takes on that role)
- There are no Community matrons in this area who have had a coordination role in other places.
- They will act as an advocate for the patient and keep them and their carers informed.

There is an argument for assigning one of the professionals as a key worker and whilst clinically this may well be appropriate, most professionals tend not to step outside their area of practice. This also becomes more difficult when the professional is no longer required to deliver professional care to the patient. The NCT worker will not have any professional barriers and it will be clear that they are the patient link as long as the patient is on the NCT list. There is also a financial argument as there will be a pay differential of up to £16,000 between the NCT worker and an experience professional.

The NCT model for Whitby and surrounding area will therefore require the following resources:
- 1 WTE Band 3 Care Navigator for Whitby, with special understanding of health, social care and voluntary sector services.
- One off investment in IT and systems £2,000

The project assumption is that approximately an admission is saved every fortnight (26 a year), out of an overall case-load of c. 15 patients. i.e. about 17% of patients will have 1 admission saved.

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Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
14/15 £80,000   15/16 £130,000 **Summary recurrent costs** • 2 WTE Band 6 case managers - £100K (each post was costed at top-of-scale - £42,155 with £7,845 to cover travel and organisational expenses) • 1 WTE care navigator - £30K • TOTAL - £130K

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
The Avoidable Admissions DES and supporting additional case management capacity should help prevent emergency admissions. A reduction in emergency admissions proportionate to the 2 WTE additional case management capacity is shown in the excel table. This saving level should be supported, and potentially exceeded, by the body of work being undertaken by GP practices to ensure 2% of their population have care plans (2,820 patients across HRW). In addition, the scheme: • Prevents avoidable non-elective admissions • Reduces potential years of life lost due to poor management of conditions amenable to healthcare • Supports better integration of GP practices with health and social care multi-disciplinary teams • Easier access to services and information for patients • Patient care plans developed • Improved access to services through delivery at the appropriate time, place and by the most appropriate professionals • Enhanced patient/client understanding of their condition and self-care skills, leading to promotion of independence • Reduction in admissions to acute settings • Reduction in length of stay in acute settings through an improvement in patient throughput • Reduction in delayed discharges from hospital • Contribute to the reduction in the number of people being admitted to residential/nursing care from hospital setting • Increased number of people supported to live at home • Increased number of people having choice to have their end of life care at home • Improved support for carers to carry out their caring roles effectively • Improved rate of timely discharge of patients from Community Hospitals who no longer require inpatient level nursing intervention

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?

General metrics to be monitored
- Vulnerable people identified as at-risk through risk stratification are maintained in a better state of health for a longer period of time, leading to prevention of avoidable admissions
- Greater proactive identification of at-risk individuals through proactive risk-profiling in conjunction with GP practices
- Improved patient experience, through clear care plan
- Greater holistic care, to prevent deterioration and proactively address risk factors
- Increased patient and carer satisfaction
- Reduction in out of hours admissions to hospital and care/nursing homes
- Reduction in readmissions
- Reduced out of hours A&E attendances
- Increase in % of home deaths for EOLC

Avoidable Admissions DES
The Avoidable Admission DES has built in quarterly monitoring requirements to confirm the number of patients who have been identified as at-risk and who have a care plan. The quarterly report also asks practices to feedback issues and problems with services that are leading to unnecessary admissions or delayed discharges.

Case management / care co-ordination
The number of patients for whom care co-ordination is provided by the STHFT case management service needs to be quantified and evaluated. This will be done though service reports and through the STHFT Community Services monitoring data-base.

- Number of patients identified by GP risk profiling tool referred to LTC service
- Number of patients discussed at multi-agency meeting
- Core central activity reports for LTC team, including new contacts, review contacts, non-face-to-face contacts
- Number of patients receiving support through a telehealth service

Whether the service has made a difference
Financial savings
- Reduction in c. 95 non-elective admissions per annum (£180K per annum) equating to an R.O.I of 1.18.
Patient impact
- Reduction in risk after a period of case management as measured by risk profiling software by the change in risk after 12 months for an individual patient
- Patient survey / feedback

Care navigator project
There will be a formal evaluation of Phase one of the NCT project conducted by an academic institution. It is the intention that this scheme is evaluated by the University of Teesside. A project research methodology is being agreed through the CSU R&D team.

The overall aim of the evaluation is to gather insights into the development and implementation of multi-disciplinary NCTs from four different perspectives:

- The patient view,
- The carer/ family view,
- The stakeholder view – members of the NCT, secondary care clinicians, care providers,
- The strategic view – members of the Integrated Care Delivery Board/ senior leaders in the local integration work-stream.

The progress with the new service will be tracked through the Whitby Steering Group. This is a local partnership group responsible for the development of community services, which is chaired by Healthwatch. It also includes membership from NYCC, CCG, YHFT, CSU, Voluntary Sector.

There will also be with co-reporting through the CCG's partnership Service Delivery and Improvement Group for unplanned care and community services (also monthly).

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

- Quality and depth of care planning, built on patient goals that properly ensure patient buy-in
- Identifying the correct patients – use of risk stratification tools will need to be refined and improved as the project progresses
- Effective collaboration between GP practices and community multi-disciplinary teams, supported by effective communication and multi-disciplinary meetings
- Effective review and evaluation to determine what is working effectively and where improvement is required
- Rapid improvement and action followed by effective discharge back to normal services so that new case-loads can be taken on

Scheme ref no.
HRW_008_CIR
Scheme name
Community-focused acute care

What is the strategic objective of this scheme?

To utilise the skills and experience within acute service providers to better redirect patients to receiving care in community settings. This incorporates:

Frail elderly 'hot' clinics - To provide 2 clinics per week, which provide comprehensive geriatric assessment and instigation of a multi-disciplinary care plan for complex older patients.

Front of House Physician – To expand the reach of senior decision makers within FHN, to provide Acute physician consultant level support to A&E, specifically at peak times, and redirect appropriate patients into community-based care

Integrated IV Antibiotic Service - Integrating the outpatient antibiotic therapy (OPAT) service and IV antibiotic administration in the community in order to significantly reduce lengths of stay and prevent unnecessary admissions

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?

A key part of STHFT's goal of becoming a centre of excellence in rural health is a redoubled effort to avoid in-patient management when care could be delivered closer to home. This aspiration is central to the "Fit for the Future" program lead by Hambleton, Richmondshire and Whitby CCG.

The consultant view is that the national agenda with the introduction of the Better Care Fund will necessitate admission avoidance on a scale previous considered unachievable. Success will require imaginative care delivery models.

Front of house physician
STHFT and partners believe the key is to employ more senior decision makers and deploy them far earlier in the patient journey than we previously have. A recent pilot study on weekday evenings has shown a 50% reduction in admissions from A&E by adoption of this approach.

The old barriers between primary, secondary and community care must be removed to develop truly integrated care pathways. This will inevitably result in a reduced hospital bed base and a completely new ways of funding secondary care. It is the belief of all

consultant physicians at Friarage Hospital that these changes can be delivered, but only with expansion of consultant numbers. Currently FHN has only six general physicians. The minimum required to realise the service benefits is eight. Looking into the future with fewer junior doctors and increased reliance on advanced nurse practitioners, STHFT may ultimately require ten.

This scheme contributes to the larger strategic initiative of redesigning the Front of House (A&E, CDU and OOH GP service) model at FHN into a more integrated approach, that improves clinical quality and reduces avoidable admissions by having a consultant lead service, supported by nurse practitioners.

Frail elderly clinics
The hot clinics will provide a twice-weekly opportunity for primary care, community and secondary care professionals to refer elderly people for a comprehensive geriatric assessment, when triggers of frailty or difficulties in coping are identified.

The clinic will be staffed by a geriatrician, physiotherapist, occupational therapist, nurse, social care who will work together to assess the patient and develop a joint plan. Following the MDT assessment a care plan will be actioned the same day so that changes in care can be implemented immediately. Follow-up will be the responsibility of the patients GP apart from in exceptional cases.

The success of this clinic involves stakeholders from primary, community, secondary and social care working together in new ways. The pilot period is supported by all stakeholder groups. Care of the Elderly consultant input in the locality has been long term request from local General Practitioners.

The service will be principally targeted at the over 75s, although this will be monitored and exceptions will be allowed.

IV antibiotics
An OPAT service has been developed at FHN which enables patients requiring IV antibiotics to have a midline inserted and daily administration as an outpatient. This scheme proposes to further develop the service to enable administration at the most appropriate venue, depending on geography, ability of patient to travel etc.

Clinical leadership for service would be provided by Dr James Dunbar and supported by nurse practitioners. Community nurses would be trained to administer IV antibiotics via midlines, inserted at the OPAT clinic.

The main patient cohorts which would be targeted are those with:
•	Cellulitis and other soft tissue infections
•	Bone infections

This is an integrated working proposal that needs to be acute-Trust based by design, so no other providers should be destabilised. This service will sit within the integrated medical centre within the Trust which will enhance service continuity across the acute and community services.

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

Commissioner / provider:

- The lead commissioner will be HRW CCG
- The principle provider will be STHFT.
- Staff for the hot clinic will be drawn from both acute and community services.
- In-reach support to the hot clinics will also be provided from social care staff (NYCC).
- Over-time further inputs from the Voluntary Sector be brought into the service, e.g. Benefits advice through the Citizen's Advice Bureau.

Frail elderly clinics Project plan:
- MDT Resources secured - by June 14
- Planning workshop to agree service model - July 14
- Clinic locations identified – by August 2014
- Final implementation workshop – September 2014
- Clinic commences   - September 2014
- Regular evaluation of progress and impact - monthly

Front of house physician Project plan:
- Commence consultant recruitment – July / August 2014
- Finalise internal STHFT business plan for both consultant posts – September 2014
- Provide additional consultant capacity – From September 2014 onwards
- Further develop integrated front of house service model based on new capacity – December 2014
- Report through to SRG – on-going

IV antibiotics Project plan:
- Design and agree service model – June 2014
- Start-service in pilot form – July 2014
- Finalise on-going funding arrangements and management of drug costs – October 2014
- Recruit additional nursing capacity to clinic – October 2014
- Develop full service specification, training programme etc. – November 2014
- Design and disseminate and implement model, including presentation / information to GPs – November 2014
- Report progress through SDIP2 - monthly

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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

Frail elderly clinics
There is increasing evidence that the management of frailty in ageing populations need to be managed in new, innovative and multi-disciplinary ways. Similar clinics have been introduced in a number of health economies, e.g. The Royal Free Hospital.

There have been a number of attempts to introduce specialist care of the elderly input in the past in this locality, so it is anticipated that this development will be welcomed across the system.

Cost assumptions:
The main service costs are as follows:

- 100 PA's per year = £20370 (comprising x 2 PA's per week 50 weeks of the year – excluding Xmas and New Year)
- HCA Band 2 support – 4 hours per clinic, 2 clinic a week, 50 weeks of the year = £3860 (if required)
- Admin support – 4 hours per clinic, 2 clinic a week, 50 weeks of the year = £4356
- Other resources – e.g. therapists and social care input, from other investments
- Summary total: £28,586 plus additional on-costs

Recurrent funding of £40K has been allocated to the clinics at this stage.

Capacity assumptions:
- Each clinic will see up to 5 patients.
- This means that up to 500 complex, frail patients can be seen per annum

Savings assumptions:
- Savings have been calculated on the assumption of a 1:1.5 ROI
- This means, as a minimum, the expectation is that approximately 6% of the patients going through the service should have an admission saved in the following 12 months.
- This equates to 32 admissions per year.

Front of house physician
Evidence for the approach was based on a prototyping pilot investigating evening A&E gatekeeping shifts. STHFT has known for some time now that many medical admissions from Friarage Hospital A&E could have been avoided with the input of an earlier consult physician assessment. As STHFT have only a small team of consultant who are fully committed during the day the only time to pilot admission avoidance shifts was between 1700 and 2000. Two consultants, Dr David Spence and Dr James Dunbar, volunteered time to staff these shifts and five shifts were performed. There was a wide variation in the number of referrals but when not in A&E the clinical decision unit benefited from the prolonged senior presence.

- Six weekday evenings from 24th April to 22th May between 1700 – 2000 were covered by Drs Spence or Dunbar

- There was a wide variation in the numbers of patients refereed per shift – between one and eight
- While not in AE increased cover was possible in CDU with consequent improvement quality and safety

Results:
- 23 patients referred (between one and eight per shift)
- 10 patients were admitted (two were as a result of inadequate community end of planning)
- 13 patients were discharged
- Three were followed up in ambulatory care
- One was followed up by the fast team
- To date only one patient (ambulatory care) has required re-admission < 24 hours

Assumptions – costs
The proposal is for BCF to make a contribution to the employment of 2 WTE additional consultants at FHN. For 14/15, BCF would contribute the full costs of 1 WTE consultant to pump-prime the scheme. From 2015/16, the BCF would contribute 50% of the costs of 1 consultant, with STHFT picking up the costs of 1.5 WTE consultants. The cost of the scheme would therefore be £50K each year. (For information – the second consultant post is being pump-primed through Winter System Resilience funding).

Assumptions – savings
The additional consultants would work as part of an extended system of community and acute services to manage the pathway of care for vulnerable older people differently. As such, savings in NEL admissions are attributable to all aspects of the pathways, including increased capacity within an integrated intermediate care service.

It is clear that having a consultant physician reviewing patients in A&E is an effective admission avoidance strategy. It stands to reason that a having a senior clinician on site later into the evening also improves the quality and safety of the service. For example two urgent chest drains for significant pleural effusions were placed during these shifts that would otherwise been left until the morning. With the additional consultants STHFT would be in a position to review all A&E referrals between 0900 and 2000. An ideal model would be for one consultant to be responsible for CDU while a second takes the on-call telephone to primary care, screen A&E admissions and support the advanced nurse practitioners who are running ambulatory care. STHFT believe that the combination of these strategies could half the number of emergency admissions to medicine.

The savings attributable to this scheme have been projected on a conservative basis as 1.5 admissions saved per week, i.e. c. 80 admissions per annum. This would equate to a financial saving of £150K per annum (based on £1,900 per admission) at full tariff cost.

IV antibiotics
There is good evidence to support the effectiveness and efficiency of OPAT services

Assumptions for the scheme are as follows;

Demand:
- There will be approximately 5 patients receiving home IV antibiotics at any given

time throughout the year;
- Average length of treatment is 7 weeks;
- Total anticipated number of patients per annum is 37, of which some will patients whose admission was prevented whereas others will have been discharged home earlier following an operation.

Capacity requirements:
- 1 PA Consultant time per week to prescribe , provide face to face attendances and monitor patients;
- 0.4wte Band 5 Nurse support;
- 0.1wte Band 7 Nurse support and education.

Charging assumptions:
- That this service will be delivered within current capacity in terms of community nursing;
- Drugs and consumables will be supplied by the acute Trust;
- Any home attendance will be recorded but non chargeable;
- Any attendance at a Community Hospital e.g. Friary will be recorded but non-chargeable;
- Any hospital attendance will be recorded but non-chargeable.
- Average cost of consumables per patient £205
- Drugs are categorised into 3 areas for costing
  - Cat 1 £10,000 per annum – 3 patients in total (daptomycin)
  - Cat 2 £ 1176 average cost per patient (teicoplanin & ertapenum) 30%
  - Cat 3 £ 350 average cost per patient (ceftriaxone) 70%

Scheme costs:
- 1 PA Consultant Time - £11534
- 0.4wte Band 5 Nurse - £12003
- 0.1wte Band 7 - £4336
- Consumables - £7585
- Cat 1 Drugs (3 patients) - £30000
- Cat 2 Drugs (10 patients)- £11760
- Cat 3 Drugs (24 patients) - £8400
- TOTAL   £85,618

Funding allocated through BCF:
- A total of £50K per annum has been allocated through BCF.
- Agreement needs to be reached on a suitable funding mechanism for the service, including how the funding for drugs and consumables is managed. This is because approximately half the patients may be acute patients who are discharged earlier as part of a planned care episode.

Savings assumptions:
- Assume approximately 70% of patients are admission avoidance as opposed to step-down after operation, i.e.27 out of 37
- Assume £1,900 per admission saved
- Assume 1st July 2014 start-date

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

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

14/15 £108,000   15/16 £140,000

The summary total recurrent investment required for the scheme is:

- Frail elderly clinics - £40K
- Front-of-house physician - £50K
- IV antibiotics - £50K
- **Total recurrent scheme value (15/16 costs) - £140K**

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

This scheme provides an opportunity to refer for a comprehensive geriatric assessment before service users hit a crisis or as an alternative to admission to hospital following attendance at A&E / CDU / OOH GP. It therefore supports admission avoidance and maintenance of elderly people in their own homes.

In addition to the savings on emergency admissions, the schemes would also facilitate a reduction in Serious Incidents.

Equity of access: By extending the model into the community all patients across Hambleton and Richmondshire will have access to this service, not just those living near to FHN. Patients requiring IV antibiotics will be able to be treated as an outpatient or in their own homes, rather than an extended inpatient stay. This may help to enable preferred place of death.

Schemes will also ensure easier access to services and information.

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 scheme will be developed alongside the other BCF schemes through the Service Development and Improvement Group for Unplanned Care and Community, which includes NYCC, STHFT, the CCG and other partners.

Patients through the service will be audited in terms of referral source, interventions and outcomes. This will be achieved by measuring clinic activity data and clinical audit of individual patients.

This scheme also sits at the interface between community service development and urgent care management. Progress will also be reported through the CCG's System Resilience Group, which has the over-arching responsibility for urgent care. The following metrics will need to be tracked as part of the project progress:

Quantity and volume:
- Number of clinic referrals
- Number of attendances / patients seen
- Number of MDT care plans completed
- Number of admissions avoided and bed days released through early discharge
- Number of readmissions

Service outcomes:
- Number of patients subsequently having an emergency admission
- Number of patients maintained living at home

Service quality
- Patient feedback / Patient satisfaction
- GP qualitative feedback on impact of clinic and quality of care plans
- Consultant and acute staff feedback
- Community service staff feedback

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

- The development of an effective vision and model as the Friarage Hospital as a beacon of rural healthcare
- Clinical consensus and buy-in from the hospital consultant body to the new working arrangements
- A system-wide vision and consensus for which patients can be clinically managed in a home setting that all partners, clinicians and professionals can buy into
- Effective communication between acute and community services, including the voluntary sector and social care
- Effective recruitment of the necessary increased capacity in community and acute services

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

Scheme ref no.	
S&R_001_CIR	
Scheme name	
Malton Care Hub	

What is the strategic objective of this scheme?

Strategic objective:

To provide a collection of services, to a defined cohort of patients at risk, to support in a crisis, avoid admission, provide ongoing care and facilitate early discharge. This would be closer to home and through a multi-disciplinary team approach to promote wellbeing, self care and confidence involving local groups and the voluntary sector.

Strategic Aims:

- Promote independence
- Increase wellbeing
- Prevention of crisis
- Users have ownership of own care and feel safe
- Users can access the service
- Carers feel supported
- Reduction in spend on acute healthcare and adult social care
- Increase efficiency of care delivery
- Provide sustainable workloads
- Ease of access to services and co-ordination
- Ensure advanced care planning in place
- Services to be available 7 days per week and extended hours

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?

In order to deliver the strategic aims listed above the Malton Care Hub scheme worked with local stakeholders to identify the priority first steps towards delivering a truly integrated and responsive service for the local population (c. 28,600 covered by three GP practices). There is a recognition that further elements will be required to build on these foundations. Building on the work of the Birmingham Health Village, the Malton Care Hub seeks to go beyond integrating traditional 'professional' health and social care services instead looking to include community, carers and voluntary sector support networks to build a 'ring of confidence' around service users.

The Birmingham model describes four, ascending, levels of need in individuals:
- Improving health and wellbeing
- Managing life-limiting long term conditions
- Care in crisis
- Specialist service

Locally stakeholders identified that the gaps in current services were most significant in supporting those complex users with life-limiting long term conditions and providing non-institutional (health or social) care in crisis. In seeking to support independence for individuals and reduce the utilisation of the most resource intensive health and social care services (inpatient beds, Emergency Department, residential care and long term social care packages) it was recognised that services needed to be both **proactive** to plan care to prevent crisis and **reactive** to respond to crisis in a timely manner.

In order to achieve this three initial service areas are being developed:

1. Multidisciplinary care home inreach

This proactive service seeks to ensure that residents of care homes all receive a comprehensive multidisciplinary geriatric assessment resulting in a detailed care plan (including advanced care planning for end of life) that would be accessible to health and social care providers (linked to single care record developments).

Jointly led by resident's named GP and a consultant geriatricians the review will include a detailed medication review and work closely with staff within the home. It is expected that the wider multidisciplinary team will include community nursing, speech and language therapy, dietetics, social services and pharmacy as required. The service will work closely with the Dementia Care Home service.

2. Case management / complex MDT approach

This proactive service seeks to support those individuals identified as having care planning needs with a complexity greater than that which can be provided by practices. Although the patient cohort will include a proportion of those being identified as 'at risk' through stratification tools it is recognised that other services (including social care, housing, secondary care, carers and the voluntary sector) will also identify individuals who would benefit from a more comprehensive review and plan.

Although a final model of care is to be determined it is envisioned that a team comprising professionals from a range of backgrounds (including nursing, therapies, social care and mental health) will assign a lead professional according to the referred individual's needs. The lead will conduct a thorough assessment (through cross training all team members will be able to conduct basic assessments in all disciplines) accessing specialist input where required. This may include liaison with a range of services involved in the individual's care.

The output will be a detailed care plan with a focus on self-management, on-going care, a plan for deterioration of conditions and advanced care planning where appropriate. This would be jointly agreed with the individual and their carers and available to health and social care providers (linked to single care record developments). Agreement for review arrangements and ongoing support (which could be provided through the voluntary sector or linked to primary care) will be made.

3. Intermediate Care / Reablement

A more reactive service predominantly supporting those in crisis the service has two functions:

a) preventing admission to hospital, residential care settings or long term high packages of social care
b) facilitating early discharge from hospital or residential care settings

Service users would be referred from a wide range of sources including GPs, community nursing, carers, ambulance service and emergency departments. The team ethos would centre on taking responsibility to ensure that appropriate care is in place for individuals referred to them. Using the analogy of a relay baton the team would take responsibility to take this from the referrer and where a referral for onward care (either at the end of a period of intervention or where a more appropriate service exists) ensure this is safely handed on in a manner that is seamless for the service user.

The team is expected to include professionals from nursing, therapies and social services with close links to mental health crisis response services. These professionals would be supported by a team of generic workers who would deliver the majority of interventions for individuals. As with the case management service a lead professional would conduct an initial assessment of need and agree a set of goals with the individual and/or their carers. With an ability to provide care up to four times a day for up to six weeks the aim would be to restore an individual to an optimal level of function.

It is expected that the team will support a 'discharge to assess' model whereby functional assessments and rehabilitation for those without acute medical needs are provided in a user's own home rather than institutional settings. For those with ongoing unpredictable nursing needs this service could be provided in a residential care setting, again with a focus on optimising an individual's level of function prior to assessment of long term need.

It is expected that all the services above will be provided both in individuals' own homes but also exploiting the community resource in Malton Hospital to bring individuals together for interventions. This will enable most efficient use of resources as well as the benefits of greater social interaction through group interventions.

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

A memorandum of understanding, in parallel with commissioning governance and assurance, supports definition of the delivery chain.

An accountable lead provider model has been adopted for the development of the community care hub, initially as a pilot. The accountable lead provider, York Teaching Hospital Foundation Trust, is commissioned through the better care fund partners and process (invoicing monthly against a submitted business plan and budget), monitored through a joint health and social care delivery group. The memorandum of understanding defines the overall engagement and principles of this arrangement between NHS Scarborough and Ryedale CCG (commissioner), North Yorkshire County Council (commissioner) and York Teaching Hospital Foundation Trust (provider). The accountable lead provider however works with multiple other providers and stakeholders to deliver the care hub aims, objectives and deliverables, including local primary and community services, county and district council provider services, mental health services and the voluntary sector, for example.

Governance arrangements for the hub are represented diagrammatically below;

```
                    Health and Wellbeing
                          Board
                             |
                    Integrated Commissioning
                          Board
                             |
NYCC Internal Governance ← Transformation Locailty → SRCCG Internal
                          Board                        Governance
                             |
                    Joint Delivery Group
                             |
                    Care Hub (operational ── Quarterly Stakeholder
                          Meeting)              Steering Group
```

HEALTH OUTCOMES

WELFARE OUTCOMES

| Voluntary and Care Sector | Primary Care | Proactive Care | Community Health and Care | Hospitals and Care Homes |

Single Point of Access

Clinical and Care Responsibility

IT and Data Sharing

Communications, Consultation and Engagement

Organisational Development

AFFORDABILITY AND VALUE FOR MONEY

The accountable lead provider is held to account against defined objectives and metrics and a defined plan for the agreed budget, however, there is flexibility for provider innovation and adaptation to ensure the model is as effective as possible in delivering the aims and objectives sought.

Acute and social care utilisation and metrics will be reported monthly.

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

In relation to selection and design of the scheme, health and social care data was gained for the practice population including activity and spend in acute and social care, with more specific understanding and breakdown of areas of opportunity based on population spend and activity broken down by demographic, gender, age, place of residence, disease area, condition-specific activity and other areas. This helped to identify patient cohorts and patient characteristics representing a higher proportion of activity and spend in the health system and work since has helped to repeat the process across social care. Additionally, retrospective data on activity and growth has been modelled in addition to

formal data modelling supported provided to the CCG and local authority to understand potential impacts further.

Audits are being undertaken by partner primary care clinicians to understand local needs and potential demand for services.

Joint strategic needs assessments and public health data has also been available to help prioritise the wider strategy for models and plans, in addition to prior public communications and engagement exercises, and a number of provider market engagement events relating to community services and admission alternatives.

The care hub model also utilises evidence from elsewhere, whilst recognising the need for effective local adaptation, delivery and implementation, the latter being particularly important. The model builds on good experience locally and draws on evidence from national and international exemplars, for example, Birmingham 'Healthy Villages', Sandwell 'iCare team', Sheffield and South Warwickshire's work on 'discharge to assess', South Lanarkshire 'integrated community support teams' and East Riding 'care home inreach'.

It is recognised, for example through the evaluation of community and integration models through the Nuffield Trust (2013) that models such as those proposed require time and scale, where supply-induced demand can often limit impact on reducing emergency admissions. It can equally be difficult to prove a negative of avoidable admissions. Where cashable savings are required, commissioners often have to use effectiveness of new models to decommission services not providing value for money which is a dependency to demonstrate cost reduction. However, the model adopted intends to create alternatives to admission and evidence-based delivery, such as risk profiling to target care appropriately to support reducing admissions.

References and an evidence-base being used to inform the model and above statements are highlighted below.

References

- Cochrane Effective Practice and Organisation of Care Group (2014). http://epoc.cochrane.org/ (Community service reviews)
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- King's Fund, The (2010). Avoiding hospital admissions; What does the research evidence say? London. The King's Fund.
- King's Fund, The (2012). Pick 'n' mix: an introduction to choosing and using indicators. London. The King's Fund.
- King's Fund, The (2013). South Devon and Torbay. Proactive case management using the community virtual ward and the Devon Predictive Model. London. The King's Fund.

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- Nuffield Trust, The (2012). The anatomy of health spending. London. The Nuffield Trust.
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- University of York (2012). http://www.crd.york.ac.uk/crdweb/ShowRecord.asp?ID=12011006375#.U8kq4rnjjl U

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

14/15 £840,000   15/16 £1,000,000

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

- Enhance quality of care for patients
- Reduction in delays to assessing patients to ensure appropriate pathways of care
- Ensuring high risk patients have an appropriate care plan in place to allow better management of their condition within the Community
- Service model that meets the needs of the population
- GPs and other health and social care services referring into this service
- Working more effectively across services boundaries

Further work is required to develop a model to identify agreed savings. It is anticipated that these would be delivered from acute non elective admissions and efficiencies within other areas of health and social care service delivery.

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?

Outcomes of the scheme are measured and/or to be measured through the following methods;

- Working with commissioners and local public health to agree measures (and data sources) to demonstrate impact against strategic outcomes
- Developing suite of process and more easily accessible outcome measures to allow real time monitoring of individual workstream developments
- Project group meetings involving local stakeholders, including GP leads, to agree models of care and monitor implementation of agreed plans
- Provider based monthly steering group reviewing key measures and timescales
- Provision of measures through commissioner delivery groups to allow wider scrutiny of impact

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

A range of broad and recognised factors consistent with any programme delivery are recognised, such as addressing barriers to change and ensuring a clear structure and approach for implementation.

Specifically related to the defined scheme and in examining the publications previously referenced key success factors relate to;

- Ongoing provider engagement in delivery
- Wide engagement with a range of stakeholders, including service users and carers
- Allowing time (for model development and scale amongst other areas), in parallel with the evidence around integration schemes specifically, for schemes to realise material reductions in admissions and other stated outcomes
- Monitoring and adapting scheme delivery though real-time and scheme-sensitive metrics (recognising external influences such as population growth, demographic changes and other influences on change)
- Utilising decision-making processes to, for example, decommission services in line with increased scheme delivery (to reduce supply-led demand and realise material cost reductions and transfer of care delivery)
- To ensure sustainability of the scheme through ongoing adaptation and learning

Scheme ref no.
AWC_001_CIR
Scheme name
Extended Intermediate Care Schemes: Assistive Technologies

What is the strategic objective of this scheme?

The strategic objectives of this scheme are to:
- support delivery of the North Yorkshire vision through providing a robust and sustainable integrated intermediate care service to the residents of the Craven locality of North Yorkshire.
- expand and test effective use of new technology in community environments
- support admission avoidance through timely access to medical advice and expertise
- support people to stay at home

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?

Assistive technology has been in use in AWC for seven years although not at scale. Use has been positively evaluated (see evidence base section).

This scheme will expand use of telemedicine assistive technology to 12 further care homes and in the homes of people who are at end of life, have heart failure or COPD within the Craven locality of North Yorkshire. This scheme is made up of 4 elements

- Telemedicine in Care homes
- Telemedicine to support End of Life care
- Telemedicine to support management of heart failure
- Tele medicine to support management of COPD

ANHSFT has been providing telemedicine (secure video consultation) for over 7 years. The Telehealth Hub now supports over 2000 patients 24/7 via Telemedicine and regularly receives more than 100 Telemedicine calls per month. A contemporaneous patient record is maintained at all times and where SystemOne is available a shared primary-secondary care electronic patient record is used. The team from the Telehealth Hub communicate a consistent message advising Telemedicine for anything other than an emergency when 999 should be used

Outcomes of telemedicine 'consultations' include: reassurance, advice, signposting or referral to other services. The findings of a 12 month independent evaluation were that for residents in care homes linked to the Telehealth Hub:
- Hospital admissions dropped by 45%

- Length of stay in hospital dropped by 30%
- Total use of bed days dropped by 60%
- A&E attendances dropped by 69%

Over the same period the results from 26 COPD patients at home with access to the Telehealth Hub were as follows:

- Hospital admissions dropped by 45%
- Length of stay in hospital dropped by 9%
- Total use of bed days dropped by 50%
- A&E attendances dropped by 60%

The evidence review section provides further detail regarding how these outcomes compared with a control group.

Please refer to the service specification for scheme detail

Specification assisted
technologies service_

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

Commissioners:
Airedale, Wharfedale and Craven CCG and North Yorkshire County Council.

Provider Delivery chain:
ANHSFT: Technical infrastructure, equipment, and the telemedicine 'hub'
ANHSFT: Clinical expertise accessed remotely via the telemedicine hub to care homes via nursing staff and consultant where necessary - determined by patient need
ANHSFT: Clinical expertise – specialist heart failure nurse, respiratory nurse, palliative care team.

Local Authority and Independent Care Homes. Direct approaches made via ANHSFT tele medicine team. Equipment, training and support provided free of charge.
Suitable patients identified through review of admissions. Offered use of telemedicine in their own homes by the telemedicine team, supported by the consultant responsible for their care, training and support provided by the telemedicine team.

The telemedicine service will liaise with a refer to, where necessary, social care, community services, specialist clinicians in acute care, GP practices and the voluntary sector.

Project Plan:
Implementation of assistive technologies is business as usual for ANHSFT.
Activity data is reported to the CCG performance lead and to the Quality and Performance Group (QPG)and through this the CMB.
Qualitative and patient experience reports are also reported to the CCG and QPG
Independent evaluation has been undertaken and is to be repeated

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

Key Milestones
2014/15 Q3 partly operational. Kit being installed & staff being trained
2014/15 Q4 fully operational

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

Assistive Technology
Use of new technology such as telemedicine is key to transformational change and new models of care including supporting self-care. Use of this type of technology is relatively new. An independent evaluation undertaken by the University of York - York Health Economic Consortium in 2013 (please see section 1 c for further detail) demonstrates a significant impact when used in care homes and peoples own homes. When compared with a control group there was a:

- 27% reduction in NE IP care for care home residents
- 7% reduction in NE IP care for people in their own homes
- 7% reduced use of emergency services for care home residents
- 2% reduced use of emergency services for people in their own homes

Telemedicine - Final
Report 13-03-12.pdf

This gave confidence in approach and NE admission reduction target. Use of telemedicine continues to be supported; the independent evaluation is being repeated with a higher number of individuals now using telemedicine. Results are expected during Q3

British Society Geriatrician Commissioning Guidance
http://www.bgs.org.uk/campaigns/2013commissioning/Commissioning_2013.pdf

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

2014/15 £276k 2015/16 £226k

2014/15

Care Homes: To install and utilise Telemedicine in the 11 remaining Care Homes within Craven @ £2400 per care home £26,400

Estimated cost of approx. 100/110 calls from each home @ £78 a call = £93,600

Total estimated cost of calls £120k

LTC & EoL telemedicine at home

During last financial year approx 80 COPD and 50 Heart Failure patients were admitted

in secondary care, where telemedicine may have been more suitable. Telemedicine will be offered to these individuals

There is an assumption that there will be a 50% uptake with a £200.00 charge per patient per month hence estimated cost implication is £156000

There is an expectation that End of Life patients will be funded via any slippage on COPD and Heart Failure patient's uptake.

2014/15
Install cost £26,400
Estimated cost of care home calls £93,600
Estimated cost of LTC & EoL calls £156,000
Total estimated cost in 2014/15 £276k

2015/16
Calls from care home expected to reduce as a result of increased confidence and that some homes may not be able to implement or adopt due to technical broadband issues. (Not known until technical survey undertaken) Estimated cost in 2015/16 £70,000
Estimated cost of LTC/EoL calls £156,000

Total estimated cost in 2015/16 £226k

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

Anticipated outcomes from this scheme are that:

- people are supported and empowered to stay at home with access to appropriate care, support and advice
- reduced A&E attendances
- reduced admissions to acute care and long term placements
- people at the end of life will be supported to die in the place of their choice
- Cost efficiencies through reduced utilisation of services such as NHS111, 999 calls, ambulance conveyance, acute admissions.
- Improved quality of care through timely access to expert advice, increased confidence and support to self care
- Increased support and confidence for carers
- Improved patient and carer experience
- Signposting to other complementary services including VCS
- Improved health and wellbeing
- Increased number of care plans developed and implemented
- Increased confidence for care home staff to manage people within their own home environment (residential 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?

A multi stakeholder group has been established to oversee implementation and monitoring of all the AWC BCF schemes. This includes members of the CCG and NYCC as commissioners. In particular input from the performance lead to whom key metrics will be reported. There are established contractual forums through which to escalate and issues, concerns and benefits such as QPG, SDG & CMB

Key metrics include:

- number of care homes utilising the service
- Number of contacts to the telemedicine hub
- Outcomes of contacts
- Numbers of people supported in their own home or residential home
- assessment against baseline position for resource utilisation (e.g. number of admissions, number of primary care visits
- experiential feedback from professionals and individuals
- the impact on the local health and social care systems will be monitored via the TIG dashboard

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

Key success factors for this scheme are as follows:

- Increased adoption and use of assistive technologies enabling more robust evaluation with a greater cohort of users
- Engagement of are homes from local authority and independent sector
- engagement of patient cohorts and care home residents
- Increased knowledge and skills of care home staff
- Increased confidence of care home staff to manage people in their home
- Increased confidence of patients and carers to self-care with support
- shared learning and peer support especially across care homes
- close working relationships with telehealth hub
- co-ordination and ownership of the scheme

Scheme ref no.
HaRD_003_CIR

Scheme name:
Intermediate Care & Clinical Assessment Team (CAT)

What is the strategic objective of this scheme?

Harrogate and Rural District (HaRD) and Harrogate District Foundation Trust (HDFT) jointly commissioned a comprehensive review of the existing community services in HaRD during 2014. Several of the schemes outlined below are designed to make immediate improvements to existing services to address weaknesses in the current system. The goal of these schemes is to improve the community team's responsiveness, connect the community team to the acute hospital's services more clearly, expand intermediate tier beds, and improve communication systems. All of these are designed to avoid emergency admissions where possible and move patients back home from hospital as soon as possible.

In addition to enhancing and improving existing service, the Harrogate and Rural District CCG, aims to commission a comprehensive redesign of local community services and decide how best to commission community-based community care in the future. The goal will be to improve patient care, wellbeing and independence while reducing reliance on hospital-based care. Commissioners also intend that establishing and supporting patient-owned goals that promote self-care or self-management will be at the centre of our design efforts.   Engaging key service providers and other stakeholders in this process is essential as well as engagement with the community of service users. Partners in this process include HDFT, North Yorkshire County Council, GPs, and the voluntary sector. HaRD also aim to make community services easily accessible and seamless to patients, carers, GPs, and other clinicians. It is believed that making the delivery system simpler and easier to navigate will also increase the job satisfaction of community team staff members. Establishing the governance arrangements to ensure that services delivered by various providers are truly coordinated and working jointly is a key success factor.

Overview of the scheme

Improving and Enhancing Existing Services
In July 2014 the report on the evidence gathered, engagement events, and data analysis was delivered. The report highlighted several areas for immediate improvement: FAST response teams were under-resourced particularly after-hours, District Nurses were under-resourced, various services such as specialist nursing were working in parallel rather than in an integrated, patient-centred manner, communication between acute, primary and community nursing needed improvement, and HDFT's community services programmes were not receiving the management time and attention to take full advantage of the opportunities for vertically integrated care with the acute hospital. HDFT has since taken steps to address these challenges, and the Better Care Fund provides an opportunity for investment to bring about needed change. The investment in the FAST Response Team, Comprehensive Assessment in A & E, Intermediate Tier Beds, Crisis Hub, Enhanced Hospital Discharge, and Community Loan Equipment are all

designed to address weaknesses identified in the Community Services Review. The Community Stroke Team and Overnight Sitting Service are two BCF programme investments identified prior to the Community Services Review report. All of these programmes are intended to address the needs of the vulnerable and/or elderly population with long term conditions, general frailty, and other complex health needs. The key components of these enhanced services are:

- Improved primary and community care providing the right care in the right place, at the right time, first time by staff with the competencies and skills to meet the needs of patients/clients and which complement and works together with acute care services. (See Integrated FAST Response, Comprehensive Assessment in A & E, Intermediate Tier Beds, Crisis Hub. Community Load Equipment, Community Stroke Team.)
- Integrated high-quality assessment and provision of 7 day services at times required to meet the needs of the community (See Overnight Sitting and CAT)
- Avoiding unnecessary hospital admissions, and keeping patients safe, independent, and well at home where possible. (All of the schemes.)
- Minimising the length of time patients are in the acute hospital, effectively supporting patients leaving hospital. (See Enhanced Hospital Discharge)

<u>Vision for Future Community Services in HaRD</u>
HaRD has developed a preliminary vision for the services providing out of hospital care and are working with partners to refine and embed a 'future-state' within which primary, community and social care services will be brought together and provided under one Integrated Care model using staff and resource flexibly which could be provided at a variety of levels. Key components of the vision are:

- Connect community services teams to GP practices in a way that creates a seamless, integrated experience for patients as well as health and social care providers.
- Create a single assessment system that reduces duplication and delays in delivering services to patients.
- Design services around the patient's needs rather than around funding and organisational terms such as Reablement, FAST, Continuing Care, Palliative Care, etc.
- A system that has "no wrong door" such that no matter how or who a patient contacts in the system, their questions or concerns are accepted as everyone's responsibility.
- Each patient has a key worker assigned to them, who could be from the GP practice, District Nursing, specialist nursing, social care, therapy, etc. depending on their primary need.
- Create a flexible workforce with front line workers trained to address a wide range of basic health and social care issues, reducing the need for referrals and delays.

HaRD CCG and HDFT expect to agree on the composition of a redesign workgroup and terms of reference for this group in October, with meetings commencing in November 2014.

Timescales and Milestones
- Additional investment in FAST Team to support quicker response, comprehensive assessment in A & E, and discharge support, and SPA "hub" – need was identified in July 2014. Investment to commence in October 2014 with new staff phased in from October through March 2015.
- Overnight Sitting Service to commence in October 2014
- Community Stroke Team expanded in August 2014
- Intermediate Tier Bed improvements – November 2014
- Community Loan Equipment enhancements – September 2014
- CAT expansion to 7 days per week – October 2014
- Community Services Redesign Group Terms of Reference agreed –Oct 2014
- Community Services Redesign Group begins – November 2014

The delivery chain

Harrogate District Foundation Trust (HDFT) is commissioned to deliver acute and community services in HaRD CCG area and will be responsible for delivering all of the enhancements to current services outlined below. All of these enhancements are considered a part of theIntermediate Care Team (ICT) at HDFT and the lead for overseeing these enhancements is the Operational Director reporting to the Chief Operating Officer.

The CCG will be partnering with HDFT, NYCC, our GPs, and the voluntary sector in redesigning community services. The CCG and HDFT are currently working on the Terms of Reference for a Programme board assigned to design and develop a new community services model of care. These Terms of Reference will clarify the governance of this project to ensure effective working across organisational boundaries.

The Intermediate Care Team services at HDFT are responsible for delivering the following enhancements to services enabling HaRD to acheive its Better Care Fund goals and objectives.
The enhancements are as follows:

Expanded Integrated FAST Response Teams

HDFT will provide an integrated FAST Response team with access to specialist services – a multi-disciplinary, rapid response to an acute or frailty crisis that is deployed appropriately following triage through the proposed crisis (single point of contact) hub can result in reduced admission rates. Our response will be a blend of nursing, therapy and social care with access to specialist nurse advice. These teams are effective in reducing admissions by responding to acute crisis in patients' homes. Evidence supports reduced admissions of at least 10 per week based on a population size of 500,000. Furthermore, recovery at home improves a patient's functioning ability and reduces the need care packages and bedded social care which has benefits for the Local Authority.

Our Community Services Review highlighted that the FAST Response team was indeed effective and highly regarded by GPs and patients but was under-resourced to meet demand. The HaRD CCG is therefore investing in an expansion of this team to ensure a quick response 24/7.

Comprehensive Assessment Service in A&E

HaRD is also expanding the FAST Response Team to provide a prompt and Comprehensive Assessment in A&E for frail elderly and other patients with complex needs. The FAST team will assess and where appropriate put in place any supports these patients need in order to go home safely.

The evidence shows that by improving the assessment in a crisis leads to improved outcomes including reducing the need for a hospital admission and the provision of residential care.

An additional 'door to bed' transport home service will be available following assessment if required or following hospital admission.

Enhanced and Effective Hospital Discharge

The enhancement of services will be achieved primarily through increasing the discharge planning resources on the wards and in the community-based FAST Response Team This will lead to improved and effective hospital discharge via the promotion of community 'pull' arrangementsi.e. Based on requests received via the "hub" element of the FAST team who will then go into the hospital and liaise with acute colleagues to help fast track ier supported discharge arrangements. Admissions will also be tracked with proactive inreach regularly provided into hospital by the FAST team to check on a patient's progress and help plan and facilitate earlier discharge.

'Push' hospital based discharge scheme – in addition to the above community based approach the hospital will identify patients each day from wards areas that require discharge (on the basis that they are clinically fit to be discharged) to enable discharge within 24 hours. This will be further enabled and informed via discharge planning arrangements commencing upon the day of admission for a patient and supporting services provided by the FAST team and other facilities such as intermediate care step down care beds. The current bed provision will need to be reviewed to enable this.(see below)

HDFT will also be working closely with North Yorkshire County Council to implement a "trusted, single" assessment initiative to expedite discharge for eligible patients requiring social care assistance.

Additional pharmacist support within the ICT model will support discharge planning and reassessment of medicine requirements and concordance following hospital discharge or within the FAST response service

Overnight Sitting Service

This new service funded through BCF is an overnight sitting service offered to patients ready to go home from A & E, or assessed by the FAST Team where they are not safe to go home or stay at home without short- term overnight support. The FAST team will have carers to accompany patients home from A & E or stay overnight at a patients home to provide short term support to an older person in crisis. A & E and FAST teams believe that this service may avoid up to 8hospital admissions per week based on current experience.

Intermediate Care Beds

Intermediate Care Beds –HaRD CCG and the LAs currently have access to a limited number of Intermediate care team bed facilities. In HaRD there are 16 beds and these largely provide step down care and two key functions
- rehabilitation and reablement following recovery from an acute illness; and
- enable earlier discharge before patients make a full recovery.

HDFT's FAST Team believes the existing beds can be better utilised, and provide better transition for patients to home. The FAST teams additional resource willimprove access to appropriate , nursing, therapy and social care staff to facilitate both admission avoidance and supported discharge arrangements however additional bed based resource is required for patients who be managed at home

The use of the existing 16 beds will be closely monitored with an aim to ensuring these beds are used effectively with a thoughtful and holistic care plan to ensure patient's independence is increased (not decreased) while occupying these intermediate tier beds. The goal will be to ensure patients are ready to go back to their own homes and that their needs are reassessed regularly to determine any appropriate follow on care and all patients receive care in the intermediate care bed based provision for a maximum of 6 weeks

Intermediate care beds provide very important facilities and can be used flexibly to meet the holistic needs of the patient. It has been assumed that there needs to be an increase in the number of beds required to be available especially to facilitate effective step up care within the FAST service. However on the basis the proposed service model will increasingly provide such care in people's own homes the proposed increase in the current service model will support the proposed transition arrangements moving from the "as is" state to the new future model.

'Crisis Hub' - Single Point of Access

The intermediate tier services will be supported by the Single Point of Access (SPA) which will provide the following functions to help prevent admissions and facilitate hospital discharge arrangements:

- The SPA will rapidly coordinate an appropriate response from the intermediate tier services following a call from an initial assessor of the crisis (i.e. GP, ambulance, A&E etc). Using real time information on service capacity, the hub will actively manage supply and demand across the system, controlling admissions to hospital where necessary or community hospitals/intermediate care facilities;
- It will also help the FAST team to ensure that appropriate patients who are fit to be discharged are moved out of hospital;
- It will liaise with the Team Co-ordinator member of the FAST team who will then ensure that the patient receives the treatment they need and that the health and social care professionals are aware of all the treatment the patient has had; and wherever possible making an admission an exception rather than the norm.

Community Loan equipment

Demands on equipment loan services are growing as the policies and strategies that drive a shift in patient care from acute settings to care closer to home are implemented

Enhancements have been made already to the model of community equipment provision which will effectively meet the response required by an individual to live as independently as possible, in their chosen home. However by managing risk through the provision of Equipment and aids to daily living additional investment is required which will increase the number of people who are enabled to remain living in their chosen home through increased access and availability of community loan equipment.

Community Stroke service

The Community Stroke Service will improve stroke care locally and its purpose is to enable earlier discharge of stroke patients to their home (or place of residence) by providing specialist intensive rehabilitation and social support in the community comparable to that of an in-patient stroke unit. The Community Stroke Service has been a successful program and BCF is enabling additional investment in this team to meet patient demand.

Clinical Assessment Team (CAT)

CAT is a Consultant led team located within HDFT and available to GPs when patients are acutely ill and need further investigation and/or tests to avoid A & E or hospital admission. The service is considered a valuable resource to GPs and patients in the community, and therefore, the CCG has agreed to expand the hours of service through BCF. This service is currently available Monday – Friday, 9 to 5 and now be available from 8 a.m. to 8 p.m. Monday through Friday, and available 3 hours per day on weekends.

Ambulatory care admissions to hospital, which are potentially avoidable, make up one in every five emergency admissions and five conditions account for half of all ambulatory care admissions. Three of these disproportionately affect older people (urinary tract infection/ pyelonephritis, pneumonia and chronic obstructive pulmonary disease (COPD)).

This proposal highlights that by placing additional resource into the Clinical Assessment Team to enable the CAT resource to be available longer hours during the week and, significantly, additional hours at weekends more patients are likely to avoid a hospital admission and have speedier access to diagnostics and appropriate medical assessment.

The evidence is overwhelming that having access to acute physicians and swift access to pathology and radiology to identify root causes of conditions and providing appropriate advice and support, along with swift access into out-patient appointments with relevant speciality teams makes a difference to admissions through the week. We therefore would want to enhance this through to weekend access and providing access to support by FAST response team who can assess a patient in their own home and provide immediate short term rehabilitation or

nursing support where required

By supporting patients in this way by speedy access to the right diagnosis and developing a management plan that patients can follow without being admitted to a hospital bed, patients are more likely to maintain their confidence and independence and therefore any additional support that may be required for nursing or social reasons are likely to be more time limited.

The evidence base

The case for better integration is compelling, particularly for the frail and elderly population, as there is both a cost benefit and growing evidence base that outcomes for managing crisis at home are better than admission to hospital and that home based services are both safe and effective where they combine health and social care (The Kings Fund, Older People and Emergency Bed Use, August 2012).

After a thorough review and analysis of current community services in a report delivered in July 2014, the CCG is working in collaboration with Harrogate and District NHS Foundation Trust (HDFT), North Yorkshire County Council, the voluntary sector and the community to redesign community services to improve efficiency, coordination of care, effective integration of services, as well as patient and staff satisfaction. The Better Care Fund (BCF) will support some of the required enhancements in our community service model.

As part of this review there was considerable stakeholder engagement to help develop the proposals the local integrated care service model. The engagement has involved members of the public, primary, community, secondary, social care and voluntary sector colleagues.

An initial statement of our vision for future community services was drafted by our Governing Body, and shared with the community at our AGM on 9th September. All elements of this vision are consistent with BCF goals for integrated care.

We have analysed our adult population using an approach called predictive risk. This has allowed us to identify those patients whose underlying health make them most likely to require a hospital admission if they are not correctly managed. These individuals are more likely to be living with one or more long term condition. By identifying these individuals we are able to plan a range of primary and community treatment and proactive support options which help them to better manage their conditions and prevent unnecessary hospital interventions.

While seeking to redesign our community services programme in HaRD, our Primary Care Practitioners are implementing a care planning initiative aimed at the 4% of patients most at risk of hospital admission. They are using the RCGP's two visit model for developing patient owned care plans and are already well underway delivering care plans to the 2% most at risk patients and expect this to be complete by end of September.

The CCG and its acute and community provider HDFT have recently submitted data to the National Intermediate Care and Community Services Benchmarking audits. The data analysis and final audit reports will enable further refinements to the model of community provision alongside national and international evidence of best practice and national policy direction.

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In addition a capacity/demand analysis in the form of a bed utilisation audit in the acute trust and community hospital will inform and refine the intermediate care bed base or home based step up/step provision requirements and a plan to procure these additional intermediate care beds or enhanced services based on the resulting recommendations will be completed in 2014/15.

Investment requirements

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

2014/15 £1,895,000   15/16 £1,895,000

Investment in the community FAST Response Team:	£ 320,000
Investment in the community stroke team:	£ 250,000
Additional discharge planning resources (incl pt transport and pharmacy support and MDT):	£ 275,000
Overnight sitting service:	£ 150,000
Community equipment improvements:	£ 150,000
Intermediate Care Bed improvements with add'l therapy	£ 400,000
CAT investment	£ 350,000

Impact of scheme

HDFT and HaRD CCG expect this investment in HDFT services to result in significant improvement in reducing emergency admissions, as well as improved patient care. HaRD CCG and HDFT expect this scheme to have a positive impact on the following indicators:

# of non-elective admissions
# of non-elective admissions for over 65s
# of delayed transfers of care
Average length of stay
Average length of stay for over 65s
# of excess bed days

However, since all of our BCF schemes are aimed at reducing reliance on A & E and hospital admission (as well as improving patient care), it is difficult to assess the financial impact of an individual scheme. The overall impact of our BCF schemes has been estimated and documented in the appropriate Annex 2 of this document.

Feedback loop

The CCG will be collecting patient reported experience and outcome measures (PREMs and PROMs) data to ensure the services commissioned are meeting the needs of the patients.

Personalised care planning will be used to ensure that a patient's goals are clearly agreed in partnership with the clinician and therefore address the patient's holistic needs effectively.

Monitor is developing a series of outcome measures that can be used by community services to evaluate the effectiveness of their service provision and clinical care packages. HDFT are actively involved in piloting this work and will be using these measures to provide feedback to the CCG on the effectiveness of their commissioned services

The CCG will be tracking the following indicators in collaboration with HDFT to monitor the success of these initiatives:

# of non-elective admissions
# of non-elective admissions for over 65s
# of delayed transfers of care
Average length of stay
Average length of stay for over 65s
# of excess bed days

The activity of CAT team will also be tracked on a monthly basis to understand the number and type of patients seen during normal business hours as well as during expanded hours.

In addition to the measures listed above, HaRD CCG and HDFT are working on identifying measures of patient self-efficacy or confidence in their own care to monitor progress on this multi-faceted approach to improving intermediate care at HDFT and in the community.

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

Key success factors for the improvements to existing services managed by HDFT are clear lines of accountability within HDFT for delivery of each scheme, agreed upon measures of performance, and regular reporting on progress. HaRD CCG and HDFT believe we have all these elements in place to ensure these projects move forward successfully. HDFT has a strong track record of delivery on projects and new schemes. HaRD meets regularly with HDFT to monitor progress and ensure investments are achieving the desired outcomes.

The Community Services Review report was researched and written by HaRD CCG and HDFT jointly, with the project leads from both organisations working together closely through the process. The conclusions and recommendations were endorsed by both senior management teams and the Governing Body and Trust Board. This first phase of re-evaluating our community services provision demonstrates that HaRD CCG and HDFT can and do work together successfully to improve patient care. The next phase of this project is to redesign these services to better meet the community's needs. Key success factors are active engagement by key stakeholders, openness to new models and new ways of thinking, and agreement on the larger vision for these services. Based on meetings of our System Resilience Group and numerous meetings with NYCC regarding Integrated Care initiatives, it is clear that we have senior leadership commitment to our goals and principles. The next steps are to create a Programme Board project workgroup with a clear governance structure with the appropriate participants. The leadership of the CCG, HDFT and NYCC are working the Terms of Reference and composition of the group now. We expect to have this group underway in November.

Scheme ref no.
AWC_003_CIR

Scheme name
Extended Intermediate Care Schemes - Specialist Community Nursing Service

What is the strategic objective of this scheme?

The strategic objectives of this scheme are to:
- Support delivery of the North Yorkshire vision through providing a robust and sustainable integrated intermediate care service to the residents of the Craven locality of North Yorkshire.
- Provide holistic quality specialist nursing care for a caseload of complex chronic patients within their own place of residence or within care homes
- Increase timely access to and completion of rehabilitation programmes for Craven patients
- Reduce the number of patients in Craven being admitted to acute care for cardiac, stroke and respiratory related conditions
- Improve signposting and onward referral to other health and social care services
- To provide holistic quality specialist nursing care for a caseload of complex chronic patients within their own place of residence or within care homes
- To provide onward referral to appropriate services to fast track support as required
- To ensure care delivery meets all necessary standards including National Service Frameworks, NICE and Care Quality Commission Standards
- To provide a range of specialist nursing care for chronic patients from prompt diagnosis and treatment to palliative and supportive care to meet the patient's needs ensuring a personalised tailored approach to care.
- To support people to stay at home avoiding unnecessary A&E attendances and hospital admissions
- To reduce the length of hospital stay and facilitate early supported discharge for those patients with chronic complex needs
- To support GP practices and primary care services in the management of patients with chronic complex need reducing the necessity and volume of GP home visits.
- To improve ability to self- manage long term conditions

Specific objectives for each specialist service can be found within the embedded service specification

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?

This scheme is to commission a specialist community nursing service to the residents of the Craven locality of North Yorkshire. These services include:

- Community Cardiac rehabilitation service

- Community Heart failure specialist nursing service
- Community Respiratory specialist nursing service

The services will integrate into the intermediate tier level of care and will be an integral part of the integrated teams.

The services are delivered by a range of specialist nurses, providing seamless care across secondary and primary care. Services are delivered through Multi-Disciplinary Teams (MDT) to create a comprehensive approach to long term management, providing local clinical expertise

Patient cohort
Patients diagnosed with CVD and / or COPD. Please refer to the specification for referral criteria

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

Commissioners AWC CCG & NYCC

Provider ANHSFT

Interdependence with Other Services/Providers
Key relationships:
• GPs – provides continuity of care
• Physiotherapists - direct referral for support as required
• Occupational Therapy - direct referral for support as required
• Practice Nurses – advice and support
• District Nurses – joint visits, support and advice
• Community Matrons – joint visits, support and advice
• Intermediate Care Team – patients with multiple complex needs
• Secondary Care – provides specialist advice
• Social Services – direct referrals for social support
• Community Mental Health Team - direct referrals and support
• Palliative Care Services – direct referrals and support
• CCCT – admission avoidance
• Psychology – direct referrals and support
• Dietician – dietetic advice and support
• Pulmonary Rehabilitation

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

Yorkshire Public Health Observatory, Commissioning for Value & Right Care Packs 2012 for Airedale, Wharfedale and Craven CCG indicates that the CCG has higher prevalence/worse outcomes for Chronic Heart Disease, Atrial Fibrillation and Heart Failure.

Unplanned hospitalisation for chronic ambulatory sensitive conditions (adults) is significantly worse than the national average.

It is suggested that patient outcomes are suboptimal due to variation in the percentage of AMI, CABG and PCI patients that receive cardiac rehabilitation. NICE recognise that as little as 44% of patients receive Cardiac Rehabilitation, which is below what might be reasonably expected of 65%. It is estimated that the vast majority (96%) of heart failure patients do not receive Cardiac Rehabilitation.

Optimal expected outcomes from rehabilitation is expected to demonstrate reductions in mortality and CVD events as a result of better control of the risk factors.

In 2013 AWC (QoF) COPD have an overall prevalence of 2% which is higher than the national prevalence of 1.8%. The expected prevalence of COPD in AWC is expected to rise to 4.5% by 2020

. The evidence base for the impact of intermediate care is well known and can be found at:

- Social Care Institute for Excellence (2013). Maximising the potential of reablement. London SCIE
- NHS Benchmarking Network, British Geriatrics Society, Association of Directors of Adult Social Services, College of Occupational Therapists, Royal College of Speech and Language Therapists, NHS England (2013)

We recognise that the evidence is mixed in terms of reducing system costs, however our approach is to provide proactive care that pre-empts ill-health and then to ensure that people are supported to regain and maintain their optimum levels of health, wellbeing and independence. Ultimately this will reduce unnecessary dependence and demand on health and care services.

> *'Transforming services require a fundamental shift towards care that is co-ordinated around the full range of an individual's needs (rather than based around single diseases) and care that truly prioritises prevention and support doe maintaining independence. Achieving this will require much more integrated working to ensure that the right mix of services are available in the right place at the right time' (Oliver et al 2014)*

We also commissioned the CSU to undertaken a national and international evidence review of integrated care models and used the outcome of this to influence development of new models of care, transformational change and inform the NE admission reduction target. The full report is included in the related document section. This review provided assurance and gave confidence that the initiatives planned or underway will realise intended benefits.

BA Integrated Care
Models.pdf

Specific models where there was evidence of outcomes delivered are:

- Kaiser Permanente, California, USA
- The Alzira Model – Valencia, Spain.
- MassGeneral Care Management Programme, Massachusetts, USA
- Virtual ward models including Greenwich (over 2000 admissions avoided & no delayed transfers of care) North West London (Curry and others, 2013)
- Marie Curie end of life nursing: significantly more home deaths and less emergency admissions than control group (Chitnis and others, 2012;2013)

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

14/15 £200,000   15/16 £200,000

- 1 WTE Band 7 heart failure nurse specialist
- 1 WTE Band 7 respiratory practitioner
- 1 WTE Band 6 cardiac rehabilitation practitioner

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

- Increase number of Craven patients accessing and completing rehabilitation programmes
- Less Craven people being admitted to acute care for cardiac, stroke and respiratory related conditions
- Reduce risk of heart attack and stroke
- Improved prescribing and medicines management and compliance
- Improved access to specialist nursing services in communities within Craven
- Improved signposting and onward referral to other health and social care services

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?

A multi stakeholder group has been established to oversee implementation and monitoring of all the AWC BCF schemes. This includes members of the CCG and NYCC as commissioners. In particular input from the performance lead to whom key metrics will be reported. There are established contractual forums through which to escalate and issues, concerns and benefits such as QPG, SDG & CMB

- For the identified cohort
- Number rehabilitation programmes delivered in a community setting within Craven
- Number patients undertaking rehabilitation programmes
- Number patients completing rehabilitation programmes
- Level of risk reduction (risk stratification)
- Number patients seen in community setting (HF & respiratory)
- Number care plans implemented
- Number medication reviews undertaken
- Prescribing savings made

Applicable Quality Requirements
Cardiac Rehabilitation
% of patients who DNA exercise sessions
% of patients assessed within two weeks
% of patients offered an exercise programme within 11 weeks of referral
Heart Failure
% of patients with a personalised care plan

% of patients who receive an appointment in a clinic or are seen at home where appropriate no later than 11 weeks from referral
% of referrals seen within 2 weeks
Participation in all relevant national audits
Pulmonary Care
% of patients who have a personalised care plan
% of patients referred with an offer of a pulmonary rehab place
% of patients with improved knowledge and understanding of self-care tools
% of referrals seen within 2 weeks
% reduction in the number of respiratory related hospital admissions
Quarterly reporting will be required to the agreed data set to give assurance that the service is delivering against the service specification and to enable future service development. A baseline against the indicators will be established

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

Ensuring the provision of existing service provision within Airedale and Wharfedale is holistic, integrated, robust and fit for purpose to meet the needs of the Craven population. This will be measured including and monitoring KPI as part of the service specification and contract ensure additional staff recruited.

Appendices

Appendix one – Service specification

Specification
Specialist Community

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

Scheme ref no.
AWC_004_CIR

Scheme name
Extended Intermediate Care Schemes - Craven Collaborative Care Team Expansion

What is the strategic objective of this scheme?

The strategic objectives of this scheme are to:

- Support delivery of the North Yorkshire vision through providing a robust and sustainable integrated intermediate care service to the residents of the Craven locality of North Yorkshire
- Expand the current intermediate care service to meet needs in the community, avoid unnecessary admission to hospital and long term care and empower and enable individuals to stay in their own home environment
- Improve health, independence and peoples experience whilst also delivering better outcomes of care and safety
- Include mental health services as part of assessment of care delivery
- Undertake assessment and pro-active reablement
- To enable delivery of a 24/7 service and a move towards an increased level of 7 day working enabling and increased level of admission prevention
- To contribute to the delivery of the CCG strategic Five Year Forward View
- To contribute to reducing the overall financial challenge by reducing demand on acute care
- To support the delivery of the shared vision by providing a robust and sustainable integrated intermediate care service to the residents of Craven.
- Protect funding for intermediate care services across all contributing partners (ANHSFT, NYCC, BDCT and VCS)
- To secure a responsive needs driven service to provide rapid response to people in need and avoiding emergency admissions whenever safe and feasible
- Creating an enabling and self-care approach to improved health, wellbeing and independence and improving people's experience whilst also delivering better outcomes in terms of care and safety
- Ensure that people with mental health needs and in particular dementia have equal access to intermediate care services
- For agencies to work in partnership to provide a truly integrated service including trusted assessments and role blurring
- To enable delivery of a 24/7 service and a move towards an increased level of 7 day working enabling an increased level of admission prevention and earlier supported discharge
- To increase the availability of step-up care significantly to prevent avoidable admissions and support GPs to manage their urgent care demand. The default setting will be people's own homes but supported by specialist beds across the LA and NHS where this is not possible
- To increase the number of people receiving proactive joined up care through

development of new models of care. Including developing an approach to enhanced primary care building on the Proactive Care Enhanced Service, embedding the Lead Practitioner Role, new types of worker including generic workers, extensivist practitioner, and comprehensive community nursing services
- To develop the infrastructure in the community that has the capacity and capability to deliver an alternative offer to acute 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?

The integrated intermediate care service is made up of a number of initiatives that all work together to deliver the objectives above.

Craven Collaborative Care Team (CCCT) is key to this as it provides the 'virtual ward' type response and also in-reach services to patients in intermediate care community beds. The CCCT was established and developed during 2012/13, the BCF investment increases the capacity and capability through an enhanced skill mix to better meet the needs of the Craven population and support deliver of the BCF outcomes.

CCCT operate in a virtual ward-type approach and support delivery of:
- Access and assessment hub triaging all referrals and ensuring that the appropriate integrated care package is commenced
- Early supported discharge

CCCT is a Multi-disciplinary team providing home based care delivered by a range of health and care professional employed by a range of partner organisations but operating as an integrated team. This includes:
- Voluntary and community sector including a Home from Hospital scheme and carers' support
- Geriatricians
- Advanced nurse practitioners
- Social workers
- mental health workers
- therapists
- Enablement workers
- Home care enablement services

CCCT support patients in intermediate care beds. This service is appropriate when people cannot be supported at home safely with care being provided by the above team. IC beds are provided in a range of settings including NHS, Local Authority and independent sector beds, and working alongside care home staff to deliver an enabling service

1. OTs , ANPs, geriatricians and acute liaison psychiatric staff working in A&E to divert admissions and enable people to return home with or without support from the virtual ward or other community-based services

2. Seven day hospital-based social workers and senior home care staff to facilitate discharges

3. A non-weight bearing pathway providing short-term residential care to ensure that people immobilised by a cast maintain their function and are better able to engage in full rehab when they can weight bear

4. Palliative care nursing and enablement support to enable people to die in their place of choosing

5. REACT provide a Home from Hospital schemes providing practical support to people on discharge from hospital including food hampers with basic provisions to address any immediate needs which may otherwise have delayed discharge or left the person vulnerable.

6. Integrated community equipment services enabling people to have their nursing needs met at home and to enable people to be as independent as possible.

7. Supporting ambulatory care pathways e.g. home-base IV antibiotic therapies, DVT pathway, heart failure diuretics etc

8. NHS funding transfer to adult social care schemes contributing to the overarching intermediate care service

9. Assistive technology including telemedicine and telecare supporting people with long-term conditions and at the end of life

Cohort: All adults, including people with dementia and other mental health needs

The additional BCF investment enhances the team as flows:

Further enhancements with additional posts as outlined below which will increase capacity to support number of patients cared for in their own home via the Craven Collaborative Care Team. It is anticipated that this will be achieved by:
- using 'step up' intermediate care beds to support acute admission
- utilisation of ambulatory care pathways including intravenous antibiotic & Heart Failure diuretic pathways
- Facilitate earlier discharge from acute to 'step down' including increased ability for weekend discharges.

Additional posts include:
- 1 WTE Carer support worker – resourced directly from carers resource
- Increased mental health nurse input from 0.5 WTE to 1 WTE
- secondment opportunities from care trust for occupational therapists with mental health skills,
- increased SW & ANP input to support more complex patients
- 0.5 WTE salaried GP to test out a different model and enhance the current service. Increase capacity including home from hospital VS support OOH to

facilitate weekend discharges

The additional capacity will enable an increased level of admission prevention, weekend discharges and prevent admission to long term care.

It is anticipated that shift based provision will enable delivery of a 24/7 service and a move towards increased level of 7 day working. There is a particular focus for the ANP & GP role, as this increases the ability to prevent admissions and also facilitate earlier discharge and support urgent care system pressures. Their pivotal role also provides education and specialist advice opportunities in the management of patients with chronic complex long term conditions.
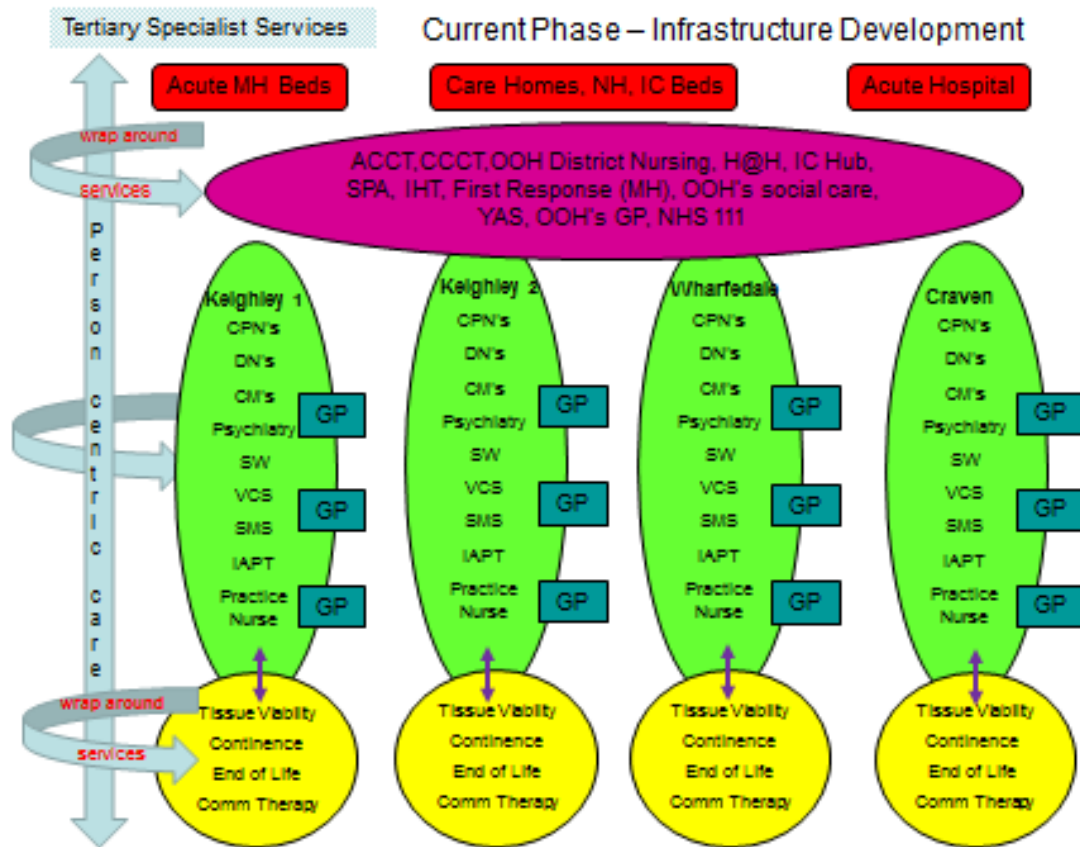
The service will increase utilisation and coordination of telecare, telehealth and telemedicine as enablers to support care outside the hospital.

The service specifications out the detail

SpecificationCrave
Collaborative Care Te

The following diagram sets out the community and intermediate care infrastructure of which CCCT is part

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

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

Commissioners: AWC CCG and NYCC

Providers
The lead provider is ANHSFT working in partnership with:
- Bradford District Care Trust
- Age UK (VCS Home from Hospital)
- Carers Resource (VCS carers support)
- NYCC (Social worker)

Interdependence with other services/providers
Key relationships
- GPs
- Physiotherapists
- Occupational therapy
- Speech and Language Therapist
- District Nurses
- Community Matrons
- Intermediate Care Team
- Secondary Care
- Social Services
- Community Mental Health Team
- Intermediate care
- Specialist Nurses for example Heart Failure or Tissue Viability Nurses

Craven Collaborative Care Team – extending Intermediate care:
2013/14 Q3 Partly operational additional staff in post
2013/14 Q4 expected to be fully operational. Recruitment underway staff expected to be in post Q4
2014/15 fully operational

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 evidence base for the impact of intermediate care is well known and can be found at:
- Social Care Institute for Excellence (2013). Maximising the potential of reablement. London SCIE
- NHS Benchmarking Network, British Geriatrics Society, Association of Directors of Adult Social Services, College of Occupational Therapists, Royal College of Speech and Language Therapists, NHS England (2013)

We recognise that the evidence is mixed in terms of reducing system costs, however our approach is to provide proactive care that pre-empts ill-health and then to ensure that people are supported to regain and maintain their optimum levels of health, wellbeing and independence. Ultimately this will reduce unnecessary dependence

and demand on health and care services.

> *'Transforming services require a fundamental shift towards care that is co-ordinated around the full range of an individual's needs (rather than based around single diseases) and care that truly prioritises prevention and support doe maintaining independence. Achieving this will require much more integrated working to ensure that the right mix of services are available in the right place at the right time' (Oliver et al 2014)*

We also commissioned the CSU to undertaken a national and international evidence review of integrated care models and used the outcome of this to influence development of new models of care, transformational change and inform the NE admission reduction target. The full report is attached. This review provided assurance and gave confidence that the initiatives planned or underway will realise intended benefits.

BA Integrated Care Models.pdf

Specific models where there was evidence of outcomes delivered are:
- Kaiser Permanente, California, USA
- The Alzira Model – Valencia, Spain.
- MassGeneral Care Management Programme, Massachusetts, USA
- Virtual ward models including Greenwich (over 2000 admissions avoided & no delayed transfers of care) North West London (Curry and others, 2013)
- Marie Curie end of life nursing: significantly more home deaths and less emergency admissions than control group (Chitnis and others, 2012;2013)

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

14/15 £343,000 (plus £214,000 from "ALL_001_RC - Reablement and Carers")
15/16 £343,000 (plus £214,000 from "ALL_001_RC - Reablement and Carers")

Current cost of service - £157,000 pa (currently funded from reablement funds)

Financial Year 13/14 and 14/15

Additional Team Costs

Advanced Nurse Practitioner	£ 63,000
Social Worker Secondment	£ 50,000
Mental Health Worker	£ 22,000 (based on band 6 0.5 WTE)
Carer Support Worker	£ 45,000
Home from Hospice	£ 12,000

Additional costs for unsocial working and moving to a different model of 7 day working - £151,000

Total Anticipated Costs to include existing reablement funding - £577,000 per annum

Excluding reablement and existing costs of the service = £ 343k BCF investment

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 number of Craven patients receiving an enhanced level of care in their own homes avoiding need for hospital admission via the enhanced virtual ward.
- Increased number of Craven carers having needs assessment and support
- High levels of patient and carer satisfaction
- More people receiving holistic care in the community 24/7 reducing the need for acute admission or long term care placements
- Increased number of care plans and referrals to other health, social & voluntary care sector
- Increase discharge support enabling early supported discharge from hospital including weekends

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?

A multi stakeholder group has been established to oversee implementation and monitoring of all the AWC BCF schemes. This includes members of the CCG and NYCC as commissioners. In particular input from the performance lead to whom key metrics will be reported. There are established contractual forums through which to escalate and issues, concerns and benefits such as QPG, SDG & CMB

For the identified cohort
- Number of patients on CCCT caseload
- % increase in number of patients on CCCT caseload compared to previous year (12/13)
- Number patients 'stepped up' and admission to acute avoided
- Number patients discharged early (step down)
- Number patients successfully stepped down and NOT readmitted to acute
- Number patients successfully rehabilitated and long term care placement avoided
- Number patients on ambulatory care community pathways
- Number patients successfully treated in the community on AC pathways (admission avoided)
- Number carer assessments offered and completed

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

Increase in 24/7 working with the possibility of merging role of care home liaison & GP in CCCT

- Number of patients on Craven Collaborative Care Team case load
  - % increase in number of patients on CCCT caseload compared to previous

- year's (12/13 and 13/14)
  - Number of patients 'stepped up' and admission to hospital avoided
  - Number of patients discharged early (step down)
  - Number of patients successfully rehabilitated and long term care placement
- avoided
  - Number of patients successfully treated in the community on Ambulatory
- Care pathways, supporting admission avoidance
  - Number of carer assessments offered and completed
  - % increase in patient and carer satisfaction (based on 12/13 and13/14)
- Number of patients who were seen within 2 hours to provide crisis interventions
- Quarterly reporting will be required to the agreed data set to give assurance that the
- Service is delivering against the service specification and to enable future service development.

Scheme ref no.
VOY_002_CIR

Scheme name
Selby Care Hub

What is the strategic objective of this scheme?

Strategic objective:

To provide a collection of services, to a defined cohort of patients at risk, to support in a crisis, avoid admission, provide ongoing care and facilitate early discharge. This would be closer to home and through a multi-disciplinary team approach to promote wellbeing, self care and confidence involving local groups and the voluntary sector.

Strategic Aims:
- Promote independence
- Increase wellbeing
- Prevention of crisis
- Users have ownership of own care and feel safe
- Users can access the service
- Carers feel supported
- Reduction in spend on acute healthcare and adult social care
- Increase efficiency of care delivery
- Provide sustainable workloads
- Ease of access to services and co-ordination
- Ensure advanced care planning in place
- Services to be available 7 days per week and extended hours

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?

In order to deliver the strategic aims listed above the Selby Care Hub scheme worked with local stakeholders to identify the priority first steps towards delivering a truly integrated and responsive service for the local population (c. 73,000 covered by six GP practices). There is a recognition that further elements will be required to build on these foundations. Building on the work of the Birmingham Health Village, the Selby Care Hub seeks to go beyond integrating traditional 'professional' health and social care services instead looking to include community, carers and voluntary sector support networks to build a 'ring of confidence' around service users.

The Birmingham model describes four, ascending, levels of need in individuals:
- Improving health and wellbeing
- Managing life-limiting long term conditions
- Care in crisis
- Specialist service

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

Locally stakeholders identified that the gaps in current services were most significant in supporting those complex users with life-limiting long term conditions and providing non-institutional (health or social) care in crisis. In seeking to support independence for individuals and reduce the utilisation of the most resource intensive health and social care services (inpatient beds, Emergency Department, residential care and long term social care packages) it was recognised that services needed to be both **proactive** to plan care to prevent crisis and **reactive** to respond to crisis in a timely manner.

In order to achieve this three initial service areas are being developed:

1. Multidisciplinary care home in-reach

This proactive service seeks to ensure that residents of care homes all receive a comprehensive multidisciplinary geriatric assessment resulting in a detailed care plan (including advanced care planning for end of life) that would be accessible to health and social care providers (linked to single care record developments).

Jointly led by resident's named GP and a consultant geriatricians the review will include a detailed medication review and work closely with staff within the home. It is expected that the wider multidisciplinary team will include community nursing, speech and language therapy, dietetics, social services and pharmacy as required. The service will work closely with the Dementia Care Home service.

2. Case management / complex MDT approach

This proactive service seeks to support those individuals identified as having care planning needs with a complexity greater than that which can be provided by practices. Although the patient cohort will include a proportion of those being identified as 'at risk' through stratification tools it is recognised that other services (including social care, housing, secondary care, carers and the voluntary sector) will also identify individuals who would benefit from a more comprehensive review and plan.

Although a final model of care is to be determined it is envisioned that a team comprising professionals from a range of backgrounds (including nursing, therapies, social care and mental health) will assign a lead professional according to the referred individual's needs. The lead will conduct a thorough assessment (through cross training all team members will be able to conduct basic assessments in all disciplines) accessing specialist input where required. This may include liaison with a range of services involved in the individual's care.

The output will be a detailed care plan with a focus on self-management, on-going care, a plan for deterioration of conditions and advanced care planning where appropriate. This would be jointly agreed with the individual and their carers and available to health and social care providers (linked to single care record developments). Agreement for review arrangements and ongoing support (which could be provided through the voluntary sector or linked to primary care) will be made.

3. Intermediate Care / Reablement

A more reactive service predominantly supporting those in crisis the service has two functions:

c) preventing admission to hospital, residential care settings or long term high packages of social care
d) facilitating early discharge from hospital or residential care settings

Service users would be referred from a wide range of sources including GPs, community nursing, carers, ambulance service and emergency departments. The team ethos would centre on taking responsibility to ensure that appropriate care is in place for individuals referred to them. Using the analogy of a relay baton the team would take responsibility to take this from the referrer and where a referral for onward care (either at the end of a period of intervention or where a more appropriate service exists) ensure this is safely handed on in a manner that is seamless for the service user.

The team is expected to include professionals from nursing, therapies and social services with close links to mental health crisis response services. These professionals would be supported by a team of generic workers who would deliver the majority of interventions for individuals. As with the case management service a lead professional would conduct an initial assessment of need and agree a set of goals with the individual and/or their carers. With an ability to provide care up to four times a day for up to six weeks the aim would be to restore an individual to an optimal level of function.

It is expected that the team will support a 'discharge to assess' model whereby functional assessments and rehabilitation for those without acute medical needs are provided in a user's own home rather than institutional settings. For those with ongoing unpredictable nursing needs this service could be provided in a residential care setting, again with a focus on optimising an individual's level of function prior to assessment of long term need.

It is expected that all the services above will be provided both in individuals' own homes but also exploiting the community resource in Selby Hospital to bring individuals together for interventions. This will enable most efficient use of resources as well as the benefits of greater social interaction through group interventions.
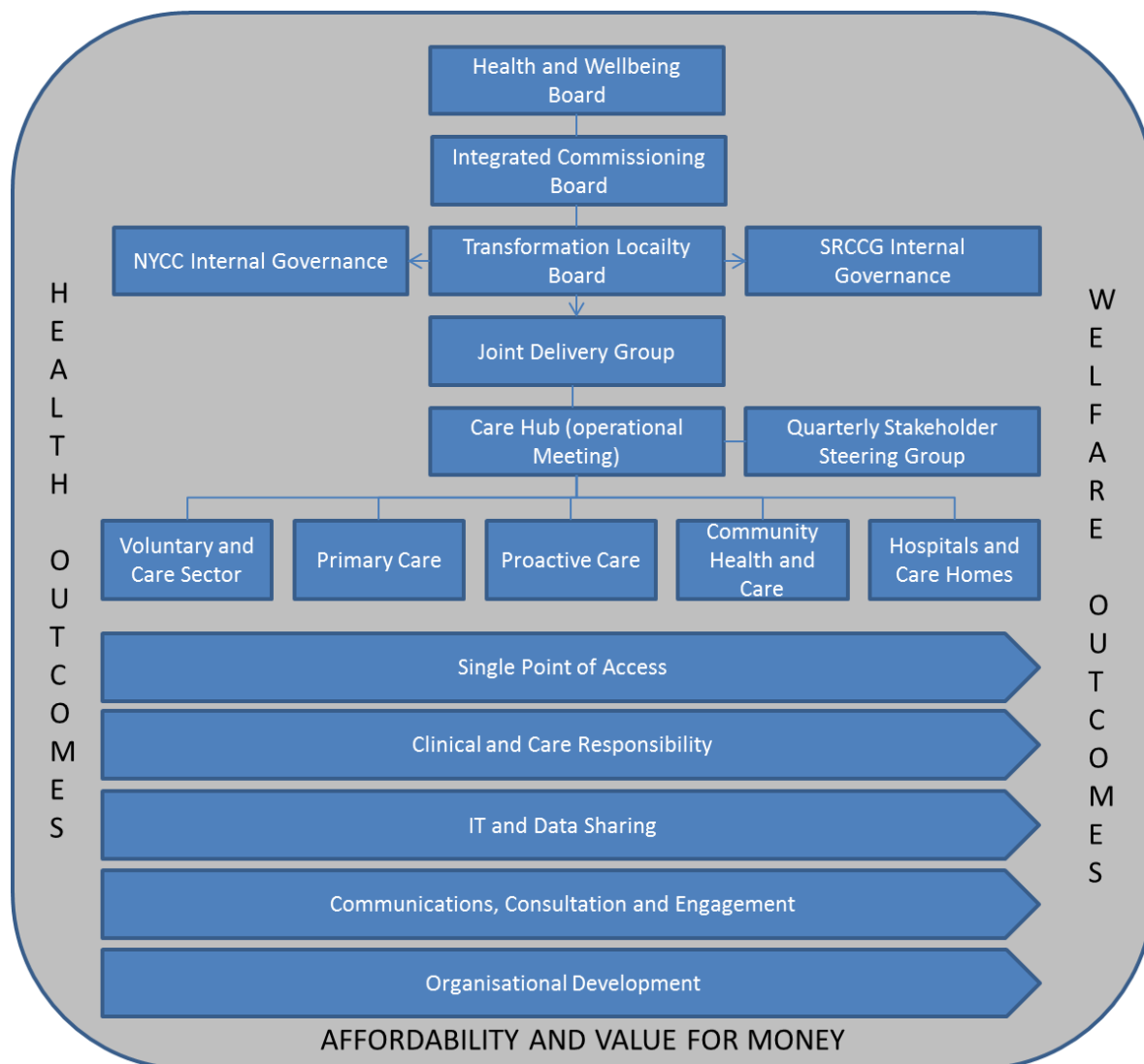
The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

A memorandum of understanding, in parallel with commissioning governance and assurance, supports definition of the delivery chain.

An accountable lead provider model has been adopted for the development of the community care hub, initially as a pilot. The accountable lead provider, York Teaching Hospital Foundation Trust, is commissioned through the better care fund partners and process (invoicing monthly against a submitted business plan and budget), monitored through a joint health and social care delivery group. The memorandum of understanding defines the overall engagement and principles of this arrangement between NHS Vale of York CCG (commissioner), North Yorkshire County Council (commissioner) and York Teaching Hospital Foundation Trust (provider). The accountable lead provider however works with multiple other providers and stakeholders to deliver the care hub aims, objectives and deliverables, including local primary and community services, county and district council provider services, mental health services and the voluntary sector, for example.

Governance arrangements for the hub are represented diagrammatically below;

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                    ┌─────────────────────────┐
                    │  Health and Wellbeing   │
                    │         Board           │
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                    │ Integrated Commissioning │
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  ┌──────────────────┐  ┌─────────────────────┐  ┌──────────────────┐
  │ NYCC Internal    │◄─│ Transformation       │─►│ SRCCG Internal   │
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                    │   Joint Delivery Group   │
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        ┌─────────────────────┐      ┌─────────────────────┐
        │ Care Hub (operational│──────│ Quarterly Stakeholder│
        │      Meeting)        │      │  Steering Group      │
        └─────────────────────┘      └─────────────────────┘
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| Voluntary and Care Sector | Primary Care | Proactive Care | Community Health and Care | Hospitals and Care Homes |

HEALTH OUTCOMES ... **WELFARE OUTCOMES**

Single Point of Access

Clinical and Care Responsibility

IT and Data Sharing

Communications, Consultation and Engagement

Organisational Development

AFFORDABILITY AND VALUE FOR MONEY

The accountable lead provider is held to account against defined objectives and metrics and a defined plan for the agreed budget, however, there is flexibility for provider innovation and adaptation to ensure the model is as effective as possible in delivering the aims and objectives sought.

Acute and social care utilisation and metrics will be reported monthly.

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

In relation to selection and design of the scheme, health and social care data was gained for the c. 73, 000 practice population including activity and spend in acute and social care, with more specific understanding and breakdown of areas of opportunity based on population spend and activity broken down by demographic, gender, age, place of residence, disease area, condition-specific activity and other areas. This helped to identify patient cohorts and patient characteristics representing a higher proportion of

activity and spend in the health system and work since has helped to repeat the process across social care. Additionally, retrospective data on activity and growth has been modelled in addition to formal data modelling supported provided to the CCG and local authority to understand potential impacts further.

Audits are being undertaken by partner primary care clinicians to understand local needs and potential demand for services.

Joint strategic needs assessments and public health data has also been available to help prioritise the wider strategy for models and plans, in addition to prior public communications and engagement exercises, and a number of provider market engagement events relating to community services and admission alternatives.

The care hub model also utilises evidence from elsewhere, whilst recognising the need for effective local adaptation, delivery and implementation, the latter being particularly important. The model builds on good experience locally and draws on evidence from national and international exemplars, for example, Birmingham 'Healthy Villages', Sandwell 'iCare team', Sheffield and South Warwickshire's work on 'discharge to assess', South Lanarkshire 'integrated community support teams' and East Riding 'care home in-reach'.

It is recognised, for example through the evaluation of community and integration models through the Nuffield Trust (2013), that models such as those proposed require time and scale, where supply-induced demand can often limit impact on reducing emergency admissions. It can equally be difficult to prove a negative of avoidable admissions. Where cashable savings are required, commissioners often have to use effectiveness of new models to decommission services not providing value for money which is a dependency to demonstrate cost reduction. However, the model adopted intends to create alternatives to admission and evidence-based delivery, such as risk profiling to target care appropriately to support reducing admissions.

References and an evidence-base being used to inform the model and above statements are highlighted below.

References

- Cochrane Effective Practice and Organisation of Care Group (2014). http://epoc.cochrane.org/ (Community service reviews)
- Department of health (2011). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216361/dh_127719.pdf
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- Health Foundation, The (2011). Getting out of hospital? The evidence for shifting acute inpatient and day case services from hospitals into the community. London. The Health Foundation.
- King's Fund, The (2010). Avoiding hospital admissions; What does the research evidence say? London. The King's Fund.
- King's Fund, The (2012). Pick 'n' mix: an introduction to choosing and using indicators. London. The King's Fund.
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using the community virtual ward and the Devon Predictive Model. London. The King's Fund.

- King's Fund, The (2014). Community services: How they can transform care. London. The King's Fund.
- Nuffield Trust, The (2012). The anatomy of health spending. London. The Nuffield Trust.
- Nuffield Trust, The (2013). Evaluating integrated and community-based care. London. The Nuffield Trust.
- University of York (2012). http://www.crd.york.ac.uk/crdweb/ShowRecord.asp?ID=12011006375#.U8kq4rnjjl U

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

14/15 £280,000   15/16 £550,000

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

- Enhance quality of care for patients
- Reduction in delays to assessing patients to ensure appropriate pathways of care
- Ensuring high risk patients have an appropriate care plan in place to allow better management of their condition within the Community
- Service model that meets the needs of the population
- GPs and other health and social care services referring into this service
- Working more effectively across services boundaries

Further work is required to develop a model to identify agreed savings. It is anticipated that these would be delivered from acute non elective admissions and efficiencies within other areas of health and social care service delivery.

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?

Outcomes of the scheme are measured and/or to be measured through the following methods;

- Working with commissioners and local public health to agree measures (and data sources) to demonstrate impact against strategic outcomes
- Developing suite of process and more easily accessible outcome measures to allow real time monitoring of individual workstream developments
- Project group meetings involving local stakeholders, including GP leads, to agree models of care and monitor implementation of agreed plans
- Provider based monthly steering group reviewing key measures and timescales
- Provision of measures through commissioner delivery groups to allow wider scrutiny of impact

What are the key success factors for implementation of this scheme?
A range of broad and recognised factors consistent with any programme delivery are recognised, such as addressing barriers to change and ensuring a clear structure and approach for implementation.

Specifically related to the defined scheme and in examining the publications previously referenced key success factors relate to;

- Ongoing provider engagement in delivery
- Wide engagement with a range of stakeholders, including service users and carers
- Allowing time (for model development and scale amongst other areas), in parallel with the evidence around integration schemes specifically, for schemes to realise material reductions in admissions and other stated outcomes
- Monitoring and adapting scheme delivery though real-time and scheme-sensitive metrics (recognising external influences such as population growth, demographic changes and other influences on change)
- Utilising decision-making processes to, for example, decommission services in line with increased scheme delivery (to reduce supply-led demand and realise material cost reductions and transfer of care delivery)
- To ensure sustainability of the scheme through ongoing adaptation and learning |

Scheme ref no.
VOY_004_CIR

Scheme name
Urgent Care Practitioners

What is the strategic objective of this scheme?

The CCG's Integrated Operational Plan 2013/14 has three local priorities, underpinned by a clear strategic intent "to improve systems for assessing the urgency of care, ensuring an appropriate and prompt response to patient need". The aim for all three is to proactively manage conditions as close to the patients' home as possible thus reducing unnecessary A&E attendances and unplanned hospital admissions.

The first and the third priorities come within the Urgent Care Programme and focus on:

- Unplanned hospitalisation for chronic ambulatory care sensitive conditions

- Reduction in emergency admissions for acute conditions that should not usually require hospital admissions

With this in mind, it has been decided within the NHS Vale of York CCG boundaries to change the name of an Emergency Care Practitioner to that of an Urgent Care Practitioner (UCP) so they are able to support the delivery of these priorities in avoiding further growth in admissions, which will reflect a considerable achievement from the 2012/13 experience of 16% increase in unplanned admissions.

Commissioning the UCP Service will also feed into the vision for health and care services (as set out at the start of this document) by ensuring individuals are able to access the right level of care and support in community based settings to help avoid unnecessary admissions to hospital and in doing so will contribute towards the reduction of emergency hospital admissions.

In achieving this it will almost certainly increase the proportion of people having a positive experience of care outside of hospital, in general practice and in the community.

With the introduction of NHS 111, which is managed by Yorkshire Ambulance Service (YAS) across Yorkshire and the Humber, there are strong links and potential benefits associated with the commissioning of an UCP service delivered by YAS. NHS 111 supports patients with urgent care needs to access the right care, in the right place, first time, which will, if appropriate, involve referral to the UCP Service. Evidence suggests that this form of signposting appears to have the advantage of reducing immediate medical workload through the substitution of telephone consultations and alternative use of clinical skills. Furthermore, this has the potential to reduce costs. (*Leibowitz, (2003)*)

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

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?

As part of the 2013 /14 winter pressures projects four members of staff from the Yorkshire Ambulance Service were employed to work alongside regular ambulance crews to attend falls, faints and minor injuries.

The success of this project enabled the CCG to continue and expand the service with funding from the York and North Yorkshire BCF.

They are working on a roving basis around the Vale of York and are called to both emergency calls to improve response times and to less urgent calls where they have appropriate skills. This service aims to see, treat and where required refer onwards individuals in the home or at the scene instead of providing conveyance to hospital.

The use of Urgent Care Practitioners Service that YAS provides for Vale of York CCG is to respond to 999 calls and to accept referrals from paramedics, nursing homes, community matrons and nurses. These referrals include, but are not limited to, falls, COPD, catheter problems, and wound care. UCPs, as independent advanced practitioners, are able to assess patients in their own home and make referrals to the most appropriate agency resulting in reduced ambulance conveyance rates to hospital.

Building on the success of this scheme will be the development of alternative pathways and integration into the community services that offer an alternative to hospital care. This additional funding for UCPs will increase the capacity and coverage of the Vale of York. Also in the rural areas of the locality this enables UCPs to be embedded within general practice. Although their primary role will still be that of an advanced paramedic practitioner responding to 999 calls, their skills and knowledge will be used to manage urgent demand which may be identified within primary care. This will support the move to Primary Care 7 day working.

The CCG have committed to fund this project through the York and North Yorkshire BCF and winter resilience monies and have committed to extend this service.

In 14/15, 4 UCPs are funded non-recurrently through system resilience monies. Recurrently an additional 4 UCPs are funded through North Yorkshire BCF and 4 through York BCF. In 15/16 4 UCPs will be funded recurrently through North Yorkshire BCF and 8 through York BCF. This gives a total of 12 UCPs in each year.

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

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The CCG, with partner organisations and stakeholders, have been working together to manage urgent care. With the national introduction of an Urgent Care Programme the focus has been placed on transformation, improvement of urgent care pathways, integration of existing and new services and close working with care homes. The Systems Resilience Group has been established that underpins the importance of working with key stakeholders to develop ideas, oversee implementation of urgent care plans and monitor the A&E recovery and improvement plans. The approach spans pre-hospital, hospital and post-hospital care.

Following the development of a joint UCP service specification, this has now been fed

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into a new contract agreement between the CCG and YAS.

YAS, as the main provider of the UCP service will be responsible for the delivery and implementation of the scheme working closely with the CCG as the contract commences. Currently a strategic meeting is held monthly to review the current levels of activity and address any issues with the scheme. It is anticipated that this will move to a contract management board (CMB) arrangement where YAS will be held account against a defined set of objectives and metrics.

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

Current Scheme Activity Across North Yorkshire & York.
Below are the latest activity figures for the current service with only 4 UCPs. The additional 8 posts will be in place by December 14. Costs have been estimated against non-conveyance rates, ED attendances and reduction in admissions.

	Total calls to UCP service	No of pts not conveyed to hospital	% of non-conv	1. Non-Conv costs £62	2. ED Atten costs £108	3. 50% reduct in admiss (£1258) at 30% (due to marginal rate effect)	Total
Apr-14	88	50	57%	£3,100	£5,000	£9,425	
May-14	147	57	39%	£3,534	£5,700	£10,933	
Jun-14	100	50	50%	£3,100	£5,000	£9,425	
Jul-14	122	82	67%	£5,084	£8,200	£15,457	
Aug-14	164	91	55%	£5,642	£9,100	£17,342	
Sep-14	210	120	57%	£7,440	£12,000	£22,620	
Oct-14	182	96	53%	£5,952	£9,600	£18,096	
Totals	**1013**	**546**	**54%**	**£33,852**	**£54,600**	**£103,298**	**£191,750**

NB:

1. Ambulance costs are based on a basic two man vehicle at £62 per journey. There are four categories of conveyance costs. YAS car booking if mobility permits - £28, Basic two man vehicle - £62, Fully kitted vehicle, two man support - £288, Frontline 999 ambulance - £288. Based on the patients seen by the UCPs the majority of patients will not require frontline, fully kitted vehicle. Therefore the cost of transport is based on a two man vehicle for most patient seen by the UCP who require ambulance conveyance to ED.

2. Attendance savings are based on 2012/13 data. Number of patients attending A&E divided by the actual cost x by the target reduction of % non-attendance. This is averaging £108 per attendance.

3. Admissions reductions are 50% of the patients attending ED conveyed by ambulance. The percentage conversion from attendance to admission has been identified through YAS experience in other areas. The costs are based on 2012/13 data for emergency admissions that met the criteria discussed above.

Forecast savings

No of UCPs	Month	Total calls	Non convey	% based	1. Non convey £62	2. ED Attend £108	3. Reduct in admiss (incl 30% marginal rate)	
4	Apr-14	88	50	57%	£3,100	£5,000	£9,450	Actual activity
4	May-14	147	57	39%	£3,534	£5,700	£10,773	
4	Jun-14	100	50	50%	£3,100	£5,000	£9,450	
4	Jul-14	122	82	67%	£5,084	£8,200	£15,498	
4	Aug-14	164	91	55%	£5,642	£9,100	£17,199	
4	Sep-14	210	120	57%	£7,440	£12,000	£22,680	
4	Oct-14	182	96	53%	£5,952	£9,600	£18,096	
4	Nov-14	210	141	67%	£8,723	£15,196	£26,592	Forecast
12	Dec-14	315	211	67%	£13,085	£22,793	£39,888	
12	Jan-15	540	362	67%	£22,444	£39,096	£68,418	
12	Feb-15	720	482	67%	£29,884	£52,056	£91,098	
12	Mar-15	720	504	70%	£31,248	£54,432	£95,256	
	Total	3,518	2,246	67%	£139,237	£242,541	£424,447 1,123	£806,224
	Target 2014/15		**2,154**			**£233,795**	**£461,1601,220**	**£676,560**
	Target 2015/16		**3,133**			**£340,056**	**£670,572 1,774**	**£983,872**

References and an evidence-base have been used to inform the development of this model further.

There have been a number of studies that support the implementation of Urgent (was Emergency) Care Practitioners roles. The references below provide an overview of these studies.

Transforming urgent and emergency care services in England First published: November 2013

Urgent and Emergency Care Review, End of Phase 1 Report.
http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

- The challenges facing our urgent and emergency care system are clear, as are the opportunities for improvement. We now need to take action. The report sets out the proposals for the future of urgent and emergency care services in England. There are five key elements summarised in the report, one of which is to provide highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E

Sheffield PCT 2012

- The Sheffield ECP service has a primary role of seeing and treating people at scene, thus ensuring patients do not have to be transported by ambulance to A&E, when this is not the most suitable pathway for them. The service typically sees about 25 patients a day, many of whom have fallen. The service has been successful in reducing the need for people to be taken to A&E for treatment as patients can be treated on scene by an advanced practitioner.

Journal of Paramedic Practice, Vol. 2, Iss. 4, **21 Apr 2010, pp 158 - 168**

- The aim of the literature review was to identify and appraise studies that have compared the effectiveness and decision-making of emergency care practitioners with other health professionals.

- Out of the twenty-nine publications, ten studies were analysed in further detail and three main themes identified: non-conveyance rates, decision-making and admission avoidance.

- The decision-making of ECPs compares favorably with other health professionals when deciding whether a patient can be treated at home, or requires ED attendance or hospital admission.

Measuring the Benefits of the Emergency Care Practitioner: Skills for Health 2007.

- 70% of patients ECPs treated, discharged or referred patients away from hospital

Paramedic Practitioner Older People's Support Trial (PPOPS): A Cluster Randomised Controlled Trial. British Medical Journal, Nov 3;335(7626):919, 2007 (Mason, 2007)

- Controlled study of ECPs in three service settings showed high rates (72.2%) of patients discharged without referral on to other provider

Collaborative practices in unscheduled emergency care. The role and impact of the Emergency Care Practitioner (ECP). Cooper S. et al University of Plymouth (UK) October 2006

- 70% of patients were seen 'in-hours'; 62% were not conveyed; 38% were referred, mainly to A&E

AACE (2014) Future Clinical Priorities for Ambulance Services in England

The Association of Ambulance Chief Executives (AACE) has identified Urgent Care as one of their seven clinical care priorities. AACE recognise a shift from traditional ambulance service delivery ('see and convey') to an increased model of 'see and treat'. This model requires an increase in advanced paramedics and / or nurses equipped with enhanced skills to assess and either treat patients on scene, or refer the patient onwards to appropriate health and social care services.

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

14/15 £198,000   15/16 £300,000

Investment for 14/15 and 15/16
Investment required: Proposed costs per UCP: £52k pay, £10k equipment, £10k travel and associated costs (£72k)

Year one 14/15:
Four UCPs for 12 months – 4X£72,000 = £288,000
Two UCPs for 6 months – 2X£36,000 = £72,000
Two UCPs for 3 months – 2x£18,000 = £36,000
Total BCF = £396,000
Of which £198,000 is funded from the North Yorkshire BCF.

Year one 14/15:
Four UCPs for 4 months – 4X£24,000

Total SRG = £96,000

Year two 15/16:
12 UCPs for 12 months – 12X£72,000 = £864,000
Total = £864,000

Of which £300,000 is funded from the North Yorkshire BCF in 15/16

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

	14/15 Activity	14/15 Saving (£K)	15/16 Activity	15/16 Saving (£K)
Reduction in emergency admissions	407	154	591	223
Reduction in A&E attendances	718	78	1044	113

NB: The above figures are for North Yorkshire BCF only.

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?

Outcomes of the scheme are measured and/or to be measured through the following methods;
- Formal strategic monthly meetings with Yorkshire Ambulance Service and its membership includes CCG and YAS staff from contracting, finance, service improvement and front line clinicians.
- Formal monthly and quarterly data evaluation has been put in place using agreed performance metrics (as per the approved service specification)

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

It is anticipated that an increase in the number of UCP's commissioned by Vale of York CCG will achieve the following key success factors:
- Increased levels of appropriate non-conveyance due to the enhanced clinical skills of UCPs allowing them to assess and treat, assess and refer and assess and convey to alternative care sites (when clinically appropriate)
- Provide an integrated service, which supports a coordinated approach from health and social care professionals
- Reduction in attendance at A&E for specific patients
- Provide direct referrals to the most appropriate pathway for the patient
- Increased management of palliative care patients at home or at the place they choose to end their life
- Increased patient satisfaction

ANNEX 1c - PUBLIC HEALTH / PREVENTION

Scheme ref no.
HRW_009_PHP

Scheme name
Prevention Initiative: Lifestyle Referral

What is the strategic objective of this scheme?

This is a joint programme of investment with NYCC to develop a lifestyle and weight management referral programme to support people with long term conditions, MSK, falls, COPD. The scheme is designed to meet the needs of the local population and GPs. Health and wellbeing officers will support people through group work and, where needed, on a one to one basis to motivate and signpost members of the public to make long-term healthy lifestyle choices.

The aim of a tier 2 lifestyle weight management service is to provide evidence based interventions which support adults aged over 18 years of age, with a BMI >30 to lose weight and learn how to maintain a healthier weight (through diet and physical activity).

The objectives of the service are:
a) To provide a lifestyle multicomponent service that demonstrates on average a weight reduction for service users at the end of their 12 week programme.
b) To improve other health related measures of clients (as identified in performance monitoring) i.e. waist circumference and quality of life at the end of the intervention.
c) To ensure the service is integrated into patient care pathways as agreed by the commissioner (e.g. MSK, diabetes, NHS Health checks) so there are clear referral routes and pathways of care for the individuals.
d) To ensure the service receives referrals from the GP practices by developing and implementing clear referral routes and fostering good relationships with practices
e) To provide timely and easy access to the service and ensure interventions provided are person centred.
f) To enable individuals to sustain their weight loss and maintain positive changes in their lifestyle behaviours.
g) To collect and report data in line with a performance and monitoring framework provided by the Commissioner.
h) To monitor and evaluate service delivery and make service improvements or changes in line with findings.
i) To signpost individuals on to other appropriate services to support lifestyle behaviour change e.g. stop smoking services

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

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?

Model of care
The scheme is based on collaborative working between the CCG, District Councils and North Yorkshire Public Health. The scheme is to develop a jointly funded, evidence based and accessible tier 2 lifestyle weight management service for adults aged over 18 years of age, which will support people with a BMI 30 to <40 to lose weight and learn how to maintain a healthier weight. This forms an integral part of the local weight management care pathway. Access to the service will be targeted in line with the local Joint Strategic Needs Assessment and will be in line with the public health prevention strategy.

Hambleton and Richmondshire:
The structured 12 week programme will provide weekly 1.5 hour sessions for new recruits aimed specifically at treating obesity. The programme will introduce service users to a variety of physical activity sessions alongside an intensive lifestyle-change programme in accordance with NICE guidance.

The Lifestyle referral service will tackle health inequalities in the more deprived areas of the locality. Clients can either be referred by professionals or they can self-refer. The service will guide and support clients with healthy eating, losing weight, physical activity, stopping smoking, reducing alcohol and substance misuse and reducing stress and anxiety. In addition the service will provide routes into existing services provided in the locality such as NHS Health Checks, Vaccinations for at risk groups, support on housing and winter warmth, alcohol services, exercise referral and smoking cessation.

On referral to the service the individual will undergo a comprehensive assessment which will result in a shared understanding and agreement of their personal goals and the creation of an action plan. The service user will then receive a 12 week programme which will involve three main components:

- Dietary advice
- Physical activity sessions (with an emphasis on variety of activities)
- Behavioural modification techniques and strategies

To ensure that the service is holistic and address other lifestyle related behaviours the service will also offer referrals to lifestyle services including: smoking cessation, alcohol and mental health services.

On exiting the programme the service user will then be followed up at 6 and 12 months to check their maintenance to behaviour changes.

The different phases of the programme are described in more detail below.

Phase 1 - Structured Programme (12 weeks)
- Baseline assessment will be carried out at initial assessment and 12 week following intervention.

- A tailored programme will be developed with the individual

Phase 2 (up to 6 months)
- Individual assessment will be carried out at 6 months from the date of the first activity session of the structured programme ± 2 weeks to monitor progress against baseline measures and to review personal goals.

Phase 3 (up to 12 months)
- During this phase support will be provided via newsletters; telephone; text and email. Additional support will be provided via the peer supporters.
- A final individual assessment will be carried out at 12 months from the date of the first activity session of the structured programme ± 2 weeks to monitor progress against baselines measures.
- Throughout all phases, service users should be encouraged to access mainstream physical activity sessions both within and outside of sport and leisure, during and following completion of the programme, with a particular emphasis on those activities that are free or in the community.

Previous to this scheme, there were no specific tier 2 weight management programmes in place. The service will therefore improve public health and provide a level of compliance. There is potential for the programme to be further developed in future to include, or work with a tier 3 weight management solution for bariatric patients.

Whitby:
Whitby will have a different service to that of Hambleton and Richmondshire due to an already existing exercise referral scheme run by Whitby Leisure Centre.

The Health Trainer (HT) service will tackle health inequalities in the more deprived areas of the locality. Clients can either be referred by professionals or they can self-refer. The HT's will guide and support clients with healthy eating, losing weight, physical activity, stopping smoking, reducing alcohol and substance misuse and reducing stress and anxiety. In addition HT's will provide routes into existing services provided in the locality such as NHS Health Checks, vaccinations for at risk groups, support on housing and winter warmth, alcohol services, exercise referral and smoking cessation.

The Health Trainer Service will have five core functions:

- Effective community engagement to support the uptake of NHS Health Checks.
- Work alongside tiered lifestyle services to develop integrated approaches to health and wellbeing
- Delivery of lifestyle interventions for patients identifying as medium to high risk post NHS Health Check.
- Delivery of lifestyle interventions and signposting to support services for people with long-term conditions in disadvantaged areas.
- Delivery of NHS Health Checks to target hard to reach groups in the community, specifically those not registered with a GP practice.

Whitby patients will have the ability to be referred into the already existing exercise scheme as well as gain support from Health Trainers. The Health Trainer will:

- Provide support and guidance on lifestyle behaviour change and broader public

health matters for the most disadvantaged across the locality
- Work with individuals to encourage a healthier lifestyle. This might include healthy eating, physical activity, giving up smoking, cutting down on alcohol and mental health problems
- Help individuals on a one-to-one basis to identify priorities, develop a personal healthy lifestyle plan and give ongoing encouragement and support
- They will signpost clients to appropriate services and introduce them to other organisations/groups that may be able to help
- Have regular follow up meetings and telephone calls and, if necessary, the Health Trainer can accompany clients to appropriate services
- Facilitate access to online information for example CQC, SCIE online directories etc.
- Help individuals access and navigate the NYCC Customer Resolution Centre
- Support clients to choose the changes they wish to make
- Provide a service that is free and confidential.

It should be noted that the exercise scheme ran by Whitby Leisure Centre is not an exact replica of the Lifestyle Referral in Hambleton and Richmondshire. There are both similarities and differences these include:

- Patients are asked to pay for the Whitby service (£25)
- The Whitby service is 10 weeks in comparison to 12 weeks in Hambleton and Richmondshire
- The Whitby service offers a tailored programme of exercise but limited support. Patients will see the exercise professional 5 times in the 10 week period this includes the first 3 visits, a mid-point assessment and at the end of the programme.
- The Whitby service focuses on weight management with little reference to signposting; this will be done by the new Health Trainer service.

Over time, this service will link with the Health and Wellbeing Hub and in rural areas providing services in local community centres, patients own homes and GP Practices.

The Health and Wellbeing Hub is currently being established and will support the prevention agenda and enable local residents to live as fulfilling a life and as health a life as possible. This will be a new service which will be delivered by all the staff employed currently in both a clinical and non-clinical roles and in conjunction with the public health and third sector colleagues. The teams will collaborate to provide drop in clinics, public health information and group sessions. It is expected further BCF and other projects (e.g. Community Agents and the Care Navigator) will also support the signposting and delivery of services from the Hub.

Target groups
Eligible to access the service
- Must be aged 18 years, in the locality
- Have a BMI equal to or greater than 30.
- Are physically inactive
- Would benefit from increasing Physical activity
- Would like support to make changes to their lifestyle
- Have been identified via NHS Health Check as being at risk of Cardio vascular disease

- Have been identified within the NHS health check as BMI greater than 30.
- Have been identified within NHS Health Check as being inactive

Excluded from the service
- Pregnant, or breastfeeding
- Have an eating disorder
- have an underlying medical cause for obesity
- have significant co-morbidity or complex needs
- With a BMI of <30
- Under the age of 18

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

Governance
The programme will be overseen by a Public Health Consultant who will chair a county wide board including key decision makers from each borough council and representatives from CCGs. The board will meet quarterly to monitor performance and provide strategic oversight of the service. The board will also ensure that the service is compliant with NICE guidance. . The Board shall have responsibility for the creation and execution of the programme plan and deliverables, and therefore it can draw technical, commercial, legal and communications resources as appropriate into the Board.

The scheme will cover all 3 localities in HRW:
- The initial roll-out of the scheme will be to the population of Hambleton.
- This programme will be rolled out to Richmondshire within 6-9 months and discussions are on-going with the local leisure provider to finalise these arrangements.
- A feasibility study has been conducted for the Whitby locality, to provide solution to improving health and wellbeing for residents of the area, this is a GP lead initiative and roll out of the Health Trainers programme would provide a solution to the issues raised within this study.

Timescale and milestones
- Agree programme structure and expected outcomes with provider – March/ April 2014
- Continue discussions with Richmondshire provider – July 2014
- Service implementation (Hambleton) – September 2014
- Liaise with Whitby locality on development of programme – September 2014
- Service implementation (Richmondshire) – November 2014
- Service implementation (Whitby) - March 2015
- Evaluation and review – on-going

Stakeholder Groups/Engagement & Frequency
CCG, NYCC and District Councils (Hambleton District Council, Richmondshire District Council and Scarborough Borough Council) will work together to agree service model and expected outcomes. Health professionals including GPs to market the service and identify referral pathways

Established communication methods will be used to engage with health professionals.

Progress with the implementation of the project will be presented to the service Development and Improvement group for unplanned and community care, which meets monthly, and includes representatives from the CCG, STHFT and NYCC.

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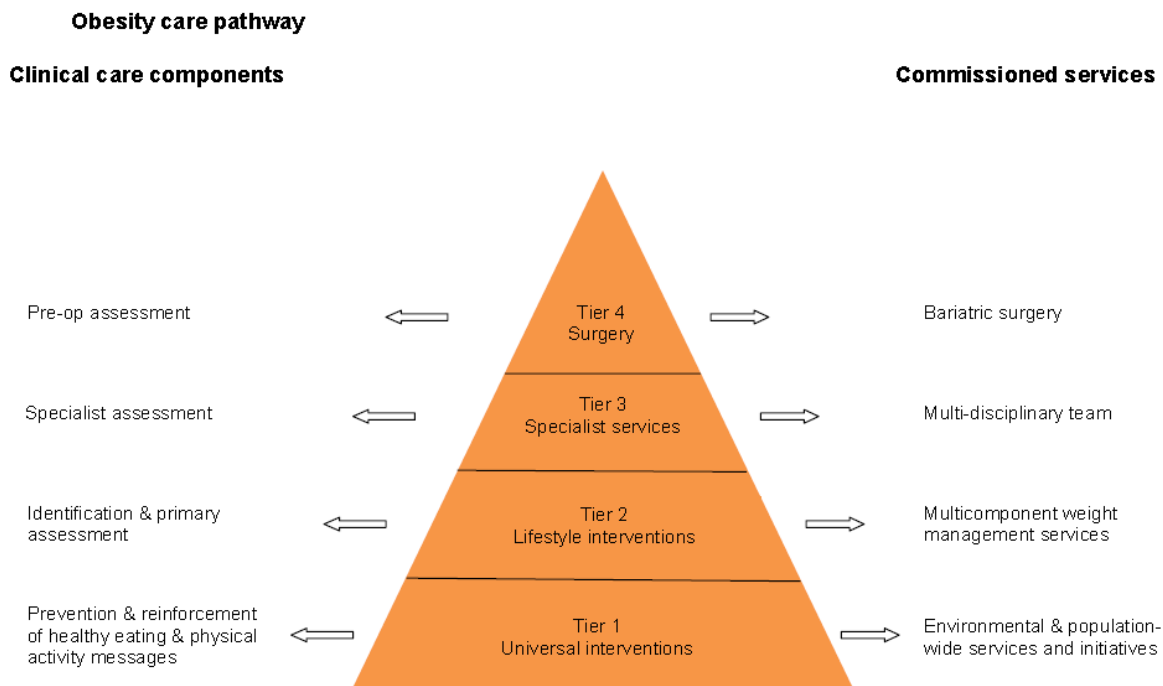Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

National evidence
The project will form part of the local integrated obesity care pathway. NICE guidance identifies an obesity care pathway as being made up for 4 tiers. Clinical Commissioning Groups are responsible for commissioning tier 3 and tier 4 services. The Local Authority is responsible for commissioning tier 2 as well as enabling and supporting tier 1 work.

NICE recommend an integrated approach to preventing and managing obesity. Local authorities, working with other local service providers, clinical commissioning groups and health and wellbeing boards, should ensure there is an integrated approach to preventing and managing obesity and its associated conditions in 'Obesity: working with local communities'. Systems should be in place to allow people to be referred to, or receive support from (or across) the different service tiers of an obesity pathway, as necessary.

There is currently very limited service provision across North Yorkshire across tier 2 – 3 services. All CCGS commission bariatric surgery (tier 4) but it is only available for patients that fit certain criteria. There are big gaps in tier 3 services across North Yorkshire. HRW CCG is currently the only CCG that commissions tier 3 specialist weight management services. At time of transfer of public health into the Local Authority on 1 April 2013, no tier 2 weight management services had been formally commissioned (although a few GP and pharmacies had tried to set up their own services for their patients).

Obesity care pathway

Clinical care components   **Commissioned services**

Pre-op assessment	←	Tier 4 Surgery	→	Bariatric surgery
Specialist assessment	←	Tier 3 Specialist services	→	Multi-disciplinary team
Identification & primary assessment	←	Tier 2 Lifestyle interventions	→	Multicomponent weight management services
Prevention & reinforcement of healthy eating & physical activity messages	←	Tier 1 Universal interventions	→	Environmental & population-wide services and initiatives

NICE guidance (53): Managing overweight and obesity in adults – lifestyle weight management services states that "The economic model estimated that a 12-week programme costing £100 or less will be cost-effective for adults who are overweight or obese under two conditions. First, the weight loss, compared with what it would have been without the intervention, must be maintained for life. Second, at least 1 kg of weight is lost and this weight difference is maintained for life (that is, the person's lifetime weight trajectory is lowered by at least 1 kg)."

Lifestyle change interventions:
Overall, the evidence summarised shows that there is sufficient evidence to justify well-targeted action to manage and treat adult obesity. The most recent rigorous and systematic reviews of the evidence for tackling obesity have been undertaken by NICE; the National Institute for Health Research; and the Cochrane.

- Interventions should be multi-component and focus on diet and physical activity together, rather than attempting to modify either diet or physical activity alone.
- Weight management interventions should include behaviour change strategies to; increase people's physical activity levels and/or decrease inactivity; improve eating behaviour and the quality of the person's diet and reduce energy intake. Many interventions have the potential to be delivered to families as well as to individuals.
- All interventions should be tailored to the individual and provide on-going support.
- Health professionals should discuss the range of weight management options with people. This might include a motivational interviewing approach if using appropriately trained staff.

This programme therefore would support NICE guidance on obesity and identification and management and NICE best practice standards for a multi-component weight management programmes and imminent draft NICE guidance.

Health trainers:
NICE have acknowledged the role of health trainers in their guidance on Behaviour Change, Smoking, Cessation, CHD & BME communities. Health trainers are also included in the guidance for stop smoking services issued by NICE in collaboration with Communities and Local Government February 2008 and in the subsequent toolkit May 2008.

The Kings Fund acknowledge the role of health trainers in their report Behaviour Change with Low Income Groups.

The Chief Medical Officers May 2008 Brief to all doctors in the country carried an article entitled "Health Trainers tackle Health Inequalities" describing the role of Health Trainers at the earliest end of the patient pathway.

Local evidence
Excess weight in adults is a public health key issue for North Yorkshire as the percentage of people who are overweight and obese is above the national average. The rising number of people who are classified as obese is growing. The costs of increasing obesity rates are multifaceted and are felt in both health and social care. Obesity related conditions are expected to increase as national projections suggest that around 90% of adult men could be obese or overweight by 2050.

Modelled estimates suggest that 24.2% (112,460) of adults in North Yorkshire are obese, the same as the national average of 24.2%. However, national projections suggest that around 90% of adult men could be obese or overweight by 2050.   North Yorkshire has have a higher than national average rate of adults with excess weight. Excess weight is categorised as having a BMI of 25+.
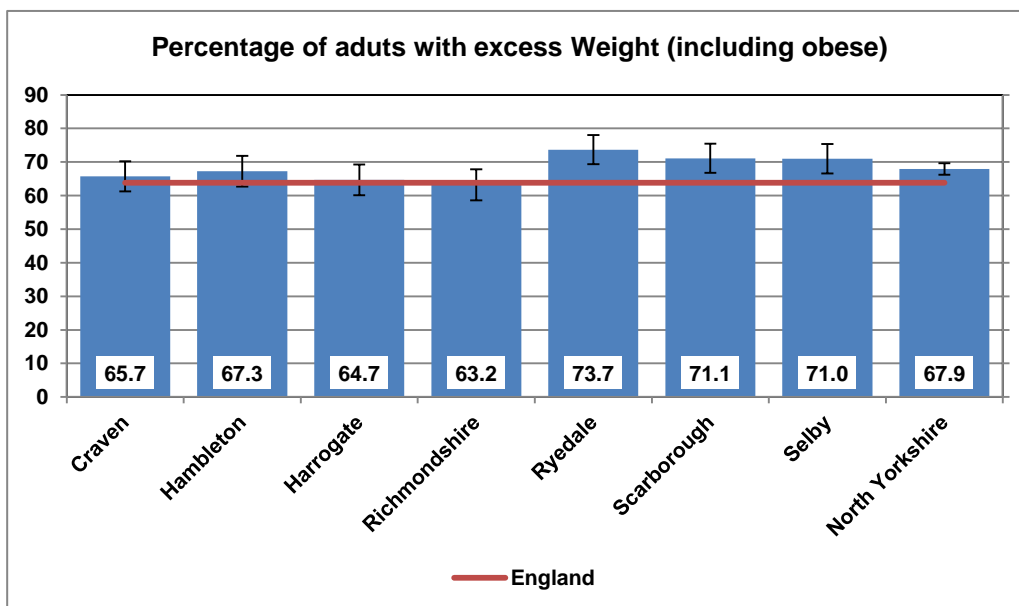
Percentage of aduts with excess Weight (including obese)

Craven	Hambleton	Harrogate	Richmondshire	Ryedale	Scarborough	Selby	North Yorkshire
65.7	67.3	64.7	63.2	73.7	71.1	71.0	67.9

— England

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

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

14/15 £50,000   15/16 £75,000

The main funding for this scheme is provided from the Public Health budget. Supplementary funding is provided through BCF as below:

Costs for year 1 (2014/2015)
- Hambleton: £18,750 (75% full costs due to July 2014 start)
- Richmondshire: £10, 417 (42% full costs due to November 2014 start date)

Full-year costs to the CCG in year 2 (2015/16)
- This equates to £25K per locality, i.e. £75K.

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

Benefits can be expected on both an individual and population level. For individuals losing weight can rescue their risk of:

- Type 2 diabetes
- Cardiovascular disease
- High blood pressure
- Respiratory disease
- Muscular skeletal disease

As obesity is a modifiable risk factor for a number of long term conditions, over time the number of people who have CVD, diabetes and other obesity related conditions will be reduced. This will result in lower expenditure on support services. Other expected benefits include:

- Reduce demands on services by empowerment of patient and carers to manage weight, which in turn improves their control of conditions such as diabetes, joint pain, and cardiovascular risk.
- Reduce morbidity in people with long term conditions through being a healthier weight.
- Reduce impact of poor nutrition and sedentary behaviour on health outcomes particularly in areas of the city with existing health inequalities
- Reduce mortality and morbidity by reducing risks associational with poor nutrition and sedentary behaviours by improving lifestyle in people with long term conditions

Excess weight in adults is an indicator identified in the Public Health Outcomes Framework. North Yorkshire is performs poorly compared to other areas in the region. Reducing the percentage of adults with excess weight would have appositive impact on this indicator.

Summary benefits:

- Reduced prevalence of obesity in North Yorkshire
- Improve the health outcomes through a reduction in prevalence and risk of disease associated with obesity and overweight
- Contribute to improved life expectancy across North Yorkshire
- Anthropometric measures, such as percentage weight loss, or changes in weight, BMI or waist circumference
- Maintenance of weight loss in the short, medium and long term
- Intermediate measures such as changes in diet or physical activity level
- Psychological outcomes such as self-efficacy, motivation or mental wellbeing
- Provide signposting to social physical activities in the local area providing both economic and social benefits
- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people to recover from episodes of ill-health or following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in safe environment and protecting them from avoidable harm

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 District Council's will be expected to deliver a set of specific outcomes. Resource will be identified by the District Council to ensure these are achieved. Provider training standards and staff competencies will be identified by the public health team to ensure appropriate support for the programme.

- This is a new service which will need to be closely evaluated on an on-going basis
- The pilot will be evaluated on outcomes achieved

The following KPIs will be key:

How much service did we deliver?
- Number of people accessing group lifestyle programme
- Number of people accessing 121 support (where available)
- Number of older people accessing older people programme
- Number of referrals to programmes
- Number of referral to other NYCC funded lifestyle services i.e. smoking cessation
- Number of people completing the programme

How well did we deliver it?
- % of appropriate referrals
- % of people who lost 3% body weight at end of intervention
- % of people who lost 5 % body weight at end of intervention
- % of clients followed up at 6 and 12 months
- % of people who increased physical activity levels from baseline to end of intervention
- % who increase their wellbeing score from baseline to end of intervention
- % of clients that rate services as good or excellent
- % of clients completing the programme.

- % of referrers (primary care) who report having a clear understanding of the service and referral process.

How much change/effect did we produce?
- Clients / service users will have increased confidence and ability to make positive, long-term behaviour changes specifically:
- Number of people who have increased their PA levels
- Number of people who have improved diet.
- Number of people who lost 3% of weight.
- Numbers of people who report have improved health and wellbeing.
- Number of people accessing wider support for lifestyle.

What quality of change/effect did we produce?
- % of people maintaining weight loss at 6 and 12 months
- % of people who maintained PA levels at 6 and 12 months
- % of clients who have increased wellbeing at 6 and 12 months.

Where possible, the project will collect other outcomes (using validated measuring tools), for example changes in eating behaviours, physical activity and sedentary behaviours and changes in self-esteem, depression or anxiety.

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

- An organisational structure that provides consistent and long-term leadership in delivery of the programmes linking together the CCG, NYCC and District Councils
- Clear organisational and integrated governance (including clinical governance) systems and structures with clear lines of accountability and responsibilities
- Effective and well-evaluated programmes that encourage further participation and have long term impacts on people's health
- Effective publicity and "good news" stories
- Effective referral arrangements and publicity amongst GP practices, local communities, social services and acute providers that ensures those people who are most in need are signposted to the service

Scheme ref no.
HRW_010_PHP

Scheme name
Prevention Officers aka "Community Navigators or Agents"

What is the strategic objective of this scheme?

The proposed scheme will target individuals (and their carers) who are at high risk or on the cusp of health and social care interventions by facilitating access to other support and helping the person find solutions for themselves. The objective of the scheme is to build a partnership between the work of the NYCC's Public Health team, local commissioners and providers including Adult Social Care, to create a local network of community-based support.

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?

This scheme will build networks, relationships, solve problems and locate resources, through what can often be a complex system of organisations and services. Through time-limited interventions. Service providers will promote the recovery, independence, health and wellbeing of service users. This type of person centred, enabling, and recovery focused process can be carried out by a number of roles and in various settings, complementing and strengthening health and social care teams and adding value to services. They will work under the ethos of Make Every Contact Count and not refer to another statutory service unless necessary – but where support is needed to access further, this will be facilitated, without providing the hands on support personally.

What is a Prevention Officer?

- Facilitator
- Communicator
- Signposter
- Advisor and educator
- Networker
- Confidence builder
- Person who can identify low level needs

Specifically this service will:

- Provide outreach support, meeting with individuals to discuss their assets and needs (time limited caseload) around their wellbeing
- Facilitate the access to telecare, equipment and adaptations through the Home Improvement Agency

- Link with GP practices, food banks, Job Centres, the voluntary sector and other community services,
- Provide an accessible signposting and advice enabling access to entitlements and local services including financial support, falls, lifestyles and making referrals to other agencies as necessary
- Build on existing partnerships and integration of voluntary and community sector. Including benefits maximisation, employment / training options, and other community based schemes
- Feed into the directory of local services to be maintained as part of *Stronger Communities*
- Help people maintain and improve their wellbeing and independence
- Be a trusted key player in the local health and care network
- Provide information to the local commissioner and Stronger Communities on gaps and needs

Target population:
This scheme will target interventions at adults who are at high risk or on the cusp of a health or social care intervention. The interventions will be time-limited to mitigate dependency but reviews will take place to ensure the preventative nature and assess the longer term impact.

This scheme will work closely with scheme HRW_007_CIR to work with the clients that have been systematically identified within the risk profiling and stratification work as well as clients with lower levels of need.

Self-referrals, district councils, the voluntary sector, GPs and community nursing teams will be key referrers; people who are already in contact with social care are also very important.

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

Commissioning the services will be a joint endeavour between North Yorkshire County Council and Hambleton, Richmondshire and Whitby CCG. This will involve a local service model to take account of the differing localities within the CCG, but in line with county-wide principles.

The delivery of the project will include two main elements:

1. The initial development will be a central initiative rolled-out by Public Health within the Local Authority. Core funding for this programme (c. £1 million for the county has been allocated outside the BCF within central public health funds).
2. Local initiatives based on an additional £75K included within the BCF to allow wider roll-out of the service and local experimentation to find the best fit with rural communities. HRW CCG will be an active partner in the broader programme, but the additional funding will provide the opportunity to test and develop different approaches and models.

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

The high level plan:

Preparing the ground
Identifying the issues, evaluation of services in operation elsewhere to ensure learning is gained and planning the process:
- Agree county –wide and local service model arrangements – November - December 2014

Building the foundations
Ensuring the service is fit for purpose and uses best practice:
- Commission a customer insight piece of work to determine the approach and model – Nov-Dec 2014
- Commission branding and marketing work – Jan-April 2015
- Consult on model with stakeholders – Nov 2014
- Provider engagement Nov 14 – March 15
- Implementation plan agreed Nov 2014
- Evaluation process agreed Dec 14 – Jan 15
- Data sharing agreements and processes Jan-Mar 2015
- Advert Dec 2014
- Interviews Jan 2015
- Commence recruitment – Feb -Mar 2015
- Training March – April 2015

Integrate our services and delivering a difference

Implementing our new service
Delivering our model to ensure that all parts of the system work together to make a difference to patients, working across primary and secondary care, mental health services, social services and the voluntary sector.

- Service Operational April 2015
- Communications Launch January – April 2015
- Evaluation – Sep 2015

Work to be progressed through regular workshop approach to create a service model supported by specific task and finish groups to ensure deadlines are met.

The model will be delivered initially within NYCC HAS with a view to commissioning the service externally long term.

Trialling local rural models
Augmenting the county-wide service with additional support to address local service gaps through BCF:
- Agree service model – December 2014
- Agree local HRW contribution to wider Public Health project – December 2014
- Consult on model with stakeholders – Jan to March 2015
- Commence recruitment – March 2015
- Model goes live – between April and June 2015

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

Public Health and NYCC have done in-depth consultation and data intelligence gathering to identify the triggers that determine whether someone ends up in health or social care services.

Key triggers include:
- Bereavement
- Perceptions of loneliness and isolation
- Inability to access support
- Family pressure/anxiety
- Carer breakdown, family move away etc.
- Onset of incontinence and need for care at night
- Onset of 'behavioural issues'
- Health incident/crisis
- Declining health/LTCs
- Falls
- Fear/community safety issues/crime
- Unsuitable housing/maintenance/warmth

Various models are being delivered across the country. We need to create a culture of prevention rather than cure, supported by effective early interventions, across agencies, organisations and citizens, coupled with a balanced approach to investment in preventative services. Investing early in public health programmes is highly cost-effective.[2] The Prevention Institute has evidenced that the return on investment in community-based prevention is five-fold; for every £1 invested the return amounts to £5.60.[3]

[1] Owen, L, Morgan, A., Fischer, A., Ellis, S., Hoy, A., Kelly, M.P. (2011) The cost-effectiveness of public health interventions, Journal of Public Health

[2] Prevention Institute (2008) *Prevention for a Healthier America: Investments in disease prevention yield significant savings and stronger communities*, accessed from www.preventioninstitute.org on 7th January 2013

The emerging system-wide vision is based on supporting people to live at home and use services delivered at home or as near as is possible and safe. We intend to make the 'National voices' narrative –"I can plan my care with people who work together to understand me and my carer(s), allowing me control and bringing together services to achieve the outcomes important to me" – central to the delivery and commissioning of this service.

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[2] Owen, L, Morgan, A., Fischer, A., Ellis, S., Hoy, A., Kelly, M.P. (2011) The cost-effectiveness of public health interventions, Journal of Public Health
[3] Prevention Institute (2008) *Prevention for a Healthier America: Investments in disease prevention yield significant savings and stronger communities*, accessed from www.preventioninstitute.org on 7th January 2013

Assumptions

Research from other authorities who have either employed or commissioned Prevention Officers indicates that a salary of between £15,000 - £18,000 strikes a good balance between getting confident and competent staff and ensuring that these staff are 'doers' and will not get overly side tracked by more strategic work which will form part of *Stronger Communities*. This salary is broadly comparable with other models that have been reviewed.

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

15/16 £75,000

BCF costs:
- Staff Cost £15,000 - £18,000 per whole-time officer, plus on costs at 20% is £18,000-21,600
- The additional funding of £75K will create 3/4 full time posts in HRW CCG area

The following costs will be attributable to Public Health:
- HRWCCG share of £1 million for first wave social care-hosted posts
- Training costs (Public Health)
- Customer insight 15k (Public Health)
- Marketing and Branding costs 20k (Public Health)
- 2 year academic evaluation £50k (Public Health)

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

The intention is for more patients to be cared for in their own homes and communities, to be actively re-abled faster, and hence to remain within their own homes as long as possible, without being admitted either back to acute care or long term residential homes. Local engagement has highlighted the value of social interaction, being involved in their communities, keeping active and receiving help as early as possible.

It is envisaged that the impact from this scheme may be longer term as this is about keeping people within their communities and ensuing they have the support they need as early as possible. This scheme will also link closely to HRW-007-CIR scheme and an enabler across the CCG for all of our community services. Therefore benefits have not been identified specifically to this scheme.

PH intelligence are working with health and social care data to determine the outcomes framework. It is envisaged that the Prevention Officers will use a HAS recording system to record outcomes with individuals.

It is envisaged that this scheme should enable savings to be made in conjunction with other schemes on:

- Reductions in the volume and cost of social care packages
- Reductions in non-elective activity
- Reduction in avoidable admissions
- Reduction in the volume of (unproductive) assessments across health and social care
- Increase in the proportion of older people living independently at home
- Reduction in long-term nursing and residential home placements including those directly from hospital.
- Reductions in GP visits
- Working more effectively across service boundaries

Better Care Metrics

The scheme should under pin and support all of the Better Care Fund Schemes. Specifically it should help support the reduction in:

- Permanent admissions to nursing homes
- Reducing delayed transfers of care
- Reduce emergency admissions
- Reduce falls in people aged 65 and over

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 project will be developed through a partnership with NYCC Public Health. The process of management and governance to ensure effective outcomes are achieved would be through the ICB or a subgroup of the ICB which will identify issues concerns and outcomes.

Local elements of the scheme will also be reported through the Service Delivery and Improvement Group for unplanned care and community services (monthly), which includes representation from the CCG, STHFT, NYCC and other partners.

The evaluation will be a 2 year academic evaluation with a mid-year report this will enable commissioners to shape the service.

The quantity and volume of the service will be measured through activity levels through the service/number of joint health and social care assessments/ no of referrals to voluntary sector etc.

KPIs to be tracked include:

- Reduction in falls
- Reduction in hospital admissions
- Reduction in GP visits

- Reduction in health and social care support
- % of people re-referred after START within x months (or average delay before re-referral)
- Monitor falls, social contact, weight, alcohol etc. at assessment, 6 week and 6 month and 12mths prevention review. Looking for % of cases where there has been an improvement over 6 weeks / 6 months
- Employment support (employment retention), maximise welfare benefits, alleviation of financial hardship
- Reduction in outpatient and accident & emergency visits, reduced medication intake
- Happiness with the services
- Health and wellbeing scores

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

- One of the key successes will be partnership working across Health, Social Care and the Voluntary Sector.
- Strong provider engagement and monitoring will enable the scheme to adapt to any real time changes and enable flexibility in service delivery.

	Outcome
1	Preventative thinking is the norm across health and social care
2	People are healthy
3	People experience economic wellbeing
4	People are safe and independent
5	People experience wellbeing
6	Carers are healthy and experience wellbeing

Scheme ref no.
HRW_011_PHP

Scheme name
Prevention Initiative – Improving Access to Psychological Therapies (IAPT)

What is the strategic objective of this scheme?

To commissioning a new IAPT service model which meets demand and provides appropriate outcomes and greater access for the population of Hambleton, Richmondshire and Whitby in line with the public health prevention strategy.

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?

Service model
Supported by additional investment from the BCF, the new service model will provide a range of therapies from low level interventions and support to high intensity treatment within primary and community settings that is responsive and accessible. This will:

- Provide an opportunity to develop a broader range of therapeutic and preventive choice, combined with elements of social care.
- Ensure service is appropriately funded for the HRW population, ensuring that the 28 day referral to treatment target is met.
- Reduce the number of patients escalated to a crisis situation.
- Improve numbers of people experiencing recovery.
- Develop a directory of IAPT services available.

IAPT service description
The service comprises a community-based Psychological Therapies service to deliver a range of services to people with common mental health disorders. These services should treat conditions that are covered by a traditional IAPT model, plus additional conditions where NICE guidance dictates, including:

- Adjustment depression or anxiety in adults with a chronic physical health problem e.g. chronic pain or medically unexplained symptoms
- Anger management
- Bulimia nervosa
- Generalised anxiety disorder
- Health anxiety (hypochondriasis)
- Mild learning disability or cognitive impairment
- Mild depression and anxiety
- Obsessive-compulsive disorder

- Other co-morbid mental health conditions e.g. non-acute or stable psychosis where anxiety or depression-related symptoms are present
- Panic disorder
- Personality disorder (not severe and where anxiety and depression related symptoms are present
- Phobias (including social anxiety disorder)
- Post-traumatic stress disorder

The Service is required to be delivered from a range of community venues in an environment which is conducive to the needs of the individual, offering anonymity if required (e.g. in some cases of self-referral).

- Delivered close to a patient's home wherever possible (and in patient's own homes where they are housebound or have prohibitive mobility issues)
- Community settings could include GP practices, libraries, resource centres and employment settings
- Closely aligned with GP practices to ensure good integration with primary care
- Integrated within local healthcare systems
- Services need to be provided in easily accessible locations well-served by public transport
- Identified space for group interventions to be easily identified

Operating hours of the service across the geographic area should be as a minimum, 8.00am – 6.00pm, Monday to Friday, with an additional minimum of 5 hours regular extended opening hours on a weekend.

GPs or other registered health professionals should ensure that only suitable persons are referred into the service and will usually include a PHQ9/GAD7 outcome measure with their referral. When a patient self refers, the Service should undertake initial screening to seek preliminary caseness prior to any assessment. The patients GP must be informed prior to any assessment commencing, to ensure that other avenues of treatment which may be contra indicated are not already in place.

Every person who is referred (or self-refers) to the IAPT Service will receive a comprehensive patient-centred assessment by a member of the psychological therapies team within 10 working days from receipt of referral. People that are identified to be at high risk (e.g. suicidal ideation, severe self- injurious behaviour, psychotic symptoms) should be referred to the appropriate step 4 mental health service, within appropriate timescales:

Patient cohorts
Prevention of ill-health is a shared priority between HRW CCG and NYCC and the inclusion of IAPT within the BCF is an important part of ensuring parity of esteem for mental health services in the context of preventative services.

The new service model will also help to ensure that national targets for IAPT are achieved for local residents, specifically ensuring that a recovery rate of 15% is achieved.

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

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

Commissioner / provider
The lead commissioner is HRWCCG. Additional support will be provided from the North Yorkshire Partnerships Commissioning Unit to oversee the delivery of IAPT services across the whole county.

The lead provider is TEWV (Tees, Esk and Wear Valleys) NHS Trust. While, there are a number of providers in the market, it was deemed more effective to work with one provider who is already established within Hambleton, Richmondshire and Whitby to develop an effective service model which meets the needs of the local population.

The new IAPT service model will be developed in partnership with provider to ensure psychological therapies are complimentary to and support other mental health services in place. Project management support is being provided from both the provider and the CCG to develop and implement a service model which meets national IAPT targets.

Timescales and Milestones
- Agreement with provider to develop IAPT model – March 2014
- Service Design co-produced with providers and commissioners – April 2014
- Devise service specification – April/May 2014
- Contract Variation – September 2014
- Devise KPI's –September 2014
- Devise service improvement plan- October 2014.
- Additional staff recruitment (provider) - October 2014
- Service go live – July 2014

Stakeholder Groups / Engagement & Frequency
- New and current service provider and relevant staff groups
- Community Teams and GPs
- Feedback to be obtained on proposed new service specification

The development is being principally taken forward through the CCG's Mental Health Service Improvement Group which meets monthly, with co-reporting through the partnership Service Delivery and Improvement Group for unplanned care and community services (also monthly).

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

National evidence
It is estimated that around 17.7% of adults aged 18 and older meet the diagnostic criteria for at least one common mental health disorder.

Reducing the prevalence of common mental health disorders such as anxiety and depressive disorders is a major public health concern. In 2007 the annual cost to treat depression and anxiety disorders in England was nearly £3 billion, with an additional

economic impact of around £13 billion in lost earnings among people of working age.

Prevalence of Common Mental Health Disorders
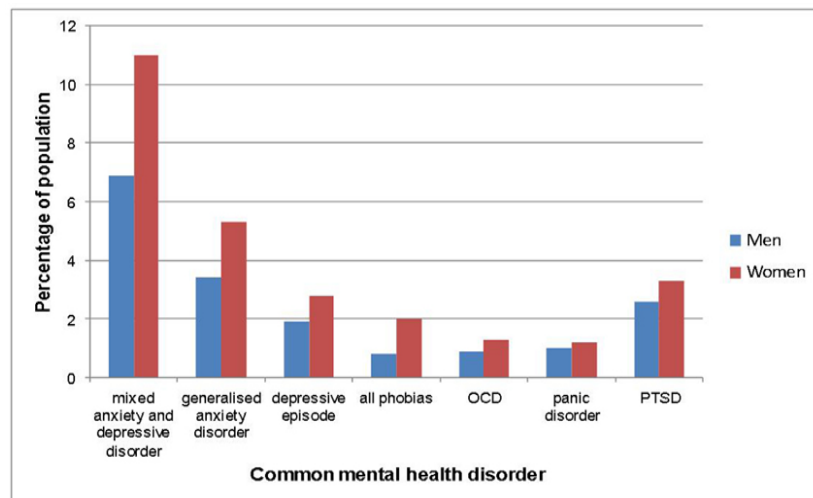
There is strong evidence that appropriate and inclusive services and pathways for people with common mental health problems, specifically depression and anxiety, reduce an individual's usage of NHS services whilst contributing to overall mental wellbeing and economic productivity.

Achieving parity of esteem between mental and physical health raises the importance of offering holistic interventions that impact on both health and mental wellbeing. It is therefore important that IAPT Services are designed to ensure that general health and wellbeing are also considerations in treatment interventions.

The Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis (2014) highlights the importance of early intervention service being in place to prevent crisis situations by having a single point of access to a multi-disciplinary mental health teams. It states that this access point should be available to agencies across the statutory and voluntary sectors.

NICE recommends a stepped care approach to providing psychological therapies, the principles of this are that treatment should have the best chance of delivering positive outcomes whilst burdening the patient as little as possible and ensure a system of scheduled review in order to step up or step down care.

The IAPT commissioning toolkit assists with the establishment of a stepped care approach and ensures NICE guidelines are incorporated into commissioned IAPT Services. IAPT is a national priority within the national planning guidance and has been identified as a national quality premium objective.

Local rationale for scheme
The service has recently moved from Leeds and York Partnership Foundation Trust (LYPFT) to Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) due to the previous provider not achieving the national targets set.

The service is expected to be up to full capacity in October 2014 and the CCG has set targets to achieve in line with the national targets. The targets are 15% referral to

psychological therapies and 50% recovery rate. These targets are expected to be achieved in quarter 4 2014/15 and maintained from this point on.

The CCG felt it was important to have a service that could achieve the targets but also understand the local population for which it provides the service.

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

14/15 £154,000   15/16 £205,000

The costs of the original service model are already provided within CCG base-line budgets. The additional costs for the new model, with improved outcomes and access have been included within the BCF. These equate to £205,000 on an annual basis.

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

- Enhance quality of care for patients
- Reduction in delays to assessing patients to ensure appropriate pathways of care
- Meeting national targets
- Service model that meets the needs of the population and GPs referring into this service
- Working more effectively across services boundaries
- Reduction in avoidable admissions
- Patient supported in the community
- Reduced repeat attendance at A&E for patients reaching crisis
- Improved patient satisfaction
- Meeting national targets
- A service model that meets the needs of the population and GPs referring into this service
- Reduce in the number of people in crisis due to lack of psychological support
- Reduce attendances to A&E
- The development of a model that identifies possible savings

Further work is required to develop a model to identify possible savings. It is anticipated that these would be delivered from acute non elective admissions and efficiencies within other areas of mental health services.

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 delivery of the service will be tracked closely with the provider as follows:
- Establish an action plan to manage the back log of patients waiting for treatment
- Working closely with the provider to continuously monitor and review the service
- Conduct regular analysis of performance and quality data
- Attend monthly quality meetings with the provider.

Progress with the IAPT recovery target will be tracked in association with the CCG's Business Intelligence Department within the Commissioning Support Unit and tracked on CCG dashboards and at the TEWV quality meeting managed by the PCU.

The service itself will ensure it delivers services of appropriate quality:
- The Service will be expected to undertake a clinical quality audit of the care of clients on an annual basis.
- The Service will have an established Clinical Governance programme.
- All clinical staff to receive regular personal development plans linked to their individual knowledge and skills framework and are encouraged to access clinical supervision and benchmarking to ensure quality of care delivery.

KPIs: The service will collect, analyse and report data covering the following KPIs:

- Accessibility
  - Ensuring waiting times and the range of interventions provided are appropriate
- Equity of access
  - Ensuring the service is available to all sections of the community, by means of a local equality impact assessment.
- Effectiveness
  - Obtaining pre and post-treatment outcome data for at least 90% of the people treated by the service.
  - Demonstrating reductions of symptoms for the conditions treated.
  - Demonstrating social inclusion and employment outcomes.
- Acceptability and quality
  - By monitoring satisfaction and choice amongst people who use the service, benchmarked against comparators nationally.
  - By monitoring supervision of trainees and qualified staff.

Clinical effectiveness measures will be achieved through:
- The IAPT assessment should include as a minimum the PHQ9 and GAD7 outcome measures, plus the IAPT Phobia Scale and Worker & Social Adjustment Scale (WSAS) outcome measures where necessary, in order to help assess service outcomes.
- Clinical outcome measures of depression and anxiety are completed pre-assessment, at initial assessment and at the end of treatment.
- Patient satisfaction surveys are sent out to the patient at the end of treatment.
- All staff received clinical supervision on a monthly basis.

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

- Reduction in mental health stigma
- Effective working links between GPs and IAPT practitioners
- Successful recruitment of additional IAPT workers
- Effective treatment that maximises a client's outcomes
- Effective identification by referrers of appropriate clients
- Effective triage of patients into the most appropriate service

Scheme ref no.
S&R_002_PHP

Scheme name
Prevention Workers (Health Trainers / Self Help)

What is the strategic objective of this scheme?

Prevention workers target their work at individuals (and their carers) who are at high risk or on the cusp of health and social care interventions by facilitating access to other support and helping the person find solutions for themselves. Prevention workers aim to deliver a bespoke understanding of current services and facilities in the locality and aim to work on a one to one basis to support, motivate and signpost members of the public to make long-term healthy lifestyle choices and lifestyle services. The target supports the clients to set achievable realistic goals and then signposts to appropriate services in the local area. Clients can either be referred by professionals or they can self-refer provide motivation, support and signposting; they do not provide any medical support to clients.

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?

The JSNA for North Yorkshire highlighted problem areas where there were shorter than average life expectancies. These were linked to low incomes, unemployment and increased occurrence of Long Term Conditions (LTC). As part of the JSNA strategy there is a priority to reduce ill health, improve information to help people manage their conditions as well as help with obesity, smoking cessation, drug and alcohol misuse and dealing with LTC.

The 2012 Joint Health Needs Assessment[4] identified the areas covered by Scarborough and Ryedale CCG, and Scarborough Borough Council as having significant health needs, particularly in relation to the additional health service requirements of an ageing population and the inequalities as a result of socio-economic deprivation.

Life Expectancy at Birth

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[4] Accessed from www.northyorks.gov.uk/jsna

The leading cause of premature death (<75 years) in Scarborough is cancer (38% of deaths), closely followed by cardiovascular disease (31%). The CVD rate of early death in Scarborough is significantly greater than both the National and North Yorkshire rate.

Premature Mortality (<75years) for Cardiovascular Disease (2009-11)
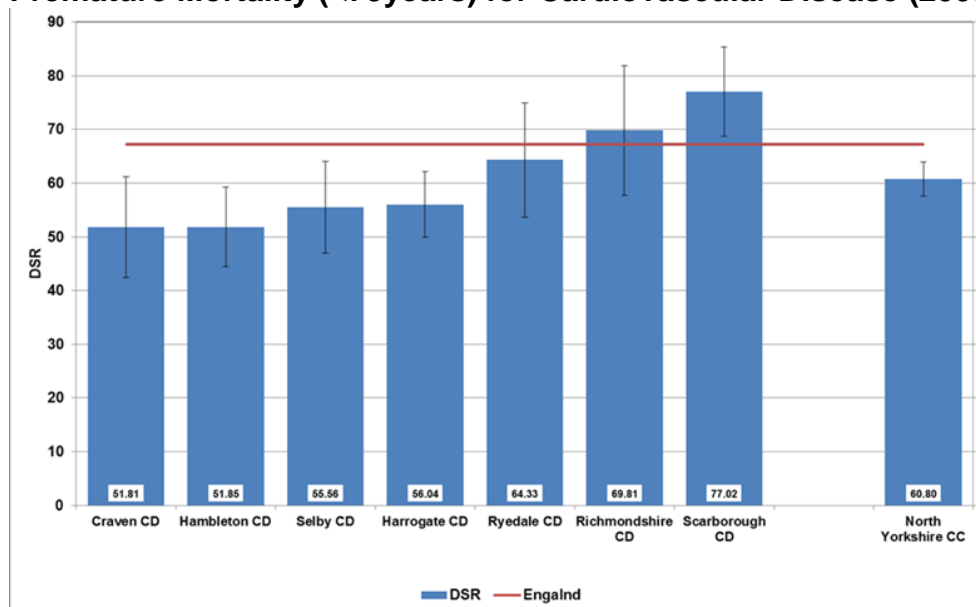
Scarborough also has a high prevalence of risky behaviours that contribute to cardiovascular disease and cancers; particularly smoking and alcohol use. Both smoking and alcohol use have been identified as behaviours that can lead to poorer outcomes for people who have a LTC; contributing to acute or chronic exacerbations of disease. There are evidence-based and cost effective interventions for both smoking and alcohol use, however additional resources could ensure that patients, particularly from deprived populations, access and successfully complete these programmes.

The population health needs place a growing burden on the resources available to SRCCG. For example, there is a high and growing rate of non-elective admissions (109 per 1,000 population in 2011)[5] in SRCCG that could be reduced by:

- Reducing the levels of disease in the population through better preventative measures,
- Improve primary care management of diseases,
- Developing clear pathways in the community to avoid unnecessary emergency service utilisation.
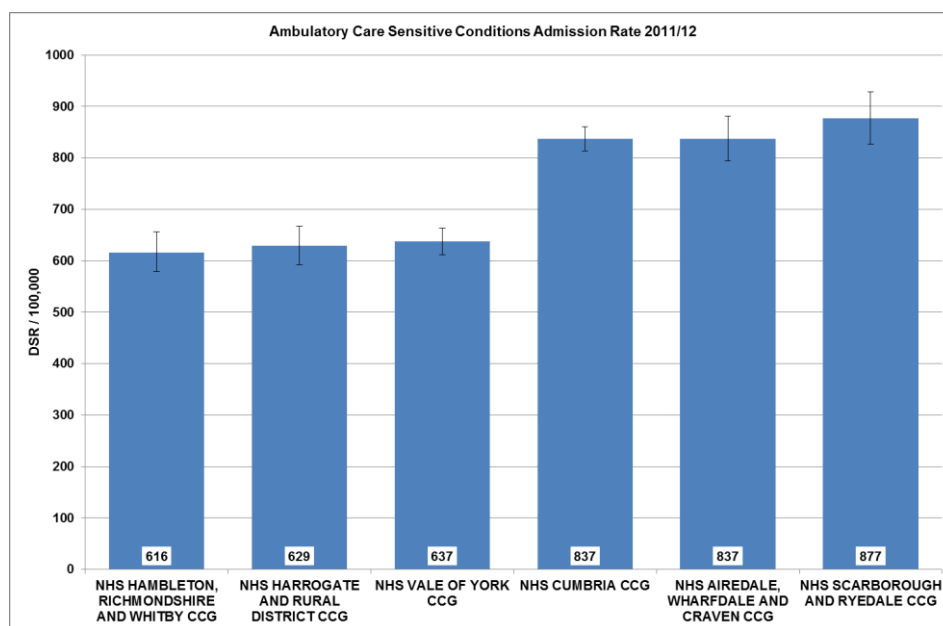
Similarly, the rate of hospital admissions for ambulatory care sensitive conditions[6] in Scarborough is significantly higher than the North Yorkshire rate. The Kings Fund[7] cite that around 16% of all emergency admissions in England are due to ACS and therefore actions to control these conditions and maintain health and wellness in individuals with

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[5] NHS England (2012) Outcomes benchmarking support packs: CCG level.

[6] Ambulatory care sensitive (ACS) conditions are chronic conditions for which it is possible to prevent acute exacerbations and reduce the need for hospital admission through active management, such as vaccination; better self-management, disease management or case management; or lifestyle interventions. Examples include congestive heart failure, diabetes, asthma, angina, epilepsy and hypertension.

[7] Accessed from http://www.kingsfund.org.uk/projects/gp-commissioning/ten-priorities-for-commissioners/acs-conditions

these conditions are recommended.

Purdy (2010)[8] suggests that evidence-based interventions for avoidable admissions (such as behavioural change programmes to encourage patient lifestyle change) should be implemented and evaluated locally. In order to support the broader strategy of SRCCG to improve health and reduce health inequalities it is proposed that a Health Trainer Service could be implemented to work (in conjunction with additional services) with individuals in deprived communities, and individuals identified with a LTC or at risk of developing a LTC.

Various national initiatives which aim to tackle health inequalities and encourage personal responsibility for health have been in existence since the early part of the millennia. These services are at the forefront of national and local strategies addressing behaviour change, using a robust evidence base.   The programme is based on behavioural science, drawing on principles of behaviour change developed in social and health psychology, and adopts a personalised care planning approach focused on self-care and empowering service user to make informed decisions about their health and behaviour. The trainer- service. user relationship is characterised by collaboration and cooperation, rather than paternalism.   It encourages people, primarily from disadvantaged communities, to make healthier lifestyle choices. The concept of Health Trainers was first identified in the 2004 White Paper 'Choosing Health'. Health Trainers are trained to use a variety of practical tools and techniques to help people change behaviour patterns that can damage their health.   These techniques are based on psychological evidence and theories.

There is an opportunity to work collaboratively within the BCF programme jointly commissioning social prescribing, prevention and redirection of high-risk patients within the Scarborough & Ryedale CCG area in collaboration with a wider piece of work across the NYCC by Public Health. The service will allow people to access help and advice prior to the need for escalation in care need.

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[8] Purdy, S. (2010) Avoiding Hospital Admissions. What does the research evidence say? www.kingsfund.org.uk

Prevention Workers build networks, relationships, solve problems and locate resources. Through time-limited interventions they will promote the recovery, independence, health and wellbeing of service users. This type of person centred, enabling, and recovery focused process can be carried out by a number of roles and in various settings, complementing and strengthening health and social care teams and adding value to services. They will work under the ethos of Make Every Contact Count and not refer to another statutory service unless necessary – but where support is needed to access further, this will be facilitated, without providing the hands on support personally.

What is a Prevention Worker:
- Facilitator,
- Communicator,
- Signposter,
- Advisor and educator,
- Networker,
- Confidence builder,
- Person who can identify low level needs.

Specifically the Prevention Workers will:
- Provide outreach support, meeting with individuals to discuss their assets and needs (time limited caseload) around their wellbeing
- Facilitate the access to telecare, equipment and adaptations through the Home Improvement Agency
- Link with GP practices, food banks, Job Centres, and other community services,
- Provide an accessible signposting and advice enabling access to entitlements and local services including financial support, falls, lifestyles and making referrals to other agencies as necessary
- Build on existing partnerships and integration of voluntary and community sector. Including benefits maximisation project, employment / training options, other community based schemes
- Feed into the directory of local services to be maintained as part of *Stronger Communities*
- Help people maintain and improve their wellbeing and independence,
- Be a trusted key player in the local health and care network,
- Provide information to the local commissioner and Stronger Communities on gaps and needs

Target population

Prevention Workers will target interventions at adults who are at high risk or on the cusp of a health or social care intervention. The interventions will be time limited to mitigate dependency but reviews will take place to ensure the preventative nature and assess the longer term impact.

Self-referrals, district councils, GPs and community nursing teams will be key referrers; people who are already in contact with social care are also very important.

**North Yorkshire Health and Wellbeing Board
Better Care Fund Plan**

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

This is a co-commissioned piece of work between NYCC Public Health and SRCCG.

Timescales and Milestones
- Project plan agreed – End Sept 2014
  - Three phase – East, West, Central
- Design group established – keep it focussed
  - ASC, CCG, PH, Academic, CRC, District?
  - Social Marketing work commissioned – Oct 2014 to report in Nov 2014,
  - Commission an evaluation – researcher to join design group to ensure outcomes and measures are built in the design phase,
  - Test with ops, older people's forums,
  - Spec and JD complete – November 2014
- Sign off of phase 1 recruitment – HASLT December 2014
- Recruitment starts December 2015
- Team in recruited Feb 2015
- Team starts – Feb – March 2015
- Team training – Feb- March 2015
- Phase 1 staff in operational – April 2015

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

Various models are being delivered across the country

We need to create a culture of prevention rather than cure, supported by effective early interventions, across agencies, organisations and citizens, coupled with a balanced approach to investment in preventative services. Investing early in public health programmes is highly cost-effective.[9] The Prevention Institute has evidenced that the return on investment in community-based prevention is five-fold; for every £1 invested the return amounts to £5.60.[10]

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

14/15 £135,000   15/16 £135,000

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[9] Owen, L, Morgan, A., Fischer, A., Ellis, S., Hoy, A., Kelly, M.P. (2011) The cost-effectiveness of public health interventions, Journal of Public Health, (NEED REST OF REF)
[10] Prevention Institute (2008) *Prevention for a Healthier America: Investments in disease prevention yield significant savings and stronger communities*, accessed from www.preventioninstitute.org on 7th January 2013

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

Research from other authorities who have either employed or commissioned Prevention Workers indicates that a salary of between £15,000 - £18,000 strikes a good balance between getting confident and competent staff and ensuring that these staff are 'doers' and will not get overly side tracked by more strategic work which will form part of *Stronger Communities*. This salary is broadly comparable with other models that have been reviewed.

- Staff Cost £15,000 - £18,000 per whole-time worker, plus on costs at 20% is £18,000-21,600
- Estimated management costs and training at 20%

In a worst case scenario the estimated cost per client is £259.20.

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 project will be developed through a partnership with NYCC Public Health. The process of management and governance to ensure effective outcomes are achieved would be through the ICB or a subgroup of the ICB which will identify issues concerns and outcomes.

Local elements of the scheme will also be reported through the Service Delivery and Improvement Group for unplanned care and community services (monthly), which includes representation from the CCG, STHFT, NYCC and other partners.

The evaluation will be a 2 year academic evaluation with a mid-year report this will enable commissioners to shape the service.

The quantity and volume of the service will be measured through activity levels through the service/number of joint health and social care assessments/ no of referrals to voluntary sector etc.

KPIs to be tracked include:

- Reduction in falls
- Reduction in hospital admissions
- Reduction in GP visits
- Reduction in health and social care support
- % of people re-referred after START within x months (or average delay before re-referral)
- Monitor falls, social contact, weight, alcohol etc. at assessment, 6 week and 6 month and 12mths prevention review. Looking for % of cases where there has been an improvement over 6 weeks / 6 months
- Employment support (employment retention), maximise welfare benefits,

alleviation of financial hardship
- Reduction in outpatient and accident & emergency visits, reduced medication intake
- Happiness with the services
- Health and wellbeing scores

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

	Outcome
1	Preventative thinking is the norm across health and social care
2	People are healthy
3	People experience economic wellbeing
4	People are safe and independent
5	People experience wellbeing
6	Carers are healthy and experience wellbeing

Measures could include;

- Reduction in falls
- Reduction in hospital admissions
- Reduction in GP visits
- Reduction in health and social care support
- % of people re-referred after START within x months (or average delay before re-referral)
- Monitor falls, social contact, weight, alcohol etc. at assessment, 6 week and 6 month and 12mths prevention review. Looking for % of cases where there has been an improvement over 6 weeks / 6 months
- Employment support (employment retention), maximise welfare benefits, alleviation of financial hardship
- Reduction in GP visits, outpatient and accident & emergency visits, reduced medication intake (referrals from 'enhanced' primary care)

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

Scheme ref no.
S&R_004_PHP
Scheme name
Community Mental Health – Improving Access to Psychological Therapies (IAPT)

What is the strategic objective of this scheme?
To commissioning a new IAPT service model which meets demand and provides appropriate outcomes and greater access to the Scarborough and Ryedale populous in line with the public health prevention strategy.

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?
Service model Supported by additional investment from the BCF, the new service model will provide a range of therapies from low level interventions and support to high intensity treatment within primary and community settings that is responsive and accessible. This will: • Provide an opportunity to develop a broader range of therapeutic and preventive choice, combined with elements of social care. • Ensure service is appropriately funded for the SR population, ensuring that the national treatment targets are met. • Reduce the number of patients escalated to a crisis situation. • Improve numbers of people experiencing recovery. • Develop a directory of IAPT services available. The costs of the original service model are already provided within CCG base-line budgets. The additional costs for the new model, with improved outcomes and access have been included within the BCF. These equate to £227,000 on an annual basis. **Patient cohorts** Prevention of ill-health is a shared priority between SR CCG and NYCC and the inclusion of IAPT within the BCF is an important part of ensuring parity of esteem for mental health services in the context of preventative services. The new service model will also help to ensure that national targets for IAPT are achieved for local residents; specifically ensuring that access is at a minimum of 15% and recovery rates of 50% for this group is achieved.

North Yorkshire Health and Wellbeing Board
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The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioner / provider
The lead commissioner is SRCCG. Additional support will be provided from the North Yorkshire Partnerships Commissioning Unit to oversee the delivery of IAPT services across the whole county.

The lead provider is TEWV (Tees, Esk and Wear Valleys) NHS Trust. While, there are a number of providers in the market, it was deemed more effective to work with one provider who is an already established provider of IAPT within the other CCG areas thus providing the Scarborough and Ryedale area an effective service model which meets the needs of the local population.

The new IAPT service model will be developed in partnership with provider to ensure psychological therapies are complimentary to and support other mental health services in place. Project management support is being provided from both the provider and the CCG to develop and implement a service model which meets national IAPT targets.

Timescales and Milestones
- Agreement with provider to move IAPT model from existing provider LYPFT – April 2014
- Service Design co-produced with providers and commissioners – May 2014
- TUPE transfer of staff to new provider (TEWV) – July 2014
- Further increases in staff to meet demand – September 2014
- Launch of new IAPT service to referring clinicians –September/ Oct 2014
- Ramp up of service to meet national standard by Q4 - Jan 2015.
- Develop self-referral mechanisms for service – April 2015

Stakeholder Groups / Engagement & Frequency
- New and current service provider and relevant staff groups
- Community Teams and GPs
- Feedback to be obtained on proposed new service specification

The development is being principally taken forward through the CCG's Mental Health strategy which acknowledges a need for further investment to deliver a more comprehensive service to the local population.

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

NICE recommends a stepped care approach to providing psychological therapies, the principles of this are that treatment should have the best chance of delivering positive outcomes whilst burdening the patient as little as possible and ensure a system of scheduled review in order to step up or step down care.

The IAPT commissioning toolkit assists with the establishment of a stepped care

approach and ensures NICE guidelines are incorporated into commissioned IAPT Services. IAPT is a national priority within the national planning guidance and has been identified as a national quality premium objective.

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

14/15 £150,000   15/16 £300,000

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

- Enhance quality of care for patients
- Reduction in delays to assessing patients to ensure appropriate pathways of care
- Meeting national targets
- Service model that meets the needs of the population and GPs referring into this service
- Working more effectively across services boundaries

Further work is required to develop a model to identify possible savings. It is anticipated that these would be delivered from acute non elective admissions and efficiencies within other areas of mental health services.

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 delivery of the service will be tracked closely with the provider as follows:
- Establish an action plan to manage the back log of patients waiting for treatment
- Working closely with the provider to continuously monitor and review the service
- Conduct regular analysis of performance and quality data
- Attend monthly quality meetings with the provider.

Progress with the IAPT recovery target will be tracked in association with the CCG's Business Intelligence Department within the Commissioning Support Unit and tracked on CCG dashboards and at the TEWV quality meeting managed by the PCU.

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

- Reduction in avoidable admissions
- Patient supported in the community
- Reduced repeat attendance at A&E for patients reaching crisis
- Improved patient satisfaction
- Meeting national targets
- A service model that meets the needs of the population and GPs referring into this service
- Reduce in the number of people in crisis due to lack of psychological support
- Reduce attendances to A&E
- The development of a model that identifies possible savings

Scheme ref no.
S&R_005_PHP

Scheme name
Smoking Cessation

What is the strategic objective of this scheme?

The objective of this proposal would be to reduce the prevalence of smoking in the Scarborough and Ryedale population, thus reducing the ill health burden on local health and social care services. Smokers who attend hospital for surgery:

- have a higher risk of lung and heart complications

- have higher risk of post-operative infection

- have impaired wound healing

- are more likely to be admitted to an intensive care unit

- have an increased risk of dying in hospital

- are at higher risk of readmission

- remain in hospital longer.

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?

Support the implementation of NICE public health guidance 48 ' Smoking Cessation in secondary care
Commission on-site stop smoking services to be provided by the Trust targeting NHS Trust Staff and patients using the following services:
- Cardiac rehab
- Mental health
- Maternity services
- Outpatients
- Rehabilitation
- Day care
- Occupational health

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

The partners involved in setting up this project would be:

Public Health NYCC Scarborough and Ryedale Clinical Commissioning Group York Hospitals NHS Foundation Trust (Scarborough Hospital site)

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

Smoking remains one of the biggest killers in our society, causing premature death in more than half of smokers. Smoking cessation interventions are evidence-based and the single most cost-effective life-saving intervention provided by the NHS. Yet, smoking cessation services within secondary care remain underfunded, under-prioritised and still not deemed a core part of treatment strategy for smoking-related illness.   Smoking is the primary cause of preventable illness and premature death, accounting for 81,400 deaths in England in 2009. Smoking harms nearly every organ of the body and dramatically reduces both quality of life and life expectancy. Smoking causes lung cancer, respiratory disease and heart disease as well as numerous cancers in other organs including lip, mouth, throat, bladder, kidney, stomach, liver and cervix. It is estimated that, in 2008-9, 462,900 NHS hospital admissions were attributable to smoking. Estimates of the cost of smoking to the NHS range from £2.7bn12 to £5.2bn a year. • Stopping smoking has been associated with a decreased risk of COPD exacerbations, the risk reducing with duration of smoking abstinence. • Stopping smoking dramatically reduces the risk of stroke occurring: within two years of stopping smoking, a former smoker's risk of stroke is reduced to that of a non-smoker. • Stopping smoking reduces all-cause mortality by 36% after an MI and by 21% in heart failure. • Stopping smoking early in rheumatoid arthritis may prevent development of high disease activity and severe extra-articular manifestations. • Stopping smoking improves exercise tolerance in peripheral vascular disease. "Smoking cessation is still the most important intervention to slow down the disease progression of chronic obstructive pulmonary disease. It decreases the annual decline in lung function, reduces symptoms of cough and sputum, improves health status and reduces exacerbations of COPD. Because of the strong association between use of healthcare services and disease severity, slowing down disease progression is likely to reduce annual COPD-related healthcare costs"[11] Intensive counselling interventions that began during the hospital stay and continued with supportive contacts for at least one month after discharge increased smoking cessation

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[11] Hoogendoorn, M. et al. Long-term effectiveness and cost effectiveness of smoking cessation interventions in patients with COPD, Thorax 2010 Aug; **65(8)**:711-8.

rates after discharge (risk ratio (RR) 1.37, 95% confidence interval (CI) 1.27 to 1.48; 25 trials)[12].

In 2010/11 Scarborough had 1,401 smoking attributable hospital admissions, which equates to a rate of 1,604 per 100,000 population; significantly worse than the rate for England. This proposal is to provide an intensive hospital-based Stop Smoking Service to work with patients, visitors and staff who smoke. This service should continue Stop Smoking support for one month post-discharge in line with evidence published by the Cochrane Tobacco Addiction Group.

The British Thoracic Society outlines five reasons why a hospital should have a comprehensive and efficient Stop Smoking Service:

- Smoking cessation treatment for sick smokers, not prevention,

- Significant numbers of smokers (and their families) who need treatment are in (or visiting) hospitals

- Evidence exists that Stop Smoking interventions are effective in hospital

- Gains for the patients are enormous

- Gains for the hospital health economy are potentially enormous, both in terms of cost savings on patient-related use of resources and also in terms of staff smoking.

Hospitalisation offers an opportune time to encourage patients to stop smoking for four main reasons:

• Firstly, this time is often a 'teachable moment' where patients are more receptive to intervention and are more motivated to quit

• Secondly, the hospital's no smoking environment creates an external force to support abstinence

• Thirdly, patients are ideally placed to be given information about treatment options, support through withdrawal and signposted to specialist services

• Fourthly, abstaining at this time can lead to significant health benefits

Most information in this template has been taken from the British Thoracic Society Report titled *"The Case for Change: Why dedicated, comprehensive and sustainable stop smoking services are necessary for hospitals"*.[13]

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

2014/15 £ 100,000   15/16 £100,000

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[12] Rigotti, N., Clair, C., Munafo, R., Stead, L. Interventions for smoking cessation in hospitalised patients, Cochrane Database of Systematic Reviews 2012; Issue 5
[13] Stern, M., Preston, W., Agrawal, S. (2013) The Case for Change: Why dedicated, comprehensive and sustainable stop smoking services are necessary for hospitals, British Thoracic Society Reports, 5(2)

| **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 |

Based on ~300 bed hospital:

£20-25k pharmacotherapies

£53k fulltime Stop Smoking Specialist (band 7)

£17k administration and consumables

~£100,000 per annum.

Stop smoking support has been shown to be highly cost-effective: ~£2,000 per Quality Adjusted Life Year (QALY).

| **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? |

How will you measure how much service is delivered through this proposal? **(quantity and volume)**

- Number of hospital patients with their smoking status recorded on admission.
- Number of patients (who smoke) accessing the hospital stop smoking service.
- Number of patients (who smoke) setting a quit date.
- Number of visitors to hospital accessing the hospital stop smoking service.
- Number of staff accessing the hospital stop smoking service.

How will you measure how well the service is delivered? **(quality of service)**

- Proportion of patients who are admitted to hospital who have their smoking status recorded on their electronic hospital record.
- Proportion of hospital staff trained in Very Brief Advice for smoking cessation.
- Proportion of patients (who smoke) accessing the hospital stop smoking service.
- Proportion of patients (who smoke) setting a quit date.
- The hospital develops a strategy and steering group (chaired by a board-level representative) to oversee stop smoking at the hospital.

How will you measure whether the service has made any difference? **(This should include financial measures and link back to the desired outcomes)**

- Proportion of admitted patients (who smoke on admission) quitting smoking.
- Proportion of admitted patients (who smoke on admission) who quit that are still smoke free at 30 day follow-up (validated by carbon monoxide testing).
- Proportion of visitors (accessing the stop smoking service) quitting smoking.
- Proportion of visitors who quit that are still smoke free at 30 day follow-up (validated by carbon monoxide testing).
- Proportion of staff (accessing the stop smoking service) quitting smoking.

- Proportion of staff who quit that are still smoke free at 30 day follow-up (validated by carbon monoxide testing).
- Reduction in average length of stay.
- Reduction in the proportion of patients who stay in hospital longer than 2 days.
- Reduction in the rate of 30 day readmissions.
- Reduction in ambulatory care sensitive admissions.
- Reductions in emergency admissions for people with a long-term condition.
- Reduction in hospital sickness/ absence rate.

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

Partnership working – strategic support for the project (champion)
Funding

**North Yorkshire Health and Wellbeing Board
Better Care Fund Plan**

ANNEX 1d - VOLUNTARY SECTOR

Scheme ref no.
HRW_012_VS
Scheme name
Carer Sitting services and training

What is the strategic objective of this scheme?

To provide additional capacity in sitting and support services for elderly people and carers. This meets the needs of the ageing population in terms of first line support for over 65's and supports the self-management and care closer to home, which is one of the priorities for HRW CCG.

To work with local carers and carer organisations to provide a programme of carer training to increase carer skills and better support carers to keep patients at home

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?

SITTING SERVICES

Objective
To support the sitting services providers to continue providing the valuable services it offers to the carers and the people they care for across the CCG and to significantly increase the activity to enable clients to remain at home for as long as possible. To enable volunteers to support their area and to help them remain active in their communities. Total Cost : £40,000

Background

There are 2 main contracts with the voluntary sector for providing sitting services for carers across HRW CCG that are held jointly with NYCC.

The main activities carried out by the charities are
- A sitting service for carers
- Support group for carers
- Visiting elderly people who don't have a named carer living with them
- Supporting by organising regular outings and social events for carers and the people they care for

Contract details:
- Current CCG funding £8794.57. Total joint contract value £79317.26 (11%)
- Current contracted hours within the joint contract are:
- 3,360 for Whitby

- 3,259 Hambleton and Richmondshire
- Currently all providers are providing services significantly above their contracted activity rates contracted for 7860 hours per annum and delivering 9524 (12/13). 21% over contract.

Proposal

Through the BCF, the proposal is to work with the carers sitting services, in each area, to identify older people who are disabled, housebound and/or socially isolated and carry out assessment visits, follow up work and on-going support.

Currently all providers are providing services significantly above their contracted activity rates contracted for 7860 hours per annum and delivering 9524 (12/13). 21% over contract.

It is anticipated that NYCC jointly with the CCGs across North Yorkshire will be undertaking a review of the sitting services contracts and funding formula going forward. It is anticipated that this will happen September 2015.

The proposal is to fund a non- recurrent set-up cost of £5000 to the 2 contract providers to recruit and train additional volunteers, and to promote the service to enable the increase in activity.

The additional funding will also fund £8 per hour over the current contract activity on a non-recurrent basis to maintain the existing demand.

The proposal is for:

- £10,000 infrastructure investment
- £30,000 additional activity, which will fund 3750 hours across the CCG.

TRAINING

Objective
The main objective of the scheme will be to bring organisations together to create holistic support to patients and carers and create a robust training programme to support carers to look after themselves and the cared for (using non-recurrent investment of £20,000).

Training will specifically cover:

- End of Life (practical)
- Sleep issues (parent carers)
- First Aid
- Falls Prevention (moving and handling)
- Nutrition and Cooking for (new to kitchen) carers
- Choosing a Care Home
- Emotional Wellbeing + stress management
- Power of Attorney + Court of Protection
- Dementia peer support
- Bereavement
- Managing medication

- Financial issues
- Confidence
- Communication
- Peer support
- Local resources for carers

It is recognised that sitting support may be required whilst the carer is trained. Funding has been provided to pay for sitting services to support and release carers to attend the training within the additional funding for the voluntary sector sitting services contained within the parallel BCF proposal.

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

There are current joint contracts in place with HRWCCG and the Local Authority (North Yorkshire County Council) with voluntary sector providers (Stokesley CCA and Caring Together Whitby).

Funding will cover the current over-activity in sitting services plus additional funding for capacity to be increased in 14/15 onwards. Meetings with providers have taken place to ensure the additional activity is deliverable. It was felt that some of the funding was required to train and develop additional volunteers to support the increase in activity. This has been incorporated into the proposal.

The CCG and LA will work with the current Carers Resource provider to produce a training implementation plan and training needs analysis and plan.

Stakeholder groups/ Engagement & Frequency
The key stakeholder groups that the CCG / LA will liaise with are:

- Carers strategy group (meets quarterly)
- Voluntary sector forums (meets quarterly)
- Discharge planning groups (meets monthly)
- Community services and NYCC social care (are engaged through local partnership arrangements, particularly the local Service Development and Improvement Group for Unplanned care and Community services, which meets monthly)

Summary project milestones:
- Finalise additional investment in sitting services – July 2014
- Hold initial discussions with the Carers Centre on scope of training – August 2014
- Agree contractual arrangements with North Yorkshire County Council – August 2014
- Track progress with activity levels following agreement of additional capacity – monthly from September onwards
- Training programme and implementation plan finalised – October 2014
- Carers training delivered – autumn / winter 2014/15
- Delivery of training tracked including evaluation and feedback – March 2015

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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

Well-trained carers are crucial in keeping patients at home longer and supporting early discharge. There is abundant national evidence to explain how improved support for carers is beneficial to patients and local health and social care services:

- The 2011 carers census highlighted that 12% of our population had a caring responsibility, and of these 19% cared for over 50 hours per week. This equates to over 17,000 carers in HRW CCG.

- Commissioning well for carers can:
  - Reduce admissions to hospital and residential care.
  - Reduce the costs of delays in transfers of care.
  - Reduce carers' need to access primary care as a result of their caring role.
  - Reduce overall spending on care.
  (Commissioning for carers – Key Principles for CCGs)

- 83% of carers said caring had a negative impact on their physical health and 87% said it had a negative impact on their mental health - Carers Week (2012) In Sickness and in Health; London: Carers Week

Locally, the CCG and its partners engage with the local Carers Centres as part of the design and improvement of carers services. The need to increase capacity in Carers Sitting Services is evidenced from the capacity and volume issues described as part of the service model. However, the requirement is endorsed by discussions with local carers, their representatives and patients who routinely confirm the importance of sitting services as part of pathways for keeping people out of hospital.

The need for improved carers training has similarly emerged from carers engagement events, where patients and carers have highlighted the importance of ensuring they have the right skills to support the patients they are caring for.

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

2014/15 £60,000   15/16 £40,000

Summary costs:
- Carers training (non-recurrent) £20K
- Sitting services (recurrent) - £40K

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

The scheme will also help to ensure:

- Holistic care to enable patients to remain independent in their own homes

- Access to additional community support
- Earlier identification of problems i.e. tissue viability issues to refer earlier to a clinician
- Increase in number of carers supported
- Increase of number carer assessments provided
- Impact on volunteering in local community

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 CCG and NYCC will work actively with the local carers organisations to understand the effectiveness of the sitting service and links to integrated care:

- Use of outcomes wheel or suitable alternative to demonstrate increased outcomes
- Client satisfaction survey to be completed
- Review of referral data to identify joint working across health and social care

The training programme will be evaluated, in terms of take-up and content, and reviewed for future training needs, i.e. repeat and / or wider roll-out. The programme may also lead to:
- a possible reduction in NEL and support with early discharge for both carers and those cared for
- Reduced need for community based beds and respite costs.

As part of evaluating the training, carers will be asked to for any feedback on perceived impact.

Evaluation of this scheme will focus specifically on:

- Activity numbers
- Training delivered
- Training feedback
- Providers to be included on directory of services
- Increase in the number of sitting services hours delivered
- Increase in the number of clients supported
- Use of outcomes wheel or suitable alternative to demonstrate increased outcomes
- Client satisfaction survey to be completed

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

- Relationship between the CCG, NYCC and Carers Centre
- Quality of training provided by Carers Centre
- Ability of Carers Centre to reach out and engage with a wide range of local carers
- Effective contractual arrangements operating between North Yorkshire County Council and HRWCCG
- Effective targeting of sitting services to those most in need

Scheme ref no.
HaRD_002_VS

Scheme name:
Voluntary Sector Projects

What is the strategic objective of this scheme?
•

To fund the voluntary sector in strategic ways to maximize the value of the Better Care Fund to patients needing additional support in Harrogate and Rural District (HaRD). This includes support for:

- End of Life Care Register project led by St. Michael's Hospice
- Patient and Carer Support for Palliative Care through Volunteer Visiting
- Age UK North Yorkshire's and British Red Cross are delivering Social Prescribing programmes
- Carers' Resource to embed staff with the local community services team to ensure that Carers are identified quickly and effectively
- Age UK Knaresborough's Long Term Integrated Care Program offering case management support to elderly residents.
- British Red Cross to reach residents in very rural areas at risk of social isolation.

Overview of the scheme

All voluntary sector schemes outlined below are underway and currently being delivered in HaRD.

EOL Register will improve patient care at the EOL through improved coordination of care and communication between providers, thus improving patient and carer experience and reducing unnecessary and disruptive hospital admissions. Improved coordination of care is a key theme of the HaRD CCGs efforts to address and improve our Community and Intermediate Care systems. This project will assess all of the options available to HaRD for creating an effective EOL register and then pilot a solution in the last Q of 2014/15.

Patient and Carer Support for Palliative Care - St. Michael's Hospice will expand its volunteer visiting program by increasing the number of volunteers that it recruits and trains to visit palliative care patients at home. The volunteers provide a variety of support to patients and their carers to help them live at home with confidence, independence and dignity. This additional support helps patients avoid the development of crisis at EOL which can lead to visits to A & E and disruptive hospital admissions.

Age UK North Yorkshire's and British Red Cross Social Prescribing schemes are designed to aide primary care (GPs) in linking patients to voluntary sector programmes available in the community to address social isolation, mobility, and other support services. Age UK and British Red Cross have a staff member present in a GP surgery with an information stand at least one day per week to ease referrals from the GP practice to the social prescribing programme and increase local awareness of the programme. Any patients who are referred by the GP or self refer are followed up by a case manager to help them identify links to appropriate programmes in the community. Both of these schemes are designed to address risks that our relatively elderly population

and rural geography present such as social isolation, loneliness and depression.

Carers' Resource will embed a member of their team within the Harrogate South Care Team including Rehabilitation, FAST Response and District Nurses to facilitate referrals for carer support. Carer support offered includes emotional support, benefits advice, assistance with respite, and liaison with health and social care providers.

Age UK Knaresborough will hire a Casework Manager to work with clients referred by DNs, GPs, the hospital, family/carers etc. to identify and address gaps in their care plans or supports and communicate with social and health care providers as needed to ensure the patient is safe at home. Age UK Knaresborough is also increasing the capacity of its Hospital to Home service through BCF funding.

British Red Cross will continue its program to identify and address the needs of elderly and disabled residents at risk of social isolation in the very rural parts of the region: Massam, Pately Bridge and Boroughbridge. Referrals are received from a variety of sources including GPs, DNs, social care and family. A case manager contacts patients and works with patients to identify and address key issues from the practical such as the availability of transportation to more complex needs such as loneliness, fear of falling, depression, etc.

The delivery chain

The EOL Locality Group for HaRD has agreed to act as the project board overseeing the delivery of this project. The group includes representatives of St. Michael's Hospice, HDFT, the Independent Care Home Group, the county council, the CCG and a GP. St. Michael's has hired a project lead who will be an employee of St. Michael's and accountable to the project board for delivery of the project objectives. The aim of the project is to assess how best to deliver the desired EOL register.

Patient and Carer Support by volunteers is administered and delivered by St. Michael's Hospice. Patients are referred by the Inpatient Unit pre-discharge, Day Therapy staff, Macmillan nurses and District Nurses in the community. Volunteers are trained to bring any critical information back to their volunteer supervisor for communication back to their GP and/or District Nurse.

Age UK North Yorkshire and British Red Cross are responsible for providing the case manager, establishing linkages with the GP practice, and following up with all residents referred for support.

Carers' Resource recruits, hires, and supervises their embedded staff and ensures that the goals of the program are met.

Age UK Knaresborough hires the staff, establishes the referral mechanisms and work protocols for its staff to ensure the goals of their programmes are met.

British Red Cross has a contract to provide support services the rural, socially isolated population.

The evidence base

Numerous research studies have demonstrated the need for older/vulnerable people experiencing health and social care crisis to be supported in their communities to remain independent specifically for people being discharged from hospital or experiencing a crisis at home. (Our Health, 2006, Our Care, Our Say; DH 2007, Putting People First)

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Harrogate and Rural District has both an relatively older population and very low density of population (except the City of Harrogate) meaning HaRD has a high number of elderly residents living in sparsely populated rural areas.

In addition, our decision to involve voluntary organisations in social prescribing, case management and volunteer visiting schemes is based on research showing that receiving support form volunteers is associated with higher self-esteem, improved wellbeing, and lower levels of social exclusion, isolation and loneliness among patients and service users. (Kings Fund Volunteering in H & SC, 2012)

The Red Cross commissioned its own external evaluation by Deloitte (November 2012) which found volunteer-led services generated significant savings in health services. "The economic impact of care in the home services" focused on six services and found they were highly rated, facilitated efficient access to additional services and service users benefitted from reduced isolation and increased independence and wellbeing.

In addition, Age UK did their own evaluation of their social prescribing pilot project in Ripon in 2011 and found the initiative to be highly rated by patients and GPs.

Evidence gathered by St. Michael's from their "Patient and Client Involvement Group", and hospice respite service revealed carer concerns about their ability to cope their caring role following a patient's discharge from the hospice's Inpatient Unit or in between Day Therapy visits. St. Michael's initial evaluation of their volunteer visiting program in 2013 revealed positive feedback from patients and carers.

Our project to create an EOL Register is based on best practice guidance that is well documented in several palliative care reviews. The Department of Health (2008) recommends implementing a EOL Registers in "End of Life Care Strategy: Promoting high quality care for all adults at the end of life". NICE's Quality Standard 13 also recommends an EOL Register.

The value of investing in Carer Support is well documented in the literature. Carers' Resource has been a consistently high quality of provider of services to the LA and health system. This BCF initiative integrates their staff with the District Nurses in a more effective system.

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

14/15 £249,500   15/16 £200,000
St. Michael's EOL Register Project totals £49,560 includes hiring a FT project manager for one year with all on costs, recruitment cost, travel, etc.

St. Michael's Hospice Volunteer Visiting Program totals £28,952 includes £14,000 for the recruitment, training, travel expenses for 60 volunteers, £12,000 for a PT Assistant Manager to supervise and support the voluneers and approximately £2,000 for admin support.

Carers' Resource cost of £43,205 includes a Carer Specialist to be embedded with the Harrogate South Team, and well as £4,000 for administrative support.

Age UK North Yorkshire has a modest cost to expand an existing program by adding additional hours to an existing case worker for £7,000.

Age UK Knaresborough is hiring a case manager for £25,000 to expand its existing case management programme to more patients who cannot afford to pay privately for this service. In addition, £25,000 in funding is added to the Hospital to Home service which provides non-clinical support to patients going home from hospital including food shopping, light housekeeping, picking up prescriptions, and sign-posting/referral to other appropriate services.

British Red Cross has two programmes to address social isolation in two different communities in Harrogate and Rural District totalling £28,000 to add two more part time case workers to these programmes so they can reach more clients more often and more quickly.

BCF is also funding a new joint venture with Harrogate Borough Council and various voluntary sector organisations called Healthy Ripon. A programme manager is being hired with £23,000 in funding.

Impact of scheme

Our voluntary sector partners each have data demonstrating the positive impact of their schemes on health outcomes for their clients. These organisations do not and cannot have access to their client's health information, so, the data is speculative or anecdotal. However, HaRD CCG is committed to working collaboratively with the voluntary sector. We are collecting data from the voluntary sector organisations to identify the initiatives that have the greatest impact by analysing services provided by postal code sector, number of clients served and contacts per client per pound invested, and interviewing service users where possible. With better reporting and oversight, the CCG can ensure both value for money and better integrate the voluntary sector's services with the health and social sectors in the most cohesive, coordinated manner. This is a work in process that will improve each year as we build our understanding of the data, the services available, opportunities for cross agency referrals, and any service gaps.

Since all of our BCF schemes are aimed at reducing reliance on A & E and hospital admission (as well as improving patient care), it is extremely difficult to assess the financial impact of an individual scheme. The overall impact of our BCF schemes has been estimated and documented in the appropriate Annex 2 of this document.

Feedback loop

The CCG has designed and implemented a report for the BCF voluntary sector schemes that requires anonymised reporting regarding each patient served, the primary need addressed, the service provided, the number of visits/interactions, as well as the age and postal code sector of each client. Each organisation involved will submit this report quarterly to the CCG. All services were underway by 1st July 2014 and the first quarterly report is due on 20th October.

We view these reports as the first steps towards building a robust data set for the voluntary sector: who they are serving, how, and where. We hope to create links to health data in the future so we can determine the impact of these schemes on health costs. At present, this presents significant information governance issues that need to be overcome.

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

For all of the schemes except the EOL Register project, the key success factors are effective referral mechanisms, strong communication skills of the staff involved, as well as ensuring staff are knowledgeable and up to date regarding local services. In particular, building a strong working relationship with the GP practices linked to the social prescribing schemes has been a key success factor in the past. The five voluntary organisations involved in these schemes have a track record of provide reliable and appropriate services with strong relationships with health and social care providers in their locality.

For the EOL Register project, the keys to success are building upon good relationships with all the palliative care providers in the area, a strong project manager with excellent communication and analytical skills to survey and document current options for an EOL register in HaRD. In addition, we will build on the strong engagement by our GP partners in coordinating care for patients at the end of life. Harrogate and Rural District has an engaged EOL Locality Group with representatives from the hospice, hospital, social care, primary care, voluntary sector and care homes all participating on a monthly basis. The project manager will also be learning from palliative care providers in neighbouring CCGs regarding how they communicate with the same ambulance and NHS111 provider and to find out what solutions to an EOL register have been explored elsewhere. Through the Yorkshire EOL Regional Network group, members of the project board have ready access to key contacts in Leeds, Bradford, and other localities with a track record of tackling the same issue. Our strong local engagement and opportunity to learn from regional palliative care providers offer the opportunity for this project to be highly successful.

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Scheme ref no.
S&R_008_VS

Scheme name
Palliative Care Pathway - Integrated end of life and palliative care (Hospice at Home)

What is the strategic objective of this scheme?
The intention would be to increase the number of people receiving appropriate care and support and reduce the number of people within an acute hospital 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?

The purpose of this service is the provision of an integrated palliative care service (provided in partnership between Saint Catherine's Hospice and Marie Curie Cancer Care) across Scarborough & Ryedale CCG.

The proposed model will provide an integrated solution for the provision of high quality end of life care for people identified as being in the last year of life. All such patients will be identified, have their needs assessed, care planned and provided for, to enable them to live well until they die, in their preferred place where possible.

It builds on the work of those local services currently provided by St Catherine's Hospice and the existing Marie Curie services and the history of joint working.

To operate effectively and efficiently, the partnership would need to work to a number of principles:

- Resources should be pooled where doing so increases capacity or improves the quality of patient care
- The organisations will work in partnership to build upon both organisation's palliative care expertise and reputation.

The purpose of the project is to support the implementation of an integrated approach to care of the dying and palliative care. The plan brings together two elements- a Marie Curie evening service which includes both HCAs and nurses and also the developing hospice at home service as outreach of St Catherine's hospice.

The CCG is working with the hospice as the lead provider to develop this service and subcontracting with Marie Curie by the hospice will take place. Health and social care elements will be included to ensure people receive seamless care and can remain at home for as long as possible where it their choice to do so.

The cohort targeted by this service includes:
- Adults with any advanced, progressive, incurable illness
- Care settings, including a person's own home
- Care given in the last year of life
- Patients, carers and family members, including care given after bereavement

The CCG has a relatively elderly population with 21.9% of its population aged over 65, many of whom have co-morbidities. Over 50% of the CCG population lives in the most deprived population quintile of North Yorkshire. The demographic profile of the CCG provides it with the combined challenge of an elderly population with high health resource usage; and significant areas of deprivation with associated poor health outcomes. As such, there is a need for joined up end of life care service provision.

We also know that patients with a non - malignant condition often have a high number of emergency admissions to hospital at the end of life.   The disease trajectory for non malignant disease is such that individuals with a non cancer diagnosis can suffer acute exacerbations in their condition as they approach the end of life. It is necessary to ensure that people have access to timely and effective interventions to prevent unnecessary hospital admission during an exacerbation.

Key Outcomes of the Service
- Reduction in admissions to Hospitals
- Early planning of care to facilitate independence
- Patient supported in the community for longer
- Reduced length of stay – where appropriate
- Reduced repeat attendance at A&E through intervention
- Improved patient and carer satisfaction
- A reduction in the number of admissions to hospital that last 8 days (of patients who die) who are known to the service
- A reduction in the number of admissions to hospital that last 0-3 days (of patients who die) who are known to the service
- A reduction in the spend on care agencies in the delivery of care to palliative patients at home who are known to the service

Measures to Support Outcomes
- Record the number of clinical referrals
- Record the diagnosis of the patient, i.e cancer, COPD, Heart Failure, Respiratory Failure
- Record the number of admissions prevented through involvement of Clinical Nurse Specialist
- Record the number of patients who specified the care home as their preferred place of dying and died there.
- Record the number of patients on an Advanced Care Plan
- Evaluate Yorkshire Ambulance Service data relating to 999 calls to care homes and of those who were transported to hospital and died there within 48 hours

Timescales and Milestones

- Seek agreement from SRCCG to commission service from provider – November 2014
- Service Design co-produced with providers and commissioners – Dec 2014

- Development of Implementation Plan including specific data set to meet KPIs – Dec 2014
- Provider finalises staffing model to meet service need – Dec 2014
- Re launch of service to referring Clinicians and other key stakeholders – January 2015

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

14/15 £62,000   15/16 £92,000

Impact of scheme
Please enter details of outcomes anticipated
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Improve end of life care for patients in the local area by providing an integrated service which reduces duplication for patients and their families/carers as well as streamlining pathways for professionals
- Increase number of patients dying in their preferred place of death;
- Reduce the number of hospital deaths;
- Increase numbers of patients with a palliative diagnosis other than cancer being cared for at home.
- Reduce the number of inappropriate hospital attendances and admissions in last year of life;
- Increase in the provision of advanced care planning
- Increased number of patients able to express choice in their care and have that choice upheld
- Decrease in number of patients who die within 24, 48 and 72 hours of admission to hospital
- Qualitative Improvements in patient experience and that of their families and carers
- Improved satisfaction levels for patients and carers

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?

Outcomes of the scheme are measured and/or to be measured through the following methods:

- Working with commissioners and local public health to agree measures (and data sources) to demonstrate impact against strategic outcomes
- Ensure that key stakeholders are kept updated about the development of the service and its impact
- Project group meetings involving local stakeholders, including GP leads, to agree models of care and monitor implementation of agreed plans
- Provider based monthly steering group reviewing key measures and timescales
- Provision of measures through commissioner delivery groups to allow wider scrutiny of impact

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Better Care Fund Plan

What are the key success factors for implementation of this scheme?
Specifically related to the defined scheme key success factors relate to: • Ongoing key provider engagement in delivery building on key relationships with the 3rd sector • Wide engagement with a range of stakeholders, including service users and carers • Realising material reductions in admissions and other stated outcomes • Opportunity to measure key quality of life outcomes for patients and their family/carers • Utilising decision-making processes to ensure that the service meets expected outcomes and benefits the patient and family/carers • Promote sustainability of the scheme through ongoing adaptation and learning

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Scheme ref no.
VOY_001_VS
Scheme name
St Leonard's 'Hospice at Home' Scheme

What is the strategic objective of this scheme?

Strategic objective:

The extended hours operation of the Hospice at Home will be a proactive and responsive care model for the population of the Vale of York which seeks to continually improve integrated health and care provision closer to or at service users usual place of residence whilst reducing per head local health and care economy cost.

Strategic Aims:

•   To put service users at the centre of hub delivery
•   To improve access to home-based care and support services to enable more people to die at home or place which has become their home, with dignity
•   To reduce population-based healthcare costs, social care costs and associated costs through providing alternatives to hospital admission
•   To improve the quality and equity of access to health and care services for palliative and end of life care service users within the Vale of York.

(Adapted from scheme better care fund plan submission)

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?

In parallel with local joint strategic needs and plans, and the better care fund strategy and objectives, the CCG and local providers have committed to an extended hours hospice at home service that provides proactive and community-centred care for the Vale of York population. The hospice at home model combines resources from St Leonard's Hospice in conjunction with Marie Curie Nursing Services team, York Teaching Hospital Foundation Trust Community Services team and other care providers to deliver joined-up care and improved outcomes for the population it serves.

The Hospice at Home extended hours service model is seen as essential to reducing acute care demand, increasing and improving primary and community care capacity and improving health and care outcomes locally whilst reducing cost to the overall health and care economy.

Model of care and care cohort

The approach will be first to look to recruit the additional team members to deliver the extended hours service as there is a pressing requirement for this service given the overwhelming evidence from the Winter Pressures pilot. The recruitment phase should

be complete within three months. Primary care colleagues continue their work to identify their palliative care patient population as part of the national "Find your 1%" challenge. These patient cohorts should be proactively managed within primary and community care teams with referrals to the 'hospice at home' service being co-ordinated via St Leonard's Hospice. The referral pathway will be communicated widely as part of the roll-out.

The model of care will be scaled in time to include other practices focussing on the most 5-10% at risk patients of hospital admission or high care utilisation in terms of activity and cost. The model uses principles of;

- Clinical leadership and ownership through St Leonard's Hospice
- Daily multi-disciplinary team meetings including health and care professionals through provider agreements
- Where practicable, care planning and case management supported through technology e.g. Electronic care records
- Single point of access for care delivery and management
- Development of new primary care and community care pathways to include voluntary sector support and sign-posting, particularly focussing on alternatives to hospital admission and admission avoidance
- Monthly monitoring and reporting through defined better care fund programme governance
- Robust evaluation and adaptation of model responding to impact
- To use principles of *communication, collaboration, co-operation, co-ordination and control* as the basis for the service delivery

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

A memorandum of understanding, in parallel with commissioning governance and assurance, will support the definition of the delivery chain and demonstrate the collaborative working approach.

The accountable lead provider, St Leonard's Hospice, is commissioned through the better care fund partners and process (invoicing monthly against a submitted business plan and budget), monitored through a joint health and social care delivery group. The memorandum of understanding defines the overall engagement and principles of this arrangement between NHS Vale of York CCG (commissioner), City of York Council (commissioner), North Yorkshire County Council (commissioner) and St Leonard's Hospice (provider). The accountable lead provider however works with multiple other providers and stakeholders to deliver the care hub aims, objectives and deliverables, including local acute services and council provider services, for example.

Governance arrangements for the hub are represented diagrammatically below:
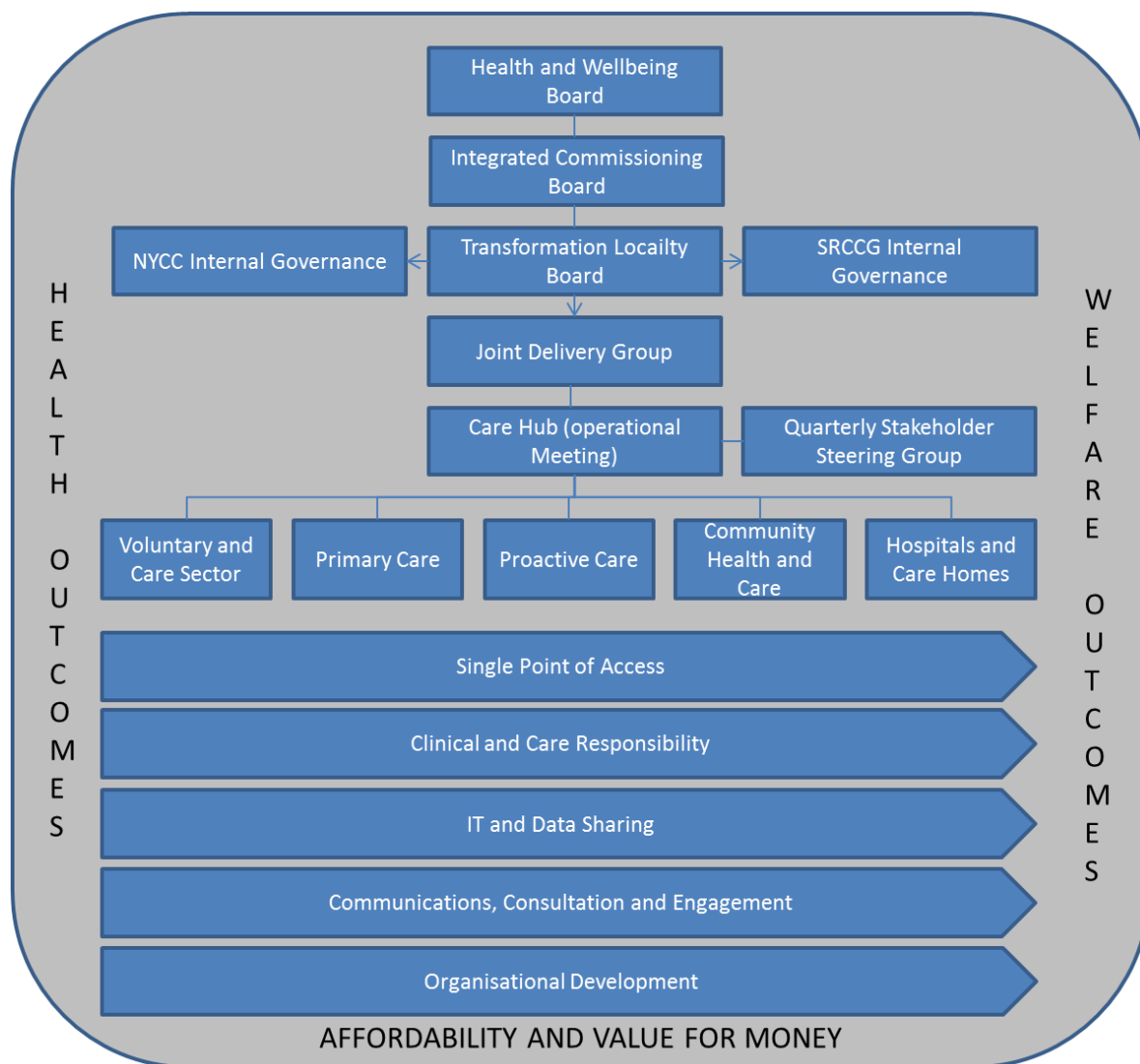
The accountable lead provider is held to account against defined objectives and metrics and a defined plan for the agreed budget, however, there is flexibility for provider innovation and adaptation to ensure the model is as effective as possible in delivering the aims and objectives sought.

Acute and social care utilisation and metrics are reported monthly.

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

From the 'Finding your 1%' initiative around 2,700 adults in the Vale of York will have a palliative care diagnosis. This scheme will work towards reducing the national metric of 25% of all inpatients at any one time in acute hospitals that will die. Similarly from the National End of Life Care Strategy (2008) over 70% of people wished to die at home yet over 50% actually died in acute hospital settings.

Joint strategic needs assessments and public health data has also been available to help

prioritise the wider strategy for models and plans, in addition to prior public communications and engagement exercises, and a number of provider market engagement events relating to community services and admission alternatives. It is hoped that this service will wrap around the developing better care fund community care hubs.

References and an evidence-base being used to inform the model and above statements are highlighted below.

References

- National End of Life Care Strategy (2008)
- Health Education England (2014);
  https://www.eoedeanery.nhs.uk/page.php?page_id=2776
- Health Foundation, The (2011). Getting out of hospital? The evidence for shifting acute inpatient and day case services from hospitals into the community. London. The Health Foundation.
- King's Fund, The (2010). Avoiding hospital admissions; What does the research evidence say? London. The King's Fund.
- King's Fund, The (2012). Pick 'n' mix: an introduction to choosing and using indicators. London. The King's Fund.
- King's Fund, The (2013). South Devon and Torbay. Proactive case management using the community virtual ward and the Devon Predictive Model. London. The King's Fund.
- King's Fund, The (2014). Community services: How they can transform care. London. The King's Fund.
- Nuffield Trust, The (2012). The anatomy of health spending. London. The Nuffield Trust.
- Nuffield Trust, The (2013). Evaluating integrated and community-based care. London. The Nuffield Trust.
- University of York (2012).
  http://www.crd.york.ac.uk/crdweb/ShowRecord.asp?ID=12011006375#.U8kq4rnjjI U
-

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

14/15 £135,000   15/16 £170,000

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

14/15 reduction in Non Elective Admissions = 60 = £33k
14/15 reduction in A&E attendances = 60 = £7k

15/16 reduction in Non Elective Admissions =180 = £100k
15/16 reduction in A&E attendances = 180 = £20k

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?

Outcomes of the scheme are measured and/or to be measured through the following methods;

- Informal regular bi-weekly action-focussed operational development meetings supporting hub development, progress, challenges, opportunities and delivery
- Formal monthly data evaluation using health and social care data across a range of activity and spend reported through the joint delivery group
- Formal evaluation through an academic partner currently being developed for formal, mixed methods (quantitative and qualitative) evaluation to understand what is working well, evidence that could inform development and evaluation of impact

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

A range of broad and recognised factors consistent with any programme delivery are recognised, such as addressing barriers to change and ensuring a clear structure and approach for implementation.

Specifically related to the defined scheme and in examining the publications previously referenced key success factors relate to;

- Ongoing provider engagement in delivery
- Allowing time (for model development and scale amongst other areas), in parallel with the evidence around integration schemes specifically, for schemes to realise material reductions in admissions and other stated outcomes
- Monitoring and adapting scheme delivery though real-time and scheme-sensitive metrics (recognising external influences such as population growth, demographic changes and other influences on change)
- Utilising decision-making processes to, for example, decommission services in line with increased scheme delivery (to reduce supply-led demand and realise material cost reductions and transfer of care delivery)
- To ensure sustainability of the scheme through ongoing adaptation and learning

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ANNEX 1e - CARE HOMES

Scheme ref no.
HRW_013_CH
Scheme name
Clinical skills educator

What is the strategic objective of this scheme?

To change and enhance the model of support to nursing homes and other care environments such as Extra Care supported housing by introducing a clinical skills facilitator to educate and advise on measures to maintain health and wellbeing and prevent avoidable harm (e.g. pressure ulcers, falls etc) and hospital admissions.

The clinical skills facilitator will also support the roll-out of telemedicine equipment in Nursing Homes to provide prompt access to consultant opinion via 24/7 video link from A&E and GP OOH (described in a parallel project).

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?

The role of the clinical skills trainer is to assist with the facilitation, teaching and assessing of clinical skills, create a structured inter-professional learning approach across the specified geographical area and ensure the provision of high quality patient care.

The main roles and responsibilities would be as follows:

1. To implement the project plan within agreed timescales, develop, co-ordinate, implement and evaluate the Clinical Skills Education Services of the North Yorkshire region alongside the existing training, creating new and innovative opportunities for all professional groups and promote effective partnership working with stakeholders. Promoting dignity and respect, care and compassion of the patients.

2. Report and feedback on issues relating to education of clinical skills and work collaboratively with the project team and key stakeholders across the North Yorkshire region.

3. Support the education and training for clinical staff in specified areas of clinical skills education with proven skills in delivery, facilitation, development of teaching plans, teaching aids and supporting documentation. Identify training needs with proven ability to share and spread good practice.

4. Disseminate information relating to the role to colleagues who are not familiar with the Community Clinical Skills Trainer speciality role, reporting directly to the Clinical Skills Regional Manager.

5. Act as an ambassador for the Clinical Skills Network and the Yorkshire & Humber SHA alongside their employing trust.

6. Be responsible for delivering a range of Clinical Skills subjects, including; venepuncture; cannulation; ECG; male and female catheterisation; care of enteral feeding; wound care; diabetic foot care; pressure area care prevention and management; baseline observation including urinalysis, BP, injection techniques (IM and SC); communication; documentation and safeguarding, using evidence based practice, innovative technologies and resources to support varying modes and methods of delivery, with the ability to respond to clinical questions and queries from all levels of clinical staff. Competency assessments of standards of clinical practice, evidence of improved patient care and assist/provide guidance to others when developing programmes in relation to quality assurance and patient safety issues, to meet the specialist training needs for a wide range of users across locality within the Yorkshire & Humber SHA.

7. Contribute to the evaluation of the project aim, which will be utilised to qualify and quantify effectiveness. This will include aspects of auditing.

8. Participate in team meetings providing and presenting information to members as appropriate, including conference and large meetings, with a requirement to be flexible to cover training at weekends, evenings and nights**.**

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

The main commissioner is HRW CCG.

The main provider is STHFT, supported by a partnership involving a clinical educational establishment, most likely Leeds Met University.

The providers the clinical skills educator will work with include:
- Care Homes
- Residential Homes
- Social Care
- Community services

Project Plan
- To agree specification for clinical skills facilitator support to nursing homes and other care environments in partnership with Leeds Met University or other educational establishment – October 2014
- Agree a job description and get the job out to advert – October 2014
- Recruit additional nursing resource – November 2014
- Conduct Training – December 2014
- Publicise the scheme to care homes through appropriate partnership groups
- Agree initial project and training plan and priority areas – December 2014
- Ensure at least 1 Extra Care housing scheme is within the pilot programme – January 2014
- Commence training with care homes – January 2015
- Review progress – From February 2015 onwards

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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

Scheme selection
The area has previously had duel role community matrons, responsible for supporting care homes as well as taking a case-load of patients for case management. With the roll-out of the risk profiling and long term conditions project to extend risk stratification to 2% of the population, the community matron capacity for care homes support is not available and a new clinical model is required.

There is a significant level of anecdotal feedback that staff in care homes do not always feel confident to manage patients appropriately within the care homes, resulting in admissions to hospital that are unnecessary and not always in the patient's best interest. There is therefore an identified need to better support care homes with a level of clinical education and training that will promote confidence for patients to be cared for in a care home environment. In particular, care for patients associated with nutrition requirements, palliative care needs and falls are all clinical areas which would benefit from a targeted approach.

In addition, the NYCC strategy is to develop extra supported housing capacity rather than see an expansion in nursing home capacity. It is recognised that these facilities have a high demand for health and social care community services and increasingly will benefit from the same clinical training and support provided to care homes.

Impact
Business intelligence suggests that there are approximately 50 admissions per month from care homes (based on post-code analysis of NEL admission data) in the HRW area. The assumption is that a percentage of these admissions can be prevented through better training.

Based on an annual reduction in NEL admissions of care homes of 32, at a cost of £1,900 per admission, the scheme should be over-all cost neutral. This equates to reducing admissions from care homes by just 5.3%. This ought to be clinically realistic given anecdotal feedback from the clinicians that suggests inappropriate admissions, particularly linked to end-of-life, occur regularly.

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

14/15 £15,000   15/16 £60,000

The assumption is that Band 7 nurse would be appointed at a 12 month cost of £60K (including on-costs).

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

Nursing Home staff and Extra Care housing will be up-skilled and supported through closer clinical contact and enhanced support. This will lead to quality improvements in care within nursing homes.

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 scheme will be developed alongside the other BCF schemes through the Service Development and Improvement Group for Unplanned Care and Community, which includes NYCC, STHFT, the CCG and other partners.

Stakeholder discussions will also be held through the local Care Home Steering Group.

The metrics that will be tracked for the scheme include:

- Hospital Admissions from Nursing Homes and ESHs (based on post-code analysis)
- Excess acute bed days for patients in Nursing Homes (based on post-code analysis)
- Improvement in quality standards in care homes
- Numbers of homes accessing training
.

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

- Successful recruitment of a clinical educator who is able to win the trust and empower the local care home community
- Successful analysis by business intelligence to track the impact
- Effective liaison between the clinical skills educator and palliative care leaders and nurses
- Effective clinical pathways relevant to care homes, particularly linked to frail elderly, long term conditions and palliative care
- Effective engagement with other urgent care providers, particularly the Yorkshire Ambulance Service, A&E and GP out-of-hours services
- Effective relationships with GP practices, particularly linked to the development of care plans with named GPs
- Effective links to mental health service providers, particularly linked to the management of dementia and the provision of dementia care services
- Effective partnership with social care Extra Care Housing to spread skills and learning beyond traditional care homes

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Scheme ref no.
HRW_014_CH
Scheme name
Care Home Support - Telemedicine

What is the strategic objective of this scheme?

To introduce the use of telemedicine technology to link remote community locations (for example Community Hospitals, Care Homes and Extra-care housing) with acute centres of expertise (for example local A&E / GP OOHs / Clinical Decisions Unit or alternate provider), which will allow improvements in the quality and safety of care delivered to patients. The intention is to use technologies to drive a better patient experience in healthcare and reduce unnecessary hospital admissions and A&E attendances. A key part of the project will be to scope what is feasible locally and where there is patient and clinical buy-in and to pilot the new arrangements to establish a workable local solution.

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?

The scheme will initially focus on developing clinical champions and successfully establishing proof of concept. The first phase will be to clarify the telemedicine requirements and ambitions for this locality, design a telemedicine solution and pilot this through a smaller number of locations with a view to wider roll-out. The pace of this first phase will depend on provider engagement and buy-in to new ways of working. At all stages the use of technology will be underpinned by safe clinical practice.

Assuming the first phase is successful, the second phase proposal will be to finalise a model for the area, then source, procure, purchase and deploy the use of telemedicine equipment across Hambleton, Richmondshire and Whitby. The vision would be prompt access to consultant opinion when it is needed and will be done via 24/7 video link from locations such as A&E, GP OOH and Clinical Decision Unit (CDU) at Friarage Hospital or other alternate provider.

Both phases of the scheme will consider the deployment of telemedicine equipment within pilot Care Homes across HRW CCG, recognising that this will be dependent on support from the care home itself and demonstrable evidence that the care home is clinically able to work safely within the operational model being tested. There are 14 care homes in HRW that could participate within this work, as well as up to a further 7 Extra Care Housing Schemes. The NYCC strategy is to develop extra supported housing capacity rather than see an expansion in nursing home capacity. The local model developed will capitalise further on these local opportunities, with the aim to improve quality and reduce avoidable conditions from these facilities.

The scheme will also consider the development of the telemedicine model within other

acute and community facilities, for example trialling a link between the Friarage hospital and its community hospitals, or possibly between the Friarage Hospital Northallerton and James Cook University Hospital.

Investment would include equipment for one year and a consultation tariff.

This project is at the early stage of development and pace of wider roll-out has not yet been established. Telemedicine may be rolled out on a phased basis, dependent on stakeholder engagement, early learning and achievements, and investment required.

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

The lead commissioner would be HRW CCG.

Providers would include:
- STHFT (both acute services – A&E and CDU – and community services such as fast response, community hospitals)
- GP out-of-hours services
- Nursing and Residential Homes
- Extra-care housing (including NYCC)

Potentially services could also be procured from an external provider.

The initial project plan would be as follows:
Phase 1 – Clinical champions and establishing proof of concept

- Identify clinical champions within acute services – December 2014
- Assess IT infrastructure starting capacity and capabilities - Dec 2014
- Conduct a workshop with all stakeholders including community teams, Nursing homes, Extra-care housing, clinical skills educator, and Acute Trusts to define project objectives and scope – Jan / February 2015
- Properly establish project costs – February 2015
- Clarify pioneer sites and trail-blazers for first phase – February 2015
- Clarify clinical support arrangements within A&E / CDU and arrangements for the management of clinical risk OR engage alternate provider– February 2015
- Agree supporting service protocols – March 2015
- Arrange for Equipment roll out and installation – March 2015
- Conduct Training with pilot sites and clinical staff – April 2015
- Develop communication and engagement plan – April 2015
- Go Live - June 2015
- Evaluate initial sites – July / August / September 2015

Phase 2 – Larger scale deployment (from summer / autumn 2015 onwards)
- Refine model
- Develop detailed business case for future model
- Roll-out more widely to agreed providers

Stakeholder group / Engagement:
- Service provider and relevant staff groups
- Acute Trust and relevant staff groups
- Community Teams
- GPs
- Care homes

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

National evidence
In July 2013 - 12 month results (April 2012 – April 2013) were published and launched at The King's Fund International Congress on Telehealth and Telecare 2013 (3 July).

Looking at 17 nursing and residential care homes linked to the 24 hour Telehealth Hub the study compared a 12 month period before the introduction of Telemedicine with a 12 month period after it was used.

The findings were that for residents in care homes linked to the Telehealth Hub:

- Hospital admissions dropped by 45%
- Length of stay in hospital dropped by 30%
- Total use of bed days dropped by 60%
- A&E attendances dropped by 69%

Local scheme costs / savings
Initial funding of £115K has been allocated to support the scheme. This will need to cover any equipment and service costs. These costs will need to be more accurately quantified as the project progresses.

At this stage savings have not been properly quantified, so a 1:1 return on investment has been provisionally allocated within the BCF as the expected benefit in terms of a saving on NEL admissions.

Currently approximately 600 patients are admitted as an emergency from care homes. This scheme would broadly equate to 60 NEL admissions saved per year. This equates to an additional 10% reduction in care home admissions, over and above the 5% saved through the work of the clinical skills educator scheme. Part of this project will be to determine whether a total 15% reduction in care homes admissions is feasible if the right clinical skills and supporting technologies were in place.

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

15/16 £115,000

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
This scheme will allow us to better support patients and enable less travel and disruption for routine check-ups along with fewer stressful, unplanned hospital admissions or unnecessary visits to A&E. Savings will be based on a reduction in emergency admissions, A&E visits and a reduction in excess bed days through supporting earlier discharge.
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 scheme will be principally developed through the CCG's "Using Technology to Improve Quality of Care" Steering Group, which is a partnership involving: the CCG, CSU, NYCC, MBC, STHFT and TEWV. This scheme sits at the interface between community service development and urgent care management. The scheme will therefore be tracked in multiple forums. • The scheme will be developed alongside the other BCF schemes through the Service Development and Improvement Group for Unplanned Care and Community, which includes NYCC, STHFT, the CCG and other partners. • Progress will also be reported through the CCG's System Resilience Group, which has the over-arching responsibility for urgent care. The KPIs that will need to be monitored include: • Participating sites • Number of patients receiving a telemedicine consultation • Reduction in hospital admissions from Nursing Homes and Extra Care Housing Schemes • Reduction in excess acute bed days for patients from Nursing Homes • Improvement in quality standards • Improved satisfaction levels for patients and carers
What are the key success factors for implementation of this scheme?
• Identifying an acute clinical champion who can help drive this work forward • Ensuring this work links to the developing vision of the Friarage Hospital Northallerton as a beacon of rural healthcare • Identifying pilot sites that are clinically safe, interested and appropriate to be involved within the project. These sites may be those which are actively supported by the clinical skills educator. • Creating a local operational model for how telemedicine would be used within an urgent pathway of care and how the model relates to other supporting services such as fast response, GP out-of-hours, A&E etc. • Effective quality and safety standards built into all approved pilots • Effective supporting IM&T infrastructure to underpin the service model

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

Scheme ref no.
S&R_006_CH
Scheme name
Nutrition in Care Homes
What is the strategic objective of this scheme?
To improve the diagnosis and treatment of undernutrition and malnutrition in adults in Care Homes in Hambleton, Richmondshire and Whitby

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?

Undernutrition is common and affects over 3 million people in the UK. It is often under-recognised and under-treated, yet it has substantial impact on health and disease in all community care settings and hospitals[14].

The healthcare cost of managing individuals with malnutrition is more than twice that of managing non-malnourished individuals, due to higher use of healthcare resources. Malnourished people have:

- More hospital admissions/readmissions
- Longer length of stay in hospital
- Greater healthcare needs in the community[15]

All of these factors lead to significantly increased costs. Disease related malnutrition costs in excess of £13 billion per annum[16]. Better nutritional care for individuals at risk can result in substantial cost savings.

Malnutrition is inevitably accompanied by increased vulnerability to illness and increased clinical complications, however, risks can be significantly reduced if malnutrition is recognised early and treated. Tackling malnutrition can therefore improve nutritional status, clinical outcomes and reduce health care use and costs.

Effective nutritional screening, nutritional care planning, high standards of food service delivery and appropriate nutritional support are essential in all settings. To achieve this, CCG's will need to work in partnership with adult social care; dietetics; medicines management; and primary care to ensure a co-ordinated and consistent approach to tackling undernutrition in adults in Scarborough.

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[14] BAPEN (2010) Malnutrition Matters: Meeting Quality Standards in Nutritional Care, www.baoen.org.uk
[15] Managing Adult Malnutrition in the Community (2012) www.malnutritionpathway.co.uk
[16] Managing Adult Malnutrition in the Community (2012) www.malnutritionpathway.co.uk

NICE guidelines CG 32 Nutrition support in adults guideline advises:

Clinical management

The guideline will include evidence on the prevalence of malnutrition in the community and in hospital settings, the causes contributing to the problem and the physiological and functional consequences of malnutrition and its effects on the cost to the NHS.

http://www.nice.org.uk/nicemedia/live/10978/29982/29982.pdf

- To train healthcare professionals and care home staff to screen, appropriately treat and monitor patients at risk of undernutrition/malnutrition.
- To compile guidelines and pathways for the diagnosis and treatment of undernutrition/malnutrition
- To review patients prescribed oral nutritional supplements to ensure appropriate and cost effective use
- To ensure adult patients are screened and treated for undernutrition wherever they are being treated by following the Scarborough dietetics Management of Undernutrition Pathways. (is this something that is developed or would need developing)
- To promote 'MUST' (Malnutrition Universal Screening Tool) in all care settings in both hospitals, care homes and other community settings.
- To ensure staff in all care settings recognise the importance of maintaining adequate hydration, normal fluid requirements and how to monitor intake.

A steering group will need to be established to develop this work and will involve representation from:

Meds management
CCG
Dietetics
Public Health
Representation from North Yorkshire Health and Adult Social care commissioning manager as they oversee the care homes

Dietetic support
To employ a dietician to work with GP practices, care homes and community staff in Scarborough to improve the identification and treatment of undernutrition/malnutrition. This includes working with the training provider, promoting the use of nutrition screening tools; Malnutrition Universal Screening Tool (MUST), provision of dietary advice and close monitoring of nutritional status of patients at risk of undernutrition/malnutrition. To work with Medicines Management to audit the use of oral nutritional supplements and reviews patients prescribed supplements to ensure appropriate use and to recommend treatment plans, including follow up as required.

Care pathways will be developed and will be implemented across acute and community settings. In order to support the implementation of the pathways, the main focus of the project will be the provision of training to ensure that all staff in a variety of settings understand the importance of nutritional care and are trained to identify and treat those at risk. Initially this training will be delivered to care homes.

Training for staff
Focus on Undernutrition (FoU), a nationally accredited training package, which can be purchased which enables delivery to care homes. This is an in-depth training package

Option 1 delivered to targeted care homes with the most significant undernutrition risk. Additional training can be developed and implemented in order to support those care homes not receiving the FoU training to ensure compliance with implementing MUST and identifying and treating those at risk.

Option 2 Training delivered to all care homes

As dehydration within care settings is frequent and is associated with increased hospitalisation, hydration training will also be developed to be delivered alongside the undernutrition training for care homes.

For quality assurance purposes and to ensure compliance, the key outcomes/competencies will be embedded into the Annual Care Home Audit carried out by adult social care.

To ensure a consistent approach across all settings, GP will receive information regarding identifying and treating undernutrition and will be offered training should they need additional support. This information and support links in with the localised pathways, establishing processes for identifying and treating undernutrition and for the appropriate prescribing of nutritional supplements.

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

Timescales and Milestones
- Seek agreement from SRCCG to commission service from provider – November 2014
- Service Design co-produced with providers and commissioners – Dec 2014
- Development of Implementation Plan including specific data set to meet KPIs – Dec 2014
- Provider finalises staffing model to meet service need – Dec 2014
- Re launch of service to referring Care Homes and other key stakeholders – January 2015

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

Underpinned by accredited guidance (NICE CG32)

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

14/15 £20,000   15/16 £40,000

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

Input of dietician required, but this is far less than savings anticipated; also non recurrent investment to review systems and commission training (this is not included in the net saving above). Training and support for care homes is available through e-learning packages and support Focus on Undernutrition provide this training and support - Appendix 3

Possible model costs include:

Annual Dietetic support band 7 point 34 0.6 wte (excluding on costs)
26,362.44

Focus on Undernutrition training is a tailored package of training support for care home staff including catering staff and can include:

E-learning resource packages each   4,950
(These can be delivered at different
Levels)
Annual licence fee   500
Catering 3 day course   250 per course
Option of train the trainer   5,000 annual fee
Resources   3,000

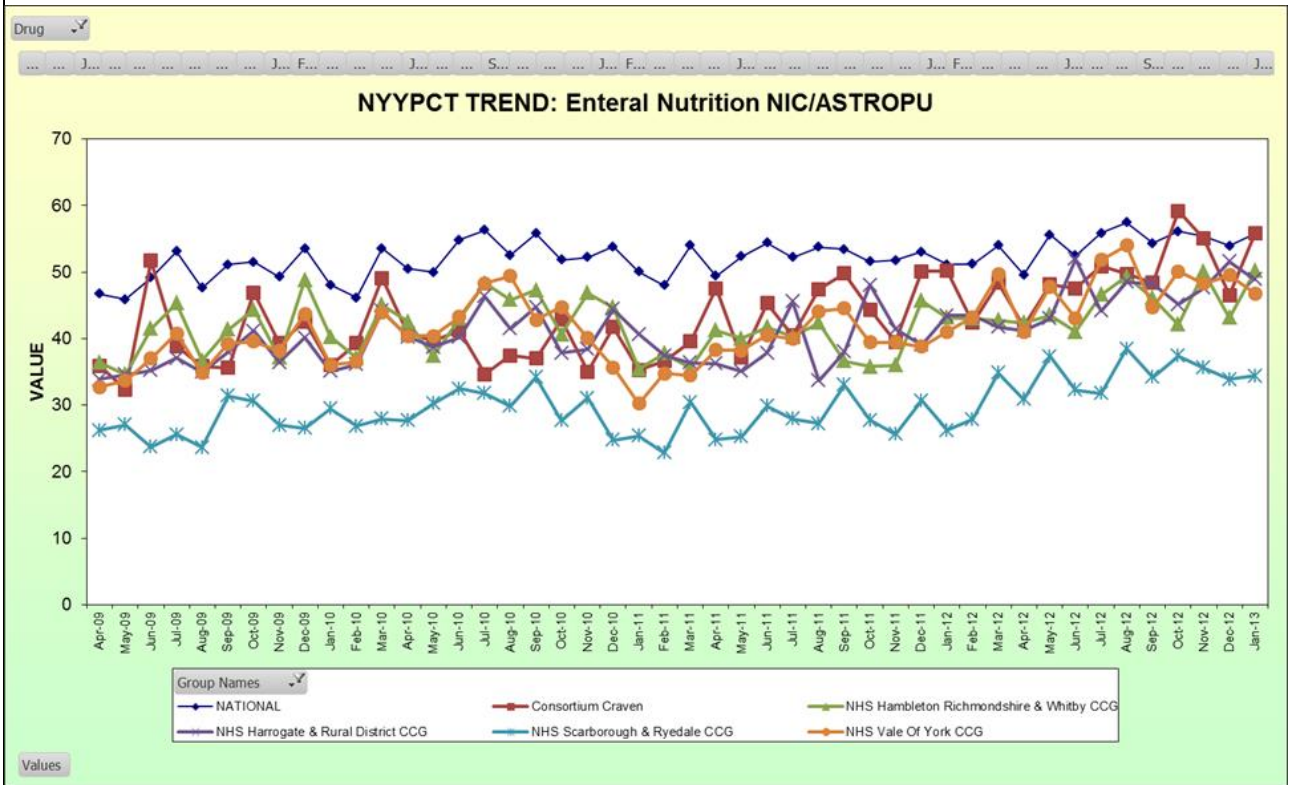| Impact on clinical quality	Significant improvement in clinical quality, such as improved outcomes. Improved identification and subsequent treatment of malnutrition reduces the risk of admission to hospital
Impact on patient safety	Patients safety is improved by the early detection of malnutrition and appropriate treatment which can reduce risk of hospitalisation
Impact on patient and carer experience	Improved identification of malnutrition. Some of the adverse effects include: - Apathy, depression and self-neglect - Increased risk of admission to hospital - Reduced muscle strength and fatigue - Impaired immune responses - Reduced respiratory muscle function

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 scheme will be monitored by the Health Improvement Manager, a joint partnership between NYCC and SRCGG, based within the SRCCG office. Reposting structures will be through the Local Transformation board and local contract management.

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

Reduction in prescribing costs
Reduction in non elective admissions

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

Scheme ref no.
AWC_002_CH
Scheme name
Extended Intermediate Care Schemes: **Care Home Quality Improvement Support Service**

What is the strategic objective of this scheme?

The strategic objectives of this scheme are to improve quality of care in care homes through education and additional targeted health service expertise and support

This scheme is intended to provide an additional level of support to care homes in the Craven locality to enable them to keep residents well and in their own home environment. An advanced nurse practitioner with support from nursing staff and GPs will provider pro-active care, training and education events and support use of basic monitoring equipment which in turn will facilitate use of telemedicine.

Overview of the scheme

The service will provide a dedicated quality improvement support and liaison service to facilitate quality improvement in care delivered across the care homes in Craven. An ANP with appropriate support from Craven practice GPs will deliver this service through working as an integral part of the Craven Collaborative Care Team (CCCT) and through working as part of community MDT's and the 'virtual ward'. As part of this service the post holder will undertake proactive reviews of care home residents, develop personalised care plans, review medicines managements arrange and support MDT assessments and promote self-care enabling people to be cared for in their places of residence.

In addition this service will provide basic observational monitoring kit and education and support to care home staff to fully utilise this and provide a comprehensive resource pack to improve and support decision making in care homes.

Cohort
Population segmentation:
- people resident within 22 Care homes across Craven.

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

Commissioners:
Airedale, Wharfedale and Craven CCG and North Yorkshire County Council.

Provider Delivery chain:
A collaboration of five GP practices within the Craven locality of North Yorkshire.

Local Authority and Independent Care Homes.

The ANP will work with care homes, residential homes. social care, community services, GP practices and the telemedicine hub

Project Plan:
A multi stakeholder group has been established to oversee implementation and monitoring of all the AWC BCF schemes. This includes members of the CCG and NYCC as commissioners. In particular input from the CCG performance lead to whom key metrics will be reported. There are established contractual forums through which to escalate and issues, concerns and benefits such as the Integrated Service Development Group

Key Milestones
Care Home Quality Improvement Scheme
2013/14 Q2 partly operational. Part time staff member recruited and in post , engagement with homes underway
2013/14 Q3 fully operational. Full time staff member in post

2014/15 Fully operational, full year effect

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 evidence base for the impact of intermediate care is well known and can be found at:
- Social Care Institute for Excellence (2013). Maximising the potential of reablement. London SCIE
- NHS Benchmarking Network, British Geriatrics Society, Association of Directors of Adult Social Services, College of Occupational Therapists, Royal College of Speech and Language Therapists, NHS England (2013)

We recognise that the evidence is mixed in terms of reducing system costs, however our approach is to provide proactive care that pre-empts ill-health and then to ensure that people are supported to regain and maintain their optimum levels of health, wellbeing and independence. Ultimately this will reduce unnecessary dependence and demand on health and care services.

> *'Transforming services require a fundamental shift towards care that is co-ordinated around the full range of an individual's needs (rather than based around single diseases) and care that truly prioritises prevention and support doe maintaining independence. Achieving this will require much more integrated working to ensure that the right mix of services are available in the right place at the right time' (Oliver et al 2014)*

We also commissioned the CSU to undertaken a national and international evidence review of integrated care models and used the outcome of this to influence development of new models of care, transformational change and inform the NE admission reduction target. The full report is included in the related document section. This review provided assurance and gave confidence that the initiatives planned or underway will realise intended benefits.

Integrated Care
Models v6.pdf

Specific models where there was evidence of outcomes delivered are:
- Kaiser Permanente, California, USA
- The Alzira Model – Valencia, Spain.
- MassGeneral Care Management Programme, Massachusetts, USA
- Virtual ward models including Greenwich (over 2000 admissions avoided & no delayed transfers of care) North West London (Curry and others, 2013)
- Marie Curie end of life nursing: significantly more home deaths and less emergency admissions than control group (Chitnis and others, 2012;2013)

Assistive Technology
Use of new technology such as telemedicine is key to transformational change and new models of care including supporting self-care. Use of this type of technology is relatively new. An independent evaluation undertaken by the University of York - York Health Economic Consortium in 2013 (please see section 1 c for further detail) demonstrates a significant impact when used in care homes and peoples own homes. When compared with a control group there was a:

- 27% reduction in NE IP care for care home residents
- 7% reduction in NE IP care for people in their own homes
- 7% reduced use of emergency services for care home residents
- 2% reduced use of emergency services for people in their own homes

This gave confidence in approach and NE admission reduction target. Use of telemedicine continues to be supported; the independent evaluation is being repeated with a higher number of individuals now using telemedicine. Results are expected during Q3

British Society Geriatrician Commissioning Guidance
http://www.bgs.org.uk/campaigns/2013commissioning/Commissioning_2013.pdf

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

14/15 £215,000   15/16 £105,000

Copy of Care Homes
QISS Costing final Ma

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

- Improved quality of care evidenced by CQC assessments, qualitative feedback clinicians, patients and carers.
- Reduced admissions and readmissions and reduced conveyance and attendances at A&E.

- High uptake and attendance at learning events
- Increased utilisation of alternative pathways
- Use of monitoring equipment to enhance telemedicine
- Improved prescribing
- Increased number of care plans in place and utilised
- Reduced risk score for care home residents

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?

A multi stakeholder group has been established to oversee implementation and monitoring of all the AWC BCF schemes. This includes members of the CCG and NYCC as commissioners. In particular input from the performance lead to whom key metrics will be reported. There are established contractual forums through which to escalate and issues, concerns and benefits such as QPG, SDG & CMB

Full project management will be in place with mechanisms to collect, collate and report the following performance indicators:

- Number of care homes engaging
- Number of learning events held and attendance
- Number of homes with QI action plans in place and being implemented
- Number of times observational kit used to inform telemed consultations
- Number of staff trained to use observational kit
- Number of care plans in place
- Number of medication reviews undertaken
- Assessment against baseline resource utilisation
- Improved CQC assessments
- Experiential feedback
- Reduction in complaints and incidents
- Reduced safeguarding incidents
- Reduced pressure sores
- Benchmarking exercise on Friends and Family test
- Impact on the health and social care system as a whole will be monitored via TIG dashboard

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

Engagement of the care homes, successful recruitment, shared learning and peer support amongst participating care homes, ownership and co-ordination of the service.

Please note a full copy of the service specification can be found at Appendix 1.

Appendix 1

Specification care
home Quality Improve

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

Scheme ref no.
HaRD_004_CH
Scheme name
Reducing Unnecessary Admissions from Care Homes

What is the strategic objective of this scheme?

To reduce the number of non-elective admissions from care homes by improving the oversight of patient care by GPs and improving the response to episodes of acute illness in the care homes.

Overview of the scheme

This scheme has three components:
- Pairing a GP practice with each care home Increasing FAST Team nursing resources to establish a Care Home In-Reach Team to respond quickly to episodes of acute illness in care homes
- The In Reach Team will be supported the existing Community Geriatrician and the GP practice assigned to each home to provide specialist, short term, expert care for acute unwell residents.
- Add a mental health professional to the community team to support care homes coping with the mental health needs of residents, working closely with the In Reach Team outlined above

Prior to pairing a GP practice with each care home in April 2014, many care homes had as many as 10 GP practices looking after residents, each GP practice had patients in as many as 20 different homes. This situation discouraged regular review, anticipatory care, good doctor/patient relationship as well as good working relationships with the care home staff. The GP practices have been funded to provide a level of care above that commissioned through their current contract including routine planned reviews of physical and mental health and medication, as well as anticipatory/care planning.

Timescales and Milestones
- GPs paired to care homes – Completed 1st April 2014
- In Reach Team begins at 4 of the largest care homes 1st October 2014
- Mental Health Liaison support – 1st October 2014

Patient cohort: The frail elderly

The delivery chain

GP practices are being commissioned by HaRD CCG to provide regular weekly visits to each of their assigned care homes, and provide a higher level of service than currently contracted including routine assessment, medication reviews, and care planning.

The HDFT community services team are being commissioned to add nursing resources to provide additional support to care homes when a resident becomes acutely ill.

Our mental health services provider in North Yorkshire, TEWV Foundation Trust, is being commissioned to provide a mental health professional to the community team.

The key stakeholders are the GPs, care home administrators and staff, care home residents, the community nursing team, and our mental health service provider, TEWV. A short survey was sent out to 30 care homes on 12th September to solicit feedback on the new GP assignment scheme. Thirteen surveys already received indicate a very high level of satisfaction amongst care home staff and a real perceived improvement in the level of care provided to residents. At least one GP reviews all patients who went to hospital in the last week with his care home to determine the causes and help care home staff avoid unnecessary hospital admissions where possible.

The evidence base

HaRD has a large number of care homes and relatively high percentage of our elderly population residing in care homes. 1.2% of HaRD's population lives in one our 38 care homes. These residents account for 5.5% of all non-elective hospital admissions. 70% of these admissions follow a 999 ambulance call. 23% of admissions are < 3 days, and 66% of these short term admissions are for chest infections, urinary infections, confusion/delirium, catheter issues, and falls/minor injuries. We believe that many of these admissions could be avoided with better care planning, and a better response to these types of health problems in the home. 34% of the unplanned admissions end in death, and 24% of these died within 24 hours. We intend to both avoid unnecessary admissions and give these residents the opportunity to die at "home", meaning their care home. Prior to reorganising our GP's relationship with the care homes, many care homes had as many of 10 GP practices overseeing their residents' care and an individual GP practice could have patients in as many as 20 care homes.

Even care homes with nursing services may not have the confidence, equipment, or time to deliver complex care to acutely ill residents leading to a 999 call. We expect this scheme will provide the support needed to avoid the 999 call if possible.

Investment requirements

14/15 £380,000   15/16 £251,000
One time payment to GP practices of £3,000 per care home supported to manage the extra work of supporting their new care home assignment and continuing to see patients at other care homes during a transition period or if they choose not to change GPs x 38 care homes = £114,000.

Ongoing payment of £35 per resident for higher level of care: £71,000.

Administrative expense of setting up and monitoring the scheme: £15,000

Coast of the In Reach Team (3 Band 6 and 2 Band 2 nurses) and mental health liaison (Band 6) = £180,600

Impact of scheme

We expect this scheme to improve patient care in care homes will result in improved care planning, better medication monitoring, increased patient satisfaction with GP services, as well as more support and guidance to care home staff when a patient is acutely ill or dying. We expect this improved care and support to also result in more care home residents dying in their preferred place of care.

In addition, we expect to see a financial impact through:
- # of emergency admissions from care home postal codes
- Ambulance call outs to postal codes associated with care homes

Since all of our BCF schemes are aimed at reducing reliance on A & E and hospital admission (as well as improving patient care), it is difficult to assess the financial impact of an individual scheme. The overall impact of our BCF schemes has been estimated and documented in Annex 2 of this document.

Anecdotal evidence and our short survey of care homes indicate the GP part of this project already implemented is very successful.

Feedback loop

We will be monitoring the following indicators:
- # of emergency admissions from care home postal codes
- Ambulance call outs to postal codes associated with care homes
- % of patients from care homes dying in their preferred place of care (Patients discharged from hospital with discharge 'died')

We are currently conducting a survey of care home managers regarding their level of satisfaction with the new GP service. This survey has been undertaken in collaboration with the Independent Care Group representing the care homes. The results will be used to further improve the service and ensure it is meeting our stated objectives for quality improvement.

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

- GPs engaging with the care homes and residents to identify and address emerging health needs and to respond effectively to acute crisis. Initial feedback indicates this is working well since implementation on 1st April.
- Care Homes understanding when and how to access GPs and the FAST Team when needed, instead of calling 999, and subsequently feeling that the response was timely and appropriate.
- The FAST Response Team has adequate resources 24/7 to support the care homes. Resources are being added as of October 2014

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

Scheme ref no.
S&R_007_CH
Scheme name
Community Services - Care Home Link Nurses

What is the strategic objective of this scheme?

- To improve the standard of end of life care for patient, facilitating the patients choice to remain within the care home where appropriate
- To educate and sustainably improve the nursing and general care skills in the workforce within participating care homes
- To improve the clinical quality of participating care homes and management of patients with the use Clinical Nurse Specialists
- To reduce the number of inappropriate 999 calls
- To reduce the amount of A&E attendances
- To reduce the amount of non-elective admissions to Hospital

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?

Saint Catherine's Hospice commenced a pilot commissioned by SRCCG/NYCC through reablement funding in September 2012. The aim of which was to improve the quality of care for residents nearing the end of their lives, improve collaboration between GP's, hospitals, primary care teams and reduce the number of unnecessary admissions to hospital in the last stages of life, enabling residents to die in their 'home'.

The table below sets out the activity between September 2012 and July 2014. The data is also shown between January 2014 and July 2014 as this is more representative following the initial set up phase.

	Sept 2012 to and July 2014	Jan 2014 – July 2014
Total clinical referrals	303	123 (21 referrals from homes not receiving intensive support)
Cancer diagnosis	107 (35%)	34 residents (28%)
Hospital admissions prevented through CNS involvement*	141 (6.7 average per month)	62 (10.3 average per month)
Earlier discharge from hospital to care home through CNS involvement**	67	25

% residents who specified a preferred place of care as care home and died there	95% (139 out of 143 residents)	92% (119 out of 129 residents)

* Avoidable admissions are attributed to the team (with the acknowledgement that other services are contributing towards care delivery) when the CNS plays a significant part in assessing, communicating and planning appropriate care that either the resident prefers or is in their best interest. This might include advice and education about disease trajectories and the stage of disease which influences how active a treatment might be, support in determining a resident's capacity, identifying potential causes if a resident deteriorates suddenly including appropriate treatment of reversible causes of deterioration or alternative symptom management within the care home environment dependant on resident wishes / best interests. A significant part of admission avoidance is effective communication between residents, care home staff, and other service providers, which is often time consuming and requires a high level of effective and sensitive communication skills, to which the CNS contributes directly and also encourages care staff to engage with such discussions to increase their knowledge and confidence.

**Earlier discharge from hospital to a care home has been enabled with increased communication and coordination of care planning between secondary and primary care services and through the support of care home staff to increase their confidence and knowledge in caring for residents in the last year of life. Patients and families have expressed a preference to hospital staff for patients to be cared for in homes which are supported by the Care Homes team.

Central to delivering these outcomes has been the training of staff within the care homes. During the last 12 months 244 education sessions have taken place within care homes. In addition to this 2 further study days have been held within the hospice education department, to enable representation from homes not receiving intensive support and 4 further days are planned for September and October 2014. Places (20 per day) are fully booked. Evaluation of the education programme demonstrates that 83% of staff feel that what they have learned will definitely help them to keep residents at home at the end of their life and provide high quality care (6 month period sample in care homes sessions).

In addition to this, evaluation of care home staff attendance at the education department demonstrates that staff benefit from receiving education along side other homes stating that this promotes collaborative working and sharing of ideas, 100% of confidence scores increased following attendance and 90% of attendees rated the skills of the teaching as 5 (scale of 1-5, where 5 is best). Main learning outcomes from all sessions include the importance of communicating effectively with other services and specific increase in clinical knowledge such as nutrition, mouth care and medication.

Of equal importance has been raising the profile of this new team, the success of which is demonstrated in the table below that shows the source of referrals to the team

Referral Source	Number of referrals	Referral Source	Number of referrals
Care Homes	69	Hospital Macmillan unit	14
Heather Unit (Day Hospice)	10	District Nurse	9
Community Macmillan CNS	7	Neurology CNS	4
Palcall	7	Social services	3
IPU	6	Marie Curie	1
GP	4	Self referral	1

The team has also implemented an adapted Gold Standards Framework for use in care homes which enables objective clinical review of all residents to allow forward care planning and anticipatory prescribing, in order to reduce unplanned avoidable hospital admissions, increase the number of residents receiving care that they prefer and a better educated workforce. It is hoped in the future to expand this framework to combine these reviews with other professional visits (e.g. Gp, disease specific clinical nurse specialists) and therefore increase collaborative working and reduce duplication.

The feedback received about care is summarised by the following quotes:

"I have every confidence that Mum's care will be right for her, with the staff here, (nursing home) with your support" (Carer via survey feedback 2014)

Care home staff frequently comment that this service enables them to:

''feel more confident and knowledgeable in appropriate decision making, and particularly appreciate the weekend support, when there is limited support from other providers''.

Discussion with District Nurses (August 2014) has highlighted that they have:

''reduced the number of inappropriate visits previously carried out in nursing homes due to the support nursing homes receive from the pilot''

and that staff in residential homes are:

''more knowledgeable, calmer and more focused'', which inevitably leads to less crisis occurring and more residents receiving appropriate end of life care, in line with their preference."

A significant part of the CNS work (approximately 30%) involves collaborative working with other hospice, primary and secondary care teams in relation to individual resident care and also at a broader more strategic level to develop effective care pathways and integrated services. An example of this collaborative working can be demonstrated through the development of a Care Homes and Domicilliary Care Providers Network which is organised by the project team and is held every second month at the hospice. This network encourages support for practitioners and managers and sharing of good practice examples, development of strong and

effective relationships across primary and secondary care, updates on current initiatives and new guidance and also has an educational component. During the project, the following services have been involved with the network meetings:

- Acute Trust – Hospital Macmillan Nurses, Hospital Discharge liaison team, Acute Services Manager
- CCG / CSU – Safeguarding officers, representation from Chief Nurse, Lead nurse Minor illnesses / injuries pilot, Continuing Health Care Funding Team, Community Medicines Optimisation Pharmacist
- Research – NIHR / ENRICH project
- Education – 2 x medical lectures on symptom management / DNACPR,

8 CNS led sessions (including dignity, end of life care, ACP, communication and SBAR tool), representation from Skills for Care and local Clinical Skills in practice project (including catheter, pressure area and PEG care, venepuncture), Bridges counselling service, Tyro apprenticeship training, Nutritional representative, Syringe Driver Task Force, DOLs officers, District Nurses, Tissue Viability Nurse Specialist. E-learning opportunities have also been highlighted.

Model is Care home Link Nurses delivering targeted education to care home staff in a phased approach. Patient Cohort: Patients identified as requiring end of life care within their last year of life or who have a chronic long care condition that would benefit from the project including those with dementia or frailty and residing within care homes including Nursing, Residential, Elderly Mentally Impaired and Learning Disabilities and are within the Scarborough and Ryedale CCG geographical patch.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
14/15 £168,000   15/16 £168,000
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

The pilot has demonstrated its effectiveness in improving skills of care home staff enabling them to provide better care to patients in their preferred care setting, reducing hospital admissions. As such the future ambition is for the services to continue to operate as it does now. As the turnover of staff in care homes is extremely high and the skills sets in relation to end of life care are often limited it is proposed that there is a requirement for the service to continue to provide the education function and further upskill the sector.

The 3 level model of care designed for the extension of the initial pilot has allowed increased access to education and clinical support for all homes and the '7 star' framework is enabling homes to develop tools and systems that will hopefully embed what staff are learning from the educational component of this project for the benefit of all residents. Examples of sustainable elements that the team have encouraged include an increasing number of staff registering as Dignity Champions (National Dignity Council initiative), more residents and relatives user group involvement in services, use of evidence based symptom assessment tools and use of formal reflection to analyse significant events and identify what can be improved in the future.

The ability to visit the care home outside of core hours also enables improved coordination and continuity of clinical and educational input across 7 days, which supports the high turnover of staffing within homes and reduced community service provision. The weekend CNS often liaises with the out of hours GP, the local authority Duty Social Worker and out of hours pharmacy services.

In addition to continue to service the Hospice would like to develop a more robust set of outcome measures and proposes the following for the next 12 month period.

- Number of referrals from Primary Care
- Number of referrals from Secondary Care
- Number of referrals from Care Homes
- Number of referrals from Hospice
- Number with and without a cancer diagnosis,
- Number of patients dying in their Preferred Place of Care
- Number of hospital admissions avoided
- Number of reduced hospital bed days
- Number of reduced hospital admissions
- Development of a Care Homes / Domiciliary Care Providers Network
- Number of education sessions provided per year
- Number of care homes involved with the team

Currently 21 homes receiving intensive support – level 1. Target: to move 8-10 homes into sustainability / extended support level 2 (over next 3 months) and invite 8-10 new homes into intensive level. All additional homes (approximately 40 homes) are now within level 3 which includes invitation to the Network, referral for clinical support for individual residents and education to support those resident's needs and invitation to the education days held at the hospice education centre.

The additional benefits of the scheme are:
- Reduced overall emergency admissions to hospital from care homes
- Provision of advanced care planning
- Improved clinical care for patients
- Improved clinical skills of staff within care homes
- Supporting care homes to provide high quality care within the patients chosen place of residence
- Improved satisfaction levels for patients and carers

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?

Outcomes of the scheme are measured and/or to be measured through the following methods;

- Working with commissioners and local public health to agree measures (and data sources) to demonstrate impact against strategic outcomes
- Ensure that key stakeholders are kept updated about the development of the service and its impact
- Project group meetings involving local stakeholders, including GP leads, to agree models of care and monitor implementation of agreed plans

- Provider based monthly steering group reviewing key measures and timescales
- Provision of measures through commissioner delivery groups to allow wider scrutiny of impact

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

Specifically related to the defined scheme key success factors relate to:

- Ongoing key provider engagement in delivery building on key relationships with the 3rd sector
- Wide engagement with a range of stakeholders, including service users and carers
- Realising material reductions in admissions and other stated outcomes
- Opportunity to measure key quality of life outcomes for patients and their family/carers
- Utilising decision-making processes to ensure that the service meets expected outcomes and benefits the patient and family/carers
- Promote sustainability of the scheme through ongoing adaptation and learning

Outcomes of the scheme are measured and/or to be measured through the following methods:

- Appointment and retention of suitably trained Clinical Nurse Specialists to deliver the programme of training and support
- Engagement of the care home staff with training and their assimilation and application of shared knowledge
- Having enough time to deliver required standards of education to a dynamic care home workforce
- Record the number of clinical referrals
- Record the diagnosis of the patient, i.e cancer, COPD, Heart Failure, Respiratory Failure
- Record the number of admissions prevented through involvement of Clinical Nurse Specialist
- Record the number of patients who specified the care home as their preferred place of dying and died there.
- Evaluate Yorkshire Ambulance Service data relating to 999 calls to care homes and of those who were transported to hospital and died there within 48 hours

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

Scheme ref no.
ALL_001_RC

Scheme name:
Reablement and Carers

What is the strategic objective of this scheme?
To harness the current programmes and schemes aimed at reablement and carers' support and ensure they are aligned to support the ambition and goals of this North Yorkshire BCF plan and build capacity to support carers through the avoidance of duplication of activity and finding efficiencies through closer joint working. This will also ensure that support for carers is consistent, affordable and deliverable across North Yorkshire.

Overview of the scheme
Underpinning BCF investment and service development

NY CCGs currently fund a variety of schemes aimed at reablement and carers that can be evaluated and repositioned to both support and enhance our BCF objectives and outcomes. Each of these schemes will benefit from evaluation of their effectiveness in light of BCF principles, with modification of their service specifications/care pathways to ensure they are re-aligned with BCF goals and objectives. Modification of their overall criteria and/or operational processes, evaluated with the whole of the health and social care in mind, will be key to ensure they support BCF goals and objectives.

These schemes include services such as rehabilitation in various intermediate care settings, respite care, advocacy, befriending, dementia navigator services, adult day care, community equipment, case management, and specialist nurses working in the community.

The carer-specific schemes will be aligned to offer specific interventions for carers that prevent, reduce or delay the need for support and well as support carers who care for patients discharged from hospital and people with long term conditions. This will include interventions, information or advice that help carers to :

- Care effectively and safely both for themselves and the person they are supporting e.g. advice on moving and handling r avoiding falls in the home
- Feel confident performing basic health care tasks as a result of training
- Look after their own physical and mental well-being including developing coping mechanisms
- Make use of IT and Assistive Technology
- Make choices about their own lives e.g. managing care and paid employment
- Link in with county wide prevention officers
- Find support and services available in their area
- Access advice, information and support they need including advice on welfare benefits and other financial information and about entitlements to carers assessments

Currently the schemes across North Yorkshire include:

- carers resource centres
- carers sitting services
- advocacy
- befriending services
- children's respite etc
- falls
- fast response
- intermediate care
- equipment services

These schemes need to be aligned so that there is a consistent offer to carers across the County, for example many of the voluntary sector contracts have befriending which means there is duplication of support in some parts of the county but there are also gaps in provision as the provision is patchy in some areas.

Review of existing schemes, in light of BCF national conditions and priorities, will be conducted through the NY BCF by the end of March 2015. Plans to improve service specifications/care pathways and metrics in line with BCF priorities will be developed and implemented during the first quarter of 2015/16. Implementation reviews and any subsequent re-development will be undertaken throughout the rest of the year.

The delivery chain

Commissioner/Provider

Commissioning these support services will be a joint endeavour between North Yorkshire County Council and each of the CCG localities. This will involve a local service model in line with county wide principles and high level aspirations.

The principal service providers will be from a range of statutory and voluntary sector services.

Delivery plan

The high level plan would be:

- Evaluation of current schemes against BCF conditions – March 2015
- Contract specifications to be reviewed and modified if needed – March 2015
- Opportunities for joint carers assessments to be explored – March 2015
- Additional service commissioned as required July 2015
- Modified carers support services in place – September 2015

Project enablers

- Data sharing agreements and processes
- Re-contracting of programmes and schemes

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The evidence base
- Social Care Institute for Excellence: Research briefing, April 2011,   - Reablement: A cost-effective route to better outcomes, Francis, Fisher and Rutter   http://www.scie.org.uk/publications/briefings/files/briefing36.pdf   - Institute for Research and Innovation in Social Services: Insights: Effectiveness of reablement services   - The effectiveness and cost-effectiveness of support and services to informal carers of older people. A review of the literature for the Audit Commission by Linda Pickard, LSE Health and Social Care, London School of Economics

Investment requirements
14/15 £4,343,000   15/16 £4,343,000

Impact of scheme
The intention is to enable many more people to be cared for in their homes whilst at the same time supporting carers to so can maintain the physical and mental health wellbeing. This will result in :   - Reduction of non elective admission into hospital   - Reduction in volume of ongoing social care packages   - Reduction in length of stay/acute bed days in acute hospital   - Reduction in the volume of unproductive assessments across health and social care   - Increase in the number of older people living at home independently at home following discharge from hospital   - Reduction in long term nursing and residential home placements including those directly from hospital

Feedback loop
Regular performance reports will be received by locality transformation boards detailing activity regarding carers assessments and carers support services and impact upon unplanned care and community services. Within the same report data will be received on emergency admissions and excess beds days. These separate data sources will be compared to help ascertain whether the services are having an impact. As the schemes are aligned and capacity for carers assessments and carer support services is increased an observed change in these metrics will be looked for.

What are the key success factors for implementation of this scheme?
Quality and volume of carer support services   - Number of carers assessments   - Activity through carer support services   - Links with county wide prevention officers

North Yorkshire Health and Wellbeing Board
Better Care Fund Plan

Scheme ref no.
ALL_002_CS

Scheme name:
Existing Schemes

What is the strategic objective of this scheme?

This annex does not describe a scheme, but the range of current programmes and schemes which underpin the current health and care system contributing to the success of our BCF programme. They are largely contracted through the Community Contracts by the CCGs. These programmes are existing services which the NY BCF is committed to continuing to fund and develop.

Overview of the scheme

As with all new and existing schemes, these areas of spend will be evaluated, analysed and compared to find the optimum investment levels in the most effective activity. This will inform future commissioning activity.

The current activity funded in this group breaks down as follows:

Tissue Viability Services	194,854
Primary Enhanced Care Model	256,315
A&E Liaison	47,118
Fast Response	3,302,778
Wheelchair services - HDFT	1,359,755
Heart Failure	336,387
COPD / Respiratory Nursing Support	191,775
Specialist Cardiac Rehabilitation	83,374
Specialist Continence / Nursing Support / Therapies	1,131,734
Other	177,910
	7,082,000

The delivery chain

Commissioner/Provider

All services are currently commissioned by CCGs on a local basis.
The principal service providers will be from a range of statutory and voluntary sector services.

Delivery plan

The high level plan would be:

- Evaluation of current schemes against BCF conditions – March 2015
- Contract specifications to be reviewed and modified if needed – March 2015
- Opportunities for joint carers assessments to be explored – March 2015
- Additional service commissioned as required July 2015
- Modified carers support services in place – September 2015

The evidence base

- Social Care Institute for Excellence: Research briefing, April 2011,
- Reablement: A cost-effective route to better outcomes, Francis, Fisher and Rutter
http://www.scie.org.uk/publications/briefings/files/briefing36.pdf

- Institute for Research and Innovation in Social Services: Insights: Effectiveness of reablement services
- The effectiveness and cost-effectiveness of support and services to informal carers of older people. A review of the literature for the Audit Commission by Linda Pickard, LSE Health and Social Care, London School of Economics

Investment requirements

15/16 £7,082,000

Impact of scheme

The intention is to enable many more people to be cared for in their homes whilst at the same time supporting carers to so can maintain the physical and mental health wellbeing.

This will result in :
- Reduction of non elective admission into hospital
- Reduction in volume of ongoing social care packages
- Reduction in length of stay/acute bed days in acute hospital
- Reduction in the volume of unproductive assessments across health and social care
- Increase in the number of older people living at home independently at home following discharge from hospital
- Reduction in long term nursing and residential home placements including those directly from hospital

Feedback loop

Regular performance reports will be received by locality transformation boards detailing activity regarding carers assessments and carers support services and impact upon unplanned care and community services. Within the same report data will be received on emergency admissions and excess beds days. These separate data sources will be compared to help ascertain whether the services are having an impact.

As the schemes are aligned and capacity for support services is increased an observed change in these metrics will be looked for.

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

n/a

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Scheme ref no.
ALL_003_PHP

Scheme name
Falls Prevention

What is the strategic objective of this scheme?

The strategic objective of the scheme is to develop a multifactorial falls prevention system for North Yorkshire, which will help prevent people from falling and both reduce the ongoing costs to health and social and improve the independence and longer-term outcomes for older people.

Multidisciplinary intervention programmes are considered effective in preventing falls, and therefore highly cost-effective interventions when the reduction in costs from emergency care, treatment, rehabilitation, and social care are considered.

The NICE guideline for falls prevention[17] identifies three primary areas where investments can lead to cost savings locally:
- reduction in the incidence of falls,
- reduction in costs from emergency admissions resulting from falls and the associated treatment costs, and
- reduction in the cost of social care for people with falls-related conditions

The scheme will have the following service improvement objectives:

- Widespread use of opportunistic screening/ trigger tools to identify people potentially at risk of falling, or who have fallen recently, who may require a structured multifactorial assessment. This screening will be supported by appropriate training and education programmes.
- Systematic access to an evidence-based and standardised multifactorial risk assessments for falls across health, social care (as a minimum), performed by an appropriate professional with skills and experience.
- Facilitate co-ordination between hospital settings on the identification and management of people at risk of a fall during their hospital stay to ensure practice is in line with NICE guidance and integrated with community care.
- Per locality, a clear process and access to the full range interventions needed to meet the needs identified in the multifactorial assessment.
- Shaping current HAS and NHS contracts to ensure that reducing falls is a key improvement priority and addressing the system capacity and capability issues needed to deliver the objectives specified above.

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[17] http://guidance.nice.org.uk/CG161

- Commission lifestyle services (including NICE approved physical activity recommendations to improve muscle strength, balance and mental health) for people either at the risk of falls or who have fallen that complement the services above.
- A shared performance framework across all service providers related to falls pathways to measure activity and outcomes through the pathway.
- Standardise education, information and training for professionals, members of the community, patients and carers (including post discharge from hospital).

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?

Falls is a cross cutting theme across community service redesign and public health/ prevention programmes identified in the BCF. However, for preventing falls, there is a specific strategic partnership group co-ordinating the implementation of the above objectives and working to ensure that the desired outcome of reducing the incidence of falls in North Yorkshire is achieved.

NYCC and individual CCGs are working collaboratively to establish best practice for falls prevention, review current delivery against this best practice in individual localities, and commission and develop improved service provision in line with the best practice identified.

This scheme involves employing a Falls Co-ordinator to take forward the objectives outlined above with the network of professionals and services that already operate in North Yorkshire.

The 2 year fixed term Falls Prevention Coordinator for North Yorkshire will jointly develop a falls implementations plan. NICE clinical guideline 161 will also be used as a framework for the development of the implementation plan along with information already gathered by local audits and multiagency workshop event held on 25th September 2014.

The head line milestones for the first 6 months of the scheme are leading to the development of a detailed plan are as follows:

- Audit local systems using NICE guidance – June 2014 **(complete)**
- Hold best practice workshop to identify optimum summary pathway and key themes– September 2014 **(complete, with input from 74 stakeholders)**
- Recruit falls co-ordinator – January 2015 **(complete, Falls Co-ordinator takes up post in January 2014)**
- Specify a detailed implementation plan and subgroup network to take forward the agreed objectives – February 2015
- Identify local CCG and county-wide commissioning objectives within implementation plan, ensuring that the falls objectives are included in related areas of commissioning – March 2015

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

The delivery of improved services will be achieved through a network of commissioners working together to commission, procure and develop local services – this will be through the Falls Pathway Group which reports to the Integrated Commissioning Board. Local developments will be owned by local integration and transformation boards.

The improvement of services will be driven by a falls implementation plan, which will identify service gaps and commissioning priorities. The commissioning plan will be developed through a county-wide steering group, including representatives of all the CCGs, NYCC, CYC and Public Health. This Falls Pathway Group is led by Public Health and will oversee the development and implementation of a plan to reduce falls and falls related injuries in North Yorkshire. A Falls Coordinator is being employed to support this group and implement and develop work with local areas.

Commissioning of additional or altered services to improve services may then be commissioned by individual CCGs, LAs, or through the BCF pooled budgets, depending on the service in question, based on the over-arching recommendations agreed through the county-wide group.

| **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 |

Nice Guidance CG161
According to NICE, around 30% of adults who are over 65 and living at home will experience at least 1 fall a year. This rises to 50% of adults over 80 who are either at home or in residential care. Most falls result in no serious injury, but annually approximately 5% of older people living in the community who fall experience a fracture or need hospitalisation.

The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falls are estimated to cost the NHS more than £2.3 billion per year. Therefore falling has an impact on quality of life, health and healthcare costs.

65% of North Yorkshire emergency admissions due to falls in 2013/14 were over the age of 65 – 72% male, 28% female.

North Yorkshire and York both have aging populations. On average the current population of North Yorkshire is older than that of England. The current population structure indicates that proportionally there are more people at each of the 5 year age groups from 45 years and older when compared with England (fig 1). Conversely North Yorkshire has a smaller population at each of the 5 year age bands under 45 years when compared with England except in 10-19 year old males.

Overall, the population of North Yorkshire is becoming older with a predicted increase in

people aged over 65 from 133,000 in 2013 to 211,000 by 2037, and a predicted increase in people aged over 85 from 17,500 to 47,000.

Compared to other upper tier local authorities, North Yorkshire had a 2% higher proportion of people aged over 65 in 2013; a gap that will widen to 4% by 2037. The corresponding 2% increase is the equivalent of an additional 13,000 people aged over 65. This ageing population is likely to lead to further increases in the rate of falls in North Yorkshire if action is not taken to ensure that local services are co-ordinated and evidence-based.

North Yorkshire and York Injuries Due to Falls in 65+ Time Series, Age/Sex Standardised per 100,000 (Source: PHE)
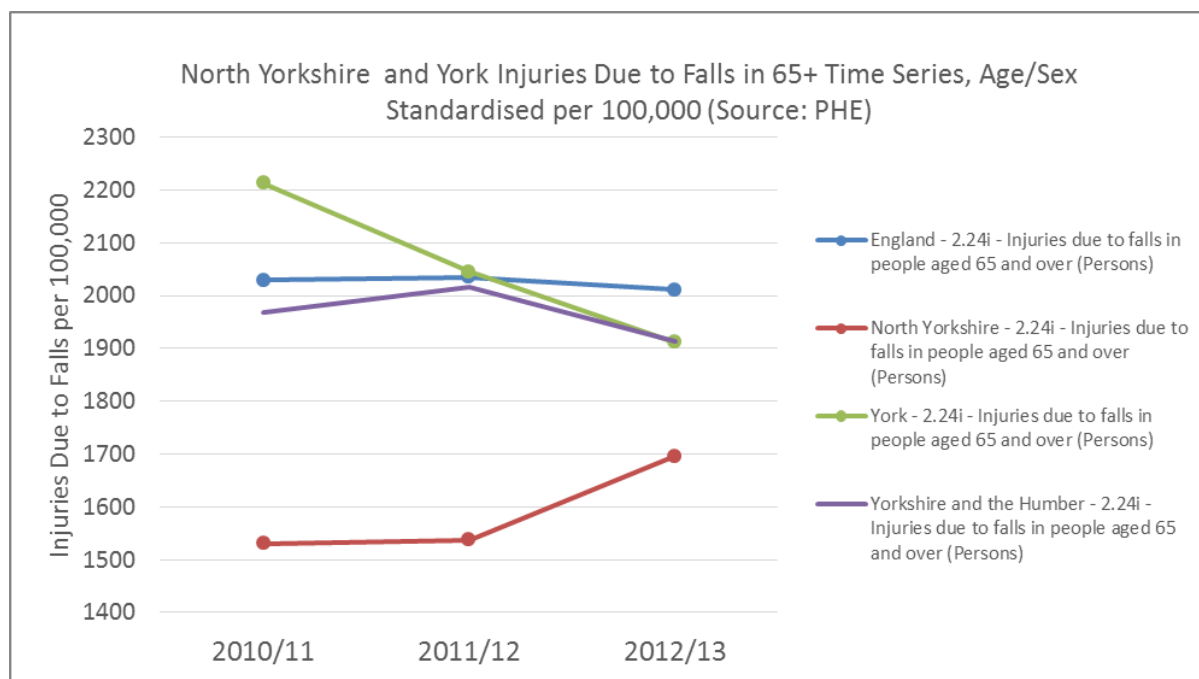
The graph above shows that the rate of injuries due to a fall in North Yorkshire is on the increase and the further ageing population will place additional pressure on acute services.

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

14/15 £10k   15/16 £40.6k

Specific funding for a falls co-ordinator has been included within the BCF for 2014-16

Cost of a FTE coordinator band 7 £40,558

Where additional investment is required as a result of pathway development work during the course of the project, leading to additional commissioning requirements, then further commissioning discussions will be undertaken at both local and county-wide level. Additional spend may be identified through CCG plans locally or additional recommendations may be made for the BCF at a later date.

North Yorkshire Health and Wellbeing Board
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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

The success of the scheme will be measured by a change in the Public Health indicator 2.24i; injuries due to falls in 65 years and over (persons)

Baseline number of falls in 2012/13 2,316 this plan to be 2,261 in 14/15 and 2,109 15/16.

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 will feedback to ICB and CCG's local integration and transformation boards

The key outcome measure of this scheme is monitored through the public health outcomes framework, however the local public health team can provide timely reporting of this indicator on a quarterly basis to the ICB and local integration and transformation boards.

Further monitoring of the implementation plan will be reported regularly to the ICB.

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

- Effective leadership from Public Health on the evidence base for falls prevention best practice
- Clear strategic objectives and the development of a clear 'SMART' implementation plan
- Effective CCG representation on the county-wide steering group, with effective reporting back into local transformation boards and service development groups
- Effective recruitment of a falls co-ordinator and establishment of effective working relationships between the falls co-ordinator and service development teams within different localities
- Effective communication, networks, and buy-in from service providers, including acute Trusts and the voluntary sector

North Yorkshire Health and Wellbeing Board
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ANNEX 2a – Provider commentary: Airedale NHS Foundation Trust

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	North Yorkshire
Name of Provider organisation	Airedale NHS Foundation Trust
Name of Provider CEO	Bridget Fletcher
Signature (electronic or typed)	Bridget Fletcher

For HWB to populate:

Total number of non-elective FFCEs in general & acute	2013/14 Outturn	4,820
	2014/15 Plan	4,651
	2015/16 Plan	4,488
	14/15 Change compared to 13/14 outturn	-3.63%
	15/16 Change compared to planned 14/15 outturn	-3.63%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	169
	How many non-elective admissions is the BCF planned to prevent in 15-16?	163

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?	**Strategic context:** Airedale is committed to working with commissioners and local health and care economy partners in pursuit of our shared *Right Care* vision. Key to realising our vision is transformation, innovation and integration to better support patients (and their carers) at home/closer to home to reduce hospital admissions, A&E attendances, bed days and length of stay. This is something we have been pursuing for some time through the use of Telemedicine in patients own homes and nursing and residential care homes," Gold Line" for End of Life care, and the work of the Airedale and Craven Community Collaborative Teams which have already reduced admissions and A&E attendances and improved patient care. With reference to the impact data you have produced, we have reviewed and tried to reconcile

		with our own projections. We cannot reconcile the figures as they do not allow for any underlying growth or if they do include this, we would require a 10~11 % reduction from our current forecast trajectory which we feel is unrealistic given current performance levels.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	As we have already signalled, the underlying trend for emergency activity has shown a year on year increase of 3-4% in acute admissions with the current forecast trajectory for 2014~15 indicating a 7% increase from 2013~14 (this is after the hospital admission avoidance schemes we have already introduced) and this does not seem to have been factored into the trajectories from outturn 2013~14 to plan for 2015~16. The figures presented for outturn 2013~14 and plans for 2014~15 appear to be lower than the actual demand currently being experienced which would indicate a lower baseline is expected than is already occurring. To achieve the net impact on the underlying trend to deliver the indicated plan for 2015~16 would require an annual reduction of 10~11% in admissions which appear to be unrealistic given the evidence to date. We feel that the realistic plans going forward would at best reduce the underlying trend of 3-4% growth down to a smaller % in the short term and therefore reducing the future growth. The investment through the BCF should therefore reduce future growth (which may be 100~200 spells each year) resulting in future plans only showing small changes from the underlying baseline at this stage. The impact of self-care in the future (3 ~5 years) may have a greater impact and reduce the level of admissions further but this will need further testing.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	We have considered the underlying trend in admissions and have been working with you on new models of care and pathways for managing admissions through Ambulatory care pathways ,Telemedicine, new models in A&E and Intermediate care teams which has resulted in reduced admissions which had we had not, would have resulted in further increased levels of admissions. Our financial strategy is to manage future growth

		down so that we can work within the existing baseline resources but the forecast trajectory indicated assumes a much greater reduction below the existing baseline which could result in a significant overtrade which would need managing through a risk pool. In line with our shared Right Care vision, to meet the underlying growth we need to work with our partners to strengthen the current service offer with extension to 24/7 services for ambulatory care, combined GP/Consultant services and the front end in A&E and AMU, whilst developing self-care models of care using Technology and a single care record in conjunction with the A&CCCT teams.

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ANNEX 2b – Provider commentary: Harrogate & District NHS Foundation Trust

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	North Yorkshire
Name of Provider organisation	Harrogate & District NHS Foundation Trust
Name of Provider CEO	Dr Ros Tolcher
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	11,572
	2014/15 Plan	11,412
	2015/16 Plan	10,887
	14/15 Change compared to 13/14 outturn	160
	15/16 Change compared to planned 14/15 outturn	525
	How many non-elective admissions is the BCF planned to prevent in 14-15?	937
	How many non-elective admissions is the BCF planned to prevent in 15-16?	1,457

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?**	The Trust agrees with the modelling which has been completed in relation to the BCF schemes. HDFT and HaRD CCG have worked together on assessing the impact of each scheme on Non Elective activity. The model attempts to take account of likely growth due to demographic change and then utilises proxy data to sense check the potential reduction identified within each BCF scheme.

In addition the CCG and Trust are jointly commissioning a Bed Utilisation Audit to provide an objective view of the opportunity for non-elective reduction.

The delivery of this level of non-elective reduction will be very challenging and therefore the investment in and transformation of community services will need to mirror the |

		planned reductions. The Trust and CCG are working closely to support achievement of this plan.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	*N/A*
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	HDFT is the main Acute and Community provider for HaRD CCG. The Trust strategy is to deliver more care outside of hospital and closer to patients' homes. This is in line with the CCG strategy and principles of the BCF.

In developing the Trust strategy the implications of this approach have been considered.

All partners recognise the substantial risks involved in translating the complex modelling into operational delivery.

Further work will need to be undertaken to ensure the transfer of the activity between acute and community is matched by changes to costs and income. |

North Yorkshire Health and Wellbeing Board
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ANNEX 2c – Provider commentary: York Teaching Hospitals Foundation Trust (Scarborough & Ryedale)

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	North Yorkshire Health & Wellbeing Board
Name of Provider organisation	York Teaching Hospitals NHS Trust
Name of Provider CEO	Patrick Crowley
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	2013/14 Outturn	9,892
	2014/15 Plan	10,117
	2015/16 Plan	10,197
	14/15 Change compared to 13/14 outturn	+225
	15/16 Change compared to planned 14/15 outturn	+80
	How many non-elective admissions is the BCF planned to prevent in 14-15?	225
	How many non-elective admissions is the BCF planned to prevent in 15-16?	782

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?**	Yes
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	Not Applicable
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Yes

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ANNEX 2d – Provider commentary: South Tees NHS Foundation Trust

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	North Yorkshire
Name of Provider organisation	South Tees NHS Foundation Trust
Name of Provider CEO	Professor Tricia Hart
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	2013/14 Outturn	13,784
	2014/15 Plan	12,897
	2015/16 Plan	11,696
	14/15 Change compared to 13/14 outturn	887
	15/16 Change compared to planned 14/15 outturn	1,201
	How many non-elective admissions is the BCF planned to prevent in 14-15?	479
	How many non-elective admissions is the BCF planned to prevent in 15-16?	1,201

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?	Yes - however this will ultimately depend on the success of the schemes proposed.
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?	Yes we have considered the theoretical modelling for the reduction in activity in terms of loss of income, cost and capacity reduction.

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ANNEX 2e – Provider commentary: York Teaching Hospitals Foundation Trust (Vale of York)

Name of Health & Wellbeing Board	North Yorkshire Health and Wellbeing Board
Name of Provider organisation	York Teaching Hospital NHS Foundation Trust
Name of Provider CEO	Pat Crowley
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	31,115 *
	2014/15 Plan	31,304 *
	2015/16 Plan	31,495 *
	14/15 Change compared to 13/14 outturn	189
	15/16 Change compared to planned 14/15 outturn	191
	How many non-elective admissions is the BCF planned to prevent in 14-15?	543
	How many non-elective admissions is the BCF planned to prevent in 15-16?	1,075

* represents whole Vale of York Area, not North Yorkshire

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?**	Yes
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	Not Applicable
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Yes