Health and Wellbeing Board
North Yorkshire

Better Care Fund
Draft Plan
14th February 2014

NHS
Airedale, Wharfedale and Craven
Clinical Commissioning Group

North
Yorkshire County Council

NHS
Hambleton, Richmondshire and Whitby
Clinical Commissioning Group

NHS
Harrogate and Rural District
Clinical Commissioning Group

NHS
Scarborough and Ryedale
Clinical Commissioning Group

NHS
Vale of York
Clinical Commissioning Group

Version History

Version Number	Changes by	Distributed to:	Changes	Date Issued
Template 'personalisation' v0.1	Keith Cheesman			
Draft v0.2	Keith Cheesman	Editorial board ICB Members Health Integration Project Team Operational GM's HAS	Initial rough cut draft	15 -01-14
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Draft v0.5	Keith Cheesman	n/a		
Draft v0.6	Keith Cheesman	Editorial Board Chief Officers Health Integration Project Team	Reduction in localised input – commonality reflected, schemes removed pending agreement on them	30-01-14
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Draft 0.9	Keith Cheesman	Editorial board ICB Members Operational GM's HAS	Final Draft for ICB review / Agreement	11-02-14
Version 1.0	Keith Cheesman	CCG Signatories NYCC Director	Final for Signing	14-02-14

Contents

1. INTRODUCTION

North Yorkshire has a complex health and social care economy, including 6 Clinical Commissioning Groups (CCGs) three of which also operate in Bradford, City of York East Riding of Yorkshire and Cumbria, 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 coterminosity between agency boundaries. The General Hospital provision for the majority of residents of North Yorkshire requires them to travel outside the county boundary to Leeds, Bradford, Darlington, York and Hull.

The Health and Wellbeing Board for North Yorkshire incorporates membership from the County Council, District Councils, 5 CCGs, (Harrogate and Rural District, Hambleton, Richmondshire and Whitby, Scarborough and Ryedale, Vale of York and Airedale Wharfedale and Craven). This plan wholly encompasses the CCG footprints of these. The footprint of Airedale, Wharfedale and Craven crosses into the Health and Wellbeing Board coverage of Bradford Metropolitan District Council and the City of York Council covers the City of York and the East Riding of Yorkshire. Finally, to the extreme west of North Yorkshire, the general practices of Ingleton, Little and High Bentham fall into Cumbria CCG. Such a small proportion of the Cumbria CCG Operating Plan will cover territory in North Yorkshire, that there is little benefit in attempting to integrate a sixth CCG's plans to this one, so the plans of Cumbria Health & Wellbeing Board will cover this area.

The North Yorkshire Health and Wellbeing Board (NYHWB) has arrangements for joint working with Bradford City and City of York Councils and HWBs. All partners have recently signed an Integration Framework Agreement which sets out the broad principles for partnership working and identifies priority areas for integration of commissioning and for service delivery.

A key element of all our work is the recognition of the need to respect and work within the governance and accountability frameworks for all agencies, recognising that CCGs have a more local focus and are accountable to their GP membership and that the County Council is accountable to the whole population of North Yorkshire via elected members. Our District Councils have similar accountability at District level.

The vision for North Yorkshire is built on the following strategies and plans:

- The Strategic Plans for the 5 Clinical Commissioning Group areas:
    - Airedale, Wharfedale and Craven,
    - Hambleton, Richmondshire & Whitby,
    - Harrogate and Rural District,
    - Scarborough and Ryedale
    - Vale of York
- North Yorkshire County Council's vision for 2020 North Yorkshire
- The NYHWB Integration Framework Agreement
- The North Yorkshire Joint Health and Wellbeing Strategy

It is underpinned by data and evidence from

- The North Yorkshire JSNA
- Customer Surveys and Consultations from the CCGs and County Council
- Performance data from the NHS and Social Care
- The financial plans for all partners

The vision sets out what we aim to deliver for all citizens wherever they live in the County, but recognises the differing geography and socio-economic factors affecting our communities and the wide range of public, private and voluntary and community sector bodies we work with. Thus it is an amalgam of 5 CCG plans and 1 County Council approach.

It is clear that we are able to build upon work that has already started in North Yorkshire; we have not started with a blank canvas or any lack of motivation to provide the best and most efficient services possible. It does mean, however, that there are test areas in place the results of which will inform decisions to extend / expand or develop new models.

Better Care Fund is already changing the way we work and engage; acute providers were already members of the Health and Wellbeing Board but now are also a part of the Integrated Commissioning Board and the local sub-groups, along with voluntary sector representation.

We are clear that substantial work is needed to support and develop staff, to ensure appropriate skills and cultural shift are built into introducing these models and that, as experience shows, these changes are not always easily or quickly achieved.

It is important to recognise that in our complex system, the bordering local authorities and, to an extent, CCGs have different plans which, although similar enough to ensure progress against the national conditions, are built around differing policies, strategies, levels of need, past performance, ways of working, health priorities and political stance.

Bringing this plan together, therefore, highlights some simple tensions such as nomenclature and local flavour. More fundamentally at times there are passages of this plan that by their nature have required us to provide specific text that reflects what might be seen as conflicting intent but is in fact simply reflecting that this submission for NYHWB includes CCGs whose plans are required to be relevant to, and supportive of, work for multiple local authorities and Health and Wellbeing Boards.

This complexity also gives us opportunity to try different models, to manage some change on a local basis to reflect local needs and most importantly to enable us to learn from a large pool of experience and knowledge to build the best possible health and social care system.

2. OUR VISION

All our consultations with communities and specific groups of people who use support point in the same direction. They know that we need to support more people, with complex needs, with less money. People say they want to be supported to live at home and to use services at home or as near as is possible and safe. They want to remain within their family, neighbourhood and community and want to contribute to the community and the economy as well as use services. They want to only tell their story once. This means that we need to transform what we do, promote self-help, independence, wellbeing and sustainable services while innovating and applying best practice in a systematic way.

> Our primary aim is to support individuals to improve and manage their own health and wellbeing. Our vision is for a collaborative approach, centred on the needs of the individual and their carers, empowering them to manage and shape their own care.

Central to our vision is an acknowledgement that services must be co-ordinated around the needs of the individual and their carers, allowing them to shape and challenge their care. We propose 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 delivering and commissioning care at all levels of our organisations.

The North Yorkshire Joint Health & Wellbeing Strategy includes the following:

"Areas for focus" for particular focus during the next 1 to 2 years…

- Social isolation and its impact on mental and wider aspects of people's health.
- … support, expand and grow the contribution people can make in developing safer, supportive communities.
- Health, social care and other organisations should […understand…] community assets …and how they can be better used and developed.
- The important role played by unpaid carers
- Ensure services are rapidly developed placing emphasis on integrated interventions which reduce unnecessary hospital admissions for people with long-term conditions and give improved outcomes.
- Encourage positive lifestyle behaviour changes... [such as action on]… smoking reduction, obesity and alcohol consumption.
- Opportunities should be sought to develop healthy lifestyles …
- Improving the availability of more affordable housing that is appropriate to people's needs.

Our vision is built around some key areas of focus, which are described in greater detail within the plan, but in summary are:

- Universal and Targeted Prevention and Support
- Reablement, Rehabilitation and Intermediate Care Services
- Integrated Health & Social Care Teams
- Development of specific high impact pathways and improved services for People with Dementia, Learning Disabilities, Mental Health Problems and for Carers
- Building Sustainable Communities
- Improved infrastructure support systems

In our consultation on the prevention strategy[1], 80% of people responded that preventative services would enable people to remain independent with the majority requesting:

- Support to live in their own homes,
- Help to manage their health and stay well,
- Access to information and advice,
- Help to keep active and meet people, including by volunteering time and skills.

We are keen to build on this through 2014 as we explore opportunities to build upon the work done by Districts, Borough and County Councils with communities, linking it with equipment services and minor adaptions, the Disabled Facilities Grant, home improvement agencies and voluntary sector organisations.

[1] "Looking Ahead" - North Yorkshire's strategy to focus on prevention and early intervention for health, wellbeing and care

3. PLAN DETAILS

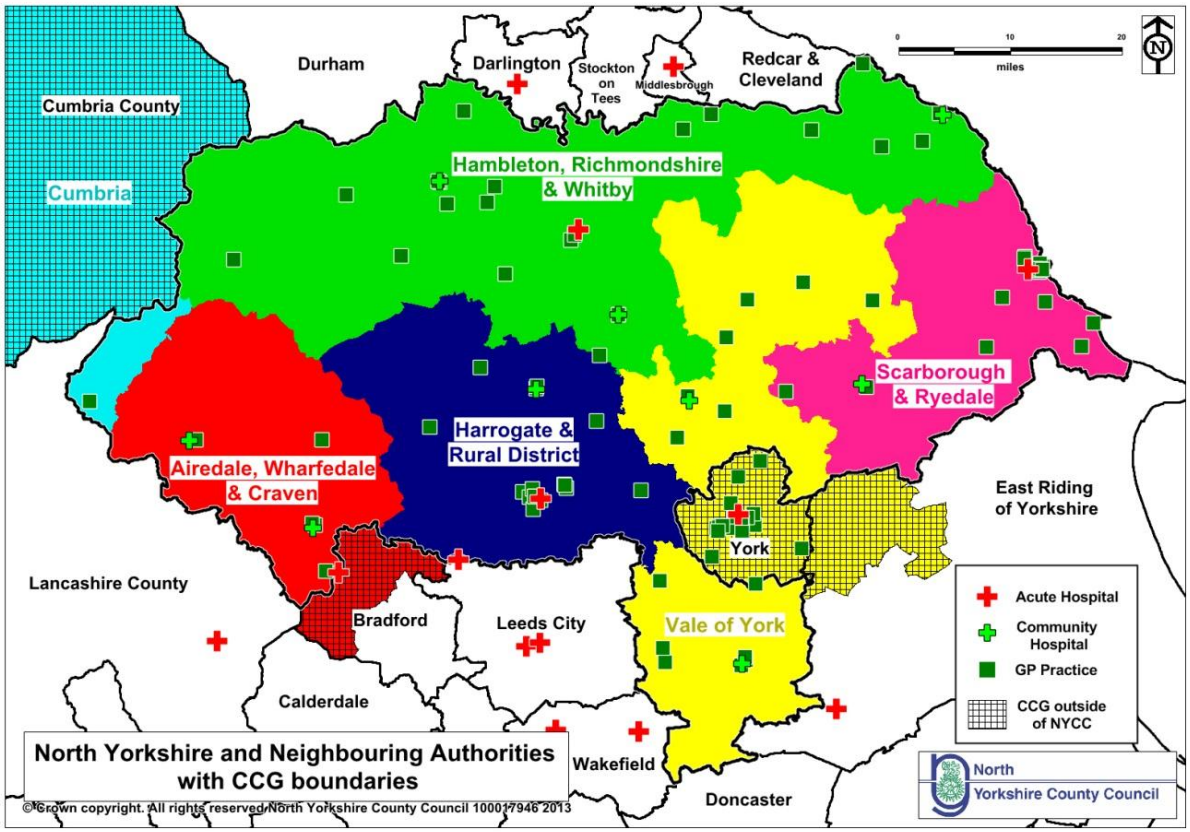
3.1. Summary of Plan

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

3.2. Boundary Differences

This submission details the plans of the North Yorkshire Health & Wellbeing Board. 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 Little and High Bentham fall into Cumbria CCG. The BCF plans of Cumbria Health & Wellbeing Board will cover this area.



Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**14/02/2014**
Minimum required value of BCF pooled budget: 2014/15	**£11.109m**
2015/16	**£39.828m**
Total agreed value of pooled budget: 2014/15	**£15.452m**
2015/16	**£39.828m**

3.3. Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Airedale, Wharfedale and Craven Clinical Commissioning Group
By	Sue Pitkethly
Position	Chief Operating Officer
Date	14th February 2014

Signed on behalf of the Clinical Commissioning Group	Hambleton, Richmondshire and Whitby Clinical Commissioning Group
By	Vicky Pleydell
Position	Clinical Chief Officer
Date	14th February 2014

Signed on behalf of the Clinical Commissioning Group	Harrogate and Rural District Clinical Commissioning Group
By	Amanda Bloor
Position	Chief Officer
Date	14th February 2014

Signed on behalf of the Clinical Commissioning Group	Scarborough & Ryedale Clinical Commissioning Group
By	Simon Cox
Position	Chief Officer
Date	14th February 2014

Signed on behalf of the Clinical Commissioning Group	Vale of York Clinical Commissioning Group
By	Dr Mark Hayes 
Position	Chief Clinical Officer
Date	14th February 2014

Signed on behalf of the Council	North Yorkshire County Council
By	 Sally Burton
Position	Interim Corporate Director, Health and Adult Services
Date	14th February 2014

This version not signed at NYHWB - principles, vision, local metric and headline fund size agreed at NYHWB 5th February 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	<date>

3.4. Service provider engagement

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

The Integrated Commissioning Board (ICB) is a HWB sub group with representation from the chief officer level of CCGs, North Yorkshire County Council Health and Adult Services and the main acute providers. Also, the City of York Council is an active participant of the ICB, reflecting and building on the early work on the Pioneer application. This board has been pivotal in bring this Better Care Fund plan together.

Each CCG hosts a local committee dealing with integration and transformation; meetings are held regularly, each with their relevant local delivery partners and providers, working to plan and manage the delivery on the ground. These also include Community and Voluntary Sector representation.

Through a series of sessions across all CCGs their major providers and commissioners have engaged and are already signed up to our vision for person centred, integrated health and social care at the highest level via the North Yorkshire Health and Wellbeing Board (H&WB). Our main providers are also represented on this board.

Major social care providers were consulted as a part of the recent (Oct-Dec 2013) public consultation on “Fair Access to Care” (FACS) criteria, “fairer contributions” policy and prevention strategy.

There is an active voluntary and community sector with partner organisations such as

University of York and Joseph Rowntree Foundation based here. Such organisations offer research and depth that is immensely valuable to developing and evaluating our plans for integration, allowing increased choice and control in our local health and wellbeing system, living longer and living well.

3.5. Patient, service user and public engagement

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

In a geographically and organisationally complex county like North Yorkshire, it is inevitable that the process of engagement is undertaken on a number of levels – countywide and local - and by a range of organisations. The value of what is found in this process is all the more significant when the returns are broadly aligned with each other; there is clear consistency coming through about what the people of North Yorkshire expect from their health and social care services.

Active engagement with Healthwatch is progressing and well-attended launch events have been conducted. It is anticipated that Healthwatch will be an important vehicle in facilitating user and public engagement.

In 2013 NYCC Health and Adult Services (HAS) conducted a large scale consultation on changes to Fair Access to Care Criteria. During the consultation we received 1,575 questionnaire responses this was made up of 1,395 Fair Access to Care questionnaires (FACS) and 180 prevention only responses. There were also thirteen focus groups with service users and providers. As part of this consultation additional questions were asked about HAS adopting a partnership approach to prevention and early intervention to improve the health and wellbeing of the population and therefore reduce the need for more formal or statutory care services. The majority of people considered prevention to be important to help to maintain their independence and agree that prevention has the potential to save money.

Over the past 2 years, with the establishment of the CCGs, the Health and Wellbeing Board and our first Joint Health and Wellbeing Strategy, both North Yorkshire County Council and CCGs have engaged extensively with patients and carers, residents, and the workforce across the public, private and voluntary sectors about the vision and priorities for health and social care. We remain committed to this level of engagement and jointly host at least two stakeholder events per year.

Locally, there are examples of pushing this engagement further – some CCGs host Public and Patient Engagement (PPE) steering groups which includes (and sometimes is chaired by) Healthwatch and lay membership to ensure that real experiences of patients and residents are encapsulated in strategic and operational planning. A number of our General Practices host patient participation groups. Some PPE events have focussed solely on integration and what this means to individuals, their support networks and the wider community. All the partner agencies have committed to joint communications and engagement events to maintain the focus on collaborative working and to sharing and adopting examples of good practice

The National Voices research provides an informative and positive framework for continuing to develop our patient, service user and public engagement. CCGs and partners are committed to this approach to progress our vision towards integrated,

person centred care and support.

The importance of staff as the closest point of contact with patients and their families has been recognised and we are working with them to ensure that patient stories, views and experiences are routinely fed in from day-to-day contact to inform the decision making process and improve the cycle of planning, commissioning, delivering and reviewing the integrated care programme.

3.6. Related documentation

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

Document or information title	Synopsis and links
Integration Framework Agreement Integration Framework Version 1	Framework agreement to promote the integration of health and social care services in North Yorkshire and the City of York
Integration Pioneer Bid for North Yorkshire and the City of York	NY&Y Pioneer bid July13.pdf
"Looking Ahead"	North Yorkshire's strategy to focus on prevention and early intervention for health, wellbeing and care – to be included at April submission
FACS Consultation Response / plans	Executive report covering the consultation, report and findings and recommendations approved at NYCC Executive on 4th February 2014 08eligibilityfo.pdf
Joint Strategic Needs Assessment NY JSNA 2012.pdf	The JSNA aims to provide a high level analysis of the current and future health and wellbeing needs of the individuals and communities within North Yorkshire. It is used to ensure that the Health and Wellbeing strategy is based on need.
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.
Project Plan – Programme overview	High Level Programme plan, to provide structure to detailed local and countywide plans for delivery of the schemes – to be

	included at April submission
Terms of Reference for North Yorkshire Integrated Commissioning Board	This sets the strategic environment in which our plans are being developed and managed Terms of Reference ICB June 2013.doc

4. VISION AND SCHEMES

4.1. Vision for health and care services

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

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

Our primary aim is to support individuals to improve and manage their own health and wellbeing. Our vision is for a collaborative approach, centred on the needs of the individual and their carers, empowering them to manage and shape their own care.

Central to our vision is an acknowledgement that services must be co-ordinated around the needs of the individual and their carers, allowing them to shape and challenge their care. We propose 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 delivering and commissioning care at all levels of our organisations.

As a partnership, we recognise the need to achieve a common approach to community system development. The initial proposed principles are:

- Our starting point is simplifying a complex system by integrating care around people rather than organisations.
- Promoting health. A priority should be given to evidenced based initiatives that improve population health. Whilst the direct health benefits and cost reductions may be largely into the longer-term, the overall gains are likely to be large (Wanless 2002).
- The patient's own residence as the default place for care delivery. Accepting that there may not necessarily be a significant evidence base that 'care closer to home' is more economically efficient; the principle should, however, underpin the overall strategy. It is considered to be supported by the majority of the patient population, and is expected to allow significant cost reduction in expensive specialist facility-based care.
- No health without mental health. Whilst many mainstream mental health services may be of high quality, there are significant gaps in 'interface' services, such as liaison

psychiatry. The principle should underpin the commissioning of all care services.

- Common procedures for individual care needs assessment. Delays in care planning and management, with resulting inefficiency and duplication, may be attributed to a lack of common, integrated care assessment. Partners commit to work to agree common assessment frameworks wherever possible.

- Pooling of resources wherever possible to support joint care delivery. The local experience of formal pooled budgets appeared relatively limited and integration may benefit from much greater use of pooled budgets. The Better Care Fund should be seen as the minimum level of investment into integrated care, not the maximum.

- Financial mechanisms that obstruct integrated care development should be adjusted or abandoned. Although the introduction of Payment by Results (PbR) by the NHS has had many benefits, in some cases it appears to provide perverse incentives and can obstruct service redesign. Partners should commit to move away from such financial flows where they appear problematic.

In keeping with these principles, we are developing local integrated care teams, focussed around the individual, and bringing together health and social care delivery. Our intention is that for every individual there is a named point of contact within the team, whose role would be to ensure delivery and review of the care plan co-authored by the individual and their carers. They would liaise with other members of the immediate team, but also the wider health, social care and voluntary sector community as required.

We recognise that different localities and integrated care teams will need to work together in a bottom-up way to develop local solutions and ways of working that address the practical differences in individual localities that come from geography, different providers and, in some cases, differing health needs. Empowered, enthused teams will drive forward change and build a culture of integrated working and coordinated care in each local area.

The teams will be clearly focussed on delivering the key aims of the outcome frameworks for both the NHS and Adult Social Care, as well as contributing to the wider delivery of Public Health Outcomes. Explicitly we would expect that the described teams would enhance quality of life and experience of care for those with care and support needs, by delivering care which is designed and agreed with the individual and their carers and by delivering a defined single point of contact to monitor and respond to changes in those needs.

A single, integrated assessment process would underpin the joint care plan. Planned reviews of the needs and outcomes the person wishes to achieve along with co-produced means of achieving these will also be embedded into the system ensuring the right care is delivered in the right place at the right time.

Whilst the primary aim of this work is to deliver better care and experience to users of the service, it is anticipated that there will be potential for financial efficiencies. This may be through a reduction in duplication of work (particularly valuable in rural areas), prevention of hospital admission, better self-care, more proactive interventions and expedited hospital discharge.

By 2018/19, the following differences will be evidenced in our health and social care system and can be illustrated through the following example personas – Sarah, Jim, Mike, Dorothy…..

To be completed for final plan

By proactively engaging with these individuals and their carers, and working with primary care to "predict" needs through risk profiling, we would anticipate earlier diagnosis, intervention and reablement, reducing the need for additional care and support, reducing the number of people who need to move to 24 hour care facilities and preventing premature death. Having a service designed around needs, with a clear network of support and integrated approach with a sense of mutual ownership and responsibility will assist with safeguarding and prevention of harm.

In bringing this plan together, we have used a process of 'bottom-up' scheme building within a 'top-down' strategic intent; this has allowed a mix of countywide and local BCF schemes to emerge that will give the best possible understanding of how best to develop the fund in future years.

All of these proposed outcomes will need to be measured and evaluated as the work progresses. Many areas within North Yorkshire and York are already monitoring many of these outcomes, from reduced hospital admissions, to patient/ carer satisfaction. However further high-level outcome measures will need to be developed across the region to ensure uniformity and consistency – preliminary work locally has identified some required information that is not routinely collected at present. We will measure user experience, and test innovative models of delivery, predicted financial benefits, and health outcomes.

Changes to the configuration of services over the next 5 years:

- Jointly commissioned health and social care services
- Creation of a digital health economy
- Changes to the provider landscape
- Fewer community hospital/local authority intermediate care beds with more people cared for at home
- Workforce planning across agencies to meet the needs of local communities
- Staff working in multi-professional and multi-agency teams
- 'Right-sizing' of acute bed capacity as community provision grows
- Staff working with managers and colleagues not within their own organisations
- Staff working across services (e.g. geriatricians)
- Changes to policy, systems and processes
- Increased skill sharing across professional groups
- Closer working between primary and secondary care
- Increased delivery of care in the community

Patient and Service User outcomes:

- Information:
    - Clear point of access, reduction in duplication, help in navigating the system.
    - Clearer messages about what to expect, reduction in duplication.

- Clear signposting of services for self-care, exercise and wellbeing.
- Better communication, co-ordination and transition between health and social care services which will be more able to collectively identify and appropriately address concerns.
- More information to encourage self-service e.g. equipment
- Nothing about me, without me – truly person-centred care

- Care:
  - A rapid and timely response, with proportionate, coordinated assessments leading to coordinated care designed to meet their goals at or closer to home, reducing avoidable hospital admissions, avoidance or reduction in premature admission to long-term care and reducing dependence on NHS and social care services
  - Better continuity, closer monitoring of conditions and care plans. Better support for staff caring for them.
  - Reduction (or prevention of exacerbation) of physical illness including long term conditions or social concerns, with improved support with palliative care, helping to provide more dignified, comfortable end of life. Better support with end of life planning.
  - Avoidance of unwanted hospital admission. Potentially improved independence.
  - More timely discharge from hospital
  - More holistic management, assessment and management of mental health issues, potentially shorter hospital inpatient stays.

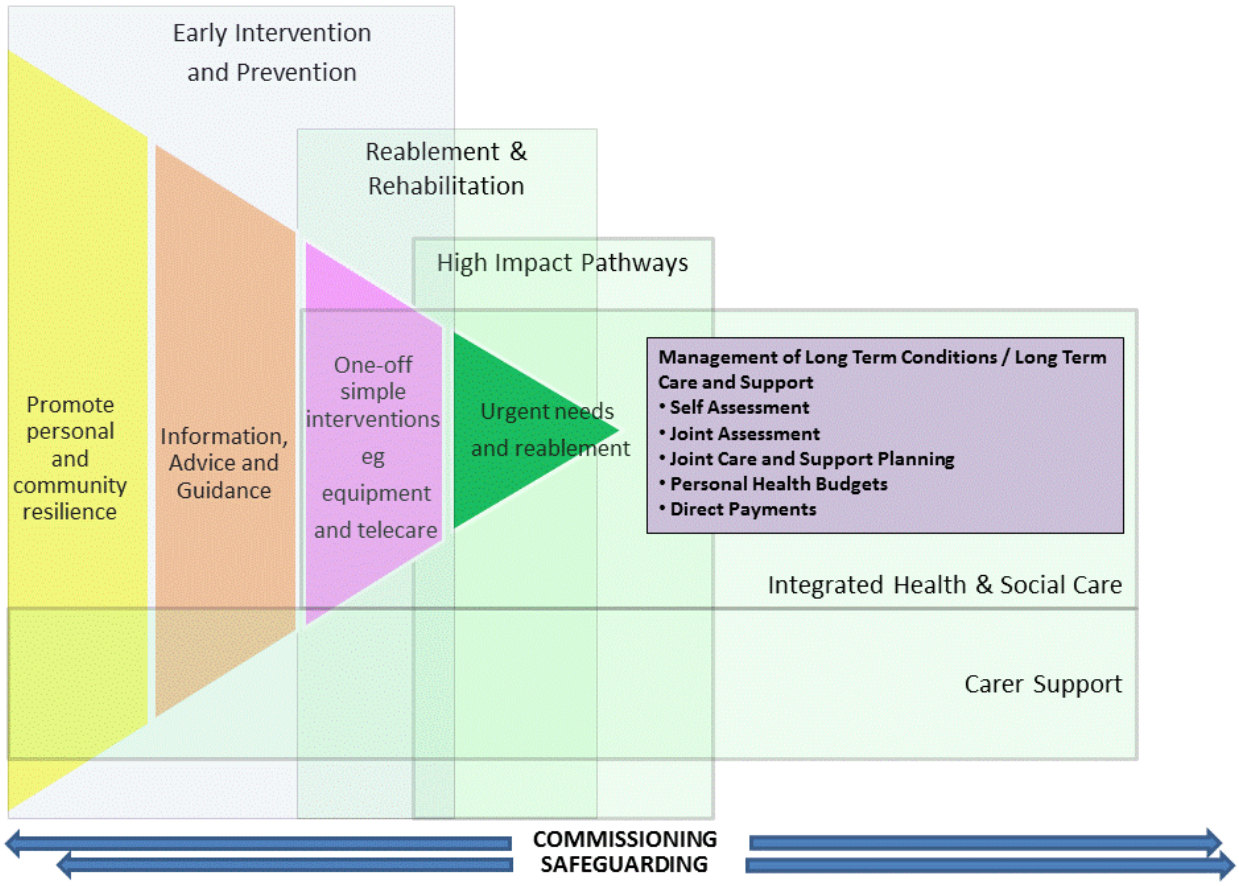
4.2. Aims and objectives

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

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

The primary objective will be to manage the health and social care demand in our system despite an increasingly difficult financial position, while improving the outcomes for the people of North Yorkshire and to provide the best possible range of services and support systems.

Partners in this system have agreed the following core areas of focus for an integrated Health and Social Care economy for North Yorkshire.



Our aim is to create a sustainable integrated health and social care economy for North Yorkshire, drawing together community health, social, primary and voluntary care to deliver a more effective and efficient person centred service. This will provide care and support for people in the most appropriate environment to enable them to be healthy, well and independent through 24/7 integrated services. We will increase community based capacity and capability to prevent avoidable demand on the system and to achieve better outcomes for people.

Promote Personal and Community Resilience

- We want to support people to live independently as possible with dignity and respect. We will help people to help themselves to take increasing responsibility for staying as active and as well as they can, for as long as possible, by ensuring easy access to a wide range of preventative and universal services and community resources.
  - Information and advice – a Single Point of Contact or information hub,
  - Navigation and support to access services
  - Proven low level early interventions and low level, practical services and support – commissioned from the community and voluntary sector,
  - Targeted prevention and lifestyle services – including physical activity, stop smoking services, low level alcohol services
  - Support for carers

Information, Advice and Guidance

- Development of a single dedicated point of access for the public in North Yorkshire and an initial point of contact for professionals to refer into integrated care arrangements designed and staffed accordingly and professionally supervised to respond to all likely enquiries
- Information/web site optimisation including consistent automation and self service
- The development of an integrated care record (via shared NHS number) will enable staff to see a person's circumstances in one place
- People only having to tell their story once. This supports the principle of the shared care record throughout the person's journey and is one of the key messages from our public engagement processes.
- Provide support to carers

One-off simple interventions e.g. equipment and telecare

- Enable electronic ordering of equipment and telecare/telemedicine to enable people to stay at home independently for longer

Urgent Needs and reablement

- Provide immediate and rapid response to an immediate issue of concern or crisis by arranging appropriate services, including provision of equipment, telecare and telehealth
- Integrated reablement and intermediate care services to facilitate early well organised and safe 7 day hospital discharge
- Expand intermediate care services maximising step-up/step down capacity and capability, delivered through integrated health and social care services in the community to meet the whole spectrum of an individual's needs
- Delivery of services aimed at preventing admission into hospital, reducing length of stays, reducing the on-going need for social service commissioned packages of care and thereby reducing a person's dependence on formalised care and support

Management of Long Term Conditions/Long Term Care and Support

- Provide clear integrated care plans for patients with Long Term Conditions and complex needs via joint working with GPs, Community Health and Social Care services
- Provide care and support interventions though intensive health support, personalised care or self-directed care (e.g. personal budgets, personal health budgets and direct payments)
- Enable better identification of underlying mental health problems for patients with Long Term Conditions
- Understand the population through the use of predictive risk stratification in every GP surgery and development of local community profiles and embed self-care as core to service delivery
- Provide support to patients and their carers on self-care and condition management

Measuring success

Integrated Commissioning Board will be responsible for the planning and implementation of our model across the health economy. There will also be a requirement to develop a suite of monitoring and reporting mechanisms (see appendix A) that will allow granular analysis of the impact of the model at all levels. Specifically, these reports will need to identify:

- The impact on our local acute provider on a case by case basis. This level of detail will be crucial in order to help build the potential funding model of pooled budgets we hope to be able to achieve
- The impact on the local authority, specifically in the Adult Social Care Sector, focussing on the financial implications of any intervention
- How activity has moved through the system in order to help future proof the model and identify new opportunities
- We intend to commission evaluation from an academic institution to explore how partners and the public are reacting and adapting to the whole-systems change required in North Yorkshire. The evaluation will take an Action Research approach so that learning from the evaluation is fed back into strategic and operational decision making throughout the process of transformation, as well as improving communication between partners and with the public.

We recognise that having a robust evidence base on which to build service change is crucial and we want to investigate further partnership opportunities across the region to maximise this requirement.

4.3. Description of planned changes

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

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

Partners from across the system have recognised that there are some tensions between local sovereignty and whole-system efficiencies. The general approach therefore has been to draw out a full list of schemes defined at a local level, group together those that align and agree a county-wide approach to these and then to agree a local mix of smaller schemes that address specific and local challenges.

It is clear from both the guidance and locally agreed plan that simply protecting social care spend is not an option; plans therefore incorporate a substantial commitment to bring about a transformation of existing services, with new models built around best practice and with integration at the heart.

It is clear that we are able to build upon work that has already started in North Yorkshire; we have not started with a blank canvas or any lack of motivation to provide the best and most efficient services possible. It does mean, however, that there are test areas in place the results of which will inform decisions to extend / expand or develop new models. There will need to be substantial work done to support and develop staff, to ensure correct skills and cultural shift are built into the process of introduction of these models and as experience shows, these are not always easily or quickly achieved.

The 'Schemes' list will show that there are five broad categories of plan for the BCF:

- Social Care base-budget protection
- Countywide infrastructure projects
- Countywide based on consistent principles, delivered locally,
- Local system projects
- Top-slices to cover mandated but as yet undefined costs – e.g. Care Bill.

By this mix of planned and sustainable changes, we believe that Social Care will be protected across the system.

Further plans for integrating areas such as commissioning and service delivery, assessment etc will be considered in due course, but the following summarises the changes expected.

a) Universal and Targeted Prevention and Support

Preventing illness and disability in the population saves lives, creates a healthy society and saves public and private sector organisations money. 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. 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. Therefore, partners in North Yorkshire have developed "Looking Ahead" - North Yorkshire's strategy to focus on prevention and early intervention for health, wellbeing and care.

For many people, taking part in local activities is a challenge and they become isolated and anxious and this can lead to poor mental health, failure to eat well, exercise or keep warm. This is particularly true for people who are caring, are recently bereaved or who have long term health conditions and for those living in unsuitable housing or on low incomes. In turn these issues impact on demand for health and social care services.

Specifically the strategy has five key delivery areas:

1. Information and advice – a Single Point of Contact or information hub. This includes the development of high quality online services and clear communication through a dedicated customer service portal,
2. Navigation and support to access services – we are developing a role that can provide low level one-to-one support for people needing additional help to navigate the myriad of low level services currently on offer through the community and voluntary and public sector, as well as provide advice and

support on healthy lifestyles. The "Community Navigator" role will help individuals make the most of community services and volunteering opportunities, helping to reduce loneliness and isolation. They will also facilitate the use of computers and the internet and ensure income is maximised. It is envisaged that this service will identify people with similar needs and also the small things that may make a difference. For example a small grant to a village hall to make the facilities more accessible, arranging transport to take a group of people to a luncheon club.

3. Proven low level early interventions and low level, practical services and support – commissioned from the community and voluntary sector. These commissioned services will be reactive to local needs but ultimately working towards the high-level objectives to reduce loneliness and isolation, prevent falls, and encourage befriending.
4. Targeted prevention and lifestyle services – these will be commissioned structured services that target higher risk populations (identified through the NHS Health Check programme, or referred into by professionals in the health and social care system) to improve mental health and wellbeing, increase physical activity levels, improve nutrition, reduce excess weight, stop smoking, and moderate alcohol intake.
5. Integrated and co-ordinated health and social care support for those in need, including support for self-care – delivered under the Better Care Fund arrangements.

b) Reablement, Rehabilitation and Intermediate Care Services.

These services are currently variable across the County in terms of both access and outcomes. They achieve good outcomes with many people and have helped North Yorkshire County Council to place less people in care homes than any other comparable county. The reach and scope of these services now needs to be extended and integrated across social care and the NHS, and be able to respond in every locality and to every customer as follows:

- **A fast response (within agreed x hours)** to GPs and Primary and Social Care with a 'virtual ward' type of intensive support and reablement, through integrated health and social care teams, to prevent admissions to hospital, support carers in crisis and facilitate a fast return home or into a reablement bed for people who have attended A&E.
- **An integrated discharge service from hospital,** with integrated teams of Nurses, Therapists, Mental Health and Social Care staff which will early-identify people who can leave hospital, ideally to go home but if not, to a short stay reablement/rehabilitation facility where they can continue to recover and receive a more comprehensive assessment. This should be proactive care, planned from the point of admission and aimed at returning people home, reducing lengths of stay, reducing readmissions and reducing long term care admissions. The team would not be able to make a long term admission to care directly from hospital.
- **A short term home based service for people who may need long term social care** who are at home or in hospital to assess capabilities, introduce equipment and assistive technology, provide reablement and rehabilitation and assistance in reducing the need for manual handling and double

handed care, encouraging self-assessment and direct payments and building a positive picture of what people can do.

- **Short term services reablement services in residential settings,** commissioned by Health and Social Care with the clear aim of maintaining people's independence, and returning them home.

c) Integrated Health & Social Care Teams

For people who have more complex needs we plan to create multi-disciplinary Teams with the NHS, Social Care and Voluntary and Community Services (VCS) to assess needs, use risk stratification to identify people at risk of hospitalisation or care home admission, create proactive care plans and support people with complex needs to manage their own condition and to use local services, reviewed on a regular basis. We will determine the optimum numbers and locations of teams needed in the medium term, using the JSNA, local intelligence, CCG boundaries and natural communities and travel routes.

Where possible these teams will be co-located with health staff and will start to share data and systems as and when the technology is available, using the NHS number as the primary identifier. The teams will also seek to engage the local VCS in supporting people and the teams will ensure that no one starts to use long term services or enter institutional care before they have had a period of reablement or rehabilitation. The teams will identify people who need to have a named co-ordinator and will liaise with CCGs and GPs to ensure that this approach is delivered. The desired longer term structure is for joint teams with integrated or single management and we will develop a route map to achieve this with each health locality.

d) Development of specific high impact pathways:

- Stroke – Being led by the 'Strategic Clinical Networks & Senate - Yorkshire and the Humber' team, work is underway to support the commissioners and providers to review the current state of stroke care along the whole pathway, identifying necessary developments to improve the service. This will entail an analysis of the relevant data (the national audit of stroke services - SSNAP) as well as mapping the current patient flows and level of service provision. It will then support commissioners and providers to work collectively towards better outcomes in stroke, drawing in expertise from across Yorkshire and the Humber and nationally to support any required improvement, redesign or reconfiguration of services. The work will be facilitated by the peer review system in stroke care that is in operation across Yorkshire and the Humber. It will need to address the needs of individual CCGs and of the relevant 'health economies', taking into account the complexities of patient flows across CCG boundaries, as well as understand the implications for stroke care across the whole of Yorkshire and the Humber.

Also, to be defined in detail, but will include:

- Frail Elderly, including dementia and falls
- Obesity
- Heart disease and heart failure
- Diabetes
- Chronic Obstructive Pulmonary Disease

e) Improvement of Services for Carers to:

- Meet Care Bill Requirements
- Provide Information and Advice
- Reduce Isolation
- Improve Skills and confidence of carers
- Ensure carers have breaks and support

f) Improvement in the quality of care in residential and nursing homes

To be defined in detail for final plan,

g) Improvement in Services for People with Dementia

There is slightly higher than average prevalence of dementia in much of North Yorkshire (*State of the Nation on Dementia Care and Support in England DH 2013*). The local priority is to ensure that people with dementia and carers are supported effectively throughout the 'journey of care'.

At a broader level this means supporting the development of dementia friendly communities, with the aim of 'community asset building', promoting inclusion and delaying the need for statutory support. This is reflected in the draft North Yorkshire Community Plan, with key strategic partners agreeing dementia as a priority.

Early diagnosis continues to be a priority for improvement. Locally, current rates are not markedly out of step with national averages but there are variations across the patch. Dementia awareness-raising has been successfully included as part of the NHS Health Check programme, commissioned by NYCC and delivered by nearly all General Practices in North Yorkshire. However the ambition to achieve early diagnosis for a higher percentage of people together with improved post-diagnostic support remains. Waiting times for assessment at memory clinics are generally low, but there is a need for partners to continue to work together to ensure effective information, signposting and guidance and on-going support and review. Alongside this, to support people with dementia throughout the journey of care, a jointly funded Dementia Care Navigator service has been commissioned across the county, including a remit for service user/carer education.

The priority in most situations is to maintain people in their familiar environment. Critical elements to support this demand:

- Assistive technology and equipment
- Short term reablement, with a focus on helping the individual and those who support them to find the best ways of managing routines and improving daily living
- Responsive community service that promote independence and person centred support
- Effective carer support

Many of these factors are pertinent where people have higher level needs that are difficult to manage in their own home and require residential or nursing care. Workforce development is also a priority here, plus a broadening of options with floating support such as Extracare housing.

A range of work has been undertaken within hospitals to improve the environment and standards of delivery for people with dementia. Further work is planned to ensure that:

- admissions of people with dementia to hospital are avoided as far as possible
- systems are in place to identify people who have or may have dementia
- people with dementia do not experience excessive lengths of stay in hospital and care is well coordinated between secondary and primary care;
- people have a named care coordinator;
- people get the support they need with basic care, eating and personal hygiene;
- Deprivation of Liberty and MCA assessments are appropriately applied, and
- carers are fully involved.

Underpinning all of this, commissioning intelligence related to dementia needs to be improved through applying national tools / frameworks, and through engaging service users and carers more effectively and systematically to help inform these processes.

h) Services for People with Learning Disabilities

We have started to transform the model of care, helping people to integrate more in local communities, improving the delivery of housing based support and providing more specialist support for people with multiple and complex needs.

We now aim to integrate our commissioning and planning of services with the CCGs (via joint work with the Partnership Commissioning Unit) to create a new model of care which will reduce the use of long term residential and nursing home placements, increase community based support and create more specialist supported housing and extra care housing for people with learning disabilities.

We aim to have a County Wide Integrated Learning Disability Strategy which will result in reduced long term placements, increased use of supported and ordinary housing, more specialised health and social care support for people who challenge services and people with Autism.

i) Services for People with Mental Health Problems

To be defined in detail, but in principle, there are some areas where we would wish to see a greater focus for use of the Better Care Fund:

- Investment in provision for people with dementia outside of hospital to reduce delayed transfers of care.
- Investment in hospital liaison services.
- Through voluntary sector and NHS services, promote peer support, self-management and recovery.

j) Improved infrastructure support systems between Health and Social Care

- Integrated arrangements for joint commissioning of complex care, Continuing

Health Care and other services
- Integration of quality assurance, safeguarding and contract management services for care homes and community services
- Dealing with problems at the first point of contact

The County Council is establishing a comprehensive Customer Resolution Service. This builds on the existing Customer Service Centre. For Health and Adult Services we are developing a new approach whereby experienced Social Care and Occupational Therapy Assessors will work within the Customer Resolution Service. Work has begun to establish how the wider health professionals play into this.

We will expect to deliver:

- **An integrated, accessible website** which meets the requirements of the Care Bill and provides advice and signposting to the public and professionals. This will be linked to advice on finances, benefits, housing issues, health issues, local community directories and all services provided by partners.

  The website will also encourage people to undertake self-assessments, identify their needs and arrange to meet these needs themselves. It will provide access to services to fit telecare, arrange disability related equipment and minor adaptations, make contact with carers services and arrange referrals to the Prevention Service. Where appropriate we will encourage people to take control and arrange their own services.

- **A telephone service** for people who need more advice than can be obtained on-line. This will be staffed by skilled advisors supported by experienced Social Care and Occupational Therapy Assessors. This will receive referrals from families, individuals and other professionals. Where possible the service will encourage customers to use the on-line service and to make contact with Prevention Services. This service will arrange simple services, take details for Social Care Assessors and will book telephone and face to face appointments for people who are deemed to need this. This will be a county wide service and the County will be talking with District Councils and the NHS about areas for possible integration of this approach and for sharing of back office capacity and capability.

- **A digital response and capability** where people will be able to access superfast Broadband and will be supported to obtain information and advice, organise services, make social contacts, manage their resources and manage their personal budgets and Care Accounts. In addition, we will create a managed system for provision of Telecare and other Assistive Technologies and ensure this links with the growing use of Telemedicine and Telehealth. This will be available to any citizen who wishes to buy into the system and we will encourage families and friends to arrange this for people. The NYNet initiative is committed to delivering broadband speeds above 25Mbps within reach of 90% of the county's premises by the end of 2014.

k) Building Sustainable Communities

Yet to be defined, but will take account of such references as the recent King's

Fund report[2] which defines nine key areas of focus, including "Strong communities, wellbeing and resilience". Fuller detail will be provided in the April submission.

4.4. Implications for the acute sector

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

The key driver for understanding the implications on the acute sector is that the funding to support BCF is already committed and the necessary shift of funding is most likely to come from spend with acute providers. We have not underestimated the impact this will have and have shaped our joint plans accordingly.

The main purpose of our joint plan is that those individuals at high risk of health and social care interventions are proactively managed and supported to avoid the requirement for hospital based interventions. We recognise that in order to make both the BCF and our joint longer term sustainability a reality, we have to reduce the overall spend in the acute sector in order to properly fund our integrated out of hospital model.

Specific implications for the acute sector are not yet fully understood but through local and system wide discussions so far, it is clear that we agree three things:

- The scale of the change in the system will have to be ambitious - large enough to be capable of delivering the large scale financial change required
- A commissioning approach will be required – providers are clear that they will be presented with a smaller cash "envelope" with which to deliver services; they take the responsibility to deliver services that meet the required specification and must be free to manage the "how" themselves – it is not for the commissioner to dictate the mechanism
- The reduction in costs of secondary care required to release funding to the BCF can only be possible with collaboration across health and social care professionals to change the care pathways, improve the community based options and bring more people the support they need in their home or closer to their homes. The BCF therefore has to be focussed towards bringing about those changes in pathways

There are many ways in which the transformation required might be brought about. Partners are clear that this can no longer be parochially determined and that major changes will be required.

The Partners' commitment is to ensure that bed-days and emergency admissions are reduced by interventions resulting from some or all (to be defined) of the following:

risk stratification, joint assessment, joint risk-based targeting, joint support planning and reviews, step-up/step down beds, intermediate care services,

[2] Kings Fund, 2014 "Improving the public's health" http://www.kingsfund.org.uk/projects/improving-publics-health

reablement services, hospital in-reach teams.

We would expect that Community Hospitals will move from historic models of care configured as a scaled down version of District General Hospitals, to a model of Community Hospitals as Community Hubs providing a base for outreaching community services and patient and carer in-reach accessing assessment and therapy. Stronger links with the care related voluntary sector will facilitate further integration of services with their hosting communities.

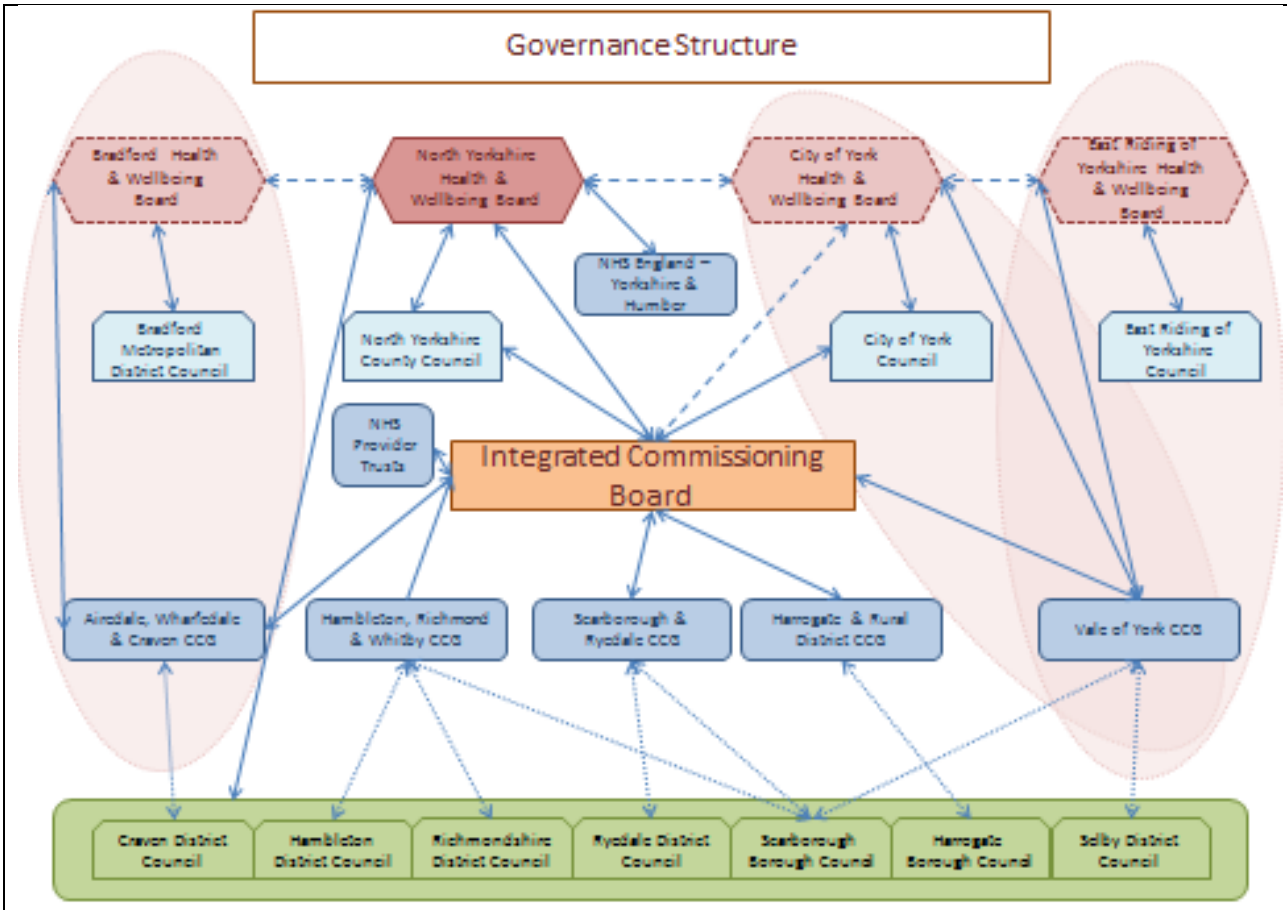
4.5. Governance

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

The Integrated Commissioning Board (ICB), a HWB sub group with representation from the senior managements of CCGs, North Yorkshire County Council Health and Adult Services and some acute providers. Also, the City of York Council is an active participant of the ICB, reflecting and building on the early work on the Pioneer application.

The partners have adopted an Integrated Framework Agreement. This Agreement reflects the commitment of the local government and NHS commissioners involved to work together to bring services together, to significantly improve outcomes and eliminate the fragmentation of services across health, care and support for patients, service users and carers. There is clear recognition that it needs to work with other neighbouring councils who share CCG populations (principally City of Bradford and East Riding of Yorkshire).

The Framework sets out a consistent approach to the key issues of governance, accountability, leadership and resources. Within the Framework, models for integration of commissioning and services will be developed, appropriate to the group, activities and locality, and it commits partners to work together on practical solutions to issues that create fragmentation and hinder progress in integrating services. Wherever possible a single model will be adopted and should reflect the commitment to better coordinated health, care and support, centred on the individual and their carers. By working within this Framework, the partners expect to be better able to deliver the outcomes described in their own Joint Strategic Plans.



ICB will act as the Programme Board to manage the business of review, issue resolution and progress monitoring, holding partners to account and will report to HWB as required to ensure visibility.

Local Boards are in place which are comprised of one senior representative with delegated decision-making authority from each of the following organisations:

- Clinical Commissioning Group (Head of Commissioning)
- Acute / Foundation Trust / Mental Health Provider
- North Yorkshire County Council (Health and Adult Services)
- North Yorkshire County Council (Public Health)
- Voluntary Sector

The local boards will be attended as required by individual work stream leads/project managers, who will present their monthly flash reports and update the members on current project issues. The local boards will be responsible for making decisions relating to the redesign of community services, for onward communication to the North Yorkshire Integrated Commissioning Board and ultimately, North Yorkshire Health & Wellbeing Board and Governing Bodies within Acute/ Foundation Trust, North Yorkshire County Council and Clinical Commissioning Groups, as appropriate. Group members of the Transformation Group are in attendance in a consulting and decision-making capacity.

The Local Boards will report to the Integrated Commissioning Board directly as well as to their membership organisations and the HWBs of City of Bradford Metropolitan District Council, City of York Council and the East Riding of Yorkshire Council.

5. NATIONAL CONDITIONS

5.1. Protecting social care services

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

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 be 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 more specifically, whenever possible, in people's own homes. We must however provide our services on a less fragmented model – the organisational distinction to the patient or service user is of low concern, save for the complex divide of charging; health services generally delivered free at the point of delivery versus generally means-tested social care.

This protection of social care is against a backdrop of unprecedented action being taken by the County Council to transform its services, in a process that began in 2011 to deliver an unchanged list of statutory services, to an increasing population, with a budget that will have been reduced by a third (c£169m per annum) between 2011 and 2019. The social care budget will be required to release recurrent savings of £21.5m from its 2013/14 level of c£138m having release some £27m in the four years to 2015. This will require substantial numbers of people to have their route through the social care system to change – for example, improving and promoting digital handling of people will need to give rise to 425 fewer assessments leading to 300 fewer care packages per year.

Significant emphasis is being placed on investment in community and personal resilience and a suite of prevention initiatives which will reduce the flow of new services users both to the health system and to social care. The connection between health and social care systems must become more symbiotic; it is well accepted, for example, that most frailty patient/service user flows are relatively predictable, many are preventable. We must develop that understanding further, to ensure that services provided are joined up, complementary and efficient. It is clear from both the guidance and locally agreed plan that simply protecting social care spend is not an option; this plan describes substantial cash support to social care in the short term but this is not sustainable at this level.

For the system to be made sustainable, a fundamental shift in model is required. This shift to build complex integrated systems cannot be done overnight and there is a risk of de-stabilising providers; the Better Care funding will allow some time to plan, design and deliver an effective cross-system model. Plans therefore incorporate a substantial commitment from the County Council to work closely with health colleagues to transform the way services are currently delivered and to develop new models built around best practice and with integration at the heart and the ICB and HWB will ensure a continuous review and scrutiny of effective use of the BCF is applied.

We will require a clear risk-share agreement as part of our Section 75 agreements and close management of outcomes to ensure that the transformation of social care services is effective and reduces the direct support it will receive in following years.

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

The current financial climate for local authorities, especially those of the upper tier with Social Care responsibilities, is one which has severe limitations on being able to deliver any level of discretionary services, and which has been severely impacted over the past ten years by increasing demand for services – mostly from increasing numbers of people who are living into older age with increasingly complex conditions. This position in North Yorkshire is exacerbated by it being a very large size (c2m acres), extremely rural, with a limited number of towns with high populous (3 with population >15,000).

Therefore, economies of scale are hard to achieve, commercial providers are unable to attract sufficient staffing and efficiencies to make provision attractive / economic and so the County, which already receives the lowest per-capita government settlement for an authority of its type, is unable to drive the kind of efficiencies open to most other shire or upper tier authorities.

Therefore, as the funding position of the County is being further hardened and with Adult Social Care being the largest single area of council spending, there is intense pressure on reducing budgets against the tide of increasing demand. North Yorkshire County Council has recently moved from "moderate and above" FACS level to one of "substantial and above". The outcome of this has a limited value in reducing the pressure on budgets and so without inward investment through the Better Care Fund (BCF) the consequence of the position will still be a reduction in overall Adult Social Care services. The BCF is therefore partly required to protect spending on core social care services.

By investing in integrated, system-wide models of care we aim to mitigate the position. Protecting adult social care services ensures the core social care offer continues to be available as follows:

- The transitioning of people across the health and social care system, arranging for and funding support packages in the community or in more institutional settings.
- Delivering robust safeguarding functions to safeguard vulnerable adults.
- Supporting carers reduces the financial burden across the health and social care system.
- The activities of early intervention and prevention which delay people needing more formal care and support services.

As stated previously, the schemes list therefore will show that there are five broad categories of plan for the BCF:

- Social Care base-budget protection e.g.
  - continued delivery of core community-based packages of care
  - building upon the reablement service
  - hospital in-reach services
- Countywide infrastructure projects, e.g.
  - Data Sharing, Information Governance
  - Organisational Development
  - Equipment Services
- Countywide - based on consistent principles, delivered locally, e.g.
  - driving the development of new models and transforming services
  - building upon prevention strategies and early intervention models
  - community development – resilience models

  - maximising the opportunity to reduce admissions and facilitate timely and safe discharge from hospital
  - minimising emergency admissions
- Local system propositions – which tackle local 'hotspots' and test further models of delivery
- Top-slices to cover mandated but as yet undefined costs – e.g. Care Bill.

By this mix of planned change, we believe that Social Care will be protected across the system.

5.2. 7 day services to support discharge

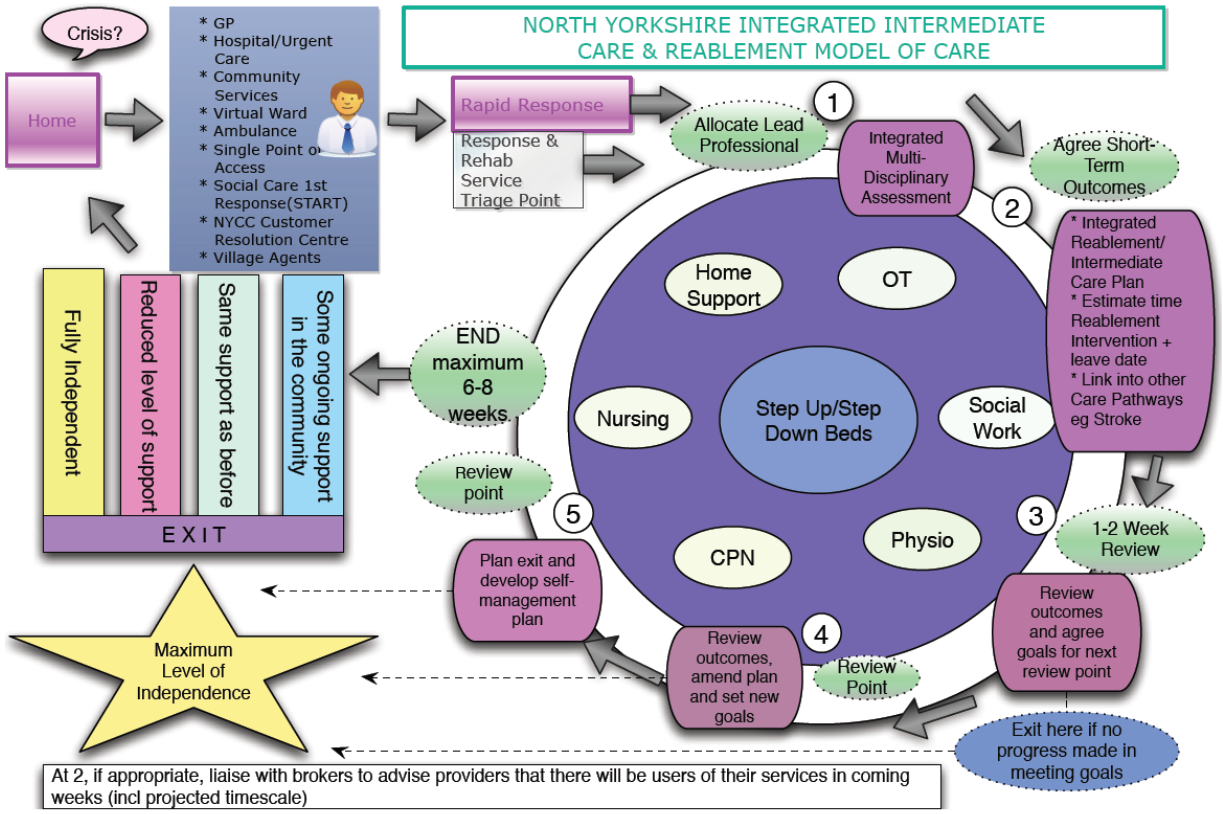
Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care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

The County Council has agreed, with its CCG partners, a blueprint for a model of integrated Reablement and Intermediate Care services for Health and Social Care in North Yorkshire. The blueprint can be adapted to reflect the local demographics and needs assessment for each CCG locality e.g. the skills mix of integrated teams may differ by CCG locality.

This new integrated Reablement and Intermediate Care service will provide care and support to people in their homes, which will prevent admission into hospital and enable timely, well planned and organised, safe 7 day hospital discharge. This will be achieved through the use of short term intensive support programmes that:

- Maximise independence, choice and quality of life; and
- Minimise on-going support required

The diagram below illustrates the proposed model of care for North Yorkshire:



Clinicians and professionals will be aligned in one service which will allow and enable joint assessment via an accountable lead professional. The planning and delivery of care and support will be implemented by an integrated care plan which will avoid duplication and any fragmentation of approach to Reablement/Intermediate Care arrangements. This will improve outcomes for the person and deliver both cashable and non-cashable efficiencies to commissioners. The accountable lead professional will be pivotal to the success of this approach. The individual that takes on the role will be critical in ensuring that the patient/service user is supported in a seamless and timely way. They will ensure that relevant care workers and specialists provide their input at the right time and in the right environment.

This new service will be rolled out across North Yorkshire during 2014/15, with 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 – and enabling joint health and social care assessments with an accountable lead professional.

Engagement is underway with primary and secondary care providers to increase the level of weekend working with CCG and County Council funding to support 7 day working.

Secondary Care providers already operate 7 days a week, but often at a reduced level of activity and will need to review and redesign some aspects of care delivery and decision making in order to enable 7 day hospital discharge to work for patients, their carers and

families. Access to senior decision makers, diagnostics, pharmacy and other support services along with enabling policies such as nurse led discharge and Early Supported Discharge schemes for frail elderly, orthopaedics and those with long term conditions will be required as will supporting in-reach from community based professionals .to create a pull based system of hospital discharge.

Additional capacity has been created through the identification of short term step up/step-down beds within the care home sector, through increasing Occupational/Physiotherapy capacity in the longer term and, increased support for carers. There will also be additional capacity with hospital-based home care managers and social workers available to arrange discharges 7 days per week and placements will be made over weekends into local authority residential homes if necessary. Our aim is that 7 day a week ward rounds will be in place during 2014/15.

Critical to the delivery of this different model of care is a robust Organisational Development plan to develop capacity, capability and resilience to support high performing hospital discharge and which addresses the cultural shifts and behavioural changes required for integrated 7 day working.

A key enabler to 7 day working is the development of an integrated electronic care record across the whole of North Yorkshire with CCG partners using NHS IT systems with interoperability with NYCC social care records.

CCG commissioning intentions also demonstrate commitment to 7 day working.

5.3. Data sharing

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

Yes all health and care systems will use the NHS Number

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

The current adult social care system is being replaced in April 2014. Both the current and new systems have the capability to record the NHS Number of an individual service user. The new system supplier (Liquidlogic) has already achieved Personal Demographic Service (PDS) compliance for the adult social care system.

Since mid-2013, NYCC has captured the NHS Number (when available) through the corporate Customer Services Centre as part of the Contact/Referral event. It is recorded in the existing adult social care system and will be migrated to the new one.

Moving forwards, it is expected that a bulk NHS Number trace routine will be introduced to obtain and validate NHS Numbers for all service users where one is not already recorded. This work would be assessed alongside the direct PDS integrated approach, but the timescale for this will be influenced by the outcome of a piece of work being undertaken by ADASS Nationally to identify the most effective ways of capturing and

maintaining NHS Numbers in adult social care.

Needs clear plans dates – to be agreed

We recognise this needs cultural shift for operational teams, assessment and support planning teams etc which will need to be managed as part of the roll-out of the new models.

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

Not all health and care systems use Open APIs and Open Standards but will do in the future

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

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.

A Caldicott Guardian is in place at Assistant Director level within adult social care and reports to a corporate information governance group chaired by the Senior Information Risk Officer for NYCC and supported by the corporate IT Security Officer.

5.4. Joint assessment and accountable lead professional

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

Our intention is that for every individual there will be an accountable lead professional within the multi-disciplinary team, whose role will be to ensure delivery and review of the care plan co-authored by the patient and their carers. The accountable lead professional will co-ordinate the joint assessment and delivery of the joint care plan with other members of the multi-disciplinary team, as well as the wider health, social care and

voluntary sector community as required.

Partner organisations are committed to establishing the use of risk profiling for the identification of patients with the greatest risk of admission into hospital over the next twelve months (highest 3-5% at risk), however this is not yet fully established due to the difficulties presented by section 152. We have work to do to improve our understanding of, and position on, data sharing, consent and inter-agency referral protocols in line with national guidance e.g. GMC, NHSE.

There are locally varied models, but in essence, currently at-risk patients are identified via multi-disciplinary team meetings, at which lead professionals are allocated, and joint plans are developed. These teams will, as a product of the investments of the Better Care Fund, be made more consistent and will ensure that all appropriate input is included in this discussion. Protocols for identification of an accountable lead professional will be a part of this process.

There will be one patient joint care plan in the home. Ultimately a single IT system, with a patient facing shared portal is the ideal, but is unlikely to emerge in the short term, and should not stand in the way of progress. The degree to which patients are prepared to have their information shared will be addressed through agreed consent protocols.

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. We will actively encourage the multi-disciplinary team to improve the interface between primary care, community health services and social care around individual patient needs and care plans. This will also allow identification of users who might most benefit from an integrated approach, through both formal risk profiling and clinical judgement in terms of sharing information about vulnerable and isolated adults. This approach, along with the personalisation of care, should facilitate the prevention of ill health (or deterioration) or health improvement as well as helping patients to be supported in the most appropriate manner when prevention is no longer an option.

6. RISKS

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

Risk	Risk rating	Mitigating Actions
The proposed model does not reduce emergency admissions		• 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 • Develop alternative models of care that provide clear alternatives to admission
Agreed system changes between partners are not realised		Monitoring and reporting processes in place with reporting to ICB and NYHWB
Impacts of the model do not have sufficient benefits for the Adult Social Care agenda		• Monitoring and reporting processes in place with reporting to ICB and NYHWB • Co-design with health and social care professionals
The model becomes politicised which hampers true innovation and risk taking		• Engage Members, GPs and public • Good and consistent communication
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		Fundamentally, the requirement and rationale for integration is not at risk; specific changes can be managed by the partnership
HR element of 7 day working		Clear plans and consultation
Regulations yet to be published for Care Bill will divert or change the current plans		Close monitoring of regulations as they emerge
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.		• 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
Commissioners not being able to agree clear common objectives with each other that can translate into workable commercial agreements.		Escalation through ICB and NYHWB if required.
Failure of different health and social care commissioners and providers to work in partnership.		Local Transformation Group has membership from key partners. Integrated Care Board and Health and Wellbeing Board should drive joint working across North Yorkshire.
Plans may not deliver financial savings necessary to make them		Each element of our planning has an identified exit strategy, should it be

sustainable		necessary to decommission them.
Public may not welcome all changes to system.		There has been early patient and public engagement, and it is intended that this will grow as plans develop further.
Financial envelope may not be sufficient to support plans, even with savings identified.		Transformation Group will continue to monitor delivery, as will Integrated Care Board, and changes can be made as required.
Risk Stratification tool not fit for purpose as SUS data cannot be accessed.		Work with Public Health to deliver fit for purpose data to for the Risk Stratification tool
Inadequate understanding of the need for and provision of an evidence based organisational development plan will impede the delivery of schemes in terms of scale, pace, impact and intention		That the OD requirements are built into business case for each scheme and that there is an overarching OD strategy across the partnership
Failure to identify and respond to the impact of the BCF in terms of the Social Care workforce. This includes, changes to workforce design, staffing requirements, skill mix and training needs. This needs to be considered in conjunction with related projects for example, Care Bill implementation. Could result in non-delivery of schemes		To develop a system wide workforce plan based on future models to identify needs, Skill Mix, staffing resources, training needs and gaps.
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.		A proper contracting function is established, clearly directed by the ICB, and whose responsiveness and performance is monitored by the ICB

Appendix A – Outcomes and Finances

Outcomes Based Accountability

Background

Outcomes Based Accountability is a method that supports organisations or partnerships to focus their activities on the things that matter to their population. The approach tries to create a common language on an issue (or issues) that is simple, common sense, and shared by everyone.

On 10th October 2013 the North Yorkshire and York Integrated Commissioning Board met to discuss the future direction for work on integration and transformation of the health and social care system – pulling together the work of 5 clinical commissioning groups and 2 upper-tier local authorities.

The Outcomes

Using the Outcomes Based Accountability (OBA) approach was to lead the ICB further down the path of thinking about outcomes at the whole population level for the integration workstream – moving from the language of "integration" (which is a means) towards the language of outcomes: *what do we want this work to do for the population?*.

OBA defines an outcome as *"a condition of wellbeing for children, adults, families or communities"*; for example, being safe or economic wellbeing. The ICB conversation about outcomes started with the visions that have been outlined by the North Yorkshire Health and Wellbeing Board and York Health and Wellbeing Board:

"People in all communities in North Yorkshire have equal opportunities to live long healthy lives" (NY Health and Wellbeing Strategy)
"For York to be a community where all residents enjoy long, healthy and independent lives" (York H&WBS)

The outcomes proposed on 10th October 2013 were:

1. The greatest benefit for the population is achieved with the available resources,
2. People receive care that is clear, co-ordinated and worry-free,
3. People are confident and safe to live where they want,
4. Staff are happy and empowered – this was considered by the group and not felt to be an outcome. The group felt that an indicator within another outcome would be more appropriate,
5. The quality of life for the population is the best it can be.

These outcomes were later translated into the project planning process by asking CCGs to consider how their strategy, programmes, schemes plan to:

- Release resources
- Improve quality of care
- Improve patient experience
- Work more effectively across services boundaries
- Improve health and wellbeing

The Indicators

In OBA an indicator *is "a measure which helps quantify the achievement of an outcome"* e.g. rate of low birthweight babies or the crime rate.

It is important to note that the indicators themselves paint a general picture for a geography; they *are not* the whole picture when viewed individually. They illustrate the prevailing direction for outcomes and provide important knowledge and intelligence for the partnership to consider as part of their strategic planning and direction setting. Although each indicator has been placed under one outcome there is likely to be significant relationships between an indicator and a number of outcomes.

The indicators selected have come from a number of sources and compiled by the Public Health Intelligence Team, therefore the report relies heavily on the support given by key partners:

- Health and Adult Services Management Information Team,
- Commissioning Support Unit Business Intelligence Team,
- Yorkshire Ambulance Service Management Information Team.

The finalised outcomes and associated indicators

1. ***EFFICIENT - The greatest benefit for the population is achieved with the available resources,***

This outcome relates to maximising the available resources across the health and social care system, therefore the indicators selected focus on where there may be potential waste or duplication.

- A&E attendances – rate, number and cost,
- Length of stay,

2. ***CLEAR AND COORDINATED - People receive care that is clear, co-ordinated and worry-free,***

This outcome relates to the direct care that the population receives and whether there is misuse or misunderstanding of the system.

- Percentage of patients with a share care plan – not yet available,
- Emergency admissions within 30 days of discharge – number and weekend vs. weekday, (we may want to examine this against length of stay to see if patients are being discharged appropriately i.e. not too early).
- Ambulatory care sensitive admissions,
- Yorkshire Ambulance Service calls (aged 65 and over),
- Sickness and absence rates for social care teams – a potential indicator of staff satisfaction in the system,

3. ***ACCESSIBLE AND RESPONSIVE - People are confident and safe to live where they want,***

This outcome relates to how well the health and social care system and individuals are able to manage their own needs i.e. self-care.

- Excess bed days – the number of days over and above the defined length of stay for the appropriate Health Resource Group,
- Discharges from hospital directly into residential care,
- Proportion of people (which people) discharged from hospital receiving a reablement service,
- Direct payments, percentage of social care customers receiving direct payments,

4. ***PREVENTATIVE - The quality of life for the population is the best it can be.***

This outcome relates to the systems success on moving towards a preventative approach, reducing unnecessary need or demand by reducing the prevalence of smoking or the incidence of falls for example.

- Hospital admissions related to a fall,
- Alcohol specific admissions,
- Smoking related admissions – only able to produce this indicator at CCG level over a longer period of time (this is because we're not dealing with specific admissions but attributable admissions).

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

The outcomes selected by the Integrated Care Board for use in this submission are:
1. EFFICIENT - The greatest benefit for the population is achieved with the available resources,
2. CLEAR AND COORDINATED - People receive care that is clear, co-ordinated and worry-free,
3. ACCESSIBLE AND RESPONSIVE - People are confident and safe to live where they want,
4. PREVENTATIVE - The quality of life for the population is the best it can be.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

Not applicable - we will be using the national metric when this is developed.

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

All the metrics presented below will be reviewed quarterly at the North Yorkshire Integrated Commissioning Board.

Additional where possible, these measures will also be broken down to individual Clinical Commissioning Group populations to show the variation across North Yorkshire.

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Not applicable - the metrics below relate only to the North Yorkshire Health and Wellbeing Board.

Metrics for the North Yorkshire County Footprint		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	520.0	N/A	476
	Numerator	675		656
	Denominator	129,802		137,952
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	85.9	N/A	89.6
	Numerator	395		395
	Denominator	460		441
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	201.1	181.12 (147.71 – 194.22)	180.23 (146.99 – 193.26)
	Numerator	978	886	886
	Denominator	484,128	489,037	491,458
		(June 2013 - Nov 2013)	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	156.87	143.53 (127.29 – 150.28)	160.21 (135.89 – 169.74)
	Numerator	950	873	976
	Denominator	605,503	608,092	610,702
		(April – September 2013)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]			N/A	
		(insert time period)		*(insert time period)*
Injuries due to falls in people aged 65 and over (crude rate per 100,000)	*Metric Value*	1,642	N/A	1,561
	Numerator	2,041		2,154
	Denominator	124,321		137,952
		April 2011 -March 2012		*April 2014 - March 2015*

******Mid 2014 Population projections used where a North Yorkshire Population is required in the projected denominator**

Finance – Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15 £m	Minimum contribution (15/16) £m	Actual contribution (15/16) £m
North Yorkshire County Council		*7.000*	*1.350*	*1.350*
Airedale, Wharfedale and Craven Clinical Commissioning Group		8.452	*2.999*	*2.999*
Hambleton, Richmondshire & Whitby Clinical Commissioning Group			*9.152*	*9.152*
Harrogate and Rural District Clinical Commissioning Group			*9.557*	*9.557*
Scarborough & Ryedale Clinical Commissioning Group			*7.538*	*7.538*
Vale of York Clinical Commissioning Group			*6.863*	*6.863*
Primary Care				
District / Borough Councils – Disabled Facilities Grant			*2.033*	*2.033*
Specialised commissioning				
Local Authority Public Health				
Total		**15.452**	***39.828***	***39.828***

To Be Agreed

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

A contingency plan requires, to an extent, an ability to implement an alternative strategy which is more effective at delivering what the plan sets out to achieve, since it has to deliver more quickly than the primary plan. Therefore, the contingency plan will be somewhat unwieldy, somewhat risky and certainly counter to the original intent. Early views on how this can be achieved centre on reverting to old processes, investment in additional capacity and cash bail-out to support over-stretched services

Contingency plans have not yet been defined in detail. There are risks inherent in the transformation of services which lead to the reduction of capacity of acute and secondary care settings instituted on the belief of reducing volumes. Reinstating this capacity at pace as a contingency response will not be quick and will not be easily achieved, especially where it concerns staffing.

To mitigate these risks, it is intended to plan for a phased introduction of our plan, with well-planned change management, robust evaluation and reporting, with carefully staged capacity release to ensure the risks are minimised and that corrective action is taken as early as possible.

Contingency plan:		**2015/16**	**Ongoing**
Outcome 1	Planned savings (if targets fully achieved)	tbc	tbc
	Maximum support needed for other services (if targets not achieved)		
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

To Be Agreed - April

North Yorkshire Health and Wellbeing Board
Better Care Fund – Draft Plan

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
£m		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Social Care Protection	NYCC	7.000				17.000			
Disabled Facilities Grant	Districts					2.033			
Care Bill Preparation including IT systems	NYCC	0				0	1.850		
Transformation Fund To fund schemes and infrastructural investment, including:		8.452				18.945			
Data Sharing & Information Governance									
Intermediate Care / Reablement / Rehabilitation									
Equipment Services and									
Further schemes to be defined									
Organisational Development									
Evaluation									
Communication									
Total		**15.452**				**37.978**	**1.850**		

Benefits and schemes to be defined and agreed