Health and Wellbeing Board
North Yorkshire

27 November 2015

Better Care Fund evaluation

1.0 Purpose of the report

1.1 This paper seeks to provide assurance to the North Yorkshire Health and Wellbeing Board (NYHWB) regarding the monitoring arrangements for the Better Care Fund (BCF).

2.0 Background

2.1 The NYHWB received a paper covering the first two quarters of the BCF reporting periods up to 30 June 2015. At that time the Board was asked to:

- Note that the level of performance against the Non Elective Admission target (NEA) was below plan at a North Yorkshire (NY) level
- Receive a report on the progress evaluating BCF schemes from local Transformation Boards in November 2015, including implications for 2016/17 planning

2.2 This report seeks to deliver this commitment within the context of the national reporting structures. This is supported by the BCF arrangements across the NYHWB footprint and at local Transformation Board level which, collectively, provide a framework for implementation of the BCF plan and evaluating progress on delivery.

3.0 National reporting

3.1 The BCF programme is routinely monitored at a national level through quarterly reports based on a HWB footprint. To date there have been two quarters of data submitted (May and August) with the third quarter due to be returned on 27 November 2015. Each submission has been a stocktake of progress to date against a set of questions supported by a free text narrative. More elements have been added to the template each quarter and the latest requirements comprise:

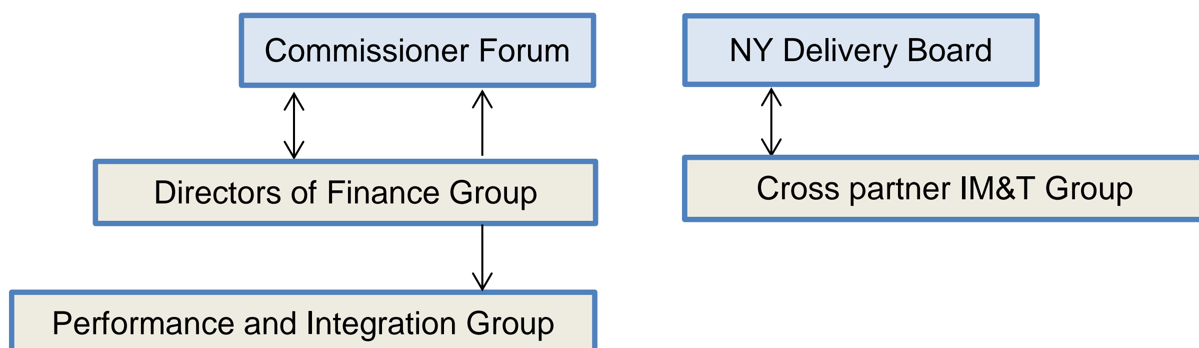
- Progress against the national conditions
- Budget arrangements
- Progress against NEA target and associated performance fund payment
- Income and expenditure against the plan
- Local metrics – additional integration metrics have now been added
- Preparations for BCF 16/17

3.2 To date, the emphasis nationally has been on delivery against the NEA target. As previously reported, there are some CCGs in NY that are achieving reductions in their individual NEA plan but this progress has not delivered at a NYHWB level. The overall performance at a NY level shows a slight improvement at 2.8% increase in non-elective admissions compared to 3% at the last reporting period (end June). The annual target for NYHWB is an 8.2% reduction which, given performance year to date, is unlikely to be achieved over the remaining 15/16 quarters.

3.3 As we move through 15/16 there has been a slight shift in focus nationally towards understanding the effect of transformation projects on the wider system. This reflects the fact that initiatives that have been invested in via BCF have been running for some time. Understanding the impact of any investment is necessary for a number of reasons: improving services for those receiving them; sharing learning across health and care systems; maximising resources and informing future commissioning plans.

4.0 NYHWB arrangements and activities

4.1 In line with the single NY BCF plan, all elements of the BCF national requirements are co-ordinated across the NY HWB footprint. This includes a range of forums which bring CCGs and NYCC together as part of the HWB substructures as follows:



4.2 As we move towards 16/17 the existing strong relationships across the health and care system will be critical in ensuring good communication flows between partners. The existing forums provide this platform for open discussions which has allowed partners to:

- Prepare and review the national quarterly submissions
- Support development of data sharing frameworks
- Establish co-location working between partner organisations
- Share learning between organisations
- Consider the developing integration agenda/potential new metrics
- Begin developing plans at transformation board level, and collectively, in readiness for 16/17

5.0 Local Transformation Boards: Progress Evaluating BCF

5.1 The following contributions have been developed by local Transformation Boards. They confirm that evaluation of schemes is underway, that different approaches have been taken and that evaluation will continue to be an iterative process to develop a fuller understanding of scheme impact and in particular the correlation with reducing NEAs. The outcomes of these reviews will inform planning for 2016/17 for which guidance is expected in December 2015.

5.2 Vale of York (VoY)

5.2.1 The key VoY schemes that sit within the boundary of North Yorkshire are the Selby Integrated Care Hub, a proportion of the Urgent Care Practitioner Scheme and a proportion of the Hospice at Home Scheme. The functions of the Mental Health Street Triage scheme have now been mainstreamed into the new mental health contract with Tees, Esk and Wear Valley Foundation Trust. All of the schemes have been monitored and demonstrate an impact on NEAs and emergency department attendances, albeit not at the scale planned.

5.2.2 Pressures elsewhere in the system often mask the impact of the specific schemes and a piece of work is being undertaken to address this. The quality impact of the schemes cannot be understated, particularly the impact of Hospice at Home, and the CCG are committed to continue to fund the schemes in North Yorkshire as long as the financial position allows it. The CCG continue to work closely with providers to develop more mature risk/share and risk/reward models and this approach is currently being tested with a draft funding model for the Selby Hub for the remainder of 15/16 and beyond

5.3 Scarborough & Ryedale (SR)

5.3.1 There has been investment in a number of schemes, some of which are local and some of which are pan North Yorkshire or partnership schemes across other CCG areas.

5.3.2 Local schemes include the Ryedale Community Response Team (Malton Hub), Hospice at Home/Care Home Link Nurse Scheme and a number of CCG funded posts supporting the North Yorkshire County Council Living Well programme. In addition Scarborough & Ryedale CCG (SRCCG) are contributing to wider schemes, in particular Improving Access to Psychological Therapies (IAPT) and Acute Hospital Psychiatric Liaison Service.

5.3.3 Schemes generally are not demonstrating the targeted reduction in NEAs, with a rise in NEAs across the CCG area. However, the overall rise is not as high as the non-mitigated rise predicted for this year. It has proved difficult to link the outputs of the schemes directly to effect on NEA rates due to the multifactorial nature of NEA variation. Work is also on-going to ensure that NEA recording is accurate.

5.3.4 Whilst the lack of effect against NEAs is disappointing, the wider impact (including qualitative) of the schemes should not be underestimated. The IAPT scheme, for example is showing such a significant improvement in access and recovery rates that local GPs are now referring at an un-precedented rate, which is in itself impacting on the scheme. All of the schemes are able to demonstrate quality improvements, and further work is needed to understand the value of this “quality premium”.

5.3.5 SRCCG carried out a formal evaluation of the schemes in September 2015, but it was deemed too early to make decisions about continued investment at that stage. There will be further evaluation of the schemes in January 2016 to inform decisions on continued funding and potential commissioning decisions for the 2016/17 BCF.

5.4 Harrogate and Rural District (HaRD)

5.4.1 The HaRD schemes have in the main been implemented since April 2014, with the exception of the FAST response into Care Homes which has recently been reviewed and commissioned through a different approach. The summary below provides an update on the schemes:

- Care Home initiative - in reach team including FAST and supported by existing Community Geriatrician, increased Community Mental Health Care Home Liaison, GP practices linked to Care Homes. The FAST response team were linked to 4 Care Homes and this has now been expanded to all Care Homes and guidance communicated to GPs to be able to refer. Emergency admissions from Care Homes in 15/16 shows a similar number compared to 14/15. A significant change has been the number of deaths in hospital following an emergency admission from a Care Home showing lower numbers compared to previous two years.

- Mental Health Liaison Service is provided in Harrogate District Foundation Trust over 7 days from 8am to 8pm. In 15/16 emergency admissions for people with a mental health diagnosis has reduced compared to Q1 14/15.

- Community Stroke Team provides MDT specialist stroke rehabilitation supporting patients prior to discharge. A review has shown the average length of stay for stroke patients as 20.8 days, for those patients receiving community support the average is reduced to 15.9 days. Additional FAST response team is to focus on improvement or maintaining patient's independence and enable them to remain in their own home. The additional capacity has provided assessments for an additional 45 new patients per month. Supporting approximately 15 additional patients each month to remain at home and assumed a saving of 75 bed days per month.

- Voluntary Sector Schemes – 5 schemes have been commissioned that support carers, social prescribing, support at Home and Volunteers. All of the schemes are going through a formal evaluation through the SRG group and will continue to be reported.

5.4.2 The evaluation of the schemes in October 2015 evidenced full assurance for quality and impact of the schemes. The providers were each asked to provide additional evidence to provide assurance on the success factors including reduction in avoidable admissions and financial evaluation. Scheme evaluation will be completed on a quarterly basis to monitor delivery of services and evidence of investment. The reports will be presented at SRG and subsequently at Harrogate Health Transformation Board to consider future investment and continuation of schemes.

5.5 Airedale, Wharfedale & Craven (AWC)

5.5.1 There are currently 4 BCF commissioned schemes being delivered in the Craven area of North Yorkshire County Council. These schemes include:

- Assisted Technologies Service - Installation of telemedicine into 12 nursing and residential homes across Craven to provide 24/7 clinical support to residents and carers. Installation of 65 iPads into 65 patients' homes across Craven with COPD, Heart Failure and any other complex needs assessed on a case by case basis i.e. end of life, complex comorbidities.

- Care Home Quality Improvement Support Service - The service provides a dedicated support and liaison service to facilitate quality improvement in care delivered across the care homes in Craven.

- Specialist Community Nursing Service - Expansion of existing specialist community services in Craven to support people with long term conditions through comprehensive assessment and care planning.

- Craven Collaborative Care Team Enhancement - Further enhancement of the existing Craven Collaborative Care team to provide a multidisciplinary, multiagency intermediate care services with the aim of preventing avoidable admissions to hospital and long term care. Funding provided to enhance the capacity and capability within the team by 1 WTE Social Care Assessor, 1 WTE Physiotherapist, 1 WTE Advanced Nurse Practitioner (ANP), 0.5 WTE Mental Health Nurse and 4 WTE Community nurses, plus 0.4 WTE link Carers' Resource worker to ensure that the health and social care needs of patients are met in a timely manner.

5.5.2 As well as using data from the AWC Transformation and Integration Group (TIG) dashboard to assess impact across the system in Craven, a local Craven dash board has been developed, covering the 5 Craven practices participating in the 'Better Care Fund' schemes. It details various pertinent activities that would be expected to change as a measure of success of the various schemes. The report shows data for the previous 12 months prior to commencement of any pilots, and in order to make comparisons, data for the following 12 months after pilot start date. Regular monthly monitoring of these measures is taking place.

5.5.3 A separate (qualitative) evaluation framework is being agreed with providers and expected to be completed by mid-December.

5.6 Hambleton, Richmondshire and Whitby (HRW)

5.6.1 The HRW BCF evaluation completed in October 2015 provided assurance that all of the schemes partially meet their evaluation criteria specified through the North Yorkshire submission.

5.6.2 Whilst each individual's schemes impact on NEL Admissions cannot be evidenced directly through quantitative data it can be assumed to be a positive impact and effect on the current position at -3% (September 2015 source MAR). The impact at our main provider is even more significant with a current position of -6% on all emergency admissions and -10% ages 18-64. A recent rise in paediatric activity across the locality is offsetting some of the impacts on adults and older people.

5.6.3 All schemes are delivering increased activity levels and qualitative service improvements strengthening the localities service resilience and the Fit 4 the Future Transformation Programme. Provider feedback includes; improved GP and Partner relations, improved services for Patients and Carers and a real and ongoing commitment to continued service improvement.

5.6.4 All schemes are now fully operational. Mental Health schemes are meeting service targets, Discharge Facilitators are established as change agents to improve discharge processes and a GP Hospitalist model has been implemented and identified as a best practice as part of the Friarage wider transformation proposals. The successes include; reductions in Emergency Admissions with Mental Health Diagnosis, -23% reduction in emergency admissions due to falls, 24 hour support for palliative patients and reduced overnight admissions.

5.6.5 Schemes identified as enabling schemes without specific saving targets are also monitored against their outputs and our service resilience, impacts include a Model of Dementia provision now outlined to inform future commissioning intentions and a District Nursing Service at full capacity and fully engaged in the CCG's Primary Care Workforce transformation project.

5.6.6 The evaluation includes the significant risks of any service reduction at this point of full service delivery and investment and recommends no significant changes to schemes or existing funding arrangements. Scheme evaluation will remain on-going with a detailed evaluation exercise being completed every quarter to continually monitor delivery of services and prototype developments to justify the investment as a positive contribution and influence to the wider integration agenda.

6.0 Conclusion

6.1 Further work needs to be done to understand the implications of the BCF schemes (see Appendix 1 for summary of all new schemes) in all localities. Discussions with health and care colleagues have identified the need to develop mechanisms that will provide regular review of schemes, both in terms of quality and financial benefits.

6.2 The national move towards measuring impact of the BCF through new integration metrics is helpful in supporting the current direction of travel of NYHWB and the Joint Health and Wellbeing Strategy.

6.3 Partners have created an environment from which to build further transformation at local level which will become increasingly important as resources continue to be stretched.

7.0 Required from the Board:

7.1 The Board is asked to note and accept the details set out in the paper as part of the assurance framework across the HWB health and care system.

Wendy Balmain
Assistant Director of Integration
19 November 2015

Appendix A: New schemes identified in the BCF submission in 2014 by CCG

CCG	Scheme	Amount
AWC	Craven Assistive Technology – Telemedicine	156,000
	Quality Improvement Support	105,000
	Craven Specialist Community Nursing (Intermediate Care)	200,000
	Craven Collaborative Care Team	413,000
	Elms 2	1,556
	Dementia navigator	6,085
	Craven equipment	22,464
	Harrogate ICES (Equipment Store)	33,626
	Equipment	135,000
	Community Services ACCT	6,500
	Young carers	3,414
	Carers resource/support schemes	1,611
	Carers resource	11,051
	Carers scheme children	123,000
	Crossroads	15,693
	Tissue viability service	52,000
	Primary enhanced care	255,000
	A & E liaison	46,000
	Palliative care nursing	56,000
	Phys therapies	30,000
HRW	Psychiatric Liaison Scheme	473,000
	Dementia Strategy	80,000
	Integrated START, Fast Response and Int Care	1,145,800
	Extended Whitby overnight nursing service	188,000
	Hospital case management	127,700
	H&R district nursing capacity	352,900
	Risk profiling and long term conditions	101,600
	Community Focused acute care	137,600
	Lifestyle Referral	50,000
	Community Navigators	0
	IAPT	205,000
	Carer Sitting Service	22,000
	Clinicial Skills Educator	0
	Telemedicine	115,000
	BCF support	73,400
	Dementia Navigator	16,648
	Equipment	275,178
	Falls	130,000
	Generic Workers	84,870
	Community support assistants	22,755
	Transport	20,997
	Advocacy - County contract	20,525
	Whitby cart	80,000
	St Johns shopping service	15,000
	Heriot Hospice Homecare support	25,856
	Young Carers	9,340
	Carers Resource/Support Scheme	5,449
	Carers Suppport Scheme/Resource	44,991
	Carers Resource	9,421
	Sitting Service	3,346
	End of Life Benefits Advisor HRW	39,106
	Fast Resonse	726,000
	Wheelchair services - hdft	309,384
	Heart Failure Nursing Support	68,267
	Respiratory Nursing Support	111,874
	Specialist Continence / & Nursing S	292,334
HaRD	Psychiatric Liaison Service	426,000
	Voluntary Sector Projects	200,000
	Clinical Assessment Team and Intermediate Care	1,895,000
	Care Home Support	251,000
	Dementia Navigator	19,033
	Equipment	389,848
	Transport	24,003
	Advocacy - County Contract from 11-12	23,464
	Cardiac re-ablement in community	69,042
	Recovery team str workers 1.5	36,973
	Recovery team admin	8,090
	Community Support Assistant	24,674
	Mental Health Crisis	13,551
	REACT	8,493
	Staion View rehabilitation	21,154
	Carers resource/support scheme	64,697
	Woodfield EMI respte	36,998
	Acorn Centre - Day care	11,195
	Claro - Day care	9,271
	Crossroads	17,981
	Fast Resonse	1,214,559
	Wheelchair services - hdft	372,533
	Heart Failure Nursing Support	85,515
	Respiratory Nursing Support	52,879
	Specialist Continence / & Nursing Support	336,047
S&R	Malton Care Hub	1,000,000
	Health Trainers	135,000
	Psychiatric Liaison	400,000
	Community Mental Health (IAPT)	300,000
	Smoking Cessation	100,000
	Nutrition in Care Homes	40,000
	Care Home Link Nurse (Linked to S&R_008_VS for delivery)	168,000
	Palliative Care Pathway	92,000
	Dementia Navigator	14,027
	- Intermediate Care	89,900
	Transport	17,690
	Advocacy - County contract from 11-12	17,292
	101 Prospect Mt Road - Rehab unit - Deputy Off	29,371
	101 Prospect Mt Road - Rehab unit - Care Assistant Hours	35,849
	Continence	221,708
	Early Supported Discharge	283,350
	Young Carers	7,869
	Carers Resource/Support scheme	33,827
	Carers Support Scheme / Resource	7,097
	Carers Resource	35,045
	Care watch	62,290
	Tissue Viability Services	51,685
	Fast Resonse	768,237
	Wheelchair services - hdft	414,236
	Heart Failure	101,527
VoY	St Leonard's Hospice at Home	170,000
	Selby Care Hub	550,000
	Street Triage service	125,000
	Urgent Care Practitioners	300,000
	Psychaitric Liaison	0
	Dementia Navigator	9,991
	Harrogate ICES (Equipment Store)	211,200
	Falls	149,343
	- Intermediate Care	13,540
	Generic Workers	5,130
	Community Support Assistants - Support Time/Recovery Worker	1,375
	Voyage - New Selby Sitting Scheme Feb 2012	28,552
	Transport	12,600
	Advocacy - County Contract from 11-12	12,316
	Young Carers	5,604
	Carers Resource/Support scheme	5,915
	Carers Support Scheme / Resource	4,868
	Carers Resource	2,719
	Carers Support Service	14,820
	Community rehabilitation	600,013
	Intermediate Care	325,000
	Tissue Viability Services	94,742
	Fast Resonse	593,982
	Wheelchair services - hdft	263,602
	Heart Failure Nursing Support	81,078
	Respiratory Nursing Support	27,022
	Specialist Cardiac Rehabilitation	83,374
	Specialist Continence / & Nursing Support	411,213