Health and Wellbeing Board
North Yorkshire

NORTH YORKSHIRE HEALTH AND WELLBEING BOARD

September 2013

Health and Wellbeing Commissioning Intentions in respect of the Joint Health and Wellbeing Strategy

NHS Vale of York Clinical Commissioning Group (CCG)

1. Purpose

Appendix 1 provides a summary of the Commissioning Intentions for NHS Vale of York CCG aligned to the North Yorkshire Health and Wellbeing Strategy priorities. It outlines the progress to date on current schemes and the longer term transformational schemes where planning has also commenced.

2. Background

NHS Vale of York CCG is committed to delivering against the priorities of the North Yorkshire Health and Wellbeing Board, outlined in the North Yorkshire Health and Wellbeing Strategy 2013-18. These informed the NHS Vale of York Integrated Operational Plan 2013-14 and the summary 'Plan on a Page', which are available at: http://www.valeofyorkccg.nhs.uk/publications/

3. Recommendations

The Board are asked to note:

3.1 The commitment from NHS Vale of York CCG to deliver against the priorities for the North Yorkshire Health and Wellbeing Board

3.2 The progress against the 2013-14 Commissioning Intentions as provided in Appendix 1

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NHS
Vale of York
Clinical Commissioning Group

Strategic Performance Framework emerging from the North Yorkshire Joint Health and Wellbeing Strategy
NHS Vale of York CCG Commissioning Intentions: Appendix 1

The following outlines some of the ways we will know the strategy has improved the Health and Wellbeing of people in North Yorkshire. It is intended that the framework is used as the starting point to develop with partners an agreed range of indicators to show how the NHS Vale of York CCG commissioning plans will seek to make an impact on the challenges and priorities contained in the strategy.

Challenges	Priorities and areas for focus	What will success look like?	How NHS Vale of York CCG will locally contribute to success. Plans for 2013/14	Progress Update: Sept 2013
Rurality Rurality leads to challenges in delivering services efficiently in remote rural areas. Access to services can be a challenge for some communities, service providers need to think creatively about rural solutions thus reducing further the need for transport. The isolation people can experience from living in	• Healthy and sustainable communities. • Emotional health and wellbeing. • Social isolation and its impact on mental and wider aspects of people's health. • Create opportunities to support, expand and grow the contribution people can make in	• Improved access to services for people in rural areas for example by enabling more local communities to manage their own support systems. • Improved rural employment opportunities. • Improved access to leisure activities for people in rural areas. • Improved availability of	<u>Integrated Operational Plan 2013-14: Aligned Priorities</u> Productive community teams incorporating an integrated approach to working Maximise independence and enabling resumption of living at home in a safe and efficient manner through: -supporting care at home - self-management education programmes	<u>Review of community services</u> • Pilot of NCT and review of model – two GP practices in Selby • Developing community indicators to evidence of impact on the system • Developing work on Integrated models of delivery with social care in line with Integrated Transformation Fund planning.

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rural locations can impact on their emotional wellbeing and mental health. Lack of readily available community support and services can reduce vulnerable people's opportunities to live safely in their own homes. Our rurality also means we have many opportunities within our countryside to improve the health and well-being of our community.	developing safer, supportive communities. • Improving the availability of more affordable housing that is appropriate to people's needs. • Maximising opportunities for local economic and job development, including the continued development of a more sustainable transport system. • Development of a North Yorkshire & York Local Nature Partnership	appropriate and affordable housing. • A reduction in the number of socially isolated vulnerable people. • Improved communications (e.g. broadband) infrastructure for both business and private premises. • The work of the North Yorkshire & York Local Nature Partnership will provide increased access to natural areas for outdoor recreation and conservation volunteering opportunities allowing people to be healthy and play an active role in maintaining our areas of natural beauty.	• Utilise assistive technology • Strategic commitment to increase services within the community, outside of hospital settings • Work with individuals and communities to develop community based solutions to improving the health and well-being of the community	<u>Urgent Care Programme</u> • Partnership approach through Urgent Care Board. • Review of Emergency Care Pathways to support care homes, e.g. heart failure, diabetes etc. to be completed by the end of year. • Emergency care practitioner to respond to Urgent Care needs pilot: Pickering. Evaluation has taken place and indicative feedback shows a significant reduction in attendance at A&E for that cohort.

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				Community engagement events: Long Term Conditions: - Pickering 30th September - Selby 10th October
An Ageing Population Over the next 10 years and beyond, we will continue to see a substantial increase in the elderly population, and in the prevalence of age-related conditions including obesity, diabetes, stroke and dementia and other long-term conditions. There is a huge challenge to find new ways of adequately meeting the resulting care and support needs of much higher numbers of very elderly	• Healthy and sustainable communities. • People with long-term conditions. • Emotional health and wellbeing. • People living with deprivation. • Social isolation and its impact on mental and wider aspects of people's health.	• A reduction in the number of socially isolated vulnerable people and the development of local strategies to tackle this issue. • The number of people living in poor quality or inappropriate housing is reduced. • Reduction in the number of people living in fuel poverty. • Increase in the number of	<u>Integrated Operational Plan 2013-14: Aligned Priorities</u> • Productive community teams incorporating an integrated approach to working • Maximise independence and enabling resumption of living at home in a safe and efficient manner through: -supporting care at home	• Initiation of the Long Term Conditions (LTC) and Older People Programme. - This will include the needs of children and young people with LTC • Collaborative Transformation Board established- collaborative working, review of pathways

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people in the County.	• Create opportunities to support, expand and grow the contribution people can make in developing safer, supportive communities. • 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. • Improving the availability of more affordable housing that is appropriate to people's needs.	people volunteering to help support their local community. • Increase in the number of people being helped by the voluntary sector. • More children, young people and other vulnerable groups are kept safe and protected from harm. • Improved support for people with LTCs: reduction in the number of emergency hospital admissions. • Improved knowledge and understanding of the assets available from within local communities by both health and social care agencies and communities themselves.	- self-management education programmes - Utilise assistive technology • Reduce unplanned hospitalisation for chronic ambulatory care sensitive conditions • Reduction in emergency admissions that should not usually require hospital admission	and admission avoidance focussing on: - re-enablement - palliative care - Frailty - Dementia • Establishment of an IV community cellulitis service planned to start April 2014 • Working collaborative with the Partnership Commissioning Unit (PCU) to address the Winterbourne Requirements • See Urgent Care (Rurality section)

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		• More services being developed and provided in partnership.		
Deprivation and wider determinates of health The health of people within North Yorkshire is generally good compared to other parts of England. However, there is a gap in life expectancy between the least and most deprived communities across North Yorkshire of around 6.3 years for men and 4.6 years for women. Within some districts, the gap is nearly 10 years. Across the life course, deprivation can affect people at every life stage, including child poverty, inequitable educational attainment, fuel poverty and social isolation.	• Ill Health Prevention. • Healthy and sustainable communities • Children and young people. • Emotional health and wellbeing • People living with deprivation. • Make a concerted multi-agency approach to identify and develop integrated solutions for children and families who are vulnerable to poverty, have high and complex needs or are in	• Reduction in the number of people living in fuel poverty. • Investment and services are provided to communities and people in the most need of health and social care. • All public agencies have the reduction of health inequalities embedded in their decision making processes. • More children and young people are helped to make positive choices for personal responsibility. • Increase in the overall employment rate and reduction in unemployment rate. • Reduction in the number and proportions of children	<u>Integrated Operational Plan 2013-14: Aligned Priorities</u> • Understand local health needs • Consider the impact on health inequalities in every decision • Work in an integrated way for individuals and communities who suffer poor outcomes • Work with individuals and communities to develop community based solutions to improving the health and well-being of the community	• JSNA engagement • Collaborative working with Public Health to implement 'Stop before Op', smoking cessation programme • Development of a community pathway for diabetes • Collaboration with PCU on children and young people's commissioning.

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	challenging situations. • Social isolation and its impact on mental and wider aspects of people's health. • Create opportunities to support, expand and grow the contribution people can make in developing safer, supportive communities. • Health, social care and other organisations should develop their knowledge of what community assets exist in their area and how they can be better used and developed. • Improving the availability of more affordable housing that	living in poverty. • More children, young people and other vulnerable groups are kept safe and protected from harm. • Reduction in the gap in life expectancy between different areas of the county. • Reduction in the variations in educational attainment believed to result from family circumstances. • The proportion of children and young people not in education, employment, or training (NEET) is reduced. • Maximising the opportunities afforded by greater access to broadband across our county. • Support and encourage the development of social enterprise approaches to community		

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	is appropriate to people's needs. • Maximising opportunities for local economic and job development, including the continued development of a more sustainable transport system to meet the social and economic needs of local communities and safeguard the environment.	support. And the maintenance of our natural assets. • Lead partner agencies to ensure their contracts support at least a minimum wage standard and encourage access to employment by vulnerable people through such approaches as innovation funds and contracting for outcomes. • Enabling the provision of more affordable homes. • Maintaining and improving existing housing stock. • Improving access to housing services. • Reduction in the rate of adult and young people homelessness.		

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Financial pressures The challenge in a period of budget constraints is to find creative, innovative and efficient solutions to address needs of an increasing and in particular an ageing population. A conclusion of the Independent Review of Health Services in North Yorkshire and York, published in 2011 was that we must deliver services within our means and place greater emphasis on prevention and support in communities, thus reducing the need for acute care. Our response to these challenges must be planned in the context of the resources available. People in North Yorkshire have high expectations of	• Integrated commissioning maximising the use of the public purse. • Integrated service provision which reduces duplication and adds value to people's care pathways. • Better support and management of long term-conditions which maximises the use of life enhancing technologies. • A better balance between investment in acute support and community focussed early intervention and prevention strategies.	• The health and social care economy delivering good quality timely support within a financially balanced system • Evidence that there is a sustainable balanced investment in: • early interventions aimed at reducing the need for statutory intervention; • a robust integrated rapid short term response system geared to quickly return people to an acceptable level of health and well-being; and • A financial sustainable acute care response geared to returning people to their appropriate community setting.	<u>Integrated Operational Plan 2013-14: Aligned Priorities</u> • To work in collaboration with our neighbouring CCGs and to share with them the risks involved in commissioning • Deliver efficiencies through the Quality, Innovation, Productivity and Prevention (QIPP) programmes • To encourage closer working between all health and social care professionals, leading to better managed and more responsive services	• Strategic Collaborative Commissioning Board (commissioning issues across the four North Yorkshire CCGs) • Revised financial plan to achieve financial balance by March 2014, including a 'confirm and challenge' process for each QIPP scheme to provide assurance on forecast savings. • Implementation of the QIPP plan covering: - Long Term Conditions - Elective Care - Urgent Care -Mental Health

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the quality and availability of health services. However the national criteria used to allocate NHS spending has resulted in North Yorkshire receiving less money per resident compared with many other areas, despite problems associated in particular with its rurality. The challenge for us as a community is to manage our expectations and find cost effective creative efficient solutions within the resources we have.				- Prescribing - Primary Care • Commitment to working jointly on health and social care funding with a principle of testing models jointly to inform the Integrated Transformation Fund.

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Killer diseases Circulatory disease (including heart disease and stroke) and cancers account for the greatest proportion of deaths within North Yorkshire. Cancers are the most common cause of death under the age of 75 years. There are particular challenges for certain conditions due to increasing age (e.g. dementia and stroke) or change in projected prevalence (e.g. obesity and diabetes). Across all age groups, there is a need to establish joined-up care pathways making best use of community support.	• Ill Health Prevention. • Children and young people. • People living with deprivation. • Create opportunities to support, expand and grow the contribution people can make in developing safer, supportive communities. • 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.	• Reduction in the instances of "killer" diseases. • Improvements in life expectancy for people with chronic/LTC. • Reduction in emergency admissions for people with LTC. • Increase in the number of people of all ages choosing to adopt healthier lifestyles (reduced smoking, alcohol consumption, lower obesity, etc).	<u>Integrated Operational Plan 2013-14: Aligned Priorities</u> Reduce unplanned hospitalisation for chronic ambulatory care sensitive conditions Reduction in emergency admissions that should not usually require hospital admission Increase diagnosis rates of dementia	• Initiation of the Long Term Conditions (LTC) and Older People Programme. • Collaborative Transformation Board established- collaborative working, review of pathways and admission avoidance focussing on: - re-enablement - palliative care - Frailty - Dementia • Establishment of an IV community cellulitis service planned to start April 2014 See Urgent Care (Rurality section)

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	• Encourage positive lifestyle behaviour changes.			
Emotional and mental wellbeing Emotional and mental wellbeing is important across all age groups. Mental health is not just the absence of mental disorder. It is defined as a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. Physical health and mental health are strongly linked. Dealing with pain or a long-term condition can impact on	• Develop the culture within our North Yorkshire communities to enable everyone to aspire to a positive sense of emotional health well-being. • In partnership to help people to better understand the connection between mental health and physical health and promote improvement through our public health agenda work. • Shifting the focus of service provision to one where the performance focus is on the numbers	• More people have better mental health. • More people with mental illness or who are substance dependent will recover. • People with mental health needs will have improved physical health. • More people have a positive experience of care and support. • Fewer people suffer avoidable harm. • Fewer people experience stigma and discrimination.	<u>Integrated Operational Plan 2013-14: Aligned Priorities</u> Commission psychiatric liaison service A local solution for out of area placements Commission dementia training Improving mental health crisis care	• Working collaborative with the Partnership Commissioning Unit (PCU) to address the Winterbourne Requirements • Working with PCU to review all Out of Contract Placements • Provision of dedicated additional capacity to support mental health commissioning • Working with the current mental health provider to review the performance management arrangements

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one's mental health and sense of wellbeing. People with persistent mental health problems often have a long-term physical complaint. Some communities and those who are lonely and isolated are at increased risk of mental ill-health. So the challenge in North Yorkshire is to give attention to develop sustainable, cohesive and connected communities; have safe places for children to engage in positive activities; reduce crime and anti-social behaviour; support more people to reduce their dependencies on substance misuse and tackle domestic violence as all having their part to play in improving emotional	of people who have recovered and the number of people positively reporting on their experience of care and support. • Partners collectively agreeing a joint strategy addressing domestic violence. • Develop and test innovative approaches to reducing loneliness and isolation.	• More local investment in schemes with a focus on reducing isolation and loneliness can demonstrate evidence of improved outcomes for people. • People who use services say that those services have made them feel safe and secure. • An increase in the number of people who feel they have more control over their service as a result of receiving self directed support. • People in contact with secondary mental health services have improved opportunities to access paid employment. • People with mental illness		• Section 136 planned to be operational by end of calendar year • Increased mental health capacity for A&E (York) during the twilight hours, linked into overall crisis service. • Review of psychological therapies has commenced • Dementia Implementation Partnership Group in place to drive forward the Dementia Strategy.

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health and well-being		have equal opportunity to live independently in settled accommodation with or without support. • People of all ages know they have a safe haven to go to if they feel under threat. • People who use services and their carers find it easy to find information about services.		