# North Yorkshire Delivery Board Workshop 14th April 2016 – Notes

## Present

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| Wendy Balmain | Assistant Director, Integration, NYCC |
| Peter Banks | General Practitioner, Harrogate and Rural District CCG |
| Neil Bartram | Technology and Change Business Partner, NYCC |
| Jane Baxter | Head of Commissioning, Harrogate and Rural District CCG |
| Alex Bird | Chief Executive Officer, Age UK, North Yorkshire |
| Kathy Clark | Assistant Director, Health and Adult Services, NYCC |
| Professor Paul Corrigan | Consultant – Better Care Support |
| Dilani Gamble | Chief Finance Officer, Harrogate and Rural District CCG |
| Paul Howatson, | Senior Innovation and Improvement Manager, Vale of York CCG |
| Shaun Jones | Head of Assurance & Delivery NHS England – North (Yorkshire & The Humber) |
| Colin Martin | Chief Executive (Designate), Tees, Esk and Wear Valleys NHS Foundation Trust |
| John McGhee | Consultant – Better Care Support |
| Richard Mellor | Chief Finance Officer, Scarborough and Ryedale CCG |
| Debbie Newton | Chief Finance Officer, Hambleton, Richmondshire and Whitby CCG |
| Sue Pitkethly | Chief Operating Officer, Airedale, Wharfedale and Craven CCG |
| Steve Reed | Head of out of Hospital Strategy, York Hospital NHS Foundation Trust |
| Lincoln Sargeant | Director of Public Health, NYCC |
| Wendy Scott | Director of Out of Hospital Care, York Hospitals NHS Foundation Trust |
| Ros Tolcher | Chief Executive, Harrogate & District NHS Foundation Trust |
| Gemma Umpleby | Service Improvement Manager, Hambleton, Richmondshire and Whitby CCG |
| Ingrid Walker | Operations Director, Friarage Hospital, South Tees NHS Foundation Trust |
| Richard Webb | Corporate Director of Health and Adult Services, NYCC |
| Bruce Willoughby | General Practitioner, Harrogate and Rural District CCG |
| Keren Wilson | Chief Executive, Independent Care Group |

## Introduction

Richard Webb welcomed people and outlined the background and context to set the scene.

The meeting took the form of a workshop facilitated by Professor Paul Corrigan and John McGhee. Paul Corrigan is assigned to North Yorkshire through a national NHSE contract following a successful bid from the Health and Wellbeing Board for support to develop the 2016/17 Plan. The focus of the support is to examine what has made a difference in 2015/16, how this is reflected in the 206/17 Plan and how we accelerate system change to support integration and new models of care.

Paul and John had previously completed a desktop review of the Better Care Fund and undertaken a series of telephone calls with commissioners. A first report from this review was shared with Delivery Board members and informed the debate.

**Session 1: The Impact of BCF Schemes**

Each CCG and the County Council outlined the impact of one or more BCF schemes in their area as follows:-.

Hambleton, Richmondshire and Whitby - Gemma Dickinson, Service Improvement Manager and Debbie Newton, Chief Finance Officer

- We were already keen to work in partnership, but the projects have accelerated this process. We wanted an element of individuality for the projects.
- It is difficult to know what had worked and what had not, as the CCG talks about its strategic plan rather than individual BCF schemes. So success was difficult to pinpoint.
- The majority of the investment had been in additional capacity – district nurses, intermediate care, etc. This has allowed us to work differently but, again, this makes evaluation difficult. However, two evaluations had demonstrated an impact on elective admissions, so it can be assumed there has been an impact. The Integrated Night Service has been a positive step. Some schemes, such as the Frail Elderly Clinics, had seen low activity. We asked ourselves: Why aren't there many referrals? We needed to take stock and change the pathway quickly.
- The "Hot" Clinics will become key and change the way we work.

Scarborough and Ryedale CCG – Richard Mellor, Chief Finance Officer

- The scheme aimed to reach as many people as we could. After the original metrics were devised, the focus of schemes was changed to Non-Elective Admissions (NEA) but the metrics remained as originally devised. So when we look at the impact, it is difficult to gauge, as some of the measures had not been intended for that purpose.
- We focussed on two or three "biggies".
- The Malton Care Hub was designed to take people out of acute setting quickly and avoid admission to hospital.
- There has been a significant non-elective growth in general, so can we say the scheme had an impact? And did we focus on the right place?
- We are looking to make changes. We will change the geography of the scheme area, or seek the same aims with different schemes.
- Most schemes have gone well, but it is the NEA that drives finances.

Harrogate and Rural District CCG – Jane Baxter, Head of Commissioning

- We operated a number of schemes. I am just focusing on one today – namely Care Homes linking with GPs to reduce NEA from care homes.
- The evaluations have been very positive. The scheme has been well received. The feedback from care homes had been excellent; they feel more informed and involved
- GPs have reported an increase in place of death at care homes.
- Care homes have significantly reduced the number of calls made to 111, which had previously been their default. They now tend to ring the GP. The GP can manage the patient immediately, due to access to medication at the care home.
- The outcome has been a reduction in NEAs.

- Bruce Willoughby gave further detail about the scheme. The overarching aim is to reduce/stop inappropriate admissions. An audit had found that two-thirds of people in hospital could have their needs met in a lesser acute setting. The new care model is attempting to solve this problem with four main aims

  1. Preventing problems by linking with the voluntary sector - social prescribing; self-care, etc.
  2. Integrated community teams as one team. The team's raison d'etre is: What can we do to solve this issue?
  3. A better more responsive service e.g. increasing overnight capacity and an increase in the number of commissioned beds releasing GP resources so that there is more time to help prevent acute care
  4. Developing the infrastructure to facilitate the above

- There have been good stories about the improved way of working. For instance, a mental health nurse undertakes joint visits with a district nurse so that a person's capacity under the Mental Health Act can be assessed i.e. there is no need for a GP to make the determination.
- Another example was with podiatry where, previously, referral would have had to be via a person's GP. The new care model enabled direct referral.
- There is a planned rollout to other localities in June.

Airedale, Wharefedale and Craven CCG - Sue Pitkethly, Chief Operating Officer

- We don't talk about "schemes" as this can result in silos. The projects are part of a wider transformation programme.
- An aim is to change language and staff perceptions.
- BCF projects are enablers to keep people in their own home – e.g. telemedicine.
- Goldline has also been a big success in helping people nearing the end of their life to stay at home.
- We aim for lots of small gains, culminating in a big win.
- There has been a 39% reduction in NEA from care homes.
- There has been an improved service. For instance, a GP will do a round with a team manager two times a week. So staff at the care homes are less inclined to ring the GP Practice, as they know a GP will be visiting soon.
- Education is key. Raising awareness about the symptoms of constipation had led to a dramatic reduction in the number of 999 calls being made from the care homes.
- A partnership between Craven Collaborative Care Team, the Voluntary Sector and the Carers Resource to keep people out of hospital is in place.
- A pyramid of care has been created. The Complex Care Model manages the top 3% to 5% of people at risk of NEA pro-actively to keep them at home with a care support "navigator" or "buddy".
- It is not seen as a "referral" – more that people transition in and out. Self-care/prevention is the golden thread
- The next level is enhanced primary care, where a pilot psychological social model is used. An outstanding example of the benefits of this is a psychologist had a discussion with a patient who had been admitted many times. She gleaned that the patient liked horse riding. The patient was helped to get a job at stables and has not accessed services for seven months.

Vale of York CCG - Paul Howatson, Senior Innovation and Improvement Manager

- Key links are with primary care. We have three local authorities to work with.
- We need to do things differently and partnership working is key.
- Maybe we have been too ambitious and, possibly, our modelling could have been better.
- The Selby Care Hub model involves local intelligence working together. There are still systems that don't talk to each other.
- Urgent Care Practitioners has been the most successful project aimed at managing conditions closer to patients homes. This project allowed local decisions to be made.
- For the scheme Enhancing Hospice Care at Home, quality was key. It is more than just "numbers" – allowing people to die at home is crucial. However, if people leave hospital they may not be aware of Hospice at Home, so things need to be joined up. The scheme had evaluated well.

NYCC – Richard Webb, Corporate Director, Health and Adult Services

- In terms of background, most organisations and many individuals in the local health economy were relatively new. There had been fractious relationships in the past.
- We had a good urban model but needed a good rural model.
- Some BCF projects funded care services that most people take for granted, such as Specialist Community Nurses.
- The County Council, comparatively, had had a lower level of funding than its health partners.
- BCF had provided some level of protection for social care.
- In 2015/2016 there had been 57,200 contacts into adult social care. Many of these had been funnelled into prevention; or directed towards benefits maximisation to help people retain their independence.
- There had been an increase in referrals from community care. Better data is required to understand why this is the case.
- Case mix is changing in that, whilst more contacts are being diverted initially, cases are becoming more complex (particularly around mental health).
- The lack of nursing staff has resulted in a reduction in nursing beds.
- The County Council is putting more funding into attracting care staff but faces continual challenges. For instance, when Aldi open a store they are direct competitors to the Council as existing and/or prospective care workers are likely to be attracted to Aldi, who pay higher salaries.
- £39 million social care funding directly supports a health benefit – particularly Secondary Care.
- More people are coming into the START Service.
- There is a good rate of discharge without a care package.
- Half of the people in North Yorkshire receiving care are self-funders.
- The "Cheshire West" case has had significant implications on Deprivation of Liberty Safeguards Assessments with a major increase in the number of people requiring an assessment.
- Performance on Delayed Transfers of Care (DToC) was one of the best among shire counties and mid-table nationally. A priority would be to maintain DToC despite a reduction in funding.
- On the issues that matter to the NHS, the County Council had done well. Performance holds up because of the money from BCF to protect services.
- Social Care is changing the way it operates. Use of the customer centre enables more rapid progression of care plans where people have routine care needs.

- There has been significant investment in prevention and self-management. For example, twenty Living Well Co-ordinators work with people on the cusp of care.
- A reduction in funding of 33% made it inevitable that things had to be done very differently.
- We need to rediscover our passion for Primary Care and to give that area equal support.
- The evidence points to integration being positive, but this doesn't show in savings.

At the end of each presentation there was the opportunity for questions and comments.

**Session 2: What can be done to ensure any reductions in demand in Non Elective Admissions can be turned into realisable savings?**

The following points were made by delegates:-

- Not admitting people to hospital does not necessarily lead to savings.
- Transformation can help but the removal of the 18 week requirement between referral and treatment would have a bigger impact.
- Questions such as whether to invest more in community care and reduce expenditure in acute care, challenge long-established ways of providing services. It was observed that a radical shift was needed.
- The Vanguard programme had led to an analysis of the tasks and competencies required across all professional groups, highlighting opportunities to reduce duplication and ensure tasks are delivered at the appropriate level.
- The health economy does not utilise the voluntary sector as much as it could. The sector has a range of expertise and can lever in other funding to support change.

**Session 3: Feeedback on the draft Plan and Groupwork**

Wendy Balmain updated delegates on the feedback received from NHS England on the first draft submission of the 2016/17 BCF Plan. These included:-

- It was recognised that the plan was still being developed.
- There needed to be clearer alignment between the Five Year Forward Plan and roadmap to achieving full integration by 2020.
- Links to other operational and service plans also needed to be clarified and the impact on people who use services described.

At this stage, delegates split into groups to consider the following questions:-

**Does the BCF plan (when aligned with other system plans) deliver sufficient change to create a sustainable health and social care system?**
In summary, feedback was that:

- BCF delivers part of what we are doing
- It has enabled some key initiatives with several notable successes
- It is assisting with service provision

**If not what more should we be doing to achieve this?**
In summary, feedback was that:

- More work was required to address funding flows
- There needed to be better/more robust monitoring and evaluation
- The plan needs to be more streamlined
- Some North Yorkshire-wide ambitions should be included
- Need a statement to monitor and act on performance metrics in addition to avoidable non-electives on a North Yorkshire basis
- Inter-dependencies need to be mapped, together with their impact
- Better data and information sharing was required
- Waiting lists – a robust front door policy required for primary care (The County Council for example has a customer resolution centre to filter/screen) so that statutory services become the last resort
- Expand use of Living Well Co-ordinators
- Make greater use of links with the Voluntary Sector
- "Push back" on NHS Constitution and waiting lists - permission to make local judgements
- Partners need to stand together collectively in conveying difficult messages

**Session 4 Summing up/Next Steps**

Paul Corrigan summed up as follows:-

- The language used was important – it is not about stopping services, more about managing demand.
- The mechanism for spreading what works across the county is key – for example, to persuade GPs in one area to follow a model developed elsewhere, as they will see it as being in their interests to do so.

Wendy Balmain outlined what she was hearing from delegates as the way forward:-

- Input will be required from transformation boards to ensure the timescales for delivery of the 2016/17 plan can be met.
- A further look needed to be taken at each narrative section. It needs to be articulated in a way that connects to the thinking around each area's Sustainability and Transformation Plan and Plan for Integration.
- Transformation Boards need to ensure they have robust measurements in place to evaluate and measure progress.
- Financial flows and spread of good practice are significant issues.

At the conclusion of the group work, Richard Webb thanked Paul Corrigan and John McGhee for facilitating the workshop. He asked colleagues to continue to give thought as to how good practice can be shared and spread across North Yorkshire.