North Yorkshire Health and Wellbeing Board

Better Care Fund Narrative Plan

2016/2017

Submitted May 2016

Contents

1. Plan Details
1.1 Summary of the 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 and Ryedale Clinical Commissioning Group
	Vale of York Clinical Commissioning Group
Date Agreed By HWB	6th May 2016 (funding gap outstanding)
Date Submitted	6th May 2016
Minimum required value of pooled budget 16/17	£42,704,278
Current commitments in 16/17 plan	£47,343,653

1.2 Summary narrative

Throughout this plan the North Yorkshire HWB recognises that there are shared challenges across the health and care system, for example workforce, technology and accelerating the spread of new models of care where a pan North Yorkshire approach is required to achieve economies of scale.

The plan also recognises the importance of place and that North Yorkshire is made up of many different communities; urban, rural, and coastal, where local Transformation Boards have an important role commissioning services that meet the needs of their diverse communities**.**

In recognition of the central importance of place in transforming health and social care services this plan is arranged by locality where appropriate.

1.3 Summary of current funding contributions by organisation

Organisation	2015/16	2016/17
Airedale, Wharfedale and Craven Clinical Commissioning Group	£2,914,000	£3,079,134
Hambleton, Richmondshire and Whitby Clinical Commissioning Group	£9,152,000	£9,120,658
Harrogate and Rural District Clinical Commissioning Group	£9,557,000	£9,415,585
Scarborough and Ryedale Clinical Commissioning Group	£7,538,000	£7,467,696
Vale of York Clinical Commissioning Group	£6,932,000	£7,174,673
Cumbria Clinical Commissioning Group	£319,000	£408,532
Sub Total	**£36,412,000**	**£36,666,278***
North Yorkshire County Council	£5,000,000	£2,500,000
Care Act	£1,932,000	£0
Sub Total	**£6,932,000**	**£2,500,000**
Social Care Capital Grant	£1,350,000	£0
Craven District Council	£238,818	£433,307
Hambleton District Council	£219,821	£375,828
Harrogate Borough Council	£329,012	£571,343
Richmondshire District Council	£118,889	£212,493
Ryedale District Council	£244,559	£452,569
Scarborough District Council	£685,399	£1,115,100
Selby District Council	£196,151	£346,958
Sub Total	**£3,383,000**	**£3,538,000 (rounded)**
Total	**£46,727,000**	**£42,704,278**

*The 2015/16 BCF plan was initially approved by the Health and Wellbeing Board in April 2014 and included £17m protection for social care, excluding Care Act funding. Following further guidance a revised plan was resubmitted in November 2014, subsequently approved by NHSE in January 2015. This continued to include a negotiated £17m for the protection of social care and comprised a £12m payment from CCGs and a one off payment of £5m by the County Council. The Care Act obligation in 2015/16 was funded through joint monies with an expectation that future costs would be met by CCGs. An agreement is in place to reduce the Council's contribution over a three year period by which time the CCGs would make the full contribution of 17m.

The '2016/17 Better Care Fund Policy Framework' issued by the Department of Health and the Department for Communities and Local Government in January 2016

sets out a detailed definition of all national conditions. 'Maintaining the provision of social care services' is one of the national conditions which states:-

> 'In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social care and health system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process.'
>
> (DH/DCLG 2016)

The 2016/17 draft plan sees the level of funding for maintaining social care identified through the CCG allocations as £11.3m incorporating funding for the Care Act. This represents a funding gap of circa £4.6m in the 2016/17 plan. This represents a significant risk to the stability of the North Yorkshire social care system and is contrary to the policy framework.

1.4 2016/17 Plans

Table 1 below is a plan summary showing the 2016/17 BCF total spend on schemes in each area of spend

Table 2 below shows the 2016/17 full BCF spending for plan by area of spend and locality

Table 1 2016/17 BCF total spend on schemes in each area of spend

Area of Spend	**£ 2016/17**
Acute	£2,635,640
Community Health	£19,263,142
Mental Health	£1,293,217
Primary Care	£731,488
Social Care	£19,213,887
Other	£4,206,279
Total	**£47,343,653**

Table 2 2016/17 full BCF spending for plan by area of spend and locality

Area of Spend	Scheme Name	Locality	Additional Description	2016/17 Expenditure (£)
Acute	Craven Assistive Technology – Telemedicine	Airedale, Wharfedale & Craven		£80,000
	Craven Stroke Rehab	Airedale, Wharfedale & Craven		£108,000
	Clinical Assessment Team	Harrogate & Rural District		£2,000,000
	Hospital Case Managers	Hambleton, Richmondshire & Whitby		£132,640
	IV Antibiotics	Hambleton, Richmondshire & Whitby		£15,000
	Urgent Care Practitioners	Vale of York		£300,000
				£2,635,640
Community Health	Carers resource	Airedale, Wharfedale & Craven		£49,809
	Community Services ACCT/CCT	Airedale, Wharfedale & Craven		£187,027
	Craven Collaborative Care Team	Airedale, Wharfedale & Craven		£309,022
	Craven Specialist Community Nursing (Intermediate Care)	Airedale, Wharfedale & Craven		£202,000
	Harrogate ICES (Equipment Store)	Airedale, Wharfedale & Craven		£33,964
	Palliative care nursing	Airedale, Wharfedale & Craven		£56,993
	Quality Improvement Support	Airedale, Wharfedale & Craven		£105,000
	TCS	Airedale, Wharfedale & Craven		£435,050
	Tissue viability service	Airedale, Wharfedale & Craven		£82,362
	Voluntary Sector - Support/Development	Airedale, Wharfedale & Craven		£17,442
	Community Services	Cumbria		£295,000
	Community Equipment	Harrogate & Rural District		£389,848
	New Care Models (Vanguard)	Harrogate & Rural District		£2,996,812
	Carer Sitting Service	Hambleton, Richmondshire & Whitby		£16,000

	Community Case Managers	Hambleton, Richmondshire & Whitby		£105,700
	Community Services	Hambleton, Richmondshire & Whitby		£1,407,000
	District Nursing	Hambleton, Richmondshire & Whitby		£365,810
	Extended Whitby Overnight Nursing Service	Hambleton, Richmondshire & Whitby		£194,820
	Frail Elderly Clinics	Hambleton, Richmondshire & Whitby		£20,000
	Integrated Night Service	Hambleton, Richmondshire & Whitby		£188,000
	Integrated Night Service	Hambleton, Richmondshire & Whitby		£177,200
	Integrated Team: Intermediate Care, Fast Response and Therapy	Hambleton, Richmondshire & Whitby		£1,203,571
	Lifestyle Referral Services	Hambleton, Richmondshire & Whitby		£21,530
	Performance Fund	Hambleton, Richmondshire & Whitby		£716,000
	Reablement and Carers	Hambleton, Richmondshire & Whitby		£1,099,000
	Social Care Coordinator	Hambleton, Richmondshire & Whitby		£25,000
	Step Up/Step Down Pilot in Dales and Sowerby House	Hambleton, Richmondshire & Whitby		£70,429
	101 Prospect Mt Road - Rehab unit - Care Assistant Hours	Scarborough & Ryedale		£41,384
	101 Prospect Mt Road - Rehab unit - Deputy Off	Scarborough & Ryedale		£31,844
	Advocacy (county contract from 11/12)	Scarborough & Ryedale		£17,475
	Community out of hospital services	Scarborough & Ryedale		£220,500
	Community Response Team - Ryedale	Scarborough & Ryedale		£1,128,840
	Continence	Scarborough & Ryedale		£279,986

	Dementia navigator	Scarborough & Ryedale		£16,726
	Early supported discharge	Scarborough & Ryedale		£323,288
	End of life care team (palliative care and care home link nurse)	Scarborough & Ryedale		£623,021
	Fast Response	Scarborough & Ryedale		£840,514
	Heart failure	Scarborough & Ryedale		£92,747
	Intermediate care	Scarborough & Ryedale		£22,713
	Support to veterans	Scarborough & Ryedale		£10,000
	Tissue viability service	Scarborough & Ryedale		£52,213
	Transport	Scarborough & Ryedale		£17,877
	Wheelchair services	Scarborough & Ryedale		£418,626
	Intermediate Care	Vale of York		£13,540
	Advocacy - County Contract from 11-12	Vale of York		£12,316
	Carers Resource	Vale of York		£2,719
	Carers Resource/Support scheme	Vale of York		£5,915
	Carers Support Scheme / Resource	Vale of York		£4,868
	Carers Support Service	Vale of York		£14,820
	Community rehabilitation	Vale of York		£600,013
	Community Support Assistants - Support Time/Recovery Worker	Vale of York		£1,375
	Dementia Navigator	Vale of York		£9,991
	Falls	Vale of York		£149,343
	Fast Response	Vale of York		£593,982
	Generic Workers	Vale of York		£5,130
	Harrogate ICES (Equipment Store)	Vale of York		£211,200
	Heart Failure Nursing Support	Vale of York		£81,078
	Intermediate Care	Vale of York		£325,000
	Respiratory Nursing Support	Vale of York		£27,022
	Selby Care Hub	Vale of York		£1,222,000
	Specialist Cardiac Rehabilitation	Vale of York		£83,374

	Specialist Continence / & Nursing Support	Vale of York		£411,213
	St Leonard's Hospice at Home	Vale of York		£175,000
	Tissue Viability Services	Vale of York		£94,742
	Transport	Vale of York		£12,600
	Voyage - New Selby Sitting Scheme Feb 2012	Vale of York		£28,552
	Wheelchair services	Vale of York		£263,602
	Young Carers	Vale of York		£5,604
				£19,263,142
Mental Health	A & E liaison	Airedale, Wharfedale & Craven		£42,861
	Care Home Support (TEWV)	Harrogate & Rural District		£37,000
	Psychiatric Liaison Service	Harrogate & Rural District		£426,000
	Acute hospital psychiatric liaison	Scarborough & Ryedale		£337,356
	IAPT (community mental health)	Scarborough & Ryedale		£300,000
	Street Triage service	Vale of York		£150,000
				£1,293,217
Primary Care	Primary enhanced care	Airedale, Wharfedale & Craven		£234,488
	Care Home Support (Primary Care)	Harrogate & Rural District		£71,000
	Primary Care Nursing Workforce	Hambleton, Richmondshire & Whitby		£426,000
				£731,488
Social Care	Advocacy - County Contract from 11-12	Harrogate & Rural District		£23,464
	Cardiac re-ablement in community	Harrogate & Rural District		£69,042
	Community Support Assistant	Harrogate & Rural District		£24,674
	Dementia Navigator	Harrogate & Rural District		£19,033
	Mental Health Crisis	Harrogate & Rural District		£13,551
	REACT	Harrogate & Rural District		£8,493

	Recovery team admin	Harrogate & Rural District		£8,090
	Recovery team workers 1.5	Harrogate & Rural District		£36,973
	Station View rehabilitation	Harrogate & Rural District		£21,154
	Transport	Harrogate & Rural District		£24,003
	Maintaining Social Care	North Yorkshire County Council		£17,000,000
	Maintaining Social Care - Care Act	North Yorkshire County Council		£1,394,000
	Care Watch	Scarborough & Ryedale		£65,687
	Carers resource	Scarborough & Ryedale		£35,415
	Carers resource/support scheme	Scarborough & Ryedale		£34,186
	Carers support scheme/resource	Scarborough & Ryedale		£7,171
	Living Well Co-ordinators	Scarborough & Ryedale		£67,000
	Other community/social schemes	Scarborough & Ryedale		£354,000
	Young carers	Scarborough & Ryedale		£7,951
				£19,213,887
Others	Care Bill	Airedale, Wharfedale & Craven	S256	£154,000
	Craven equipment	Airedale, Wharfedale & Craven	S256	£22,464
	Crossroads	Airedale, Wharfedale & Craven	S256	£15,693
	Dementia navigator	Airedale, Wharfedale & Craven	S256	£7,545
	Young carers	Airedale, Wharfedale & Craven	S256	£3,414
	Acorn Centre - Day care	Harrogate & Rural District	Voluntary Sector	£11,195
	Carers resource/support scheme	Harrogate & Rural District	Voluntary Sector	£64,697
	Claro - Day care	Harrogate & Rural District	Voluntary Sector	£9,271
	Crossroads	Harrogate & Rural District	Voluntary Sector	£17,981

	Voluntary Sector Projects (Age UK Knaresborough)	Harrogate & Rural District	Voluntary Sector	£25,000
	Voluntary Sector Projects (Age UK NY)	Harrogate & Rural District	Voluntary Sector	£6,135
	Voluntary Sector Projects (British Red Cross)	Harrogate & Rural District	Voluntary Sector	£49,429
	Voluntary Sector Projects (Carers Resource)	Harrogate & Rural District	Voluntary Sector	£43,205
	Voluntary Sector Projects (St Michaels)	Harrogate & Rural District	Voluntary Sector	£28,952
	Woodfield EMI respite	Harrogate & Rural District	Voluntary Sector	£36,998
	Project Management	Hambleton, Richmondshire & Whitby	Staffing	£80,300
	Disabled Facilities Grant	North Yorkshire County Council	Grants to individuals.	£3,538,000
	Falls Coordinator	North Yorkshire County Council	Prevention	£42,000
	Smoking cessation	Scarborough & Ryedale	Health promotion	£50,000
				£4,206,279

1.5 Authorisation and signoff

This plan was agreed by the HWB on [date] by delegated authority granted [date].

Signed on behalf of the Clinical Commissioning Group	Airedale, Wharfedale and Craven Clinical Commissioning Group
By	
Position	
Date	[date]

Signed on behalf of the Clinical Commissioning Group	Hambleton, Richmondshire and Whitby Clinical Commissioning Group
By	Janet Probert
Position	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	Helen Hirst
Position	Interim Accountable Officer
Date	[date]

Signed on behalf of the Council	North Yorkshire County Council
By	Richard Flinton
Position	Chief Executive
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]

1.6 Related documents

The Better Care Fund 2015/16 'A New Era for Health and Social Care in North Yorkshire'
NHS CCG Operational Plans 2016/17 x 6
Sustainability and Transformation Plans x 3
North Yorkshire Joint Health and Wellbeing Strategy 2015-2020
North Yorkshire 2012 JSNA Report
North Yorkshire JSNA Annual Update 2014/15
2020 North Yorkshire –County Council transformation programme
'Hope, Control and Choice' North Yorkshire Mental Health Strategy 2015-20

2. The local vision for health and social care services

2.1 Ambitions and outcomes for health and wellbeing in North Yorkshire

The agreed North Yorkshire ambition for health and wellbeing is:-

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

Delivery of the ambition is set out in the Joint Health and Wellbeing Strategy 2015-2020, setting the direction for change across North Yorkshire health and care system. The strategy is underpinned by five key strategic themes and four enablers:

Strategic Themes

- Connected Communities
- Start Well
- Live Well
- Age Well
- Dying Well

Enablers - Getting the whole system working better

- A new relationship with people who use services
- Workforce
- Technology
- Economic prosperity

The combination of themes and system enablers when linked to organisational commissioning plans will deliver our commitment to develop a sustainable health and care system for the future and is the starting point for a North Yorkshire roadmap towards further integration.

Approved by the Health and Wellbeing Board (HWB) in November 2015 the JHWS embodies the collective ambition of partners, feedback from local people the latest evidence from the JSNA and changes to national policy.

The BCF plan when combined with our JHWS, reinforces our commitment to improving the following outcomes for local people:

- Improved choice and control – patients will feel more involved in designing care services and being in control of care when they need it
- Improved experience of care – patients and service users will experience a more joined-up approach to care supported by sharing information and more integrated working between staff
- Improved safety of care – people should experience fewer incidences of poor quality care or adverse incidents through higher quality services and less hand-overs between different services
- Improved outcomes of care – people's health will be improved leading to, for example, fewer years of life lost due to conditions amenable to healthcare, fewer falls, and improved management of long term conditions

2.2 Delivering fully integrated health and social care by 2020

In North Yorkshire the health and social care landscape is complex and we know from experience that what works best is when we combine local knowledge and delivery with county-wide collaboration and scale. This is helping us to plan together for the next ten years and beyond.

Our immediate focus is to consolidate progress made so far and embed this in wider system planning for new models of care. This will accelerate spread of effective service planning and support delivery of the 'Five Year Forward View' according to our three overarching priorities for joint work stated in last year's plan:-

- **Prevention and community resilience**
  Public health/prevention
  Voluntary sector
- **Integrated locality services**
  Community/intermediate care/reablement/multi-disciplinary case management teams
- **High impact interventions**
  Mental health and dementia
  Care home support

Multiple organisations with multiple services, North Yorkshire's size and geography, when coupled with the presence of six CCG's and seven district councils, makes the journey towards integration more complex than the norm.

Recognising the complexity of the health and care system, partners remain committed to working together, and with the people of North Yorkshire to maximise opportunities for improved health and wellbeing outcomes across the County and build on the successes delivered through the BCF in 2015/16.

System leaders understand the unique mix of urban, rural and coastal communities and the importance of local Transformation Boards developing a new model of care that meets the needs of their local areas. This will support graduation from a BCF plan to an outline integration plan by 2017. Examples of success in this area include:-

- **Harrogate**: 'What Matters to Us', a new model of care encompassing community hubs and integrated care delivery, shared care plans, and a virtual information hub
- **Scarborough and Ryedale:** Delivery of the Ambition for Health programme focussing on Healthy lifestyles, care at home and sustainable services
- **Hambleton, Richmondshire and Whitby**: Fit 4 the Future, a new model of care in urgent care, intermediate care, diabetes services and rural community services
- **Airedale, Wharfedale and Craven**: Implementing New Models of Care as part of the National Integrated 'Pioneer Programme' including developing,

reconfiguring and expanding integrated community services. This compliments the Vanguard work in care homes.

- **Vale of York:** has established a System Leaders Board and a Transformation Executive Group which will further develop their plans for a new model of care and integration

North Yorkshire County Council's 2020 programme describes an ambitious transformation programme for adult social care, adapting to meet the challenges of the future and in response to the Care Act 2014. The change programme is focussed on four areas that will maintain provision of social care and support stability across the North Yorkshire health and care system:-

- Distinctive Public Health
- Independence with Support when I need it
- Care and Support where I live
- Better Value for money

These programmes are integral to the work of the local Transformation Boards developing integration plans for the future.

2.2 How the BCF contributes to local integration

The approach to implementation and integration in each locality is described more fully in the context of the BCF for 2016/17 in section 4.

This 2016/17 plan recognises local Transformation Boards are at different stages in delivering new services and developing their approach to integration. However all local boards, and the HWB, recognise that investment through BCF should support improved patient flow through the system to reduce inappropriate admissions to hospital and the need for longer term care, and importantly prevent and delay the need for any care.

3. An evidence base for supporting the case for change

3.1 Local narrative

As outlined above we have come a long way in 2015/16.

Effective system leadership is in place at County and local level as described in section four. This is key in providing clear direction to support the development of full integration plans by 2020. The JHWS states:

'**a new focus on ways in which local health and social care organisations can work together so that people's experience of care is more integrated.'**

The following principles, which underpin the North Yorkshire approach to developing local integration models have been adopted by all partners, against which they can be held to account by local people:

- Recognise where things are different
- Tackle issues early
- Join things up to make life simpler
- Empower local people to make a positive contribution
- Keep people safe
- Spend money wisely

The BCF has strengthened focus on integration, developed and accelerated our journey, and now provides the platform for further integration aligned to the development of sustainability and transformation plans and other organisational plans.

3.2 The evidence base

The evidence base for change remains consistent with our 2015/16 plan in that cost, demand and the expectations of people and communities set fundamental challenges for the sustainability of our health and care system in the future. We know that by 2020:

- Nearly 1/4 of residents will be over 65
- The number of people with dementia will have increased by more than 20%
- 1 in 4 will have a mental health issue

Our JSNA highlights the following key risks to health including:

- The gap in life expectancy both between localities, and within them: the greatest male life expectancy gap within a single North Yorkshire locality is in Scarborough (11 years) and the greatest female life expectancy gap is in Selby (7.4 years)
- The projected increase in the over 75 population, which is above the England average (15.0% for 75-84 year olds between 2015 and 2020 compared to 12.35 in England, and 19.8% for those aged over 85 compared to 17.8% in England)
- Higher than average levels of fuel poverty, especially in Craven, Richmondshire, Ryedale and Scarborough
- The continued prevalence of smoking at the time of delivery, with the rate of 22% at Scarborough Hospital a significant national and local outlier
- Significantly higher than average England estimated levels of adult excess weight, equating to around 400,000 adults who are either overweight or obese in North Yorkshire

Risk stratification has been widely used in developing new services as part of the 2015/16 BCF. Changes in the arrangements for commissioning support for Yorkshire & Humber CCGs mean that this function will transfer to a new provider for 2016/17. The potential loss of continuity in relation to the reporting and management of risk in the system creates a new risk to business continuity and this should be noted in relation to the delivery of this 2016/17 plan. This has been added to the risk log but

due to the nature of the transition process and the management resources being deployed across the region it is considered to be a low risk.

3.3 Progress in 2015/16

Throughout 2015/16 partners have been developing new services that are coordinated around the needs of people. The Health and Wellbeing Board have monitored progress of the BCF and a range of other programmes that support improved outcomes in health and social care. There has been one conversation about performance, what has worked well and what needs to change.

Local Transformation Boards have evaluated individual schemes funded through BCF in 2015/16 and this has contributed to the collective understanding of progress by HWB members. We recognise though that more needs to be done to better understand impact.

A desktop review through the national support offer will support this. The understanding of how the services developed in 2015/6 have improved patient flow will go some way in providing confidence that investment in 2016/17 is targeted at those schemes that are likely to have the greatest impact on reducing inappropriate admissions to hospital and long term care, in addition to stimulating wider system change.

A prevention framework is also being developed, which will form the basis for a North Yorkshire prevention strategy in 2016/17.

As in the rest of the country across North Yorkshire, performance reducing non-elective admissions has been varied. Transformation Boards have reported through their evaluations that it has proved difficult to link the outputs of BCF schemes directly to reductions in non-elective admissions.

The desktop review is expected to add further value in demonstrating which schemes have had the greatest impact and are likely to continue to do so in line with stated outcomes. The wider impact (including qualitative) of schemes should not be underestimated and further work is under way to clarify the value of this where schemes are able to demonstrate quality improvements. The BCF has seen greater investment in community services through 15/16 and these schemes may require further time to fully realise expected benefits.

In the case of the other national conditions i.e. reablement, delayed transfers of care and residential care admissions - North Yorkshire continues to perform above the average England level and whilst planned levels of improvement have not been achieved in 2015/16 progress continues to be made.

3.4 Achievement of key metrics in 2015/16

Table 3 below shows the forecast outturn for each of the high level metrics (including national conditions) in the 2015/16 plan.

Table 3 Target and forecast outturn for each of the high level metrics in the 2015/16 plan.

Metric Description	Target 2015/16	Forecast Outturn 2015/16	Comments
Non Elective Admissions (NEA) Reduction in the numbers of admissions to Hospitals for non-elective episodes	To reduce the overall numbers of NEA across the HWB area by **4908 NEA**	An increase in NEA across the HWB area of **1656 NEA**	6564 NEA above the anticipated target position
Residential Admissions Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	To reduce the use of residential and Nursing accommodation to **447.2 placements per 100,000 pop 65+**	The forecast outturn is **560 placements per 100,000 pop 65+**	This represents 158 placements above the anticipated target position.
Reablement Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	To increase the proportion of people at home 91 days after discharge to 85.5%	The forecast outturn is 88.7% of people now remain at home 91 days after discharge	3.2% more people remained at home following discharge
Delayed Transfers of Care (DToC) Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+) for both HAS and Social Care delayed days .	To reduce the numbers of DToC by 647 delayed days	1593 additional delayed days where recorded for North Yorkshire residents	2240 delayed days above the anticipated target position for Both NHS and Social Care delayed days
Falls Injuries due to falls in people aged 65 and over	To reduce the numbers of injuries attributed to falls by 152 during the year	The forecast outturn is a reduction of 124 injuries due to falls during the year was recorded	2137 people were recorded as been injured due to falls as opposed to the target of 2109 a difference of 28
Patient Experience Proportion of people with a long term condition who use their written care plan to manage their day-to-day health. (based on patient survey data)	To increase the proportion of people who have a LTC and use their written Care plan manage their condition to 72.5%	The forecast outturn is that 63.1 % of patients use their written Care plan manage their condition	

* As set out in BCF 16/17 submission data

3.5 Conclusions - Opportunities and challenges for improved quality, reduced costs and sustainability.

In 2015/6 some better care schemes have better managed the demand for hospital ED attendance and even more importantly have successfully diverted patients who would otherwise have spent time in in patent hospital beds. This is very good for the patients and very good for the use of resources for the health and social care economy. One of the aims of this management of demand is to create a more sustainable health economy. However given the nature of financial flows within this health and social care economy, it is not clear how the resources that are saved by the management of demand can be secured and invested in more demand management. There will need to be some agreement across national ALBs to secure a set of financial flows that will create a more sustainable system.

3.6 2015/16 Locality progress review

A review of progress made in each locality against the themes developed for 15/16 plan can be seen in **Table 4** below

Table 4 Review of Progress in 2015/16 by Locality

Locality	Review of progress in 2015/16
Airedale, Wharfedale and Craven	**Integrated locality services** • Integrated teams are embedded in localities • Intermediate care hub established, joint H&SC assessment • New phone service *Goldline* is helping people nearing the end of their life to stay at home • A partnership between Craven Collaborative Care Team, the Voluntary Sector and the Carers resource to keep people out of hospital in a holistic way by speedy proactive firm services. **Prevention and Community Resilience** • Prevention and Self Care programme of work underway includes training and implementation of tools and techniques to support self-care, self-management and support cultural change, mind-sets of individuals and professionals **High Impact Interventions** • National vanguard leader in enhanced health care in residential care homes has led to a 30%+reduction in non-emergency admissions from those homes , a GP will do a round with a Team manager two times a week reducing the demand or hospital services • Dementia Friendly organisation, dementia friendly communities, dementia care embedded in new models of care • 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". • Consistent approach to falls prevention within provider organisations and community including VCS, use of assessment tools and falls response services **Invest in Primary Care & Community Services** • Investment in a new model of pro-active primary care – enhanced care. Part of the National Pioneer Programme • Integrated community service across AW&C delivered by two FTs ensuring a consistent offer, extended core hours, supports 7 day services • First Response model for mental health services implemented resulting in no out of area placements in over a year • Specialist Community Nurses supporting individuals with heart failure, respiratory conditions and needing cardiac rehabilitation demonstrating improved outcomes for individuals, reduced emergency admissions & A&E **Create a Sustainable System** • Stakeholder dialogue to explore accountable care organisations commenced • Complex care model commissioned supporting alternative to long term care. Reduce the demand for non-elective admissions by using telemedicine in care homes – part of national Care Home Vanguard programme. Raising awareness about the symptoms of constipation had led to a dramatic reduction in the number of 999 calls being made.

Locality	Review of progress in 2015/16
Hambleton, Richmondshire and Whitby	**All schemes included in the 2015/16 plan are now fully operational.** . • We have increased service resilience through investment in services increasing the capacity of District Nursing, Integrated Care and Therapy. The District Nursing service is at full capacity and fully engaged in the CCG's Primary Care Workforce transformation project. • All schemes are now fully operational. Mental Health schemes are meeting service targets • Discharge Facilitators are established as change agents to improve discharge processes • A GP Hospitalist model has been implemented and identified as a best practice as part of the Friarage wider transformation proposal • A model of dementia provision is now outlined to inform future commissioning intentions • Frail elderly clinics are now providing multi agency assessments to patients identified at risk of frailty earlier in the pathway to reduce duplication of assessment, the risk of falls, hospital admissions - Lessons learned from delivery of frail elderly clinics in15/16 has informed future commissioning intentions and the development of a frailty pathway utilising early identification tool. **Creating a sustainable system** • For 2015-16 BCF directly funded commissioned out of hospital services that led a reduction in non-elective admissions and increased delivery of integrated services, for example the 7 day Integrated Night Service. • BCF funds deliver further service resilience through providing 24 hour support to vulnerable Patients, including 24 hour support for palliative patients. An outcome of this is reduced overnight admissions. This service is provided by a team of staff employed by both Social Care and Health providing joint visits to Patients in their own homes • Reductions in emergency admissions with Mental Health Diagnosis including patients diagnosed with Dementia and patients from care and residential homes • Reduced emergency admissions due to falls • Whilst the impact of each individual scheme on NEL Admissions cannot be evidenced directly through quantitative data it can be assumed to contribute positively to affect our current position at -4% overall and -7 % for over 65s (December 2015 source MAR) • The impact of non-electives with our main provider is even more significant with a current position of -7% on all emergency admissions • All schemes are delivering increased activity levels and qualitative service improvements strengthening the localities service resilience and the Fit 4 the Future Transformation Programme

Locality	Review of progress in 2015/16
Harrogate and Rural District	**Throughout 2015/16 the following schemes were fully implemented and are now operational.** • Psychiatric Liaison Scheme in place in the Emergency Department (ED) at Harrogate District Foundation Trust. The Mental Health team provides education and professional advice/ support in discharge planning in ED. The service also supports ward staff in care and management of patients with dementia and delirium • Mental Health support into Care Homes provides education and professional advice to Care Home staff in the care and management of residents (with dementia, delirium and depression) and supports residents prescribed with anti-psychotics • Community Stroke Team at Harrogate District Foundation Trust facilitates an earlier discharge of a cohort of stroke patients from the stroke unit with specialist stoke rehabilitation provided up to 12 weeks post discharge. The service involves patients and carers and offers lifestyle management advice and support • Additional FAST response at Harrogate District Foundation Trust provides short term support for patients (up to 6 weeks) preventing admissions and support after a hospital stay • GPs linked to Care Homes - includes all elderly Care Homes in Harrogate and Rural District and are linked to a single GP practice to provide routine and review visits. Over the last year there has been an improved professional relationship between Care Homes and GPs, better prescribing and monitoring of residents • Voluntary Sector schemes. Five schemes support patients and carers providing tailored support to enable individuals to remain at home and also provide advice and guidance **In addition there is a New Care model vanguard attempting to reduce demand for secondary health care with four main aims** • Preventing problems by linking with the voluntary Sector - social prescribing; and better self-management. • Integrated Community Teams as one Team. The Team's raison d'etre is: *What can we do to solve this issue?* • A better more responsive service e.g. increasing overnight capacity and an increase in the number of commissioned beds releasing GP resources so that more time to help prevent acute care • Developing the infrastructure to facilitate the above This has diminished the need for GPs to cover all the work of primary care. For example, 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. All of the Nurses will receive training in capacity. **Outcomes include**: • **Mental Health Schemes**: Reduction of Care Home residents on anti-psychotics

	Reduction of admissions to older persons' inpatient psychiatric ward Increased number of Care Home residents supported Reduction in delay in referral and being seen Increased knowledge of ward staff Service addresses mental health re-admissions Reduction in LOS • **Community Stroke Team**: Stroke service meets 80% stroke unit standard ensuring patients who are diagnosed with stroke spend 90% or more of IP stay on stroke unit No waiting list – once patient requires support this is available Average LOS for stroke patients is 20.8 days, for those patients receiving community stroke team average LOS is 15.9 days Recent survey of patients demonstrates satisfaction with service received • **Additional FAST response:** Providing capacity to assess an additional 45 new patients per month Support approximately 15 additional patients each month to remain at home Average LOS of 5 days estimated as saving 75 bed days per month • **GPs linked to 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 Last year there were 454 deaths of Care Home residents and only 81 (18%) of these were in hospital. 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. Positive feedback from GPs and Care Homes • **Voluntary Sector Schemes:** Seen increase in number of referrals from primary care Increased number of volunteers trained to support people with long term conditions and carers Patient and carer case studies provide evidence of impact
Locality	**Review of progress in 2015/16**
Scarborough and Ryedale	**All schemes included in the plan for 15/16 are fully operational albeit with some changes to scope for a small number of them:** • **Community Response Team Ryedale (Malton Hub):** During the year this scheme became more focussed on reducing non elective admissions. There have been

	approximately 600 referrals to the Community Response Team of which two thirds have been step up from GPs There has been a reduction in ED attendances for the patient cohort covered by the Community Response Team Non-elective admissions due to falls (for over 65's) showed no growth Readmissions within 28 days reduced by 0.5% Readmissions within 91 days reduced by 2.2% Although there was a growth in occupied bed days this was less than half that seen across the CCG as a whole. • **Mental Health In The Community (IAPT)**: There is no data on the impact of this scheme on NEAs Since commencing the scheme in Jan 15 there has been a dramatic and significant increase in GP referrals to service and the opinion of the service among referrers has improved. Although the year average against the Prevalence Target of 15% has been achieved (15.97%) the Recovery Target of 50% has not been (39.07%). The IAPT Intensive Support Team from NHSE have been invited to provide support. Patient satisfaction is High – 89% positive on the Friends and Family test • **Psychiatric Liaison** It has been very difficult to measure the effect on NEA/LOS – In order to better measure the effect a data sharing agreement between the service provider and the acute trust is being enabled. The service is now provided 7 days/week The service is reported positively by acute hospital staff, delivering education and advice to ward and ED staff. Patient satisfaction is high demonstrating 86% positive responses on the Friends and Family Test • **Palliative Care Pathway and Care Home Link Nurse Scheme (including Nutrition in Care Homes)**: These schemes listed separately on the original plan were combined for delivery as they were delivered by an integrated team. Over 500 referrals received to year end 91% patients dying in place of own choosing 65% of patients with a palliative care diagnosis other than cancer being cared for at home Over 200 education sessions and 4 Care Home Forums with a total of 104 attendees have been provided for Care Home staff since April 2015 • **Health Trainers/Self Help (Living Well Coordinators)** This service did not go live until quarter 2 of FY15/16 so it is too early to measure impacts. Rollout of the full service to Health providers and other partners is planned for Apr 16 • **Smoking Cessation in Hospital**: The original model proved challenging to implement so the scope of the scheme was changed to focus on reducing smoking at time of delivery for expectant mothers. The service went live in Jan 16. Early indications are positive with all clinics fully attended.

Locality	Review of progress in 2015/16
Vale of York	Vale of York works across 3 local authorities. The 2015/6 Better Care Service have been concentrated on three services • **Urgent Care Practitioners (UCPs).** The development of the UCP see and treat service with Yorkshire Ambulance Service has reduced the number of people in crisis taken to hospital Emergency Departments (ED) For the first 9 months of 15/16 just under a thousand people were not taken to hospital and using the accepted algorithm this would convert to over 250 emergency admission stopped. Taken together the savings from A & E attendance and NE admissions this managed demand would save just under £500,000 • **Hospice at Home (H@H).** This scheme, in partnership with St Leonards Hospice, funds additional out of hours support to provide palliative care to assist patients to die where they want to in their own homes. This also reduces ED attendances and hospital admissions for end of life patients. Since it went fully operational in January 2015, providing additional out of hours support from 6pm to 12 midnight, the team have supported 284 patients during this time period, some 49% of all overall H@H activity. It is recognised that this service has not always been operating at capacity due in some significant part to a lack of integrated working across the system. • **Selby Care Hub.** This scheme is based out of Selby Hospital and is delivered by York Hospital, in partnership with NYCC and GP practices covering a patient population of approximately 80,000. The hub delivers Care Home in reach services, home based intermediate care services through an integrated health and social care team and an Older Persons Clinic. This scheme operates primarily across the North Yorkshire County Council area. The Selby and District Community Response Team commenced operation in January 2015. To the 11 months to end of November 2015 the team had received 647 referrals, 381 being step up referrals from the community. In the hub Care Home in reach programme, some 240 residents were reviewed and approximately 260 medications are being stopped or reviewed.

4 A co-ordinated and integrated plan of action for delivering the change

4.1 Overview

Following evaluation, the majority of schemes implemented through the BCF in 2015/16 are being continued and/or extended in scope to achieve scale and sustainability. Some schemes which have not delivered the planned outcomes have been revised or withdrawn to allow for BCF funds to be deployed more effectively.

The contribution of the BCF in 2016/17 towards achieving the Five Year Forward View and the aim of full integration by 2020 is described in section 4.2 below.

In recognition of the central importance of place in transforming health and social care services, this North Yorkshire BCF Plan for 2016/17 is arranged by locality

Whilst plan details vary by locality there are some recognisable features for 2016/17 across the North Yorkshire footprint. Namely:-

- A recognition that BCF has acted as a key enabler for testing out new models of integrated care
- Building on the successes of the 2015/16 plan with a continued commitment to integration
- A commitment to addressing delayed transfers of care
- Greater investment in community based new models of care to further improve, health, independence, choice and control
- Robust governance and a commitment to improved performance management
- Robust alignment between BCF and CCG Operational plans with a commitment to future alignment with STP's and graduation from BCF

4.2 Goals, activity and delivery for 2016/17 by locality

4.2i Airedale, Wharfedale and Craven

Goals

Our Better Care Fund plan is an integral part and critical enabler of the objectives stated in our operational plan for 2016/17. With respect to changing patient/user service flows, we will continue to reduce reliance on emergency and urgent care through more planned and proactive service models in the community. Other initiatives that support us in these ambitions include our status as a national Integrated Care Pioneer and participant in the Airedale & Partners Vanguard.

We are conscious of the need to support implementation of 7 day services and are continuing to strengthen community services and infrastructure to deliver this. For instance, our investment in collaborative care has released capacity for our community teams to be more flexible and resilient in delivering 7 day working. Beyond BCF, we have a range of other initiatives in place to support 7 day services;

we have agreed delivery of the four high impact areas and mental health standard from the clinical standards for seven day services as the priority for 2016/17 with our local acute provider, and expanded access by commissioning primary care to work alongside A&E and strengthen joint working with the primary care out of hours services.

Activities for 2016/17

Following successful mobilisation and delivery of our BCF schemes in 2015/16, we will continue with and drive further improvement in these schemes, but our focus of our transformation work will shift to testing out further innovations in models of care in 2016/17.

BCF schemes that will continue in 2016/17 will include the development, reconfiguration and expansion of our integrated community services to incorporate enablement and rehabilitation services. These services already successfully deliver multidisciplinary fast response services to step-up patients with acute needs. We will develop further our quality improvement in care homes scheme, particularly focusing on strengthening training and education. Through the national Vanguard initiative, we will expand our telemedicine scheme to include health improvement in care homes. We will also continue to support new specialist nursing services targeting patients with long-term conditions in the community.

However, our focus for 2016/17 will be on developing and putting in place new models of care that are more pre-emptive and proactive, and delivering these on a larger scale than our current BCF work supports. For instance, we are in the process of implementing a new 'extensivist' clinical model, providing a more proactive service supported by the wraparound services, building on those developed in the BCF.

Our leadership has stated its strong commitment to delivering health and social care integration and its intention to develop a local Accountable Care Organisation. In 2016/17, we will continue to detail our roadmap to create an ACO alongside driving greater operational integration between health and social care.

Ensuring delivery

We demonstrated strong BCF delivery in 2015/16, and this was due in part to robust programme management and governance, which we will keep in place for 16/17. Qualitative and quantitative evaluations were embedded when schemes commenced, so we have had clear visibility of the performance of our initiatives. Regular highlight reports and a dashboard of indicators demonstrating programme delivery are scrutinised by our Transformation Integration Group, comprising senior executives from providers, commissioners and local authorities.

There is full alignment between our BCF locality plan and our CCG operational plan, the BCF plan addressing a selected subset of initiatives from our local plan. We are part of the Bradford, Airedale, Wharfedale and Craven Sustainability and Transformation Plan and in turn the West Yorkshire Sustainability and Transformation Planning footprint. We have begun to work with our partner

organisations to progress this planning process, identifying areas where common objectives and aligned initiatives could be agreed.

4.2ii Hambleton, Richmondshire and Whitby

Goals

We are committed to deliver an ambitious CCG transformation programme in 2016/17 that aims to strengthen local services and improve the lives of people in Hambleton, Richmondshire and Whitby. This programme will deliver significant shifts in patient/service user flows, treating people closer to home and enabling those who require hospital treatment to return to their homes faster.

HRW CCG supports the continuation of BCF as an enabler to much greater health and social care integration by 2020. 2016-17 will therefore see HRWCCG graduate from delivery of the BCF to the continued delivery of schemes as part of our commitment to Local Integration and delivery of Patient focused care.

A key requirement needed to deliver on the ambitions of our transformation programme will be the expanded availability of 7-day services. Through our primary care workforce development programme and the implementation of integrated locality teams, we will continue to deliver this expansion in 2016/17.

Activities for 2016/17

In 2015/16, we mobilised our BCF initiatives, commenced project delivery and, for many schemes, started to realise benefits. Our BCF work in 2016/17 will comprise both mainstream delivery of schemes, service improvement and innovation.

All BCF schemes from 2015/16 have already been absorbed into the CCG transformation programme and our CCG operational plan; for instance, the psychiatric liaison service, GP hospitalists and IV Antibiotics schemes were absorbed into our transformation programme for the Urgent and Emergency Care Integrated Service.

This year our focus will remain on driving service improvement to increase the activity of individual services as drivers of our transformational objectives, and seek opportunities for further innovation., We will continue to work with partners to ensure learning is shared and best practice models identified and spread. Models of care that we are testing are aligned to those proposed in the Five Year Forward View.

We remain committed to additional investment in community staff, including the delivery of the Integrated Night Service as we develop locality-based Integrated Community Teams and increase our focus on the Frailty pathway (including frail elderly clinics as a model of care).

Newly-established Primary Care Clusters along with locality teams will further support out of hospital services schemes to improve whole system patient flow and patient choice, reinforced by a local Delayed Transfer of Care Plan.

Another intention in BCF for 2016/17 is to further drive our preventative schemes in 2016/17, being developed and delivered in collaboration with public health.

We are committed to the continuation of BCF as one lever to achieve our vision of health and social care integration. We see the work completed to date as a first step towards this and will work with partner organisations to deliver a full integration plan by 2020.

Ensuring delivery

A dedicated Programme Board is in place for 2016-17 accountable for the leadership of the community transformation programme and overseeing the BCF schemes. In addition, it will review scheme impact on performance and outcomes as exception. All providers are represented through the senior membership of this Board to enable decision making. Any specific contractual issues arising will be flagged to Provider/Commissioner business meetings. The Board will provide reports as necessary to HRWCCG Transformation Board and Audit and Information Governance Committee.

A range of Task and Finish Groups will report to the delivery Board on a regular basis and be exception-reported during the meetings on the progress of our transformation projects (including Frailty pathway, End of Life pathway, DTOC Plan and Integrated Locality Teams). All Task and Finish Groups will be delivered with providers as members as well as representation from third and independent sector.

Our BCF plan is being managed as an essential part of our overarching local transformation programme, as detailed in the CCG operational plan. We recognise the need that our CCG transformation plan (and therefore our BCF plans) will inform and align with our local Sustainability and Transformation Plan (comprising Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby). In discussions with local partners, we will aim to take the opportunity presented by the STP to further accelerate delivery of our transformation ambition, to collaborate more broadly and work at greater scale where appropriate.

4.2iii Harrogate and Rural District

Goals

We are using the Better Care Fund as an enabler for the delivery our New Care Model. This is a place-based system of care that will ensure more people stay healthier and independent for longer, and have choice and control over their lives and care. It will also deliver cost reductions across the system.

In 16/17, the New Care Model will deliver a shift in patient/user flow in the local health system, resulting in targeted reductions in emergency admissions and emergency department attendances. Our plans will also deliver improved quality of care, improved patient/user experience and reduced health inequalities.

Our BCF plans are aligned to our work in the West Yorkshire Urgent and Emergency Care Vanguard which will oversee, with local partners, the transformation of urgent and emergency care for more than three million people in West Yorkshire.

To support these goals, we are planning to extend our 7 day services in 2016/17. We are using the Calderdale Framework to redesign a more flexible health and social care workforce and integrated multidisciplinary community teams, working closer with primary care.

Activities for 2016/17

Given the solid progress we made in 2015/16, our focus for BCF in 2016/17 will be on driving further improvements through existing successful schemes, spreading and expanding these where we can, and refining our approach for other schemes where needed, based on learning from last year.

Our priority for 2016/17 will be increasing the coverage of the New Care Model, expanding this to additional localities. This will include expanded integrated community-based health, mental health and social care teams delivering person-driven care planning and proactive management.

We will enhance our rapid response services in the community, to keep acutely unwell people at home where appropriate. The New Care Model will be supported through collaboration with an empowered and active voluntary sector.

Successful schemes from 2015/16 – including our psychiatric liaison and primary care in care home initiatives – will continue and we will seek opportunities to spread this good practice.

We see the BCF, in terms of the collaboration it has driven between health and social care organisations and the development of integrated community teams with health and social care input, as a critical step towards much greater health and social care integration in the short-term and full integration by 2020.

Ensuring delivery

The programme management and governance we established for BCF proved robust and effective in 2015/16 and we will continue using these arrangements (i.e. our Programme Management Office for the New Care Model and Systems Reliance Group, reporting to our Transformation Board, will continue to manage and oversee delivery of BCF schemes). As a member of the West Yorkshire Vanguard initiative, we are also accountable to NHS England. Therefore, we will continue to ensure a high standard of evaluation for all schemes, meeting NHS England's exacting requirements.

The goals and activities described in our BCF locality plan derive from, and are therefore fully aligned with, our CCG operational plan. The New Care Model we are deploying is itself aligned to models of care described in the Five Year Forward View.

We will progress with delivery of the New Care Model whilst the detail of our Sustainability and Transformation Plan is finalised over the coming weeks. As a contributor to the West Yorkshire STP, we are now in the process of aligning goals and activities local partner organisations.

4.2iv Scarborough and Ryedale

Goals

The BCF is a crucial component of our local transformation programme, *Ambition for Health*, which addresses three main aspects of health and social care. Through this programme, we will help people lead healthy lifestyles, supporting them to take control of their own health to prevent illness. We will improve out of hospital care so health and social care services work more closely together, with the aim of preventing people from needing treatment in hospital. We are also ensuring our hospitals and other major services are of a high quality, are financially sustainable and that our local population has access to the right care, in the right place, at the right time. The first two aims of *Ambition for Health* are directly related to and driven by our BCF work. BCF has acted as a catalyst for *Ambition for Health,* supporting us to work with greater pace, test more innovative schemes, and work more collaboratively than before. It will be successful delivery of *Ambition for Health* as a whole that will lead to the material shifts in patient/service user flows that we are targeting. Collaborative working through Ambition for Health will also support our commitments to greater health and social care integration over the coming years.

We note that 7 day working will be necessary to support delivery of many of our *Ambition for Health* objectives. We are taking the opportunity BCF provides to extend services where needed. For instance, our community hub and hospice-at-home schemes both operate over 7 days, and our plans for psychiatric liaison will extend this service to 7 days in 2016/17.

Activities for 2016/17

In 2015/16, our focus was on scoping BCF schemes, getting them up and running and testing new models of care. For 2016/17, we will shift focus to embedding and rolling out successful schemes, and re-scoping and reshaping schemes where needed, in the light of evidence and experience gained in the previous year.

We will continue to review implementation of our community response team initiative as more robust evaluation data is gathered. Our psychiatric liaison scheme, which delivered material improvements in service quality last year, will continue into 2016/17, as will our hospital-at-home model and we will continue to flexibly refine these schemes in the light of emerging data. We have already identified options for refining our Malton Care Hub scheme to drive improved delivery (i.e. altering the service's geographic catchment to drive patient volume, and revising incentives for our local acute trust) and will seek to implement these for 2016/17.

Ensuring delivery

Given our experience of BCF in 2015/16, we will refine our metrics and make these more robust for 2016/17. Data sharing with partners proved problematic last year; difficulties in accessing data have, in some cases, limited our ability to fully evaluate schemes and addressing this issue will assist greatly in our understanding of how well schemes are performing and what changes we should make to improve delivery. We are also developing more robust baselining and growth assumptions to inform our scheme evaluations.

The BCF plan is derived from objectives in our *Ambition for Health* programme and this programme is itself designed to respond to national and local strategies, including the NHS Five Year Forward View and the Joint Health and Wellbeing Strategies of North Yorkshire and the East Riding of Yorkshire. We are working with other partners in the Coast, Humber and Vale Sustainability and Transformation Plan area to define specific areas for alignment and future joint working.

4.2v Vale of York

Goals

Our priority for 2016/17 will be to deliver on our agreed recovery and turnaround plan for the CCG and local health care system. This priority will inform all our other planning requirements, including plans for the Better Care Fund. In terms of system transformation in 2016/17, we will aim to continue redesigning community-based pathways to enable people to receive health and social care closer to home. We will develop preventative services and continue to promote self-care, and explore new models of care, working with partners in the local health and social care economy. Our turnaround plan will deliver the stability and sustainability required to then deliver our ambitions to significantly shift patient/user flows out of acute settings.

Activities for 2016/17

We will build on our work in 2015/16 to initiate and set up BCF schemes by sustaining this work in 2016/17 and ensuring that the benefits of these schemes are fully realised. For instance, our Urgent Care Practitioners scheme (our most successful project in managing conditions closer to patients' homes) and Enhanced Hospital Care at Home (where evaluation demonstrated a substantial improvement in quality and patient choice) will continue, and we are evolving the model of care provided in the Selby Care Hub to deliver greater impact on volumes of non-elective admissions.

We remain committed to supporting full health and social care integration by 2020 and, as a national Integrated Care Pioneer, we are developing and testing new and different ways of joining up local health and social care services.

Ensuring delivery

Strong BCF delivery in 2016/17 will be critical. A Systems Leaders' Board, comprised of senior leaders from local commissioners, providers and local authorities, was established during 2015/16 to support and oversee transformational work across the local health and care system and accelerate the pace of reform to

deliver financial sustainability across the system. The Board will have oversight of the joint system work, particularly focused on the development of new models of care, digital integration and shared system public campaigns on self-care, preventative actions and signposting to services. During 2016/17, we will work with partners to develop programme management and governance arrangements for shared work to ensure transparency in decision making and strengthen delivery on joint commitments.

The annual operating plan will be the CCG's commitment to action as part of the system plan, supported by targeted joint work using the BCF, delivering year 1 of the recovery plan.

The local system recovery plan will, in turn, inform and be informed by the broader Sustainability and Transformation Plan for Coast, Humber and Vale, in which we will participate, maximising opportunities at scale, identifying areas that cannot be resolved at local level alone and accessing targeted funding opportunities through the STP.

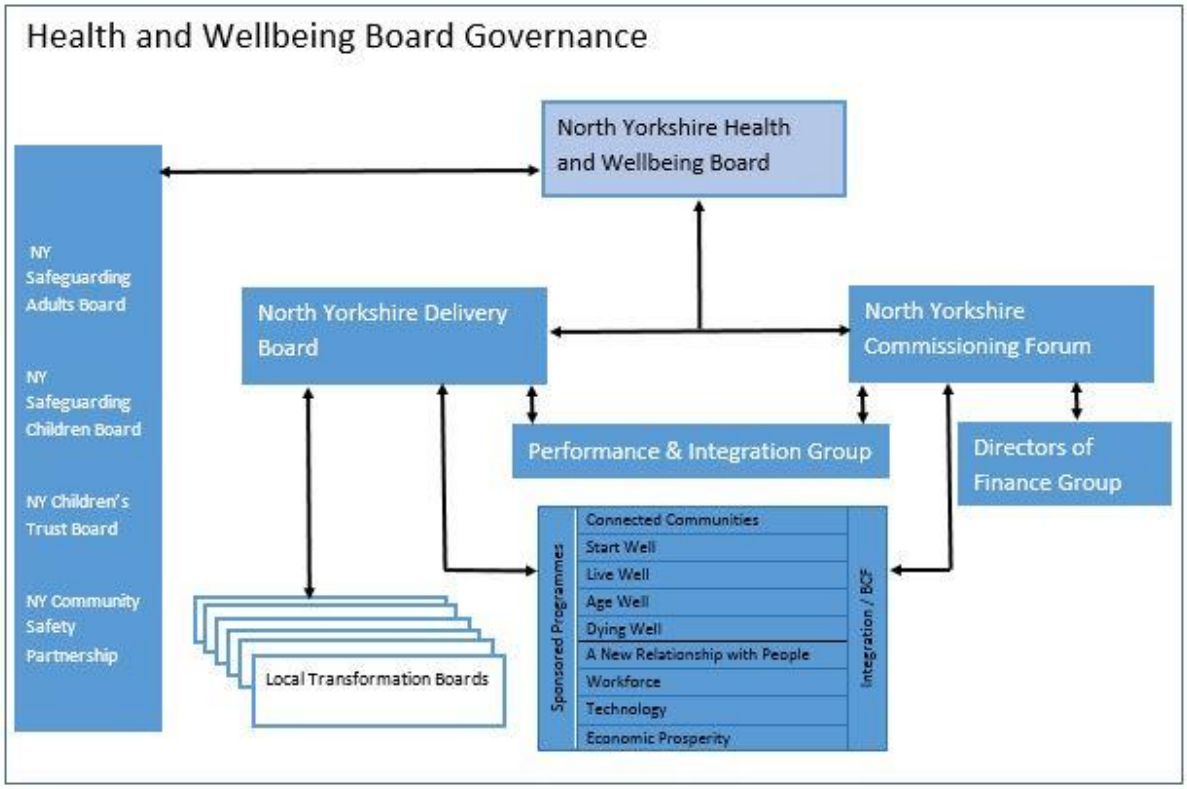
4.3 Governance

The governance and accountability arrangements remain in place for 2016 with the HWB being ultimately responsible for maintaining oversight of the health and social care system including driving progress towards integration. The Board continues to be member led and vice chaired by a CCG chief officer with representation from all key stakeholders including mental health and acute trusts, district councils and the voluntary and community sector.

The diagram below shows an updated HWB governance structure further to developments in 2105/16. The Commissioner Forum has been established in place of the Integrated Commissioning Board to ensure a strategic approach that aligns commissioning intentions across organisations and supports the HWB to realise the ambitions of the JHWS. The forum analyses information to enable the HWB and the public to see how well services are being delivered and where improvements are needed and explores opportunities for further integration and joint commissioning. Supported by the Performance and Integration group and working closely with the Delivery Board the forum also oversees implementation of key projects and ensures a continued focus on health and well-being priorities. This forum is actively involved developing the 2016/17 BCF plan and its links to local operational plans and STP's.

Assurance regarding monitoring arrangements for the Better Care Fund is provided routinely through quarterly reports to the HWB and the Delivery Board

As previously indicated Health and Social Care Transformation Boards also operate in each locality with responsibility for developing a new model of care that will support graduation from a BCF plan to an outline integration plan by 2017. Theses boards are similarly representative of key stakeholders including acute trusts, district councils and the voluntary and community sector.



Task and finish groups have been revised to mirror and ensure delivery of the key themes and enablers of the JHWBS with sponsorship for each being provided by a key member of the HWB.

Formal engagement in the BCF process with District Council and acute trusts is evidenced primarily through the HWB, Delivery Board and Local Transformation Boards with wider engagement opportunities feeding in as appropriate.

4.4 2016/17 Risk Log

The 2015/16 risk log has been updated to better reflect plans for 2016/17 and is attached as appendix 1

5. Delivering the BCF National Conditions

5.1 Plans to be jointly agreed

The governance arrangements described above demonstrate the extent to which health and care providers affected by use of the BCF have been engaged, with further detail of engagement activity for those predicted to be substantially affected described in section **5.6** below

District Councils are involved in development and implementation of the BCF with representation on the HWB (Chief Officer and Council Leader rep) Delivery Board and Locality Transformation boards.

Similarly health and care providers are represented on the HWB, (Mental health, acute trust and voluntary sector reps), Delivery Board, (all acute trusts, voluntary

sector and Independent care group representatives) and again through locality transformation boards.

Our BCF sits within our overall framework for integration by 2020 with BCF plans being a critical enabler and integral to CCG operational Plans. Through the process of STP planning – work is underway to define specific areas for alignment and future joint working.

5.2 Maintaining the provision of social care services

We remain clear that maintaining social care is critical to ensuring that wider system changes can occur within an environment where safe care and support is available to those who need it and which prevents unnecessary admission to acute care and or facilitate timely and safe discharge.

Our definition of maintaining social care remains consistent with the 2015/16 plan to deliver 'care closer to home' with investment targeted towards a range of activities that are of benefit to the wider health and care system including those which reduce and or delay demand.

The Health and Adult Services transformation programme outlined in the 2015/16 plan therefore continues to be delivered and includes the following activities:

- 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;
- Developing our current and future capacity to develop the market, developing our own and the independent sector workforce and preparing for greater public service integration.

The 2015/16 BCF plan was initially approved by the Health and Wellbeing Board in April 2014 and included £17m protection for social care, excluding Care Act funding. Following further guidance a revised plan was resubmitted in November 2014, subsequently approved by NHSE in January 2015. This continued to include a negotiated £17m for the protection of social care and comprised a £12m payment from CCGs and a one off payment of £5m by the County Council. The Care Act obligation in 2015/16 was funded through joint monies with an expectation that future costs would be met by CCGs. An agreement is in place to reduce the Council's contribution over a three year period by which time the CCGs would make the full contribution of 17m.

The 2016/17 draft plan sees the level of funding for maintaining social care identified through the CCG allocations as £11.3m incorporating funding for the Care Act. This represents a funding gap of circa £4.6m in the 2016/17 plan. This represents a significant risk to the stability of the North Yorkshire social care system and is contrary to the policy framework.

5.3 Progress towards meeting the 2020 standards for seven day services

Across North Yorkshire there are a number of services in place providing 7 day cover for example, reablement, intermediate care, community hubs, hospice at home and the emergency duty team.

In 2016/17 further progress towards improving consistency and meeting the 2020 standards for seven day services is referenced in section 4 with plans focussed on:

- Building on investment in 2015/16 by further expanding access to existing services
- Investment in workforce redesign and development to improve flexibility and resilience
- Further implementation of integrated locality teams improving the ability of local hospital services to discharge patients on a 7 day basis

CCGs continue to actively work with acute and community providers to ensure clinical standards relating to 7 day working are achieved and that they are appropriately reflected in contract quality schedules, this will include the expectations for services to provide an equitable response to discharge and admissions regardless of the day or time.

The County Council is currently consulting on a new operating model for social care. The model was co-designed with CCGs with reference to new models of care and to support the development of more joined up working at locality level. Due for implementation in April 2017 the model will further enhance the flexibility and resilience to deliver 7 day services. Online assessments are currently being tested which will enhance 24/7 access to information and advice.

The impact upon hospital admissions remains consistent with the 2015/16 plan. In summary the system continues to be redesigned to facilitate a more proactive and preventative approach with increased access to integrated and timely assessments and services supported by improved information, advice and guidance. This will help people remain in or return to their home environment and avoid unnecessary admissions to and/or facilitate timely and safe discharge from acute settings.

5.4 Better data sharing between health and social care

Review of Progress in 2015/16

Good progress was made in 2015/16 against the national condition around better data sharing and this will continue into the 2016/17 plan.

Some specific highlights are set out below:

- Technology and data sharing was identified as a key enabler for 'getting the whole health and social care system working better together in the JHWB strategy approved in 15/16 by the HWB. The Board recognises the significant role that technology can play in achieving better outcomes for local people and communities which demonstrates **leadership** commitment and provides a platform for determining **behaviours** and **cultures** moving forward.
- A pan-County IM&T Board was established by the North Yorkshire Delivery Board to provide **oversight and management** of strategic BCF IM&T issues affecting partners. The Board also acted as a forum for agreeing how the IM&T implications of national initiatives would be taken forward locally. Representatives came from the 2 local authorities, the Clinical Commissioning Groups and the Commissioning Support Unit. In addition, CCG's have established local IM&T working groups to manage the delivery of individual projects within their locality.
- Excellent progress has been made in populating systems with the **NHS Number**. The NHS Number has been the established consistent identifier for Health services for some time. Within Adult Social Care, the national Demographics Batch Service (DBS) is used and NHS Numbers are now populated for around 86% of active cases and individuals can be searched for using the number.
- To inform commissioning plans and/or targeting of preventative services, commissioners have access to a **risk stratification** tool where activity data from NHS organisations can be aggregated and analysed. At the moment the CSU provide the risk stratification tool to all North Yorkshire CCGs.
- There is still some way to go to obtain **Open-API's** from the software suppliers across the health and social care economy. We have been involved in work taking place nationally to encourage those suppliers to be more forthcoming with their plans for delivery of these tools. The signing of the "Newcastle Declaration" at the 2015 CCIO Summer School (http://systems.hscic.gov.uk/interop/news/newcdec.pdf) and the techUK Interoperability Charter (https://www.techuk.org/insights/news/item/5276-techuk-s-interoperability-charter) provided a real step forward in this respect.
- A new **information sharing framework** (ISF) has been adopted by a number of partners including NYCC, City of York, York Teaching Hospital, Harrogate District Foundation Trust, North Yorkshire Police and the Fire and Rescue Service. The North Yorkshire Delivery Board has received the framework and it is under consideration by all North Yorkshire CCGs. The ISF has been designed to ensure we have the appropriate information governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA).
- BCF activity in 2015/16 has **improved co-location** working through co-operation between partner IM&T departments, and this will be continued in 2016/17 as co-location working is extended in scope and scale. Particular successes from 2015/16 have included the establishment of 2 fully integrated community-based multi-disciplinary team bases under the Harrogate New Models of Care (Vanguard) programme. Multiple networks were aligned to provide improved access to partner systems.

Activities for 2016/17

Continuing on from 2015/16 we recognise that many of the individual schemes within the BCF Plan will benefit from the same IM&T based solutions and these form the main priorities for delivery in 2016-17.

They are:

- An **electronic shared care record** accessed by partners involved in direct patient care. This involves joining together separate sets of data about the same patient using the NHS Number as the primary identifier and using the latest technical standards.
- A sophisticated **risk stratification** tool where activity data from partners can be aggregated and analysed to inform future commissioning plans and/or targeting preventative services. This is partly in place through the CSU delivered risk stratification tool.
- Clear **information governance** processes and agreements that allow the sharing of data between partners for direct care, commissioning and preventative services.
- All the above require **improved access to networks and systems** for staff from all partners when working away from their host organisation.

The electronic shared care record – Local Digital Roadmaps

CCGs are required to submit their plans - Local Digital Roadmaps (LDR's) - for how their local health and care economies will achieve the ambition of being paper-free at the point of care by 2020. These plans are will cover a system footprint, determined locally, and support the development of integrated working. Local Digital Roadmap activity is underway within localities and all CCGs are on track to deliver the digital road map by June 2016, as part of their Sustainability & Transformation Plans.

As part of the LDR development, and to complement the work already completed by Provider Trusts in the patch, NYCC will be submitting a Digital Maturity Self-Assessment for Adult Social Care. This is an optional requirement for local authorities within the LDR process but is seen as a valuable method of ensuring consistency of input across multiple LDR's.

The County Council will introduce automated updates using the National Demographics Batch Service (DBS) in 2016/17 for missing NHS Numbers following internal testing. Also in 2016/17, aligned to our implementation of the National Child Protection Information System (CP-IS), we will be considering the adoption of the NHS Number for children's health and social care records. There will still be a small core of people who will not have an NHS Number matched through the DBS process and alternative methods of obtaining that number will be deployed (examination of other related documentation such as previous prescriptions or appointment letters).

We will continue to work with software suppliers on a local and, where necessary, national basis to progress the delivery of Open-API's for each case management system. Within North Yorkshire are 2 Integration Pioneers and 1 New Model of Care (Vanguard) so the additional national attention and support from the NHS England Interoperability Team on those schemes has also been useful.

Risk stratification

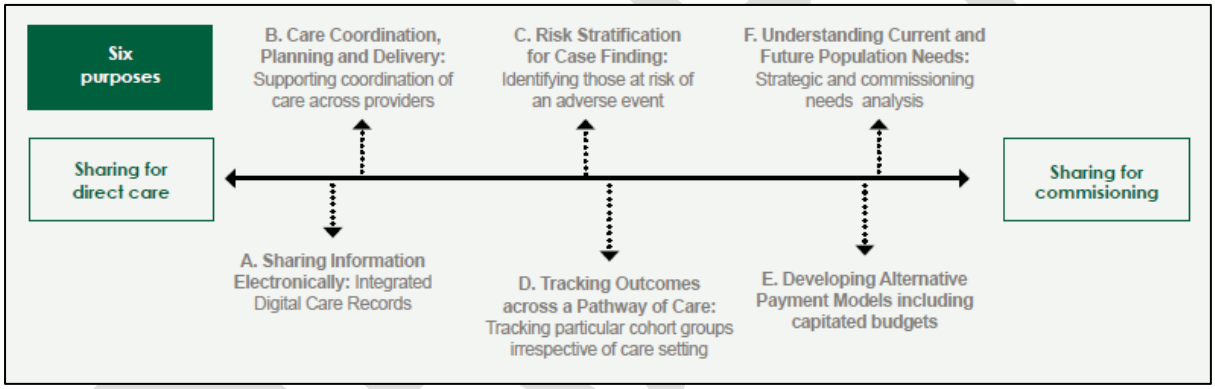
Following transition of services from the CSU to a new provider, a review of risk stratification tools will take place. There is a limitation at present around the inclusion of social care data sets alongside NHS data sets within a risk stratification process and this will be factored into that review.

As highlighted in risk log, the services provided by the CSU including the tool are to be transitioned to a new provider from 2016/17. This has been identified as a risk, but due to the nature of the transition process and the management resources being deployed across the region it is considered to be a low risk.

Information governance

We recognise and agree that data sharing is needed to support two main outcomes. Firstly, sharing at the point of care including care co-ordination and care planning (Direct Care). Secondly, system level sharing across health and care for risk stratification and tracking patient journeys & outcomes (Indirect Care).

Information governance activities are aligned with the different purposes for information sharing as set out in the diagram below (taken from the Information Governance Alliance).



We will continue to adopt the existing ISF across public sector organisations in North Yorkshire. All partner organisations have nominated leads for Information Governance and have an appointed Caldicott Guardian where required. Caldicott Guardians are registered on the National Register of Caldicott Guardians (http://systems.hscic.gov.uk/infogov/caldicott).

Services have their own individual methods for ensuring that local people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. Information is provided through website materials, leaflets and during 1:1 consultations between the person and their health or care professional.

We are committed to ensuring that the appropriate IG controls are in place to support this. NHS partners are already committed to the IG Toolkit compliance process for connection to the N3 network and onward access to national systems. NYCC is also committed to the IG Toolkit and has maintained an N3 connection for many years alongside the Public Services Network (PSN) required for other local authority specific service needs.

Improved access to networks and systems

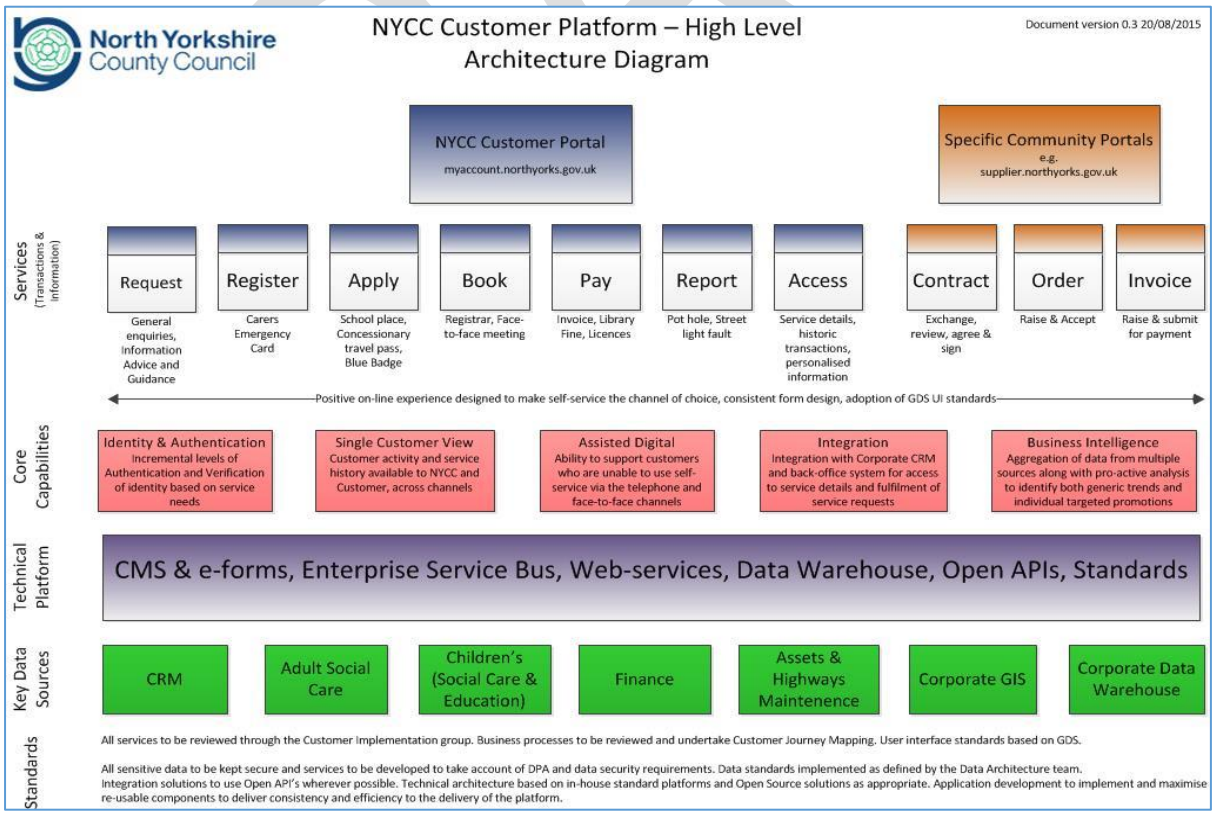
The BCF schemes require staff from different partners to work flexibly across care settings while still being able to access their own records systems. Historically, separate IT networks have been put in place by each organisation with limited scope for joining them together. More recently, the introduction of widespread Wi-Fi services and better technical compliance has made it possible to enable secure access to systems across those multiple networks.

National programmes of work & related support

A number of national initiatives to progress integration of IM&T across health & social care have potential benefits for BCF work in 2016/17. In particular, the proposed nhs.uk platform has a number of similarities with the proposals under the *Customer Theme* of the NYCC 2020 Programme. For example:

- online access to information on health & care services and the ability to transact directly with those services
- provision of a shared electronic health & care record holding data from all organisations involved in commissioning and providing services
- management of citizen preferences to allow sharing across organisations through consent and opt-out processes
- online access to that electronic record by citizens for self-management of care
- use of approved "apps" as part of a prescribed package of care

The County Council is currently engaged with national representatives working on the nhs.uk platform to see what benefits could be realised for the local system through the programme.



Programme Governance

Each CCG has established a governance structure for the production of LDR's aligned to the STP's, within their respective locality. These have built upon the work already carried out by the local IM&T working groups. Health and care partners, both commissioners and providers, are represented on each governance board or steering group. As indicated earlier, the role and representation on the pan-County IM&T Board and the relationships with locality groups will need to be reviewed once these new LDR/STP groups have been established.

5.5 A Joint approach to assessment and care planning

A number of initiatives across North Yorkshire have been developed or implemented to support health and social care to work more effectively together, improve the joint approach to assessment and care management and the outcomes for people who use services.

Improvements are based on best practice and tailored according to progress within individual localities but include:-

- Further alignment and integration of integrated locality teams
- Trusted Assessors
- Improved processes and paperwork to support joint assessments and care planning

The County Council has established a small professional Care and Support Team within North Yorkshire County Council Customer Services Centre, to trial new ways to resolve a range of care and support enquiries at the front door wherever possible. This work is not part of this BCF plan, but is complementary to the work taking place within it to extend joint working. One of the pieces of activity that the team is doing is restarting packages of care without the need for a reassessment ("Re-sets").

A Re-set refers to someone that has a long term care and support package, and has an episode which results in admission to hospital. Once treated in hospital, the person is more quickly able to return to the package of that they were receiving prior to admission.

The pilot aims to benefit health and social care, as well as the person who has been admitted, by:

- Supporting a person to leave hospital in a timely and safe way
- Preventing the need for a reassessment of their care needs
- Reducing the number of Hospital Notifications being submitted to North Yorkshire County Council

The service has been operational since November 2015 and is piloting this work with Scarborough General Hospital and the Friarage Hospital. The numbers of referrals for 're-sets' has so far been relatively small, therefore the approach is to be planning to reviewed and rolled out to Harrogate District Hospital.

A countywide dementia strategy to improve outcomes for people living with dementia and their carers is currently being developed in partnership with CCGs, Dementia Action Alliance, Alzheimer's Society, Dementia Forward, Making Space and people with dementia and their carers.

Initial engagement suggests that the care and support people receive from NYCC, the NHS and our commissioned dementia support services is of good quality but that the process of navigating through a complex system is the greatest source of frustration for many people. Understanding and simplifying this pathway will therefore be a key area for the strategy and action plan.

Governance for the overall development of the strategy and delivery of the action plan will be via the Health and Wellbeing Board. Our aim is to publish the strategy by the end of 2016.

Table 5 below shows each localities response to improving the joint approach to assessment and care planning

Table 5 Locality response to improving the joint approach to assessment and care planning

Locality	Joint approach to assessment and care planning
Airedale, Wharfedale and Craven	BCF monies fund an SCA post in Craven which works in the Collaborative Care Team. This has been extended for a further year. A new post, (not funded through BCF monies), is being set up from AWC New Models of Care for their Complex Care Proof of Concept. The post is a care navigator which will cover a wide range of tasks such as financial assessments and navigation through the care system. The voluntary sector are likely to provide for the non-Craven part of the patch. However in Craven we are looking to appoint an SCA but to work closer with partners.
Hambleton, Richmondshire and Whitby	BCF monies have funded additional service resilience and capacity across Community Services to enable a series of prototyping to develop trusted assessment referrals and pathways to deliver joint care plans. There has been a project to further align and integrate intermediate Care, START and Fast Response Team Service within the locality. Two prototypes have been developed as part of this project that have focussed on joint assessment and support planning processes. • Best Practice Case Studies and Joint Review Process- The prototype has built on good assessment and review practice that had been developed between practitioners from the Dales START and Intermediate Care Team. The prototype captured case studies demonstrating the value of colleagues working together to jointly assess, develop support plans and review at 4 to 6 weeks. The process has been captured within flowcharts and rolled out across the locality. • Trusted Assessor prototype- this prototype developed and tested a new process to empower colleagues in acute setting to act in a trusted assessor role and provide assessment information that could be used by intermediate care and START to provide an initial service without them attending the hospital site to complete an assessment. Joint documentation and operating procedures have been developed as part of the prototype work. This has proven to be a complex area of change that requires further work in relation to culture and practice. The intention is to build on the prototype work and continue the development the trusted assessor concept within future plans to take forward integration. These prototypes have informed plans for 2016 as we are working with our Partners to create an integrated locality team model for the provision of community services. The teams will be based and work within specific localities centred upon GP clusters and will incorporate and take advantage of advanced nursing practitioners within the community. The model will take elements of the “Buurtzorg Model” and adapt it to the specific requirements of this area. This approach will be prototyped in Richmondshire in September 2016 and with lessons learnt from both Richmondshire and Whitby, will inform

	the model for the rest of the CCG's area of responsibility.
Harrogate and Rural District	The Vanguard is looking at community teams/beds to prevent people going into hospital or expediting discharges. It is expected that the teams will be made up of health and social care staff, co-located around a geographical location. As part of the project, shared records/assessments are being looked at via a sub group of the programme.
Scarborough and Ryedale	The Ryedale hub, Community Response Team (CRT) has been operational since January 2015. This is multi-disciplinary team which is co-located at Malton Hospital. The team is made up of health and social care staff as well as having input from the voluntary sector who also sits as part of the team. The health component of the team is made up of nurses, occupational therapist and physiotherapist, along with generic care workers. From a social care perspective assessment staff from both START (Short Term Assessment and Reablement Team) and professionally qualified locality assessment staff sit as part of the CRT. The teams have developed agreement on 'shared paperwork' depending upon which service first see the person in service. The shared paperwork includes shared assessments including risk assessment and support plans to reduce duplication. Also across the Scarborough and Ryedale locality the psychiatric liaison service is now operational within Scarborough General Hospital. In addition the Palliative Care service aimed at reducing admissions to hospital for those people at the end of life through education in residential care settings continue to operate.
Vale of York	Selby CRT continues to work well and is set up similarly to the Ryedale CRT with START resource workers forming part of the team. The work around joint paperwork is also being progressed.

5.6 Consequential impact of changes on providers

The complex health and social care geography of North Yorkshire means that a large number of providers will be substantially affected by the changes made across the county as a whole.

The mechanism for engaging with providers at all levels is clearly shown in the governance arrangements described in section 5

Table 6 below shows how each locality has engaged relevant providers in planning

Table 6 How each locality has engaged with providers

Locality	Provider Engagement Activity
Airedale, Wharfedale and Craven	Dialogue with the main acute providers regarding the planned reductions in non-elective activity is discussed and agreed via planning and contract negotiations. In addition the BCF and impact of system change is regularly reviewed by system leaders through the Transformation & Integration Group (TIG) and Integration and Change Board (ICB) which in turn report to the respective HWBs (North Yorkshire and Bradford)
Hambleton, Richmondshire and Whitby	Our local providers are an integral part of the delivery of BCF schemes as an element of our wider transformation programmes. Throughout 15-16 STHFT, as our main local provider, have influenced the implementation and service monitoring of the BCF programme through our local service delivery group and as key stakeholders in project specific steering groups. A series of multi-agency workshops were delivered throughout 2015-16 in Hambleton and Richmondshire to develop an Integrated Model of Care and a series of prototypes including a 'Trusted Assessment Referral' form. Local Providers were fully represented at these events both from the Acute and Voluntary Sector. The Whitby Fit 4 the Future Programme vision to deliver an Integrated Model of Care has been progressed through an open competitive dialogue process, through which Humber Foundation Trust were appointed, to ensure local providers work with the CCG as the manufactures of the model. Equally the vision of the redevelopment of Whitby Hospital has been developed with all key stakeholders including; third sector partners, housing providers, NYCC and District Councils. This includes the development of an integrated multi-agency Hub to support and provide facilities for a front-line integrated front of house. A Whitby Service Development Group was established in January 2015 delivering a series of mini workshops to further enhance the delivery of integrated care in this locality with specific reference to BCF schemes.
Harrogate and Rural District	Our commissioning plans for 2015/16 were centred on the robust delivery of our Better Care Fund schemes with our key partners across primary care, acute providers and the voluntary sector. Throughout 2016/17 this will continue as part of the New Care Model to support the case for change. The programme is made up of the following organisations: • Harrogate and Rural District Clinical Commissioning Group • Harrogate and District NHS Foundation Trust • North Yorkshire County Council • Tees Esk and Wear Valleys NHS Foundation Trust • Harrogate Borough Council and • Yorkshire Health Network (federation of all the practices) In addition, our local Centre for Voluntary Services and the Yorkshire Ambulance Service are also included in our New Model of Care Delivery Group to ensure that they are included in our strategy, design and delivery.

	The Better Care Fund schemes success are reviewed and evaluated through the Systems Resilience Group including representatives from Health, Social Care, Ambulance Services, Mental Health Services, Primary Care and the Voluntary Sector. Subsequently the schemes are reported to the Harrogate Health and Transformation Board along with the New Care Models work.
Scarborough and Ryedale	Scarborough and Ryedale CCG has embarked on a transformation programme known as "Ambition for Health" in partnership with a number of local and regional organisations, both providers and commissioners. The key partners are: • Scarborough and Ryedale CCG • East Riding of Yorkshire CCG • North Yorkshire County Council • Scarborough Borough Council • Ryedale District Council • York Teaching Hospital NHS Foundation Trust • Tees Esk and Wear Valleys NHS Foundation Trust The Better Care Fund schemes are being incorporated in this programme, in order to provide a coherent approach to transformation. Performance management of the Better Care Fund Schemes is incorporated into the contract management governance process for each of the providers and coordination of performance management will sit with a joint CCG/NYCC steering group.
Vale of York	Working closely with local providers, the Vale of York, Scarborough and East Riding System Resilience Group (SRG) have refreshed the local System Resilience Plan for 2016-17. The NHS Vale of York CCG will work in partnership with the SRG members to deliver the SRG plan, with an immediate focus on stabilisation of urgent care performance. Key enablers for this have been mainstreamed into contracts for the NHS Vale of York CCG including Ambulatory Care, Urgent Care Practitioners, Psychiatric Liaison and Hospice@Home. The CCG has provided additional capacity through funding urgent care slots over the winter period, with a positive 80% fill rate, providing alternatives to the Emergency Department. Transforming the 'front door' of York ED is the priority for the NHS Vale of York CCG to support system resilience and recovery, alongside enhanced clinical triage and assessment. The SRG plan encompasses the Concordat with the Emergency Care Improvement Partnership and has adopted the principles of the 'Safer, Faster, Better' guidance to be implemented across the local system. The SRG continues to monitor planned care, mental health and cancer targets across the system to ensure improvement work carried out during 2015-16 through the performance recovery plan is maintained and enhanced.

5.7 NHS commissioned out of hospital services

There has been a shift in spending towards out of hospital commissioned services with significant investment in new models of care and community services. This trend is continuing through detailed work being developed by local Transformation Boards. There have been some key successes particularly where efforts have been targeted towards specific populations. The Airedale hub for example achieved a 37% reduction in hospital admissions and 45% reduction in A & E attendances and HRW achieved a non-elective position of -4% all ages and - 7% for the over 65's. Further examples can are highlighted in the review of progressed shown in table 4

Good practice has been shared and in 2016/17 some local CCG's are joining existing pilots or adopting similar approaches.

Across North Yorkshire as a whole the 2015/16 emergency admissions reduction target was not met but there is evidence that schemes managed growth in non-elective activity. For 2016/17, each locality has determined how it will use its share of funding in line with its performance against the 2015/16 target.

Table 7 shows each localities response to this condition

Table 7 Locality response to NHS out of hospital services

Locality	NHS out of hospital services
Airedale, Wharfedale and Craven	As AWC did not achieve the target reductions for NEA in 15/16, the CCG has decided, in line with the planning requirements, that the risk share approach for the 'payment for performance' as per 15/16 should be maintained. As such, the performance funds will continue at the 15/16 levels and will only be released to fund out of hospital services if non-elective targets are met.
Hambleton, Richmondshire and Whitby	Current position at -4% overall and -7 % for over 65s (December 2015 source MAR). The impact of non-electives with our main provider is even more significant with a current position of -7% on all emergency admissions. The BCF schemes have been absorbed into the CCG transformation programme making up the operational plan for the next 5 years, for example the Psychiatric Liaison Service, GP Hospitalists and IV Antibiotics as enablers have been absorbed into our transformation programme for the Urgent and Emergency Care Integrated Front of House. In 2016-17 we will deliver a Frailty project to provide an integrated pathway of care with a focus on prevention and risk identification, building on work commenced through Frail Elderly Clinics and improved Multi-Disciplinary working. In 2016-17 we are working with primary care colleagues to ensure the continued delivery of high quality primary care services that receive high levels of patient satisfaction while transforming services for the future and embedding primary care at scale. The programme builds on significant work already undertaken by both the CCG and Heartbeat Alliance, for example increasing primary care nursing capacity, assessing the primary care estate through a six-facet survey approach, and trialling approaches to increased access to understand what patients really want locally. This includes a series of projects focussing on Patient Access, Workforce Development and technology all with a focus on Frailty and the delivery local patient focused care. Our Primary Care Workforce Development programme has been included in BCF to strengthen our focus on whole system improvement including a focus on 'assessing to admit.' Newly established Primary Care Clusters will further support Out of Hospital Services Schemes to improve whole system Patient Flow and Patient Choice, reinforced by a local Delayed Transfer of Care plan.
Harrogate and Rural District	Our Strategic Priorities include the delivery of the Better Care Fund schemes which are embedded into the delivery of our place-based system of care 'New Care Model'. The key elements of our new model are: • Embedding prevention and early intervention and to empower the community – the core purpose of our local integrated teams is better planned and proactive care to pre-empt need and avoid unplanned care. • Integrate and expand community health, mental health and social care teams – the Calderdale Framework approach is assessing the skill required to meet local needs and will enable us to develop the workforce to suit. • Expand the rapid response in the community – our new care model is supporting GP practices to change their skill mix to free-up GP time to support the integrated teams and respond rapidly to acute need in the community. We have commissioned 10 extra community beds to support step-up and step-down care. A district wide

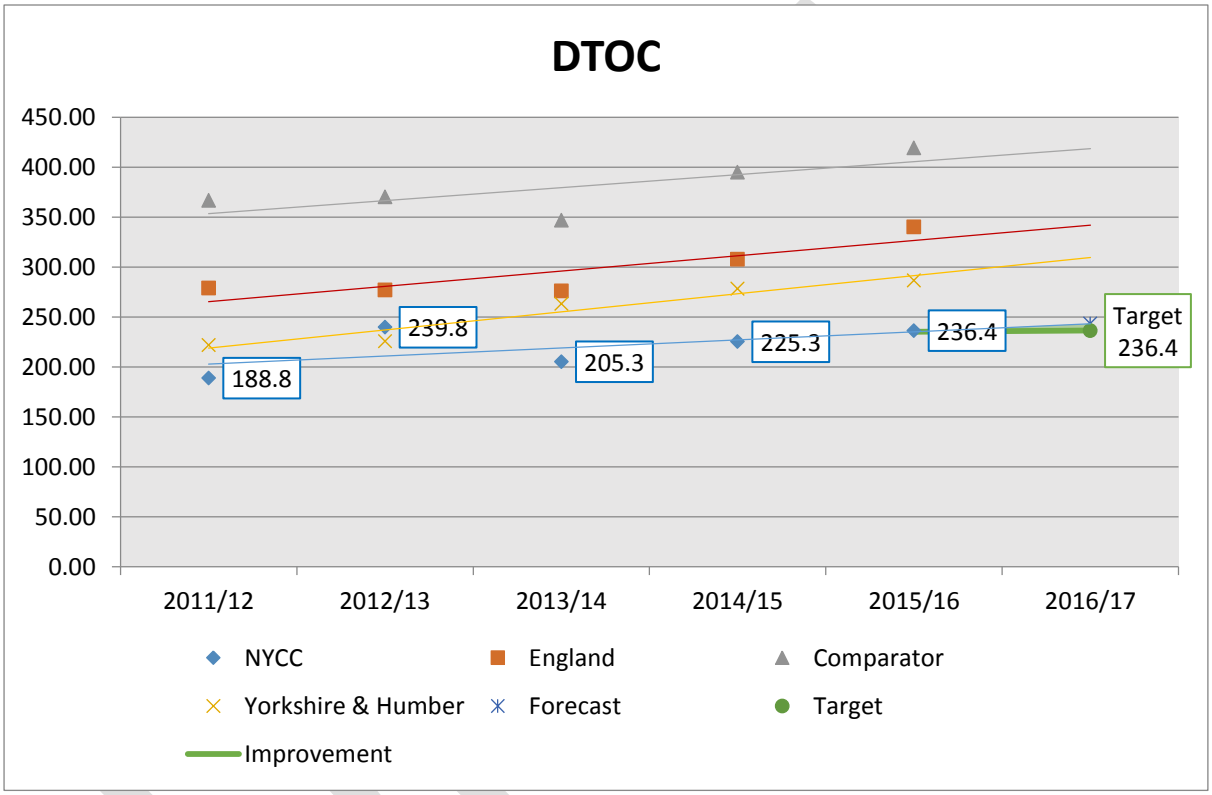
	Response and Overnight service provides rapid response to de-escalate and stabilise acute cases and support carers with a night sitting service. • Develop systems and infrastructure to enable delivery of the new care model: share IT records, estate and business intelligence. • Mental health care is a core to the proposed delivery. Mental Health specialists are part of our Locality Integrated Teams, supporting a holistic approach to care.
Scarborough and Ryedale	Scarborough and Ryedale CCG is currently in the process of re-letting the contracts for Out of Hospital Services. The work for this is incorporated in to the Community pillar of the "Ambition for Health" programme. A key element of the "Ambition for Health" programme is to better manage patients in the community and reduce non elective admissions, in order to drive costs down for the local health and social care economy and promote sustainability of local acute services.
Vale of York	As Vale of York did not achieve the target reductions for NEA in 15/16, the CCG has decided, in line with the planning requirements, that the risk share approach for the 'payment for performance' as per 15/16 should be maintained. As such, the performance funds will continue at the 15/16 levels and will only be released to fund out of hospital services if non-elective targets are met.

5.8 Reducing delayed transfers of care

Situation analysis

North Yorkshires current performance of 236.4 delayed days per month (per 100,000 population 18+) benchmarks well against comparators (avg: 419.2) ranking 4th best out of 16 and is also below the Yorkshire and Humber average of 286.5 and England average of 340.2. Comparatively therefore performance against Delayed Transfers of Care within North Yorkshire is good. **See Chart 1** below

Chart 1 DToC Comparative performance



From this strong position, opportunities to improve are understood and acknowledged across the partnership. However, there are significant challenges with care market conditions. North Yorkshire's care market is already operating at 90-97% capacity in different localities, five years ahead of nationally projected occupancy levels. Near full employment makes recruitment and retention particularly challenging and the transactional costs and logistical requirements of remote rural and coastal areas, means that the normal market assumptions that apply to most of England do not apply in large parts of the County.

Locally agreed target

Taking account of good performance, the current financial context, market challenges and the expected increase in population there is agreement across partners that a stretch target would not be realistic at this time.

The target for DToC in 2016/17 has therefore been established on the basis of maintaining the 2015/16 outturn position.

The estimated outturn for 2015/16 is 13,932 DToC days across the North Yorkshire health and social care system which gives a rate per 100, 000 population 18+ of **236.4**

Maintaining the same rate will result in a 2016/17 outturn of no more than **13,988 days See table 8** below

Notwithstanding this there remains a strong ambition across the partnership to reduce delayed transfers of care and a shared commitment to locality based action that continues a trajectory of improvement linked directly to targets contained within the CCG operational plans.

Table 8 Historic performance and target outturn for 2016/17

Year	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Annual DToC days	10,970	13,939	12,004	13,225	13,932	13,988
Monthly average	914	1161	1000	1102	1161	1165
Population Base	484,100	484,432	487,301	489,218	491,167	493,122
Rate per month	188.8	239.8	205.3	225.3	236.4	236.4

The reduction in CCG allocations for 2016/17 and the subsequent impact on maintenance of social care presents a further risk to the system and would significantly affect North Yorkshire's ability to maintain current levels of performance. The potential funding gap of £2.1m to maintain social care is the equivalent of purchasing 127,300 hours of home care - supporting 244 people for 10hrs per week, or 4250 weeks of residential or nursing care. If agreement cannot be reached to address this funding gap for the maintenance of social care, this will inevitably result in an increase in DToC, which, whilst difficult to quantify in absolute terms is likely to be significant given that delays currently attributable to social care represent circa 40% of days delayed as at February 2016 – some 4600 days.

The impact of a 10 and 20% increase in DToC days attributable to adult social care would result in a 2016/17 outturn of **244.2** per 100,000 pop 18+ (an increase of 460 days) and **251.9** per 100,000 respectively.

Other mechanisms for addressing the funding gap – such as a moratorium on paying providers enhanced rates could be considered but are still likely to have a negative impact on DToC figures

Locality DToC plans

Detailed DToC plans are being developed and agreed at locality level linked to wider system transformation through transformation boards and operationally through System Resilience Groups. This approach recognises that each locality within North Yorkshire has different Patient Flows and STP footprints. DToC plans will reflect local population needs and ensure that all relevant acute and community trusts are engaged. Each locality have an identified DToC lead who will be responsible, via the Performance and Integration Group for ensuring that progress is monitored, understood and shared, including barriers and lessons learned.

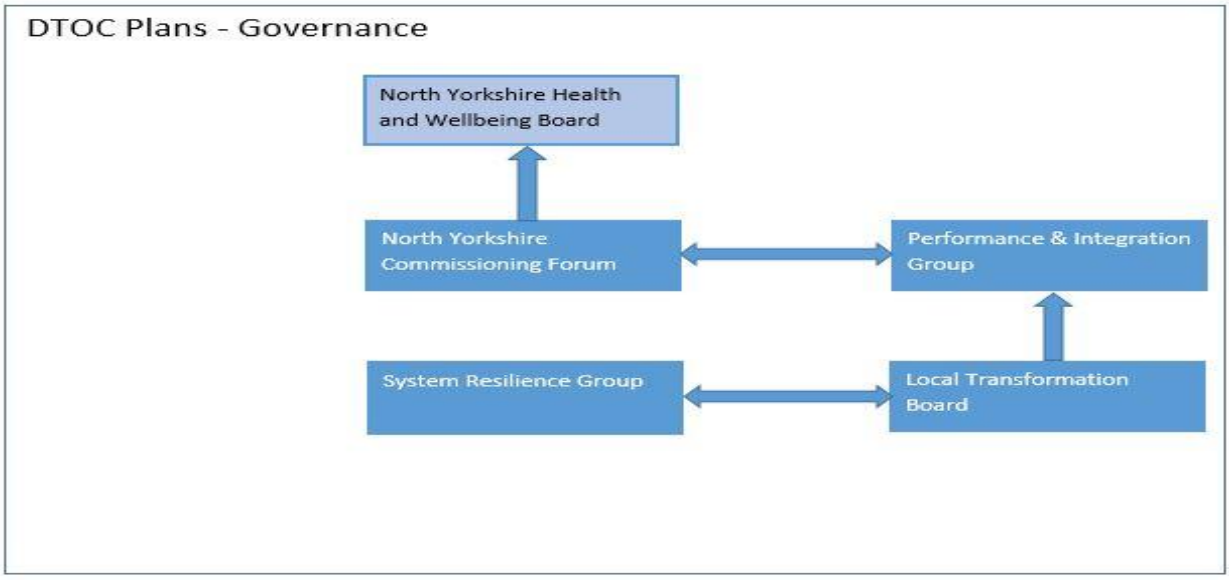
Performance against DToC plans will be reported to the HWB quarterly and supported by the Commissioner Forum and Performance and Integration Group. Reporting on an exception basis will be to Commissioner Forum and escalated to HWB as necessary.

Chart 2 shows governance arrangements for DToC.

Local DToC plans will address issues affecting the efficiency of existing discharge processes, and drive a better system of discharge planning by encouraging the development of proactive planning for discharge rather than the reactive planning that still exists in some areas.

In particular local patient flow will be carefully scrutinised to ascertain the journey required for the locality to achieve the 8 changes identified as the 'High Impact Change Model' in order to reduce delayed transfers of care. The High Impact Change Model identifies 8 key areas to support reduction of DTOC's: Early Discharge Planning, Systems to Monitor Patient Flow, MD/MA Discharge Teams including the voluntary and community sector, Home First/Discharge to Assess, Seven-Day Service, Trusted Assessors, Focus on Choice and Enhancing Health in Care Homes.

Chart 2 DToC Governance



Arrangements for managing and monitoring Delayed Transfers of Care along with key priorities for planning in each locality are set out in **table 9** below:-

Risk Sharing

Risk sharing arrangements for delayed transfers have been considered across the partnership with the conclusion that an agreement is not required at this time due to our relatively strong performance, working relationships and management arrangements at locality level.

Table 9 Locality management and monitoring of DToC plans

Locality	Governance	Developing plans
Airedale, Wharfedale and Craven	The AWC health and social care system will take ownership of DTOC through the local system resilience group. Development and implementation of the DTOC action plan will be led through this group along with responsibility for monitoring delivery of the target reduction. This will ensure a Health & social care partnership approach including commissioners and providers.	The developing plan for 2016/17 includes: Review and adopt as appropriate the high impact change model – Managing Transfers of Care Review and take account of NICE Guidelines – Transition between inpatient hospital settings and community or care home settings for adults with social care needs Develop CQUINs to incentivise new ways of working, improved flows and discharge to assess Review and reconfiguration of community based enablement and rehabilitations services
Hambleton, Richmondshire and Whitby	A local task and finish group will be established in May 2016 under the CCG's Community Transformation Delivery Board. The role of this group will be to deliver a jointly agreed integrated DTOC plan with NYCC and other key partners to deliver an agreed local target. The local DTOC targets recognise that we are just commencing the development of an Integration plan which will include a clear joint vision for 2020. This will demonstrate our graduation from BCF. For 2016-17 we will continue to deliver service improvement through our established Discharge Steering Group and utilisation of Medworx data. We have strengthened communication flow across services which will facilitate the delivery of the DTOC Plan.	The developing plan for 2016/17 includes: • Identify existing service gaps and issues. • A locally agreed DTOC Target and profile for improvement underpinned by planned service / operational changes and their associated timelines. • Identify national best practice initiatives • Revise local reporting templates to support weekly DTOC Conference Calls • Engage with Out- of County Providers • Independent Sector Engagement The CCG welcomes the current attention that the Local Government Associations is paying to this issue and that the lessons from the Health and Care system across the Country last winter about what works well and have been built into the High Impact Change model. This model

		echoes the key themes throughout our transformational programme Fit 4 the Future
Harrogate and Rural District	Responsibility for managing and monitoring the DTOC target reduction is through the System Resilience Group which ensures that health and social care colleague's work together to agree and deliver the action plan.	Our New Care Model will be bringing more care out of the high acuity hospital setting resulting in delivering a number of metrics and targets including reducing: Delayed Transfers of Care Non elective admissions Emergency re-admissions ED attendances Excess bed days and Conveyance rates. In 2015/16 we have commissioned additional community bed capacity at Station View and Ripon Hospital as step up or step down beds to reduce DTOC. The expansion of the rapid response care in the community has also provided capacity to reduce reliance on non-elective hospital beds. Plans for 2016/17 include continued rolled out of this work including 4 locality based teams functioning 7 days a week, multidisciplinary and integrated assessments, care planning that is person-centred and joined up and establishing new roles within teams, e.g. Pharmacists, Advanced Care Practitioners.
Scarborough and Ryedale	Ownership and management of DTOC is through the local system resilience group and Ambition for Health Board	Better Care Fund schemes are being incorporated in the "Ambition for Health" programme, in order to provide a coherent approach to transformation. The "Ambition for Health" programme incorporates transformation to Health and Social Care, including a specific ambition for improving transfers of care and a review of intermediate care provision The DTOC targets for 16/17 will therefore be informed by both the Ambition for Health work and the BCF schemes outcomes.
Vale of York	Ownership and management of DTOC is through the local system resilience group	The CCG's Operational Plan - which is intrinsically linked to the BCF plan highlights 7 key areas we intend to address in 16/17 to contribute to the

		reduction in delayed transfers of care. The plan for 2016/17 includes • Implementation of patient choice policy • Increased capacity of dementia care beds, developing plans with partners • Implement Trusted Assessor role to reduce variation and reduce delays • Reduce hospital admission for most frequent attenders by implementing robust care packages • Develop and implement 'discharge to assess' model • Ensure discharges 7 days a week • Develop Telecare in local authority provided care • Detailed plans to support these areas are being jointly produced across the system.

6 National metrics 2016/17

6.1 Non elective admissions

Whilst there were some areas of relatively good performance in 2015/16 the overall targets for non-elective admissions were not met in all localities No additional quarterly reductions in elective admissions are therefore planned for 2016/17.

Notwithstanding this there remains a strong ambition across the partnership to reduce non elective admissions and there is evidence of impact on growth.

6.2 Residential admissions

The target for residential admissions in 2016/17 has been set on the basis of matching the total number of admissions required against a backdrop of an increase in the Over 65 population, and more importantly, a significant increase in the Over 85 population. Market forces in certain areas of the County, predominantly those more rural areas means that care at home is more difficult to source leading to an increase in the use of residential accommodation. It is anticipated that the Councils Extra-Care programme will ultimately provide reduce the demand on residential care.

6.3 Reablement

The target for 2016/17 has been set on the basis of matching the forecast 2015/16 outturn of 88.7% of patients discharged to reablement being in their own homes 91 days after discharge. The fragility of the domiciliary care market has resulted in a shortage of providers able to deliver reablement and as a result in-house staff are being used to support longer term packages. A standstill target will be an achievement in this context.

6.4 Delayed transfers of care

Taking account of good performance, the current financial context, market challenges and the expected increase in population there is agreement across partners that a stretch target would not be realistic at this time.

The target for DToC in 2016/17 has therefore been established on the basis of maintaining the 2015/16 outturn position.

The estimated outturn for 2015/16 is 13,932 DToC days across the North Yorkshire health and social care system which gives a rate per 100, 000 population 18+ of 236.4

Maintaining the same rate will result in a 2016/17 outturn of no more than 13,988 days

Notwithstanding this there remains a strong ambition across the partnership to reduce delayed transfers of care and a shared commitment to locality based action plans that continues a trajectory of improvement linked directly to targets contained within the CCG operational plans.

6.5Local performance metric – Falls

The target for 2016/17 has been set on the basis of matching the rate per 100,000 people aged 65 and over achieved in 2015/16: The forecast outturn is a rate of 1562.1.

6.6 Local performance metric – Patient experience

The target for 2016/17 has been set on the basis of matching the performance achieved in 2015/16, namely that 63.1% of people with a long-term condition and a written care plan are using it to manage their day to day health. CCG's are currently identifying 2% of their list size with HaRD CCG having a local enhanced service that increases this to 4%.

Appendix 1 Risk Log

There is a risk that:	National Condition	How likely is the risk to materialise? *1-5 with 1 being very unlikely and 5 being very likely*	Potential impact *1-5 with 1 being a relatively small impact and 5 being a major impact*	Overall risk factor *(likelihood *potential impact)*	Mitigating Actions	Risk Owner
Financial contributions to the BCF plan for 2016/17 are not agreed and the plan remains unsigned.	Achieving signoff of BCF Plan	5	5	25	• Ongoing dialogue between local partners at senior level supported by NHSE. • Plan submitted without agreement on finances. • National escalation process.	• HWB • NYDB
Plans/schemes may not deliver financial savings necessary to make them sustainable.	All	4	5	20	• Each element of our planning has an identified exit strategy, should it be necessary to decommission them	• HWB, • Managed through monthly reporting to NYCF / NYDB by Chief Finance Officers Group
Non Elective Admissions do not reduce in line with expectations.	Impact of changes on providers NHS commissioned OOH services	4	5	20	• 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 • Review models of care and care pathways in response to performance and activity • Clear procedures and training • Monitoring of process effectiveness • On-going leadership from the NYCF / NYDB	• HWB • Managed through monthly reporting to NYCF / NYDB by Chief Finance Officers Group
Delayed Transfers do not reduce in line with expectations.	Reducing DTOC's	3	4	12		
Admissions to Care Homes do not reduce in line with expectations.	Impact of changes on providers NHS	4	4	20		

	commissioned OOH services					
There is a lack of availability of providers of support for carers.	Progress towards seven day services Impact of changes on providers	4	4	16	• Market development including with voluntary sector providers • Embedding services and realising the benefits from the work of the Stronger Communities and Living Well teams • Utilising and expanding existing bed bases to provide innovative alternatives to long term care and to enable Patients to remain within their home environment • Monitoring through survey and analysis	• HAS Commissioning Team
Data analysis, segmentation and benchmarking are constrained by perceived and actual restrictions on data and information governance.	Better data sharing between health and social care NHS commissioned OOH services	4	4	16	• Define and engage support / expertise • Seek legal clarification of acceptability of proposed approaches • Monitor and respond to guidance from the Information Governance Alliance, HSCIC and other national bodies.	• Partner IG Leads • Caldicott Guardians
Financial allocation is inadequate to meet duties arising from Phase 1 of the Care Act, resulting in • additional pressure on NYCC and Health budgets • duties not being met in full • reputational damage and negative impact on performance targets	Maintain provision of social care services Progress towards seven day services Impact of changes on providers	5	4	20	• Modelling and analysis • Careful monitoring of volumes of new case-loads • Representation to government • Monitoring of new guidance and allocation announcements	• HAS Leadership Team

	NHS commissioned OOH services					
Agreed system changes between partners are not realised.	Impact of changes on providers NHS commissioned OOH services	3	5	15	• Monitoring and reporting processes in place with reporting to NYCF / NYDB and NYHWB	• HWB • Managed through monthly reporting to NYCF / NYDB
There might be double counting in the estimates for scheme achievement.		4	3	12	• Scheme planning with clear cohorts identified for each scheme • Evaluation of results on a regular basis • Adoption of Improved data segmentation and analysis tools	• NYCF / NYDB • Managed through monthly reporting by Chief Finance Officers Group
Differing Information Governance regimes prevent information sharing between health and social care for citizen care.	Better data sharing between health and social care Joint approach to assessment and care planning	3	3	9	• Organisations will achieve separate compliance for local purposes. • Rollout of Countywide Information Sharing Framework (ISF) and subsequent Information Sharing Agreements (ISA). • Workaround is to delivery separate systems on separate devices in the same location for MDT's.	• Partner IG Leads • Caldicott Guardians
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.	Maintain provision of social care services Impact of changes on	3	3	9	• NYCF / NYDB responsible for managing the conflicts of local directional 'pull' and will monitor delivery • Stakeholder engagement • Programme reporting and evaluation of metrics/data	• NYCF / NYDB through monitoring / reporting

	providers NHS commissioned OOH services					
Existing systems not able to support the chosen model of recording and managing consent.	Better data sharing between health and social care Joint approach to assessment and care planning	3	3	9	• Some systems may need additional manual workarounds to be applied if the consent model can't be supported.	• Partner IG Leads • Caldicott Guardians
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.		3	3	9	• Fundamentally, the requirement and rationale for integration is not at risk; specific changes can be managed by the partnership • Monitoring of policies / manifestos ahead of elections	• HWB / NYCF / NYDB
NHS Number is not used for communication between organisations.	Better data sharing between health and social care Joint approach to assessment and care planning	3	3	9	• Organisational development plans including staff training will be monitored. • Local Digital Roadmap development will set out how the NHS Number will be used across organisational boundaries.	• Locality Boards
Public may not welcome all changes to system. Or not fully engaged or involved.	Progress towards seven	4	2	8	• There has been early patient and public engagement, and it is intended that this	• Partner communication & engagement leads

	day services Impact of changes on providers				will grow as plans develop further	• HWB oversight
Transition of services from Yorkshire & Humber Commissioning Support Unit to new provider (eMBED Health Consortium) impacts on availability of risk stratification tools.	Better data sharing between health and social care	2	4	8	• Close management of transition plan by all CSU customers. • Engagement with new provider. • Pilot/testing period of new tools.	• Locality Boards
There is a lack of joint working between partners, resulting in duplication of effort.	Progress towards seven day services Impact of changes on providers NHS commissioned OOH services Joint approach to assessment and care planning	2	4	8	• Locality Boards and NYCF / NYDB monitoring the implementation and management of on-going services	• Locality Boards / NYCF / NYDB
Automated matching of NHS Numbers is not done in a timely manner.	Better data sharing between health and social care	2	3	6	• Plans will be in place to manually populate NHS Numbers from current correspondence.	• Partner IM&T Leads

	Joint approach to assessment and care planning					
ITK standards are not sufficiently developed to meet the timetable of integration work.	Better data sharing between health and social care	3	2	6	• Local standards will be developed and applied through agreement across all partners affected. • Monitor and respond to guidance from the NHSE Interoperability Programme, HSCIC and other national bodies.	• Partner IM&T Leads
Legacy systems may not have suitable Open API's published.	Better data sharing between health and social care Joint approach to assessment and care planning	3	2	6	• Most likely to affect the social care system. Other methods for exchanging data already exist. • Monitor and respond to guidance from the NHSE Interoperability Programme, HSCIC and other national bodies.	• Partner IM&T Leads
The return on investment from carer-specific support is not properly recognised.		2	2	4	• Proper communications, engagement and information available to all organisations	• Locality Boards
The CCG Allocation (£114k net) from Cumbria CCG may not be transferred to this BCF Pooled Fund.		4	1	4	• Further work is to be completed to agree how the investment might be made in this area of the county and understand what Cumbria CCG are planning already	• HWB, managed through NYCF / NYDB