Health and Wellbeing Board
North Yorkshire

The Better Care Fund

A New Era for Health and Social Care in North Yorkshire

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

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1. INTRODUCTION

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

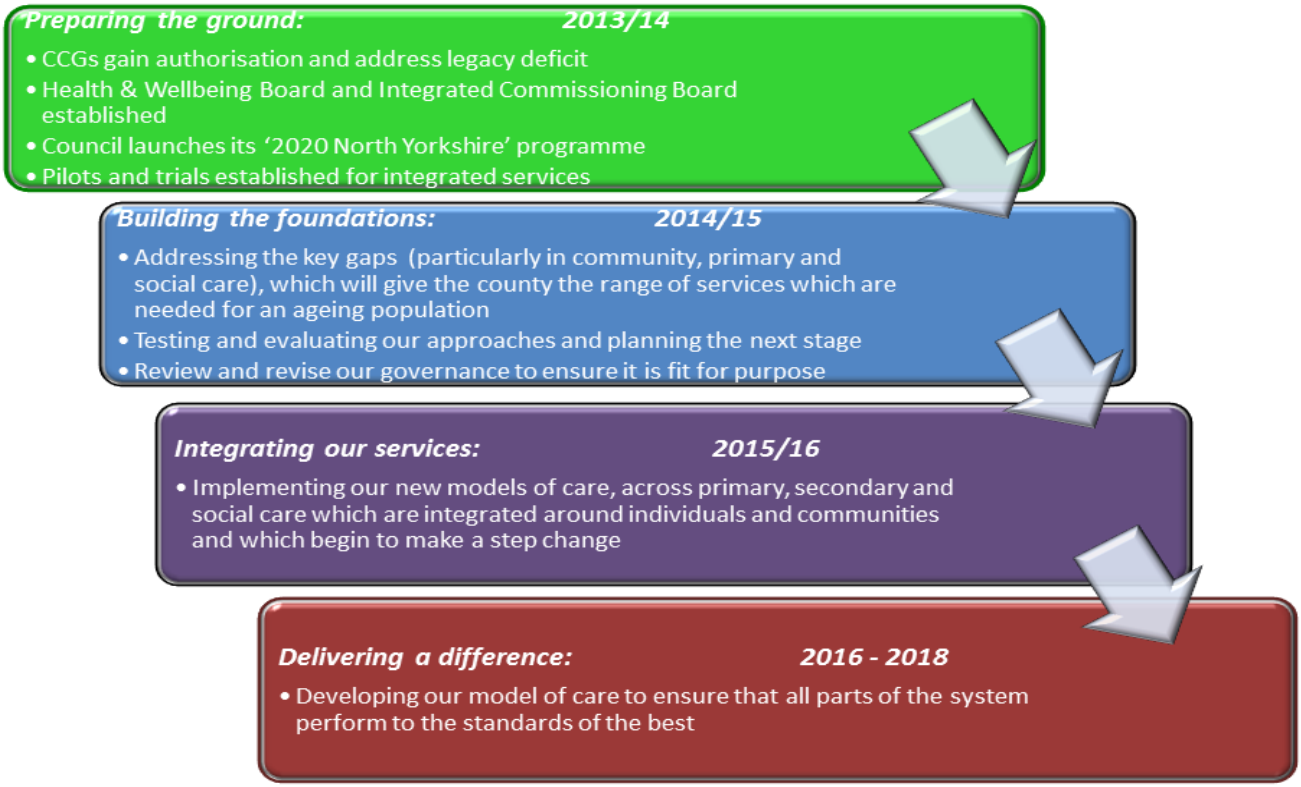
The Better Care Fund is providing the impetus for the NHS and local government in the county to set out a shared vision, underpinned by practical actions and joint investment, which breaks the cycle of the past. As a public services economy, we know we face the challenges that come with rurality, geography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

This plan describes how our shared investment will:

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

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

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



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

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

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

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

We have achieved a balance between county-wide and local approaches and the specific schemes can be grouped under our 3 main priority areas of:

1. Prevention and community resilience to reduce demand for health and social care
2. Integrated locality services to include multi-agency reablement and intermediate care services and multi-disciplinary case management teams.
3. Programmes of high impact interventions which including falls, mental health, dementia, care home support.

2. OUR VISION

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

Therefore, our collective vision is for:

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

The Council and CCGs are committed to the following principles for how people should experience services:

- Promoting health and wellbeing
- Care is integrated around people rather than organisations
- Treating the patient's home as the main focus of care and services
- No health without mental health
- No decision about me without me

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

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

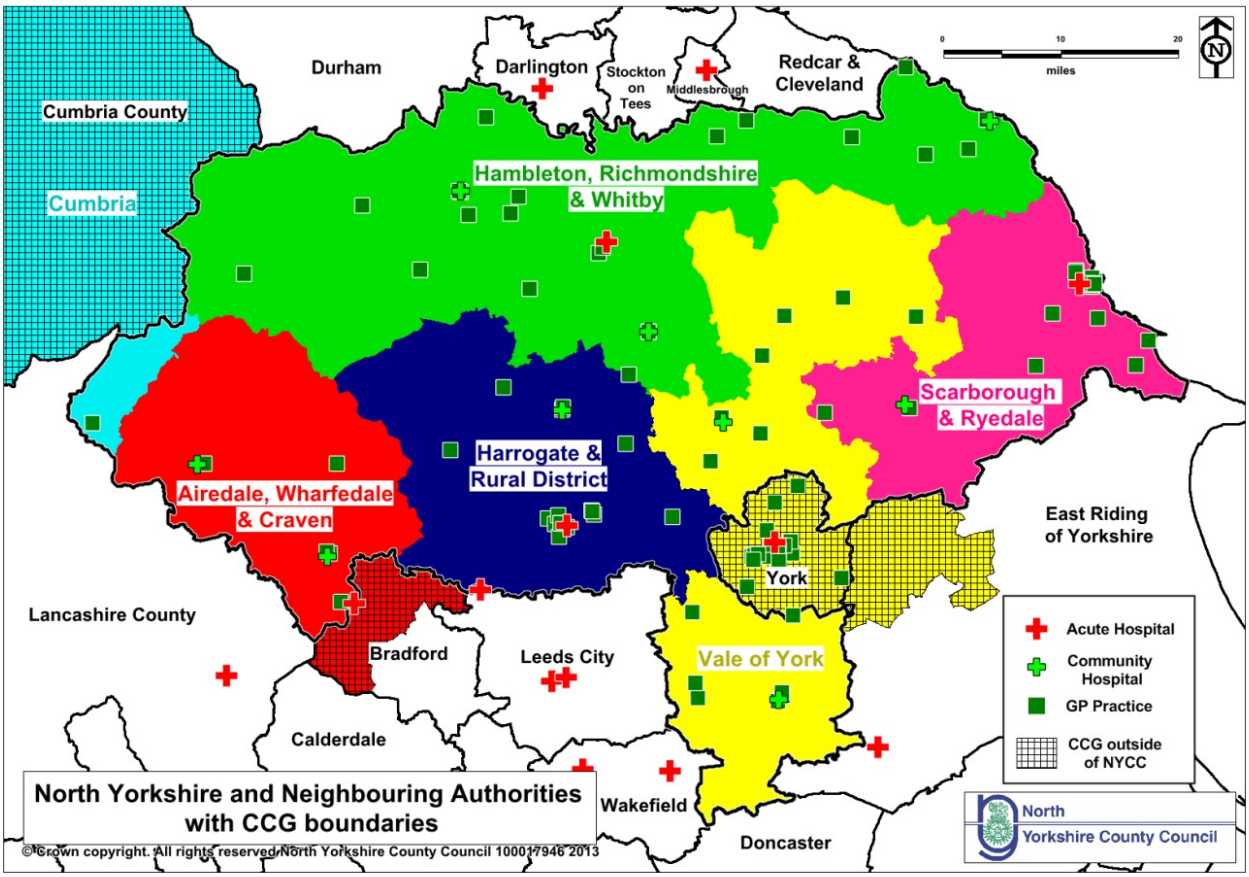
3. PLAN DETAILS

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. As previously described, the territory of North Yorkshire is complex and crosses local authority, CCG and NHS provider boundaries. North Yorkshire County Council has seven district councils within its boundary and six Clinical Commissioning Groups. This plan wholly encompasses the CCG footprints of Harrogate and Rural District, Hambleton Richmond and Whitby, and Scarborough and Ryedale; the footprint of Airedale, Wharfedale and Craven CCG crosses into the Health and Wellbeing Board coverage of Bradford Metropolitan District Council and the Vale of York CCG covers the City of York and the East Riding of Yorkshire. Finally, to the extreme west of North Yorkshire, the general practices of Low and High Bentham fall into Cumbria CCG. The Cumbria Health & Wellbeing Board BCF plan will cover this area.



Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	
Minimum required value of ITF pooled budget: 2014/15	**£11,109,000**
2015/16	**£39,795,000**
Total agreed value of pooled budget: 2014/15	**£28,203,000**
2015/16	**£39,795,000**

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	<date>

Signed on behalf of the Clinical Commissioning Group	Hambleton, Richmondshire and Whitby Clinical Commissioning Group
By	Vicky Pleydell
Position	Clinical Chief Officer
Date	<date>

Signed on behalf of the Clinical Commissioning Group	Harrogate and Rural District Clinical Commissioning Group
By	Amanda Bloor
Position	Chief Officer
Date	<date>

Signed on behalf of the Clinical Commissioning Group	Scarborough & Ryedale Clinical Commissioning Group
By	Simon Cox
Position	Chief Officer
Date	<date>

Signed on behalf of the Clinical Commissioning Group	Vale of York Clinical Commissioning Group
By	Dr Mark Hayes
Position	Chief Clinical Officer
Date	<date>

Signed on behalf of the Council	North Yorkshire County Council
By	Richard Webb
Position	Corporate Director, Health and Adult Services
Date	<date>

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), as described in section 4.5, includes in its membership the main mental health and acute trusts and as such, they have been present and engaged in discussion of the BCF Plan. The discussion about the impact on Trust activity takes place at CCG levels. Over the next year all the main Trusts are committed to working with the CCGs and Social Care to test and further model the proposed schemes with a view to this being reflected in 2015-16 contracts. In addition, all Community Services and some Mental Health Services will potentially be re-tendered in the next year and the shared learning will feed into these specifications.

North Yorkshire Health and Wellbeing Board includes voting representatives of acute and

mental health providers and the voluntary sector.

Each CCG hosts a local committee dealing with integration and transformation and 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.

Over the last 18 months all CCGs have been actively engaging with local stakeholders. Initially this was to support their Authorisation and more lately it has been to support the development of 2 and 5 year strategies as well as on specific service issues.

CCGs give presentations regularly to the Scrutiny of Health Committee on tier plans and activity and Council's Health & Adult Services Directorate offer regular updates to the Care and Independence Overview and Scrutiny Committee.

Examples of the scale of the engagement and the outcomes are listed below:

Hambleton, Richmondshire and Whitby CCG: has consulted widely on its 'Fit 4 The Future' plan which sets out a vision for Older People as well as holding more specific engagement processes, on the future model of care in each of 3 localities. One outcome of consultation in Whitby has been to agree with the current NHS Provider that the CCG will serve notice and begin to draw up a new service model along with local GPs and the County Council.

Airedale Wharfedale and Craven CCG:
The Transformation and Integration Group (TIG) is chaired by the CCG Clinical Chief Officer and membership includes, Airedale Foundation Trust (AFT), Bradford District Care Trust (BDCT) Yorkshire Ambulance Service (provider of ambulance & GP OOH service) City Bradford Metropolitan Council., North Yorkshire County Council and Craven District Council. The TIG provides oversight of the whole health and social care system leading the 'transform' element as well as ensuring accelerated progress of integration of services. Through this group all providers are involved in planning at the highest level and are actively involved in the change processes and monitoring impact. As an example both providers of community services (AFT & BDCT) have engaged in a review of community nursing service provision and are engaged in an ambitious approach to remodelling the configuration of services which is likely to lead to re-procurement.

Harrogate and Rural District CCG:
The Local Integration Board is chaired by the GP lead and includes representatives from Harrogate NHS FT, Tees, Esk and Wear Valley Mental Health Foundation Trust; NYCC, HBC along with Social Care and the Voluntary Sector. There have been specific detailed planning sessions with the NHS Trusts to identify local priorities, particularly in relation to urgent care provision and detail relating to the BCF plans.

Vale of York CCG:
The York NHS FT is involved in all local planning and will be leading one of the pilots to test out the development of new Community Hubs bringing Primary, Community and Social Care together around groups of GPs serving populations of between 50,000 and 100,000.

Scarborough and Ryedale CCG:
The York NHS FT and TEWV FT are part of the local Transformation Group. In addition York Trust is working with the CCG on specific initiatives to re-model the shape of Scarborough hospital such as a 'Perfect Week' modelling exercise to review bed use and patient flow and improved patient discharge.

North Yorkshire County Council:
NYCC regularly meets with the Independent Care Group, an umbrella group of Residential, Nursing and Domiciliary Care Agencies to discuss capacity and quality and ensure they are updated on Council strategy and national issues such as the Care Bill.
The Council recently undertook extensive consultation with customers and providers of Domiciliary Care in preparation for a new tender for services. This gave us a lot of feedback about market conditions and the value customers place on continuity of care and joined up services. The Council also leads a Market Development Board which includes representatives of the Independent Care Sector. They held a facilitated session supported by the Institute of Public Care (IPC) at Oxford Brookes University to co-produce the Market Position Statement. In 2013 the Council also consulted with over 120 Providers about the proposal to change FACs criteria.

Public Health
In October 2013 the Director of Public Health led a County Wide Conference on Health Inequalities which included all District Councils and CCGs and was attended by over 150 Voluntary Sector representatives and partners such as the Police and Universities. Some distinctive Public Health themes for North Yorkshire were identified and debated, namely social isolation and loneliness, fuel poverty and excess winter mortality as well as reflecting on the specific needs of some of the more deprived communities in Selby, Scarborough and Catterick Garrison. These themes are picked up specifically in the BCF theme of Prevention and by wider work underway in NYCC aimed at strengthening communities.

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

The NHS and the County Council have engaged in significant local consultation over the last year. A number of key themes have emerged from all areas. These are that:

- People want to be supported to live at home for as long as possible
- People want to be given help to be independent
- People want access to good quality primary care and GP Services
- People understand that they may have to travel further for specialist services and to secure the best outcomes
- Support for carers is a priority
- People believe that we should invest in prevention.

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

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

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

Hambleton Richmondshire and Whitby CCG have consulted widely on their Fit 4 The Future model in Whitby and this is now being extended with a programme of events in Hambleton.

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

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

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

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

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

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

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

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
Joint Health and Wellbeing Strategy NY-JHWBS 13-18.pdf	The JHWS sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out in the period 2013 to 2016.
Terms of Reference 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
North Yorkshire Public Health Report	To be attached.

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 vision is that people in North Yorkshire will be empowered to take control of their health and independence supported by a sustainable health and social care system which promotes health and wellbeing, provides timely access to joined-up services and responds to the distinctive rural and coastal features of North Yorkshire.

The vision is supported by the Health and Wellbeing Strategy, CCG Strategic plans and Annual Public Health Report.

Our vision for integrated services combines a county-wide vision and principles with locally tailored services and approaches. We have a county-wide commitment to ensure everyone has access to core services for Prevention, Reablement, Integrated Health and Social Care Teams and specific interventions. However, we also recognise that needs differ, existing community services are variable and local teams wish to innovate and evaluate new ways of doing things. All developments are in line with our shared Statement of Principles for Integration. In addition we have taken the call for Parity of Esteem for Mental Health very seriously and are embedding this in our plans, both for prevention and for reablement, as well as for specialist mental health services and for integrated community services. We believe that there can be 'No Health without Mental Health'.

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

Over the next five years we expect to see:

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

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

tune of £17m from the BCF, recognising how critical social care services are to the overall system.
- We have agreed that all investments in Social Care will be transparent and that CCGs will be able to influence and shape local service delivery in line with local strategies.
- We will work with Secondary Care providers to secure the hospital, mental health and community services needed in North Yorkshire, underpinned by a network of modern community hospitals delivering a new generation of health and social care services.
- The Council and NHS are working together to support the development of Personal Budgets for Health and also to start to share contracting and commissioning capacity.

Next steps
Having repaid the PCT legacy deficit and built new clinically led organisations the CCGs will be working with NYCC during 2014-15 to develop and test out some new approaches. We fully expect that some will be more successful than others and we will share learning and evidence and make decisions about what to continue in 2015-16. Our immediate priorities for joint work are:

- extending current work to roll out integrated teams in localities
- testing out models of GP led Community Health and Care Hubs
- integrating approaches to Prevention and Reablement
- developing a blue print for the future of Health and Social Care Services in each CCG area
- developing a county-wide Dementia Strategy to be implemented locally
- reviewing falls services and commissioning services to ensure we have a comprehensive service accessible to all patients
- collaboration on the re-design of mental health services
- completing, launching and implementing our Prevention Strategy
- using learning from the above to develop the detailed implementation plans for 2015-16 and beyond
- reviewing community equipment services to secure a highly efficient service offering the best value for money
- starting the process of aligning the work of the County Council and NHS on Mental Health and Learning Disability Services with a view to developing an integrated approach to commissioning in these areas

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?

Our aims are to deliver our vision of person-centred care in a sustainable way by creating an integrated health and social care economy drawing together primary, secondary, community, social care with the voluntary and independent sector to be more efficient, provide the right care in the right place and by focusing on prevention and predictive care.

We aim that a greater proportion of care is delivered outside acute settings with clinicians working seamlessly across primary and secondary care to keep people at home. We recognise that integrating primary and secondary health care and mental health services is as vital to this vision as is integrating health and social care.

We aim to improve outcomes for customers and patients and carers, improving their experience of services as well as improving our use of resources and meeting national and local performance targets.

Improve health, self-help and independence for North Yorkshire people by:

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

Invest in Primary Care and Community Services

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

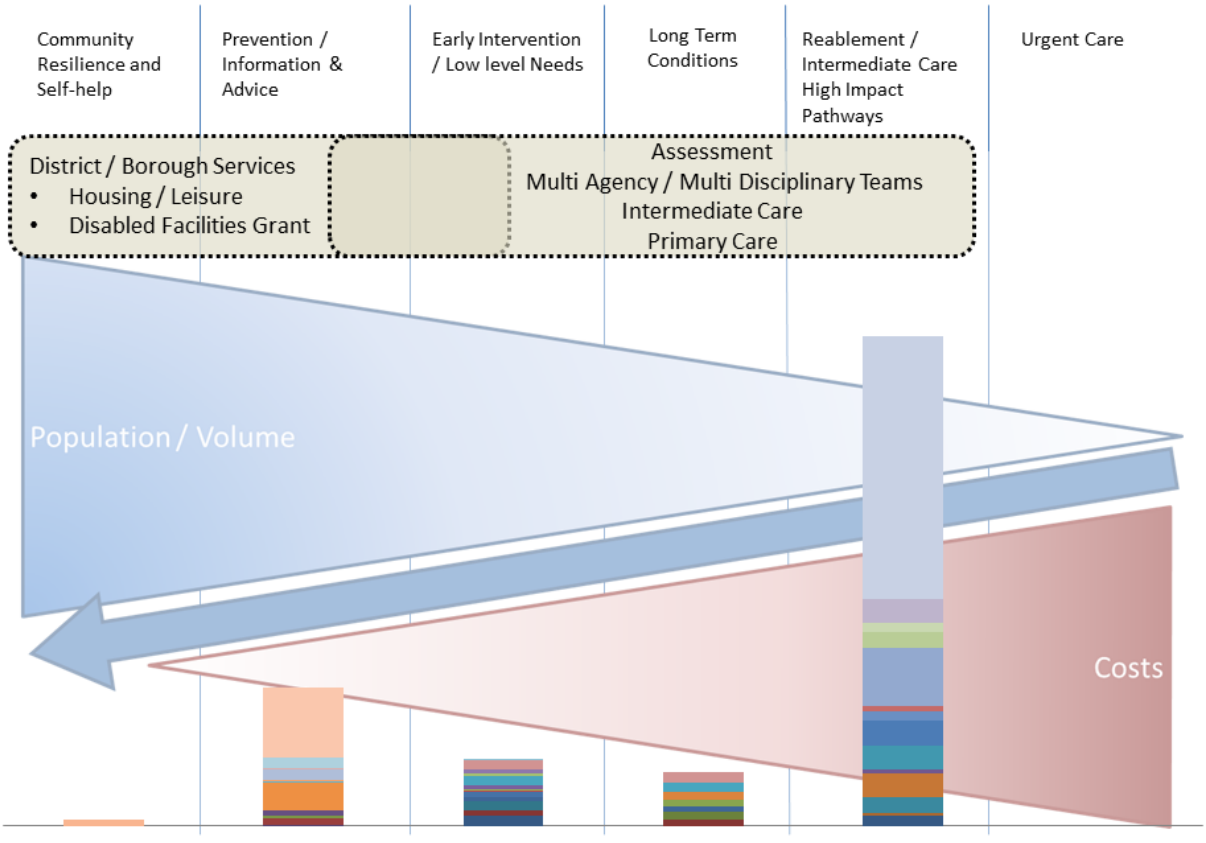
Create a sustainable system

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

The table below sets out at a high level the changes in the health and care system that will be achieved by the BCF schemes. The forty three schemes are represented in the coloured stacks, apportioned to their target area and sized relative to the size of investment.

It shows that we are investing the biggest share of the BCF in services which should reduce the use of secondary and institutional care. These are integrated reablement/intermediate care services, case management teams, mental health in-reach and dementia services. This in turn will support the delivery of the BCF metrics of reducing avoidable admissions, reducing care home placements and reducing delayed transfers of care.

The second largest proportion of funding is for prevention services and this is anticipated to have a longer period before the impact is felt. We can evidence that we are placing initial resources in services which deal with the immediate and pressing challenges of increased demand and balancing this with the need to invest in ways which prevent or delay people needing formal services. This includes Social Prescribing, Care Navigators, Falls Prevention, Carers Services, and Assistive Technology. The diagram below shows how we plan to support more people upstream to be more self-reliant and to move spend to prevention and predictive care over time.



Investment profile of BCF Schemes,
to be underpinned by Social Care and wider NHS services

This position can be seen as 'stage one' and as the system develops and confidence increases in our ability to continue to invest 'up-stream' in prevention and early intervention, we will be able to reduce the intensity of service spend and reduce costs at

the acute end still further. Work will be required to ensure this is factored into planning and commissioning of services in the future and to increase the certainty for providers to enable them to plan effectively. This in effect signals a longer term planning cycle for the integrated system.

Measuring aims and objectives

We will measure and evaluate an agreed list of qualitative and quantitative KPIs. These will mainly be PIs that we collect already as we want to keep the process as simple and focused as possible. We will also commission an independent academic evaluation from an academic. Our KPIs will relate to:

What we will do	How we will know we are successful	Metric or Method
Improving health, self-help, and independence :		
Take-up of housing related solutions	• Monitoring of Residential Care admissions • Liaison with District Housing leads	• Part of NYCC transformation model • BCF Protecting Social Care funding
Take-up of lifestyle services.	• Evidence that service up-take is increasing	• PH measure
Reduce the number of falls	• Metrics • Evaluation / Feedback	• Local BCF metric
Deliver enhanced Prevention Services	• Metrics • Evaluation / Feedback	• local measures to support implementation of Prevention Strategy
Deliver on national loneliness campaign and local priority in NYCC	• Patient/Customer reported reductions in social isolation and loneliness	• BCF Protecting Social Care funding
Reduce referrals and demand for formal social care services	• Evidence that capacity and services are maintained whilst major transformation underway • Demonstrate that channel shift is underway	• Part of NYCC transformation model • BCF Protecting Social Care
Investing in Primary Care and Community Services :		
Increased referrals to and successful outcomes from reablement	• Reablement volumes increasing • Number of people still at home after 91 days of support	• Metrics (BCF metric) • Evaluation / Feedback • Evidence from monitoring of reablement service
Appropriate utilisation of community health and social care beds.	• Delayed transfers of care reduce • Monitoring of bed occupancy figures for community beds / residential care/ nursing care	• Local measure for new reablement services and supported by BCF Protecting Social Care funding)

Effective case management of people with complex needs	• Numerical and qualitative outcomes • Overall packages of care	• Metrics (BCF metric) • Evaluation / Feedback • Evidence from monitoring of reablement service •
Increased use of people's own home as the 'bed base' for care.	• Monitoring of new reablement services • Monitoring of bed occupancy figures for community beds / residential care/ nursing care	• Metrics (BCF metric) • Evaluation / Feedback • Evidence from monitoring of reablement service
Improved quality of care in care home settings	• Reduced admissions to hospital • Reduced attendance by secondary / primary care	• Local priority • avoidable emergency admissions BCF metric
Creating a sustainable system :		
Reducing emergency admissions	• Data monitoring	• BCF metric
Reduced delayed transfers of care	• Monitoring of new reablement services • Monitoring of bed occupancy figures for community beds / residential care/ nursing care	• BCF metric and supported by BCF Protecting Social Care funding
Reduced occupied bed days	• Monitoring of new reablement services • Monitoring of bed occupancy figures for community beds / residential care/ nursing care	• Local measure of the overall shift in activity from beds to community
Reduce readmission rates	• Reduced admissions to hospital	• Local measure of effectiveness of reablement
Reduced long term placements for older people, and people with Mental Health and Learning Disability related needs	• Data monitoring	• BCF metric and supported by BCF Protecting Social Care funding
Reduced use of Mental Health inpatient facilities	• Data monitoring	• local measure to improve MH services

Patient/Customer experience

- Qualitative evaluation of patient and carer experience within key services

Workforce

- Staff surveys
- Qualitative research on staff attitudes and opinions
- Take up and availability of training for front line and management staff.

Measuring Success
We will measure the KPIs in a number of ways. The Integrated Commissioning Board will take an overview and will report on progress to the Health and Wellbeing Board. In that way our overall ambition will be measured in the public domain. The ICB will assure itself that there is a clear performance monitoring system at countywide and at CCG level to monitor progress on each KPI.

There will be regular reports on:
- Overall progress across North Yorkshire
- The impact on Providers on a case by case basis
- The impact on social services of schemes
- The shifts in activity between secondary and community care

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

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

The priorities and specific schemes have been developed using evidence from the North Yorkshire JSNA and from extensive consultations. They have also been considered by the local CCG Boards in the context of their wider local priorities and the existing pattern of services.

At a County Wide Level:
The Integrated Commissioning Board has undertaken a number of activities to coordinate our approaches. In 2013 it agreed the high level Principles for Integration which each CCG Governing Body and the Council's Executive and the HWB all adopted.

In October 2013 the ICB undertook a joint workshop led by Public Health on 'Outcomes Based Accountability' and agreed the following headings, which align to our performance indicators, metrics and patient/customer experience:
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. The quality of life for the population is the best it can be

The ICB has also identified resources to pump prime new initiatives, provide

infrastructure support on key enablers including Information Management & Technology, public engagement and evaluation.

The ICB has held county-wide sessions to share priorities and to consider our approach to Outcome Based Accountability. This enabled us to agree a template and set of requirements that schemes must achieve.

The details on schemes has been developed at local levels within local Integration and Transformation Boards, which have CCG, NHS Provider, Social Care and Voluntary Sector representation. The local schemes have been prioritised and approved by the Governing Bodies of each CCG and with the Council's senior team.

The ICB sponsored an Editorial Group to draft the BCF plan and provide assurance that all schemes met our shared vision and local priorities. Our approach has been to draw out a full list of schemes defined at local level, group those which align and agree a county-wide approach to them and then agree a mix of smaller local schemes which address local needs and challenges.

All plans have synergy with the wider CCG Strategic Plans and will contribute to general commissioning intentions and monitoring the schemes will be by a combination of existing performance systems and scheme specific reporting to ICB and HWB.

Specific BCF Requirements

7 Day Provision and Access
All of the schemes listed as avoiding emergency admissions, facilitating timely discharge and developing Community and Primary Care have an assumption of appropriate 7 day working and access. The detailed modelling of exact levels of capacity, and whether some resources in sparsely populated areas may be shared across boundaries will be undertaken in 2014-15. We will engage the public to help shape and inform the model of care and to ensure they are aware of changes so that expectations are managed. Depending on levels of success in 2014-15 the CCGs will negotiate changes to contracts. It must however be noted that the BCF is only one component of ensuring 7 day access. For example in HRW CCG the BCF plans for integrating Intermediate Care and Reablement need to be also considered alongside the Urgent Care investments which include additional Emergency Care Practitioners and extensions to Out of Hours Services. NYCC Reablement Service already works 7 days, but will be strengthened in future to facilitate 7 day discharge.

In each area the plans to integrate and strengthen reablement and intermediate care will include demand and capacity modelling will incorporate 7 day access and responses. This modelling will ensure that resources are available in the community but also will need to ensure that NHS Trusts deploy the optimum level of skilled practitioners over 7 days.

At a Trust and CCG level, we will measure:
- Reduction in avoidable emergency admissions
- Reduction in Delayed Transfers of care
- Reduction in admissions to long term care

Supporting Integration
Creating an integrated workforce across a complex system is challenging and we want to ensure that we focus on creating a seamless experience for the public rather than on all the administrative and HR processes needed to join staff up. We intend to work across all CCGs, to test out some slightly different approaches and to identify the best possible model, skill mix and managerial relationships. We will then agree whether this will be formalised by jointly commissioning a new service or by more formal integration of NHS and LA staff under single management.

We have selected two main areas for integrated services. These are the creation of Integrated Reablement and Intermediate Care Services and the extension of multi-disciplinary locality teams.

For reablement/intermediate care we are seeking to increase capacity, extend cover to 24/7 where needed, identify where additional community beds may be needed for step up and step down capacity and ensure a seamless approach to people who are at home and need support to prevent an admission, are in A&E and need help to avoid admission to a ward, and people who are in hospital and need support to get home and regain optimum functioning. We will map out the referral routes in and out of the service and how it fits together with all other aspects of service, including Ambulance and ECPs, GPs, Social Care, hospitals and core community health services.

For integrated multi-disciplinary teams, during 2014-15 we will build on the existing pilots across the County and determine the best model for sharing data and risk stratification, locating teams with and around GP practices, getting the best skill mix, obtaining secondary care input, involving patients and service users in their own predictive and proactive care planning and involving carers. This will in turn enable the Council and NHS to discuss whether there should be shared management of teams, how to achieve professional and clinical supervision and how the teams interface with other aspects of the system.

For both of the above, detailed planning will be needed to achieve optimum capacity in our deeply rural areas.

At CCG and County Level, we will measure:
- Increases in integrated services and staff numbers working in an integrated function
- Reduction in avoidable admissions
- Reduction in delayed transfers of care
- Reduction in admissions to long term care
- Increase in take up of housing related solutions and assistive technology
- Customer/Patient experience of MDT working and measures of carer confidence
- Better use of resources via shared management and facilities and joint commissioning
- Staff surveys to reflect attitude and culture

Protecting Social Services
This is covered in section 5.1. However, it is important to note here that alongside the BCF, Social Care is undertaking a transformation programme and that the BCF process will be aligned with the Council's transformation programme to seek synergy, integrate commissioning and align outcomes wherever possible. This protection of social care is

against a backdrop of an ambitious transformation programme being undertaken by the County Council. The social care budget is already profiled to reduce by £21.5m from its 2013/14 level of c£138m having reduced by £27m in the four years to 2015. This will require substantial numbers of people to have their route through the social care system changed – for example, improving and promoting people's use of digital channels, reducing the number of long term placements to the lowest nationally and investing Public Health resources in Prevention schemes to ensure we can divert or delay demand.

Social Care Measures of Success will be:

- Reduction in admissions to long term care
- Reductions in delayed transfers of care
- Reductions in safeguarding concerns in community settings
- Reductions in referrals for formal services
- Take up of prevention and early intervention services
- Reductions in emergency admissions to dementia services

Timely Discharge from Hospital

North Yorkshire performs well on delayed transfers of care and we aim to improve this even further with a prudent target for further reduction. Therefore we will remodel our processes to develop 'transfer to assess' where possible ensuring that assessments for long term services take place at home or in a community setting. Our goal is to reduce occupied bed days and reduce the numbers of people being placed directly into care from hospital as well as create a better environment for patients and families to make choices. This will be supported by the improvements in reablement and intermediate care and multi-disciplinary teams.

In support of this, we are also keen in 2014 to explore opportunities to build upon the work done by District, Borough and County Councils with communities with regard to housing options and linking it with equipment services and minor adaptions, the Disabled Facilities Grant, home improvement agencies and voluntary sector organisations.

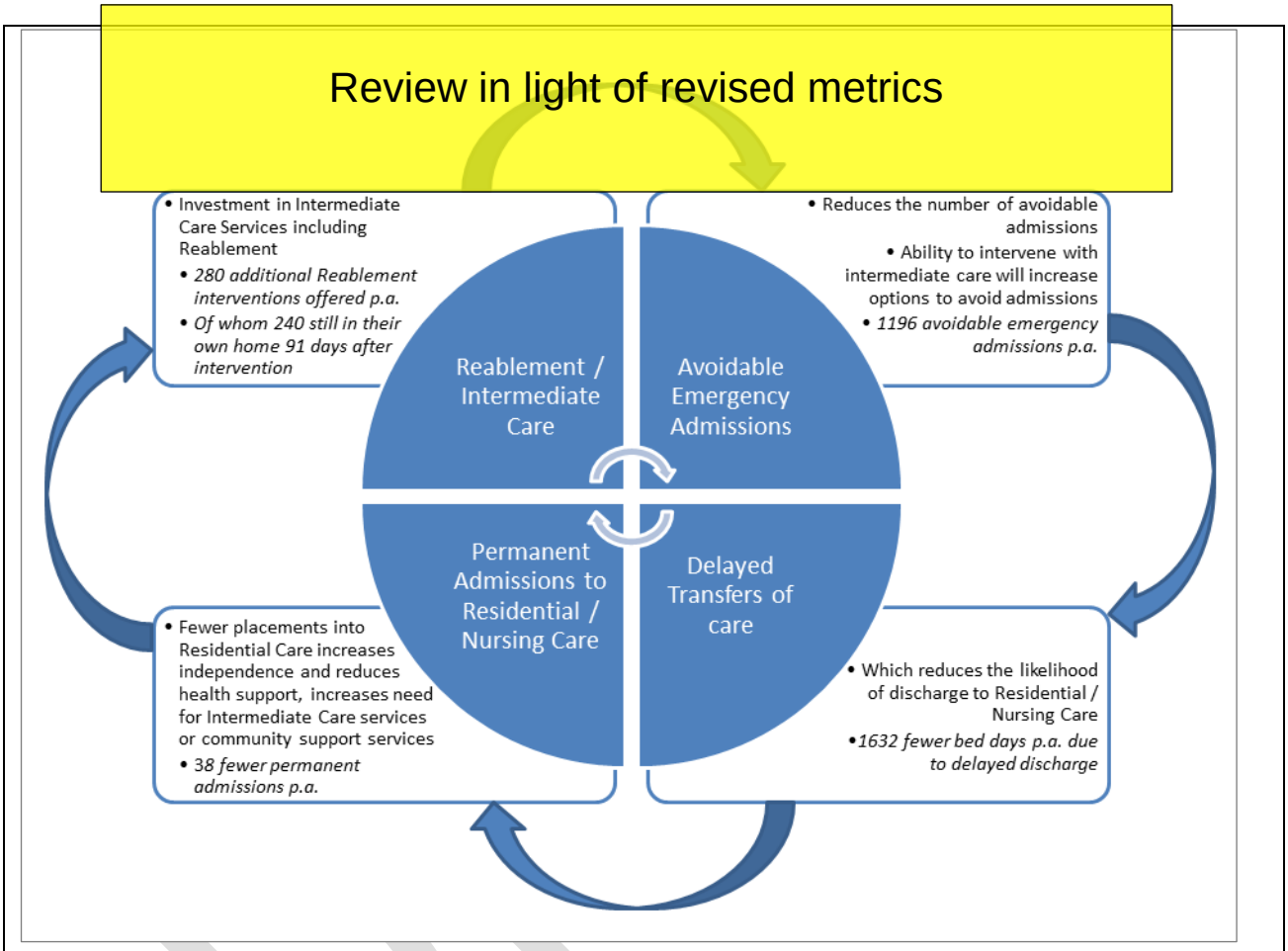
High Impact Interventions / Long Term Conditions

The CCGs and County Council have reviewed the priorities at local level and this has led to decisions to invest in some interventions which fill local gaps. These include Mental Health In reach (RAID), Dementia, Support to Care Homes and falls. The ICB has agreed to review falls across North Yorkshire in the first quarter of 2014-15 and invest accordingly to fill gaps. North Yorkshire's strategy to focus on prevention and early intervention for health, wellbeing and care ("Looking Ahead") and North Yorkshire's proposal for the Better Care Fund identify reducing the incidence of falls, and the harm caused by falls, as a key priority. The need for a comprehensive falls pathway was also identified in the 2012 Joint Strategic Needs Assessment.

Good falls services exist in North Yorkshire, however they are not consistent across the North Yorkshire geography and they are not fully integrated with prevention, health and social care services. We see reducing falls and preventing secondary falls as key markers of our progress as a health and social care economy to integrate, and manage need and demand. Therefore we are prioritising joint work to create a comprehensive, pan-North Yorkshire pathway to prevent, identify and manage falls based on NICE guidance.

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 above diagram shows how we intend to see money and activity move across the system.

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 modelled 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. Partners are clear that this can no longer be parochially determined
- A commissioning approach will be required and providers are clear that they will be presented with a smaller cash "envelope" with which to deliver services.

Providers will take the responsibility to deliver services that meet the required specification and are clear that they 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

The fund for both 2014/15 and 2015/16 currently identify c£9m of unallocated funds against the total pool; this is deliberate and allows us to:

a) Invest further in schemes that demonstrate positive results from the first phase;
b) Hold funds in reserve to cover the performance element of the fund in case of underperformance
c) Invest to tackle seasonal pressures
d) Invest in other initiatives or schemes, such as the expected need to bolster falls prevention and carer support services

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, 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 within their local community.

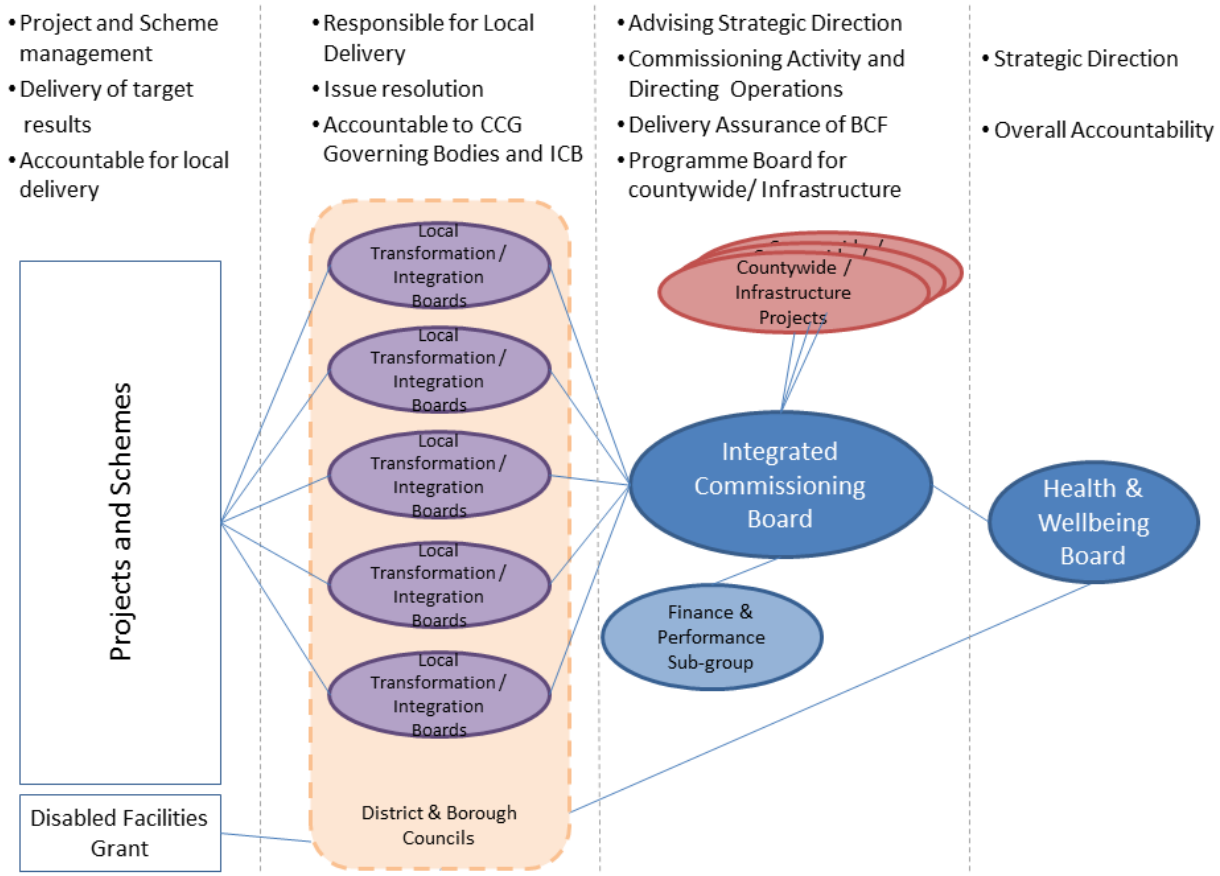
4.5. Governance

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

Health and Wellbeing Board (HWB) sets, and is accountable for the strategic direction and the delivery of the BCF ambitions. HWB is member led and vice-chaired by a CCG Chief Officer, with representation from the County Council, each of the CCGs, Public Health, Districts, Healthwatch, NHS England and the Voluntary Sector.

Leadership of the BCF will be overseen by the Integrated Commissioning Board (ICB), underpinned by a network of local transformation / transformation boards. The Health and Wellbeing Board includes representation from all CCGs, County and District Councils, mental health and acute trusts, Health Watch and the Voluntary Sector. The

HWB sets, and is accountable for the strategic direction of services in North Yorkshire and for assurance that all parties are working together to deliver agreed strategies.
Leadership of the BCF will be overseen by the Integrated Commissioning Board (ICB), underpinned by a network of local transformation/integration boards.
The ICB is a HWB sub-group with representation from the Chief Officer level of CCGs, North Yorkshire County Council Health and Adult Services and Children's Services, and the Director of Public Health. The ICB also includes representation from the main NHS Trusts and the City of York Council is also an active participant. The diagram shows how these groups relate to each other.



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 has agreed that a review of the governance and its role will take in 2014/15 to ensure it is fit for purpose and provides the most effective means to manage the delivery of BCF.

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, whenever possible, in people's own homes.

This protection of social care is against a backdrop of an ambitious transformation programme being undertaken by the County Council. The social care budget is already profiled to reduce by £21.5m from its 2013/14 level of c£138m having reduced by £27m in the four years to 2015.

North Yorkshire County Council has recently consulted on eligibility and as a result moved the criteria from Moderate to Critical and Substantial, in line with the expectations of the Care Bill.

The nationally recognised growth in demand for Social Care is exacerbated in North Yorkshire by its size (c2m acres) and rurality with a limited number of large towns high (only 3 with a population >15,000). Therefore, services are expensive to deliver, commercial providers are unable to attract sufficient staffing and efficiencies to make provision attractive / economic and so the County faces high delivery costs.

Therefore our priorities in protecting Adult Social Services are to recognise the severe pressure the department is under and to provide sufficient funding to support the transformation programme which aims to reduce and delay demand, focus on prevention, self-help and independence and maintain current good performance on delayed transfers of care and customer satisfaction. The funds will be used to ensure that Social Services can respond to existing and new service users in the context of a known increase in older people and younger adults with very complex needs.

The Council has an ambitious programme known as '2020 North Yorkshire'. This involves corporate activity to strengthen local community resilience, invest in a digital and telephone Customer Resolution Service, support self-help and increase the Council's ability to generate income via commercial solutions.

The Health and Adult Services Transformation Programme includes:

- Reducing demand, investing in prevention and diverting people to self-help and community solutions;
- Promoting independence by improving reablement, integration with the NHS, extending the use of Assistive Technology and improving equipment services;
- Developing a wider range of Accommodation and Care and building on our flagship programme of Extra Care to support more groups of customers to live independently;
- Developing a distinctive NY Public Health agenda and in particular linking this to the rural nature of the County and the challenges of reducing social isolation and loneliness, affordable warmth and the challenges posed by garrisons and coastal communities;
- Fit for Purpose: developing our current and future capacity to develop the market, developing our own and the independent sector workforce and prepare for greater public service integration.

The NYCC programme requires us to substantially change the way people receive information and advice and the ways in which they manage their own health and well-being. This will require substantial numbers of people to have their route through the social care system changed – for example, improving and promoting people's use of digital channels, reducing the number of long term placements to the lowest nationally and investing Public Health resources in Prevention schemes to ensure we can divert or delay demand.

The BCF will also support the Council to implement new duties while will arise from 2015 as a result of the Care Bill. We anticipate a significant challenge in North Yorkshire in creating the capacity to offer assessments to the current and future self-funding population, as well as meeting the requirements with regard to Carers and advice and information.

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

We will include clear risk-share and gain-share agreements as part of our Section 75 agreements and close management of outcomes to ensure that the transformation of social care services is effective and contributes to the wider system.

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

In the context of the Better Care Fund our priorities for protecting Social Care Services are:

- Investing in prevention and in innovative approaches which in turn reduce or delay long term dependence on health and social care services
- Enabling investment in Prevention services
- Funding the costs implementing the Care Bill

- Maintaining essential social care services
- Maintaining and where possible increasing investment in support to Carers
- Maintaining investment in Reablement Services so that they can be integrated with NHS Intermediate Care to create a stronger and more comprehensive service
- Maintaining investment in skilled care management capacity to ensure that Social Services can play a full role in local multi-disciplinary teams with Primary and Community Care
- Maintaining capacity to reduce delayed transfers of care and to arrange alternatives to hospital care
- Delivering robust safeguarding functions to safeguard vulnerable adults

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

North Yorkshire already has some 7 day services in place but these are not consistent and a priority will be for all areas to have a consistent level of service, even if the local models differ.

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

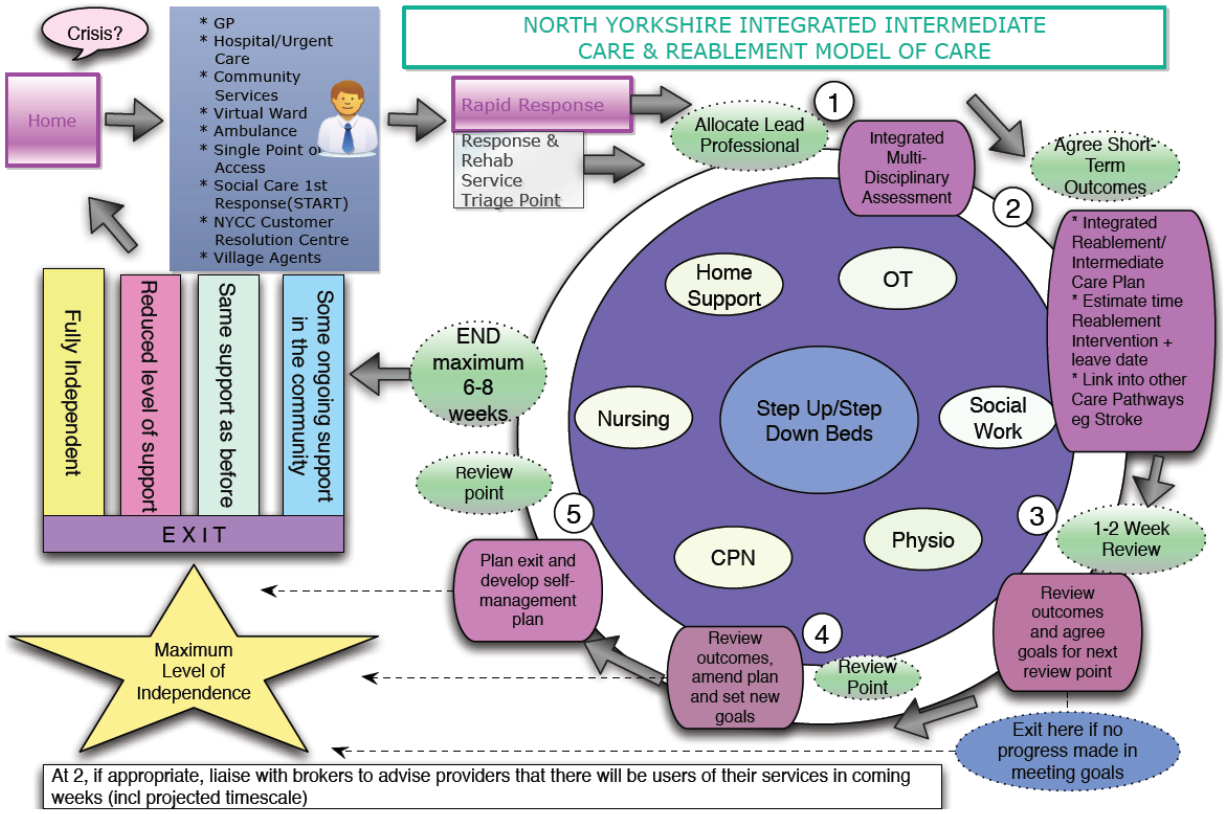
The Integrated Commissioning Board has identified the need for a short term project to map provision and support each area to undertake a gap analysis, along with capacity and demand profiling. This will enable each CCG along with Social Care to identify how the existing resources can be better coordinated as well as how new investment should be targeted. This will be undertaken in the first quarter of 2014-15 to allow for service improvements during the year. This work will also feed into the work underway with all CCGs to re-commission Community Health Services.

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

We anticipate that by aligning resources we will create additional capacity with hospital-based home care managers and social care workers available to arrange discharges 7 days per week. We aim to model the introduction of 7 day ward rounds during 2014-15 to

ensure that such an intervention would be cost effective and clinically safe.

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



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.

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 (Liquid logic) 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.

We plan to use the NHS 'bulk tracing' service 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.

ICB have agreed that NYCC will lead a project that brings together the above ADASS work and the local requirements and funds have been made available from the 14/15 fund. Detailed work will get underway in April, with a series of workshop sessions, which will produce a clear plan by the end of May 2014.

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 of care.

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.

Caldicott Guardians are in place across the system.

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.

Over the last two years there have been a number of models of Multi-Disciplinary Team (MDT) piloted in different CCG areas. This learning is now being incorporated into the

BCF plans and we aim to have integrated multi-disciplinary teams delivering predictive and proactive care to our most vulnerable people across all GP groupings by the end of 2014-15. These will include Health, Social Care, Mental Health and in some cases Voluntary Sector members.

Clinicians and professionals will be aligned in one service which will enable joint assessment to be coordinated via an accountable lead professional. The planning and delivery of care and support will be implemented by an integrated care plan which will proactively plan the self-management and care of high risk patients.

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. They will also ensure that the plan is jointly develop with the patient and carer.

All partners 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 in the first instance). The IM&T strand of our work will help address the challenges on data sharing, consent and inter-agency referral protocols in line with national guidance e.g. GMC, NHSE.

Currently at-risk patients are identified via multi-disciplinary team meetings, at which lead professionals are allocated. Joint plans are developed with patients and carers in their homes. Our plan is to extend the number of teams in a planned manner so that the entire County is covered by MDTs for the most complex high risk patients.

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 this 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. Currently the GP is rarely the named care coordinator. With the 2014/15 GMS Contract change, this will change and we will ensure that all patients with a certain risk level are assigned to an accountable GP who will ensure they are receiving coordinated care. This will be supported by members of the multi-disciplinary team.

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 a degree of clinical judgement. We have the benefit of a range of emerging models of Joint Assessment and Accountable Lead Professionals across the County and during 2014-15 will ensure that we learn from and adopt the most effective approaches.

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
Avoidable Admissions do not reduce in line with expectations Delayed Transfers do not reduce in line with expectations Admissions to care homes do not reduce in line with expectations	HIGH impact HIGH likelihood	• 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 • Clear procedures and training • Monitoring of process effectiveness • On-going leadership from the ICB
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.	MEDIUM impact MEDIUM likelihood	• 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.	HIGH impact MEDIUM likelihood	• Escalation through ICB and NYHWB if required.
Agreed system changes between partners are not realised	HIGH impact MEDIUM likelihood	• 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	HIGH impact MEDIUM likelihood	• Monitoring and reporting processes in place with reporting to ICB and NYHWB • Co-design with health and social care professionals
Regulations yet to be published for Care Bill will divert or change the current plans	HIGH impact MEDIUM likelihood	• Close monitoring of regulations as they emerge and embed in the service redesign and changes
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	MEDIUM impact MEDIUM likelihood	• Fundamentally, the requirement and rationale for integration is not at risk; specific changes can be managed by the partnership
Plans may not deliver financial savings necessary to make them sustainable	HIGH impact HIGH likelihood	• Each element of our planning has an identified exit strategy, should it be necessary to decommission them
Public may not welcome all changes to	MEDIUM	• There has been early patient and

system.	impact LOW likelihood	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.	MEDIUM impact MEDIUM likelihood	• Local Transformation Groups will continue to monitor delivery, as will Integrated Care Board, and changes can be made as required
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.	MEDIUM impact MEDIUM likelihood	• A proper contracting function is established, clearly directed by the ICB, and whose responsiveness and performance is monitored by the ICB

7. METRICS

As required, this plan sets out a series of metrics in the associated spread-sheet. The targets detailed reflect a cautionary stance based on our strong belief that there is significant work to be done before it can perform to the changes and transformation can properly begin to add the value expected. The following section provides a commentary on how we have chosen the figures and why we expect them to be somewhat lower than expected by external assessment.

We set out in section 4.4 the links between the Reablement and Intermediate Care capacity and the delivery of 'Delayed Transfers' and 'Avoidable Admissions' both to acute and residential care settings. While we have operated a reablement service for some time in North Yorkshire, we are planning a review and redesign of a new model. To assume that results will be demonstrable in the timeframe these metrics deal with would be highly inappropriate.

Clearly we would expect wherever possible to exceed targets if at all possible, but we believe that setting unachievable targets gives no benefit.

Metrics		Baseline*	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	475.5
	Numerator	675		656
	Denominator	129802		137952
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services *NB. The metric can be entered either as a % or as a figure e.g. 75% (0.75) or 75.0*	*Metric Value*	85.90	N/A	85.90
	Numerator	395		455
	Denominator	460		530
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	201.1	200.0	191.3
	Numerator	978	978	940
	Denominator	486594	489037	491458
		(June 2013 - Nov 2013) 6	Apr - Dec 2014 (9 months)	Jan - Jun 2015 (6 months)
Avoidable emergency admissions (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	156.9	154.5	170.1
	Numerator	950	940	1039
	Denominator	605503	608092	610702
		(April - September 2013) 6	Apr - Sep 2014 (6 months)	Oct 2014 - Mar 2015 (6 months)
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*		*(State time period and select no. of months)* 1	N/A	*(State time period and select no. of months)* 1
Local measure *Injuries due to falls in people aged 65 and over (crude rate per 100,000) Source: PHOF LBOI 2.24i*	*Metric Value*	1641.7	1638.6	1604.9
	Numerator	2041	1099	1107
	Denominator	124321	134139	137952
		Apr 2011 - Mar 2012 12	*Apr - Sep 2014* 6	*Oct 2014 - Mar 2015* 6

This improvement reflects a total of 19 (3%) avoided admissions, but is set against a rising demographic profile. The implied improvement against that profile is 61 avoided (9%).

This improvement reflects a total of 280 additional reablement interventions in the year (+15%), with 241 remaining in their home. This is somewhat ambitious given our high performance in this region and there is likely to be a small drop in the proportion due to the likelihood of taking on increasingly complex cases.

Work in progress – to be circulated before HWB

This improvement reflects a total of 836 (7%) avoided delays per year and is set against a rising trend. The implied improvement against that trend is 1,275 avoided (10%). This again needs to be considered in light of a relatively high current performance.

This improvement reflects a total of 196 (2%) avoided admissions per year and is set against a rising trend. The implied improvement against that trend is 926 avoided (7%). It must also be taken into account that the second period is taken using winter data and comparing it to summer performance is inconsistent.

This metric is rather unhelpfully based on annual data that needs to be artificially split to aid half year assessment, but does show an improvement of 165 (8%) avoided injuries due to falls. This set against a steeply rising trend. The implied improvement against that trend is an overall increase despite the above of 59 (3%). As described in the plan, we are reviewing our falls prevention provision with an aim to ensure that this service will address this growing problem.

This diagram plots our current high level plan for Intermediate Care and Reablement service redesign against the timeline for the metrics.

The pink panels depict the assessment periods defined by the guidance for our metrics; the blue panels show our programme plan for implementation.

Although for later years, we would expect the new model to deliver substantially against these targets, it is clear that it will be almost impossible for this programme to deliver against the metrics in this phase.

The diagram illustrates the contention between viable progress against the BCF required ambition and the need for properly organised, planned and delivered transformational change in a complex system.