Health and Wellbeing Board
North Yorkshire

Integration of health and social care in North Yorkshire and the Better Care Fund plan 2017- 2019

6th September 2017

Presented by: Michaela Pinchard

Summary:

'People and Place' Integration of health and social care in North Yorkshire and the Better Care Fund draft plan 2017- 2019 will be presented to the Health and Wellbeing Board.

The plan is still in draft albeit a near final draft. Health and Wellbeing Board are asked to comment and approve the plan ahead of submission to NHSE on the 11th of September.

Which of the themes and/or enablers in the North Yorkshire Joint Health & Wellbeing Strategy are addressed in this paper?

[Please tick as appropriate]

Themes	✓
Connected Communities	✓
Start Well	✓
Live Well	✓
Age Well	✓
Dying Well	✓
Enablers	
A new relationship with people using services	✓
Workforce	✓
Technology	✓
Economic Prosperity	

How does this paper fit with <u>other</u> strategies and plans in place in North Yorkshire?

The Better Care Fund is a financial incentive for the integration of health and social care and as such enables delivery of a number of joint strategies and plans within North Yorkshire. E.g. Joint Health and Wellbeing Strategy, New Care Models, Dementia etc.

The narrative plan includes an overview of progress and plans for integration of health and care in North Yorkshire and as such has a wider view of partnership working than the better care fund schemes

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What do you want the Health & Wellbeing Board to do as a result of this paper?

HWB is asked to:

- Receive a presentation on the Integration of health and social care in North Yorkshire and the Better Care Fund draft plan 2017- 2019 recognising that the plan is still a working draft for comment
- Acknowledge the cooperation between partners in developing the Plan
- Agree the plan ahead of submission on the 11th of September

Health and Wellbeing Board
North Yorkshire

North Yorkshire Health and Wellbeing Board

'People and Place'

Integration of health and social care in North Yorkshire and the Better Care Fund plan 2017- 2019

DRAFT V3ii

Submitted 11th September 2017

Contents

1. Exec summary – Plan Details

1.1 Summary plan

Council	North Yorkshire County Council	
	Craven District Council	
	Hambleton District Council	
	Harrogate Borough Council	
	Richmondshire District Council	
	Ryedale District Council	
	Scarborough Borough Council	
	Selby District 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	
	Cumbria Clinical commissioning group	
Date Agreed By HWB	6th September 2017	
Date Submitted	11th September 2017	
	2017/18	2018/19
Minimum required value of pooled budget	**£50,488,333**	**£54,327,838**
Total agreed value of pooled budget	**£50,488,333**	**£54,327,838 TBC**
Commitments	**£50,488,333**	**£54,327,838 TBC**

1.2 Introduction

This plan reflects the significant progress made over the last year towards integrated commissioning and delivery of health and social care services in North Yorkshire and sets out our ambition for further integration by 2020 and beyond. It acknowledges the successes and challenges across the health and care system and describes how system leaders aim to build on those successes and address the challenges over the coming years.

The plan is aligned with the ambitions of the three Sustainability and Transformation Partnerships (STPs) across the North Yorkshire footprint, and describes a pan North Yorkshire approach to achieve economies of scale and to advocate for North Yorkshire in the STPs.

Acknowledging the central importance of place in transforming health and social care services, the plan is also arranged on the basis of the five key local health and care delivery

systems serving the North Yorkshire population reflecting their local transformation boards and associated transformation plans. Local governance applies to these plans and the North Yorkshire Health and Wellbeing Board has oversight via the governance structure shown in section X.

When adopting a pan North Yorkshire approach the principle of subsidiarity will be applied.

The North Yorkshire Health and Wellbeing Board has been updated throughout the process of developing the plan.

It should be noted that it is increasingly difficult for localities to disaggregate Better Care Fund activity as integration becomes business as usual across local systems.

1.3 Summary narrative

North Yorkshire is one of the most beautiful and exciting places to live, work and spend time. It is made up of unique mix of urban, rural and coastal communities and is one of the least deprived areas in England.

The geographic scale and diversity of North Yorkshire however creates a number of challenges for the heath and care system in terms of service delivery, market development, stability and sustainability.

System leaders understand North Yorkshire and the diverse communities within it. They also understand the benefits of combining local knowledge and delivery with county-wide collaboration and scale, and are committed to maximising the strengths of a devolved approach, where local Transformation Boards, Accident and Emergency (A&E) Delivery Boards and wider partners such as housing and the voluntary and community sector, have an important role in commissioning and delivering services that meet the needs of their diverse communities

During 2016-17 there has been significant progress made to determine and deliver a more integrated approach to commissioning and delivery, both at a locality level and at a pan North Yorkshire level where it makes sense to do so.

The North Yorkshire Commissioning Forum has made clear its ambition for a more integrated approach to commissioning at a countywide population level which could include mental health, children's services and public health.

Strong local leadership has also seen significant progress towards the development of joint locality commissioning arrangements which will act as a key driver for place based system transformation and delivering new models of integrated care that meet the needs of local areas. These arrangements will be underpinned by s75 agreements in some localities

System leaders expect that this approach will support graduation from the Better Care Fund within the next couple of years.

Building on the progress made to date, our ambition is to establish an unprecedented focus on Place, Prevention and Wellbeing in order to; consistently improve health and care outcomes across the North Yorkshire population; support more people to remain independent; better manage and reduce demand on health and care sectors, and deliver financial sustainability in the longer-term.

In terms of Better Care schemes there have been some notable successes such as quality improvement in care homes, frailty pathways, end of life care, improved access to psychological therapies and urgent care practitioners. These schemes support the North Yorkshire ambition for Wellbeing, enabling people to remain in their own home and or diverting them away from hospital care towards more appropriate settings.

A number of challenges remain however including financial pressures, variation in performance particularly around delayed transfers of care and non-elective admissions, recruitment and retention, market stability, technology and accelerating the spread of new models of care.

Strong and consistent leadership across such a complex and diverse system is a fundamental challenge in itself but system leaders in North Yorkshire are committed to working together with determination and focus to ensure consistency of approach where this is needed, share learning so that services can be transformed at scale and with pace and to address the key challenges that we all share.

Recognising that financial sustainability in North Yorkshire is a critical success factor in delivering a transformed health and social care economy partners have worked collaboratively to agree the plan including the Improved Better Care Fund (IBCF)

This will clearly help to address some of challenges we face though system leaders believe that greater gains will be derived from the wider programme of integration and transformation.

1.4 Summary of funding contributions

Organisation	2016/17	2017/18	2018/19 Indicative
NHS			
Airedale, Wharfedale and Craven Clinical Commissioning Group	£3,079,134	£3,134,250	£3,193,801
Hambleton, Richmondshire and Whitby Clinical Commissioning Group	£9,120,658	£9,283,918	£9,460,312
Harrogate and Rural District Clinical Commissioning Group	£9,415,585	£9,584,124	£9,766,223
Scarborough and Ryedale Clinical Commissioning Group	£7,467,696	£7,601,367	£7,745,793
Vale of York Clinical Commissioning Group	£7,174,673	£7,303,100	£7,441,858
Cumbria Clinical Commissioning Group	£408,532	£415,845	£423,746
Sub Total	**£36,666,278**	**£37,322,604**	**£38,031,734**
Council			
North Yorkshire County Council	£0	£9,308,112	£12,118,469
Craven District Council	£433,307	£474,664	£516,021
Hambleton District Council	£375,828	£409,002	£442,176
Harrogate Borough Council	£571,343	£622,873	£674,403
Richmondshire District Council	£212,493	£232,398	£252,302
Ryedale District Council	£452,569	£496,801	£541,033
Scarborough Borough Council	£1,145,100	£1,242,853	£1,340,605
Selby District Council	£346,958	£379,026	£411,094
Sub Total	**£3,538,000 (rounded)**	**£13,165,729**	**£16,296,104**
Total	**£40,204,278**	**£50,488,333**	**£54,327,838**

1.5 2017-19 Plans

The table below is a plan summary showing the 2017-19 BCF total spend on schemes in each area of spend.

Appendix 1 Shows the 2017-19 full BCF spending for plan by area of spend and locality Still to be inserted

Area of Spend	2017/18	2018/19
Acute	TBC	TBC
Community Health	TBC	TBC
Mental Health	TBC	TBC
Primary Care	TBC	TBC
Social Care	TBC	TBC
Other	TBC	TBC
Total	**£50,488,333**	**£54,327,838**

1.6. Authorisation and signoff

This plan was agreed by the HWB on 6th September 2017

Signed on behalf of the Clinical Commissioning Group	Airedale, Wharfedale and Craven Clinical Commissioning Group
By	
Position	Accountable Officer
Date	

Signed on behalf of the Clinical Commissioning Group	Hambleton, Richmondshire and Whitby Clinical Commissioning Group
By	Janet Probert
Position	Chief Officer
Date	

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

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

Signed on behalf of the Clinical Commissioning Group	Vale of York Clinical Commissioning Group
By	
Position	
Date	

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

Signed on behalf of the Health and Wellbeing Board	North Yorkshire Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Cllr Michael Harrison
Date	

1.7 Related documents

The North Yorkshire Better Care Fund 2016/17 '
NHS Clinical Commissioning Group (CCG) Operational Plans 2017/18 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
2020 North Yorkshire County Council transformation programme
'Hope, Control and Choice' North Yorkshire Mental Health Strategy 2015-20
North Yorkshire County Council Market Position Statement
'Bring me Sunshine' – North Yorkshire Dementia Strategy

2. The local vision for integrating health and social care services

2.1 Ambitions and outcomes for health and wellbeing in North Yorkshire

The 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 the 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 is delivering our commitment to develop a sustainable health and care system for the future and acts as the roadmap towards further integration in North Yorkshire.

Our Integration and Better Care Fund plan when combined with our Joint Health and Wellbeing Strategy, reinforces our commitment to improving the following outcomes for local people:-

- Improved choice and control – people will feel more involved in designing care services and being in control of care when they need it

- Improved experience of care – people 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 integrated health and social care by 2020

Multiple organisations with multiple services, North Yorkshire's size and geography, when coupled with the presence of three current STPs, six CCGs, seven district councils, four acute trusts, two mental health trusts and 90 GP practices makes the journey towards integration more complex than the norm.

System leaders across North Yorkshire however understand the unique mix of urban, rural and coastal communities and the importance of local Transformation Boards in developing new models of care. They also know from experience that what works best is when we combine local knowledge and delivery with county-wide collaboration and scale.

2.2i Links to STPs

The three current STPs that work across the North Yorkshire footprint ; Humber Coast and Vale; West Yorkshire and Harrogate; Durham, Darlington, Teeside, Hambleton, Richmondshire and Whitby, identified a funding gap of nearly £2bn up to 2020 if more of the same is done. The planning process highlighted that radical change is required in the flow of money around the system to develop preventative and out of hospital services that can effectively manage demand and deliver sustainability.

Key building blocks to the STPs are local partnerships and detailed locality plans. These local arrangements are essential to delivering efficiencies and new models of integrated care that will improve the wellbeing, health and independence of more locally recognised populations.

Throughout 2017-2019 localities will continue to align the Better Care Fund plan with wider transformation programmes that are described in Sustainability and Transformation Plans. This will maximise opportunities for accelerated learning and the spread of ideas that support delivery of the 'Five Year Forward View'.

2.2ii A plan for integration for North Yorkshire

CCG Chief Officers, Chief Officers from the County Council and NHSE Yorkshire and the Humber are holding detailed talks about future joint working arrangements. These arrangements share the core elements of integrated commissioning at county wide and locality level and integrated delivery with potential opportunities for further efficiencies through shared support services.

While necessarily reflecting differences in localities, the following principles are understood by all partners and underpin the North Yorkshire approach to developing and delivering integrated health and social care:

- Recognise where things are different
- Transform delivery through new integrated models of care with primary care at the heart of out of hospital care
- Tackle issues early
- Join things up to make life simpler
- Empower local people to self-care
- Keep people safe
- Spend money wisely

2.2iii Integrated Commissioning

Through placed based commissioning our aim is to better use the power of collective action to commission more effectively, primarily at locality level and at a North Yorkshire wide level where it makes sense to do so, and to move increasingly towards commissioning for outcomes with funding being allocated to ensure services deliver better health and care for local people.

Commissioners across North Yorkshire are leading a strategic approach to prevention and community services addressing system challenges at two levels:

- Supporting the transformation, reconfiguration and delivery of acute services using an evidence-based best practice approach
- Developing primary and community based alternatives to support people to live well and independently at home or as close to home as possible

Investment in community based services wrapped around primary care will support the shift in focus for acute services towards planned, rather than unplanned care thereby improving outcomes for people and supporting the move to reduced growth in acute spend.

Where appropriate we plan to establish joint locality commissioning arrangements, underpinned by s75 agreements to commission at a local level, thus ensuring that new models of care have a strong local focus, involve member practices and communities and can influence countywide decision-making.

2.2iv Integrated Delivery

Similarly, each locality has an integrated plan for delivery which recognise a number of work programmes as described in CCG operational plans. Localities are working towards new models of integrated care provision which aim to shift and rebalance how people receive out of hospital care, including primary care, community physical and mental health care, social care and public health. The journey toward establishing integrated provision, and

organisational forms for delivering joined up care will be different in each locality. Nonetheless, the key aim will be the same: more efficient and effective health and care services that make sense to local people.

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 public health and 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 in developing integration plans for the future.

2.3 How the BCF contributes to local integration

Our 2016/17 Better Care Fund provided a good opportunity for Health and Care Commissioners to consider whether the progress made was sufficient given the current and future context of increased demand and financial pressures, and to extend their thinking beyond the boundaries of the Better Care Fund towards greater integration of commissioning and innovation in delivery. From this perspective the Better Care Fund is seen in a wider context as a mechanism to help deliver what we want to achieve rather than an end in itself.

With this in mind we will continue to consolidate the progress made so far and embed this into 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

As in 2016/17 this plan recognises that local Transformation Boards are at different stages in delivering new services and developing their approach to integration. In all localities the

Better Care Fund is supporting transformation and the delivery of integration. Importantly, local boards and the HWB recognise that any investment through the Better Care Fund should support improved patient flow through the system to reduce inappropriate admissions to hospital, reduce delays in people being discharged and reduce the need for longer term care. More crucially this investment will prevent and delay the need for any care.

The approach to implementation and integration in each locality is described more fully in the context of the Better Care Fund for 2017-19 in section 4.

2.4 Continuing progress against the former national conditions

Building on the progress made in 2016/17 plans will continue to support implementation of the former national conditions.

Examples of activities in 2017-19 to ensure that progress continues include:-

2.4i Better Data Sharing

- Delivery plans for each Local Digital Roadmap will be produced in line with ambitions set out in STP's. Each CCG has established a governance process for delivery
- Delivery plans for the Technology theme of the Joint Health and Well Being Strategy will be developed and aligned with Local Digital Roadmaps & STP's
- Digital maturity self-assessments will continue to be carried jointly
- Plans are in place for the creation of a "digital village" in a rural part of North Yorkshire to allow innovative home-based technology solutions to be trialled as alternatives to traditional health and care services
- NHS Numbers will continue to be traced and uploaded to relevant systems
- Work with software suppliers will continue on a local and, where necessary, national basis to progress the delivery of Open-API's for each case management system
- All partners are committed to migrating their infrastructure from the N3 network to the new Health and Social Care Network in line with the transition timetable produced by NHS Digital. Along with the delivery of Open-API's this will provide the foundations for interoperable shared care records.

2.4ii Continuing progress towards meeting the 2020 standards for seven day services

Work with acute and community providers continues to ensure clinical standards relating to seven 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.

Examples of how progress towards meeting the 2020 standards for seven day services during 2017-19 include:

- An additional 18,000 appointments outside core hours for patients in Scarborough and Ryedale. Further work on local delivery plans to establish a draft service model with local need to be determined following patient and public feedback. Exploring solutions such as implementing the summary care record additional information for the most

vulnerable patients with a view to extending to all patients including those who request access to services during the extended hours' appointments. Further work with primary care to understand;

  - Patient needs
  - The scope of services offered
  - Delivery models
  - Impact on other services, and Infrastructure requirements

- Hambleton, Richmondshire and Whitby will focus on investment in community teams and continue to actively work to deliver seven day services as part of its Community 'Fit 4 the Future' strategy and ambition for transforming mental health services. 2016-17 resulted in continued investment in Intermediate Care and District Nursing and the implementation of eight community based Step Up/ Down Beds supporting discharges seven days a week. A new integrated End of Life service has increased services in patients' home environment or preferred place of care 24/7. Implementation in 2017 of three Discharge 2 Assess pathways including trusted assessment will enable the discharge processes to continue over a weekend.
- Following consultation with local people, Harrogate and Rural District are launching an 18 months pilot in Autumn 2017 to extend access to primary care in the evenings and at weekends through a hub model. This is a joint project with the Yorkshire Health Network and will enable access to routine primary care seven days a week.
- Within the Vale of York, the extension of psychiatric liaison services in 2017/18 across seven days operating from the local acute trust (YFT) as part of the A & E team which supports admission avoidance into an in-patient bed for those in crises. Fully staffing the service is a priority going forward following which redefined service pathways are expected to reduce hand-offs and unnecessary delays for people. An external evaluation will assess the impact of the scheme early in 2018 and will be used to support financial modelling once the current national monies expire.
- The Craven system has made significant progress against the national conditions. Plans for seven day service have been self-assessed as mature. Health and social care teams' work on a seven day basis covering evenings and weekends including hospital and community teams. Our plan is to continue to progress against the former national conditions using established improvement mechanisms.
- Implementation of a new operating model for adult social care commenced in April 2017. 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. The model will further enhance the flexibility and resilience to deliver seven day services. Additional social care capacity for seven day working is a priority for IBCF investment.

2.4iii Continuing progress towards a joint approach to assessment and care planning

Building on the progress made so far the emphasis for health and social care partners during 2017-18 and 2018-19 is to continue to transform out of hospital care and further develop and embed integrated locality team models and principles, particularly around assessment and care planning. Examples of how progress will be made include:

- The emergence of Multi-speciality Community Care Provider models across a number of localities, e.g. Hambeton Richmondshire and Whitby and Scarborough and Ryedale, bringing together social care and primary care while linking with current community providers to deliver service models that will ensure:
    - Improved prevention through single contact system of advice, guidance, signposting and direction into community support.
    - Rapid access to community response for those in crisis or stepping down from acute care
    - Combined care teams, based around practice populations, to provide planned care and proactive management of chronic diseases.
- Hambleton, Richmondshire and Whitby has undertaken significant work to establish discharge to assess pathways and the principles have been agreed across the system. Implementation will enhance discharge processes and more effective assessment and care planning for people with long term care needs in a more appropriate setting. Jointly commissioned Discharge 2 Assess beds have been agreed with the County Council for people requiring complex care outside of an acute setting. A Trusted assessment process has been developed and tested through commissioning step up step down beds and the end of life pathway. This will be crucial in further developing effective discharge and wider care planning.
- Through the New Care Model work Harrogate and Rural District are implementing lean methodology called 'productive and purposeful' which is supporting the development of joint assessment and care planning by bringing people who uses services and professionals together to have one conversation about care.
- The Vale of York locality model is establishing integrated services wrapped around primary care in the two sub-geographies that sit within the North Yorkshire boundaries. For the North locality (Selby and the surrounding vale) discussions are progressing to bring primary care together into virtual teams that can manage healthcare at scale. Further work is required to bring this model together with the current service provided through the Selby hub. This will be accelerated in 2017/19.
- The Vale of York is also reviewing Continuing Health Care recognising there are opportunities to manage this activity in a more integrated way leading to an improvement in pathways for people.
- Further to completion of the joint dementia strategy local plans are being developed with Dementia Collaborative's and will include areas such as improved dementia diagnosis rates in primary care, shared care processes, better support post diagnosis with greater signposting and navigation to support services for people with dementia and their carers.
- A scheme to facilitate implementation of Trusted Assessor is a priority for IBCF investment.

3. Evidence base supporting the plan

3.1 Local demography and future demographic challenges

A two-tier shire County; North Yorkshire is England's largest County covering 3,103 square miles and comprises some of the most remote, rural and coastal communities in the country.

The total population is just over 600,000 with 132,000 0-19 year olds and 130,000 people aged 65 and over. Life expectancy is better than the England average, but the gap between the least and most deprived communities is around 6.3 years for men and 4.6 years for women.

There is a higher than average employment rate in the County, although earnings and Gross Value Added per head are less than the national average. In addition to this, the County has a greater than national rate of inactive working age people, mostly through early retirement. Whilst overall the County is one of the least deprived areas in England, there are 23 super output areas in Scarborough, Whitby, Skipton, Harrogate and Richmondshire that are within the most deprived 20% in England, including Catterick Garrison, which is the largest military base in Western Europe

Cost, demand and the expectations of people and communities remain fundamental challenges for the sustainability of our health and care system in the future. We know that by 2020:-

- Nearly 23% of residents will be over 65
- The number of people with dementia will have increased by more than 20%.
- 1 in 4 people 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% 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 18% in Scarborough a significant national and local outlier

- Significantly higher than average England estimated levels of adult excess weight, equating to around 325,000 adults who are either overweight or obese in North Yorkshire'

3.2 Current state of the Health and Care Market

Local Government and the NHS are experiencing significant financial challenges and across North Yorkshire the NHS has a legacy of financial pressures. Some localities have more financial and service pressures than others with the York and Scarborough areas under particular pressure.

There are an increasing number of people with multiple long term conditions, frailty and complex social, emotional, medical and psychological problems in North Yorkshire and too many frail and elderly people are attending emergency departments with conditions that could be managed in the home setting with the right level of support. Furthermore there is often a lack of emphasis on prevention in out of hospital community settings.

While there is an extensive and varied market for care and support with over 120 domiciliary care providers and 200+ care homes in the county, the market has become increasing fragile over the last few years. It is a struggle in many, though not exclusively, very rural areas of the county to secure care at home for people.

Care Homes do not rely solely on council placements. Only a third of beds are funded by the Council; a further third occupied by people who are self-funders; and the rest by people who are funded by Continuing Health Care or other councils.

Domiciliary and care home providers across the county are above the national average for good and outstanding Care Quality Commission ratings, however a number of providers have been lost from the care home market because of quality issues. Many are impacted by failings around leadership and retention of nursing staff. New homes are still being developed, although most with fee levels far in excess of the County Council's standard fees. More can be done to support improvement and with a strong self-funding market we have to look at commissioning levers beyond our purchasing power to shape the market.

Social Care providers are keen to work collaboratively with commissioners on a wide range of issue and do so through a number of channels including the Independent Care Group, regular locality based provider forums and an emerging Partnership Board with the Independent Sector.

A second cost of care exercise for residential and nursing care homes undertaken last year, demonstrated that fee levels in North Yorkshire are relatively high compared with the rest of the region. However fee levels continue to be a key concern to providers.

Recruitment and retention is also a key pressure for both health and social care. With near full employment health and care providers find it hard to attract and retain quality staff. In

social care, the workforce is predominantly female and employed on zero hour type contracts. This leads to seasonal capacity issues around school holidays, whilst the scale of local tourism creates additional pressures in coastal areas through the summer.

A Workforce Heatmap confirms there are issues with wage levels and the demands placed on care workers' from the increasingly complex set of needs they are asked to support. A number of care providers are already paying above National Minimum Wage, but still struggle to recruit. Competition with other sectors, including retail and tourism, offer attractive alternatives for the workforce. The County Council has developed www.makecarematter.co.uk which will act as a recruitment and information hub for the entire sector across North Yorkshire.

The Council, working with partners is exploring how it can influence the development of new nursing care homes and how together with health partners the challenges around nursing and care home staff can be addressed.

An approach which tailors solutions to different localities and develop the home care market and Extra Care as alternatives has been largely successful with for example a domiciliary procurement exercise that covers areas with the largest population concentrations i.e. Selby and Harrogate. For domiciliary care the approach is now to work with providers to develop local solutions. This includes but is not limited to rural payment structures, use of PAs and Direct Payments, better streamlined brokerage processes and a move towards outcome based care. There is an acceptance that given the geographic and workforce issues we face, there is no simple option which can be pursued through a one off or phased procurement.

There is a good voluntary sector offer, and the council's stronger communities programme, funded through the Public Health Grant, is working with partners to develop new local community support and to shape and sustain the sector.

3.3. Progress in 2016/17

In 2016-17 there has been significant progress made to determine and deliver a more integrated approach to commissioning and delivery, both at a locality level and at a pan North Yorkshire level where it makes sense to do so.

The North Yorkshire Commissioning Forum has made clear its ambition for a more integrated approach to commissioning at a countywide population level which could include mental health, children's services and public health.

Strong local leadership has also seen significant progress towards the development of joint locality commissioning arrangements which will be a key future driver for place based system transformation and delivering new models of integrated care that meet the needs of local areas and support more people closer to home. These arrangements will be underpinned by s75 agreements.

Throughout 2016/17 Locality transformation boards have continued to deliver services that are coordinated around the needs of people and build on progress made last year to develop and implement new models of care. For example:-

- Harrogate – early work in integrated commissioning and provision and - What Matters to Us', a new model of care encompassing community hubs and integrated care delivery, shared care plans, and a virtual information hub

- Airedale, Wharfedale and Craven 'Happy, Healthy, at Home' programme, a care home vanguard and work to develop, reconfigure and expand integrated community services as part of the National Integrated 'Pioneer Programme

- Integrated Pioneer Status for Vale of York for work on health and care improvement through integrated care pilots

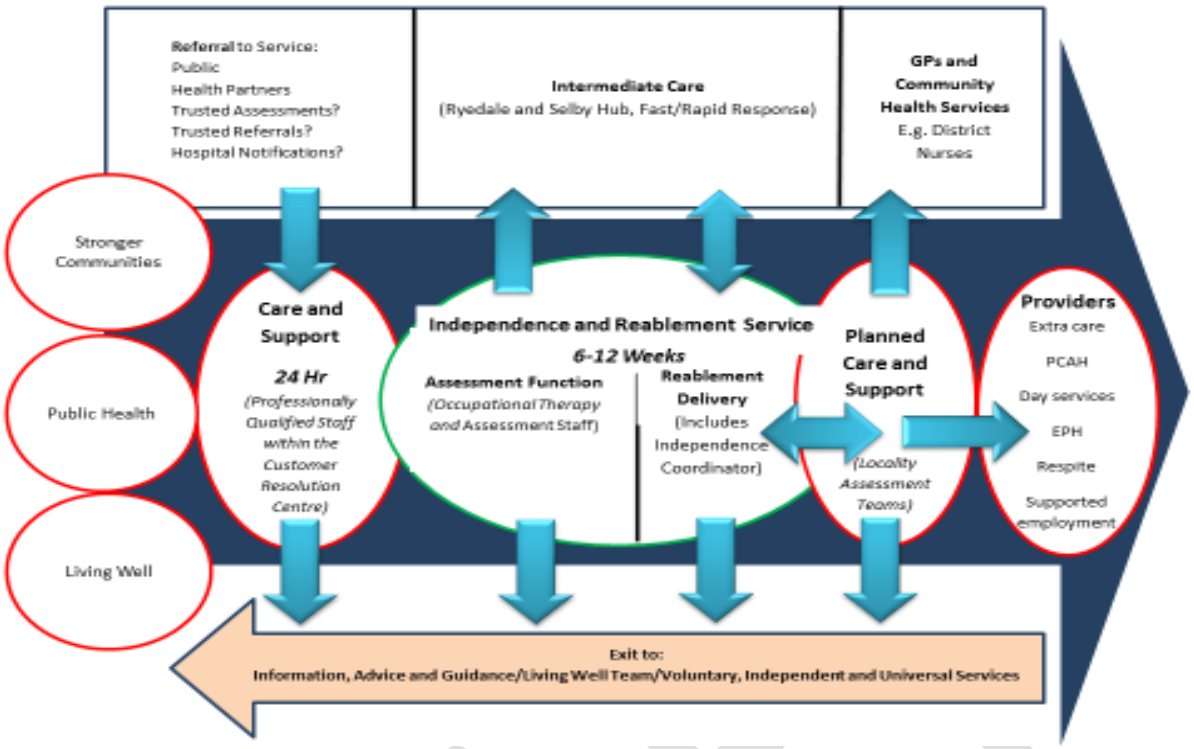
- Hambleton, Richmondshire and Whitby's Fit 4 the Future strategy; new model of care around urgent care, community and primary care services, mental health, diabetes services and development of planning to move to an MCP model.

- Scarborough and Ryedale's 'Ambition for Health' programme and work on an emerging ambition for integrated community health and care MCP model, putting GPs at the heart of service delivery.

For adult social care the key area of focus over the past 12 months has been the launch of the new Care and Support Pathway which is key to the transformation of the adult social care offer in North Yorkshire and has been co-produced with local health partners, to optimise opportunities for integration.

Key Elements of the Pathway which is shown in diagram x below are:

- A Strong Front Door – Customer Resolution Centre (CRC) and Living Well Services Stronger Communities and Public Health
- Independence and Reablement - supporting people to maximise their independence
- Planned Care - supporting people with long term social care and support needs and their carers
- Provider Services – developing a niche role for directly provided services



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.

3.4 2016/17 Progress review by locality

A review of progress by locality during 2016/17 can be seen in **Appendix x**

3.5 Achievement of key metrics in 2016/17

Table x below shows the forecast outturn for each of the high level metrics in the 2016/17 plan.

Table x Target and forecast outturn for high level metrics in the 2016/17 plan.

Metric Description	Target 2016/17	Forecast Outturn 2016/17	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 **3,187 NEA**	An increase in NEA across the HWB area of **2,782 NEA**	**5,969 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 552.5 placements per 100,000 pop 65+	The outturn was **489.5** placements per 100,000 pop 65+	This represents **63** placements per 100,000 pop 65+ below 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 88.7%	The outturn was **83.6%** of people now remain at home 91 days after discharge	**5.1%** fewer 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 (from 2015/16 outturn position)	The 2016/17 plan was for **14,330** delayed days. The actual number of delayed days recorded for North Yorkshire residents was **25,576**.	**11,246** 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 match the 2015/16 rate per 100,000 people aged 65 and over achieved in 2015/16: 1562.1	The 2016/17 plan was for **2,147** people being injured due to falls. The actual number recorded was **2,228.**	The outturn was an increase of **213** injuries due to falls during the year.
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 match 2015/16 performance of 63.1% for the proportion of people who have a LTC and use their written Care plan manage their condition	The outturn is **61.5%** of patients use their written Care plan manage their condition	This represents a **1.6%** difference between the plan and the actual outturn.

3.6 Successes

2016/17 has seen a stronger commitment to joint working between health and social care teams ensuring appropriate care is delivered outside hospitals and accelerating the pace of reform to deliver financial sustainability across the system.

Partners are seeking to develop a more consistent approach to delivering out of hospital services across North Yorkshire which has resulted in discussions to create of a number of joint locality led commissioning boards underpinned by Section 75 agreements.

There are good examples of localised achievements e.g. Airedale, Wharfedale and Craven are top performers in delayed transfers of care and emergency stays following admission; Scarborough and Ryedale has seen significant success in avoiding NEAs at the end of life through the work of the integrated palliative care scheme and access and recovery targets for the IAPT service have been met this year, for the first time since the scheme was introduced; GPs working with Care Homes across Harrogate and Rural District has been well received, improving relationships between sectors, preventing admissions and enhancing end of life care. In the Vale of York, Urgent Care Practitioner activity has helped avoid admissions in a significant number of cases.

Performance in relation to admissions to residential and nursing care (65 and over) has improved. The forecast outturn of 500 placements per 100,000 pop 65+ represents 52 placements per 100,000 pop 65+ below the anticipated target position. This could in no small part be attributed to the increased availability of Extra Care accommodation in three localities across the County and greater use being made of reablement and community based packages of care.

There are a number of examples of good practice that are impacting on metrics and /or being spread more widely. For example Vale of York: Hospice at Home Service and Selby Care Hub, the integrated palliative care scheme in Scarborough and Ryedale, use of the Immedicare 24/7 telemedicine service in Hambleton, Richmondshire and Whitby to access the Airedale and Wharfdale hub for clinical advice, an Integrated End of Life Pathway, enhanced community bed model of eight step up/down beds across Hambleton, Richmondshire and Whitby, living well teams and further development of extra care.

The percentage of NHS Numbers held within adult social care has reached 92% from 90% at the start of 2016/17. Further work is ongoing to improve core data quality which will result in an increase of matched NHS Numbers returned through the Demographics Batch Service

3.7 Challenges and opportunities

The system continues to face significant financial, demographic and workforce pressures that impact on the sustainability of the market, the ability of the health and care system to effectively manage demand, and ultimately the ability to achieve good outcomes for people in need of health and care support and their carer's.

The nature of financial flows within this health and social care economy make it unclear how the resources that are saved by the management of demand can be secured and invested in more demand management.

While there are some examples of localised improvements, in line with the national trends - NEAs and DTOCs figures continue to show an increase.

Working across 5 CCGs coupled with the complex environment in which the BCF schemes are commissioned, makes it difficult to link activity in a scheme with effect on NEA and DTOC, except where there is a direct measurement of avoided admission and delayed transfer as an outcome.

It is clear however that during 2015-16 & 2016-17 a number of better care schemes have supported the move towards more integrated care, contributed to managing the demand for hospital emergency department attendance and diverted many who would otherwise have spent time as inpatients. Even more importantly they have successfully enabled people to be cared for at home. This is good for people and good use of resources across the health and social care economy.

Furthermore 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 continued investment in community services through 2015/16 & 2016/17 which are already showing benefits and will continue to fully realise expected benefits over time.

System leaders believe many of these challenges can be addressed successfully through strong system wide leadership good integrated out of hospital services, working at a cluster level to actively support frail elderly people with locality transformation programmes each articulating the vision for transforming services to better the needs of their respective populations.

Greater collaboration between health and care partners in North Yorkshire is helping to accelerate the pace of change towards this through more integrated commissioning and delivery.

4. Plan of action to contribute to delivering the vision for social care and health integration

4.1 Overview

During 2017-19 we will build on the progress made to determine and deliver a more integrated approach to commissioning and delivery, both at a locality level and at a pan North Yorkshire level.

System leaders are committed to the idea of joint locality commissioning arrangements as a key driver for place based system transformation and delivering new models of integrated care that meet the needs of local areas. Consultation has commenced in one area and about to commence in a second. These arrangements will be underpinned by s75 agreements

Each locality has a co-ordinated and integrated plan of action for delivering transformation and their better care fund schemes. In recognition of the central importance of place in transforming health and social care services, this plan is described by locality in sections x - x

While plan details vary by locality there are some recognisable features for 2017-19 across the North Yorkshire footprint. Namely:-

- The BCF has acted as a key enabler for testing out community based new models of integrated care and plans demonstrate a commitment to integration through continued investment in new models of care to improve outcomes for local people
- Plans build on the successes of the last two years and schemes implemented through the BCF in 2015/16 & 2016/17 will continue where outcomes have been delivered and or are beginning to realise benefits
- A system wide commitment to effectively tackle delayed transfers of care
- Strong governance and a commitment to improved performance management
- Strong alignment between BCF, CCG Operational plans and STPs and a commitment to future graduation from BCF

4.2 Improved Better Care Fund

While the County Council has faced severe funding reductions and efficiencies are being sought right across the council, we have and will continue to invest in adult social care.

The Councils Section 151 officer has confirmed in a letter to the Secretary of State that the new grant announced in the 2015 spending review and the additional funding announced in the 2017 spring budget will be used to prioritise Adult Social Care allocating additional budget of over £9m to its recurring pressures, whilst raising £5.3m through the precept.

In accordance with the conditions of the grant the funding will be used to:-

- contribute to addressing adult social care pressures
- help stabilise the care market
- assist with the reduction in delayed transfers of care

While the additional grant is welcome there is a risk associated with recurrent spend which has been considered as part of developing the proposals. The grant does however provide an opportunity to launch new initiatives across North Yorkshire that will help to reduce pressures, stabilise the care market and improve the position on delayed hospital transfers.

The priorities and proposals for investment were developed with regard to

- Market intelligence regarding pressures and capacity in the care and support markets in North Yorkshire
- DTOCs across North Yorkshire, including work to implement the High Impact Changes for managing transfers of care
- Underlying £3.8 million pressure on social care purchasing budgets based 16/17.
- Feedback from the North Yorkshire NHS and care provider partners

- Steer from NYCC Executive Members: agreement in principle to underwrite up to £3.4m of recurrent spend.

The proposals were grouped into sections which relate to the conditions for the use of the grant. Subsequent to the initial long-list a prioritisation exercise was undertaken with partners based on the following criteria:

- Benefit to the NHS particularly in relation to delayed transfers of care
- Evidence for the effectiveness of the scheme
- Whether the funding commitment is recurrent or not and are schemes that need recurrent funding these that we would prioritise
- Whether there is an exit strategy if recurrent funding isn't available
- Whether the scheme relieves pressure, supports or develops social care capacity
- Whether the scheme addresses or reduces the continuing pressure on social care budgets
- Whether schemes clearly linked to the Local Authorities strategic objectives
- Confidence in delivery given constraints of time and availability of workforce
- Ability to measure the impact and effectiveness of schemes

Subsequent to agreement to the proposals work is well underway to implement the proposals within a robust programme approach.

4.3 Disabled Facilities Grant

A draft Memorandum of Understanding developed during 2016/17 provides the basis of an agreed approach to the administration of Disabled Facilities Grant and a foundation upon which to build on existing partnerships and take a more joined up approach to improving outcomes across health, social care and housing.

While it is acknowledged that the activity required will vary by district and locality the following aims and objectives form the basis of the understanding:

Aims

- Support the drive for integration between health, social care and housing to achieve positive outcomes for people living in North Yorkshire
- Promote, develop and standardise good practice in the administration of Disabled Facilities Grants so that statutory duties are delivered efficiently and with the needs of the customer at the centre of service design.

Objectives

- Further improve the effectiveness of partnership working between the county council, CCGs and the seven district councils to ensure there is transparency for the North Yorkshire Health and Wellbeing Board between the Disabled Facilities Grant and the North Yorkshire Integration and Better Care Fund Plan
- Improve end to end Disabled Facilities Grant pathways and delivery mechanisms

- Work towards establishing a performance framework comprising of satisfaction and timeliness measures and indicators to ensure service standards are understood by all Partners and all Partners can be reasonably held to account.

The Memorandum of Understanding will be finalised over the coming months.

4.4 Goals, activity and delivery for 2017-19 by locality
4.4i Airedale, Wharfedale and Craven locality. 'Happy, Healthy, at Home'
Goals
The plan for Airedale, Wharfedale and Craven is spread across two health and wellbeing board plans. Further information and plans for Airedale and Wharfedale that cross into Craven can be found in the Bradford district plan. This narrative focuses on our Craven locality.

A wave two pioneer, the CCG has ensured the pioneer programme support is tailored to the vision for accountable care and there have been new projects looking at payment and contracting models as well as organisation development and design work across the system.

Linked to our Better Care Plan is the focus on providing advice on disabled adaptations and energy efficiency, working in partnership to increase the supply of affordable housing, improving private sector housing conditions for people in Craven and enabling active communities to improve quality of life. As a national integrated care pioneer site and have benefitted from support and help to develop our new models of care. These models will ensure that people in our area receive individualised seamless care, and reduce their need for urgent and unplanned care by proactively managing their physical, psychological and social care needs. Areas of care being developed include:

- complex care - people with complex care needs are supported to take control of their own care and given support and help from the personal support navigators to access, where eligible, personal health budgets;
- enhanced care - people with long-term conditions are provided with tailored support by their GP practice to support them in achieving their own personal
- goals;
- wrap around care - an integrated community care response, which includes therapy support to help people stay independent for longer;
- self-care - people are encouraged to set their own goals and look after themselves and seek professional support and advice when needed.

This reflects and compliments the goals of our Better Care plan over the last year supporting the transformation of services and experience of care in relation to Non Elective Admissions, Residential Admissions, Reablement, Delayed Transfers of Care (DToC), Falls and Patient Experience.

Activities for 2017-19

This year has seen a change to how we work across the health care and support system as we create a new way of working across providers and commissioners. We are developing a population health management approach to provision and commissioning of care similar to that seen in accountable care systems in other parts of the world. We expect this new approach to improve health inequalities as well as help us manage rising demand. Our work as a national Integrated Care Pioneer to deliver new models of care continues. The new complex care team, funded by the CCG, is a fantastic example of the partnerships being established to transform how care is delivered. Involving health and social care professionals from Airedale NHS Foundation Trust, Bradford District Care NHS Foundation Trust and Yordales (a federation of local GPs), the team has provided additional physical, mental and social support to people with complex needs since April 2016. The unique role of the personal support navigator, delivered in partnership with Bradford Council and local voluntary and community services, is working closely with people to help connect them with activities in their community.

Ensuring delivery

We demonstrated strong BCF delivery over the last two years, and this was due in part to robust programme management and governance, which we will keep in place for 2017-19 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.

4.4ii Hambleton, Richmondshire and Whitby locality – 'Fit 4 the Future'

Goals

We are committed to deliver an ambitious transformation programme in 2017-19 that aims to strengthen local services and improve the lives of people in Hambleton, Richmondshire and Whitby. This programme will deliver new models of care, 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 with the right care and support.

The HRW BCF schemes are embedded as part of our transformation plan for primary and community care and have seen some significant success in working collaboratively with partners to date.

The establishment of a Joint Commissioning Board will harness further opportunities for integration to better support our frail/ vulnerable population in a consistent manner. These arrangement will be formalised through a section 75 agreement

Activities for 2017-19

For 2017-19 the frailty pathway encapsulates our new model of care by bringing each element of community and primary care transformation together under an end to end pathway. This requires a collaborative approach including community providers, acute providers, primary care, social care and the voluntary sector. Priorities include:

- early identification and proactive integrated support for the most vulnerable
- Further establishment of integrated locality teams leading to MCP development
- Embedding trusted assessment principles that have already been tested successfully
- Discharge to assess pathways to reduce DTOCs and improve long term outcomes for patients
- Further enhance the integrated end of life pathway
- Further roll out of Immedicare telemedicine service
- Ensure an integrated model of community mental health services

Our priorities focus on areas where we can make a real difference to improving the health of our population locally and are also aligned to achieve the aims of our STP and those of the National Outcomes detailed in the NHS Operating Framework.

We aim to constantly improve the quality of care through active engagement with all stakeholders throughout the commissioning processes, recent consultation has taken place on transforming our communities and we are in the process of consulting on the transformation of mental health services. It is imperative to our planning process that quality is measured not just through clinical outcomes but also through patient experience.

We also aim to support our member practices to work together through the establishment of Primary Care Clusters and to share best clinical practice and to continue to develop a strong communication network with our members.

We have a strong focus on joined up working between health and social care teams ensuring appropriate care is delivered outside hospitals e.g. this work includes Integrated Locality Teams and Integrated End of Life service. Our plans seek to ensure that hospitals are used only when appropriate in order to provide urgent and specialist treatments for those that will benefit most. We have ambitious plans to strengthen services delivered in primary care and pursing all opportunities for out of hospital care through cluster working, attracting more GPs to the area and growing the work force. Our cluster development work will enhance proactive care planning and delivery for patients at risk of hospital admission that require wider service support.

We will increase the number of services that are delivered outside of hospital settings. We will be developing 'multi-community specialty provider' (MCP) health and social care hubs proactively targeting services to registered patients with complex ongoing needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients. The model is expanding the leadership of primary care to include nurses, therapists and other community based professionals.

Joint Commissioning arrangements will enhance opportunities for collaborative working to reduce the number of people that require admission to hospital, this is evident from our work on community step up/down beds and the integrated End of Life pathway. We recognise that we need a strong focus on creating sustainable nursing and residential care provision to support timely hospital discharge, our discharge to assess pathways have been agreed and an implementation plan is in place to establish and embed these into frontline services. This will impact positively on delayed transfers of care.

We are in the process of strengthening links between health and social care commissioners. Plans are being developed to integrate commissioning functions where it makes sense to do so and we want to build and encourage the development of the voluntary sector so they can support patient care in the community, ensuring health and social care services are used effectively.

These principles apply entirely equitably for both physical and mental health and for service users with a learning disability.

Above all we will continue to ensure that the patient is at the heart of everything we do.

Ensuring delivery

We are establishing two locality transformation boards to replace our programme boards these will be accountable for the leadership of the community transformation, primary care 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 these Boards to enable decision making. The Board will provide reports as necessary to the locality Transformation Board and Audit and HRW Information Governance Committee.

A range of Task and Finish Groups report to the Local Transformation Boards 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, Discharge 2 Assess and Integrated Locality Teams, Immedicare Telemedicine Service). All Task and Finish Groups are 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.

4.4iii Harrogate and Rural District locality – 'What Matters to Us'

Goals

Harrogate and Rural District is committed to working with system partners to transform the delivery of local health and care services for Harrogate communities. We believe that integrated commissioning and integrated delivery models are the enablers to achieve our ambition of building a sustainable health and care model that invests the Harrogate pound wisely.

Since 2015 the Better Care Fund (BCF) has provided a platform to shape and implement a more integrated health and care local offer. Through 2017-2019 our focus is to align the BCF plan with wider transformation programmes that are described in the Harrogate Sustainability and Transformation Plan (STP). This will maximise opportunity for accelerated learning and spread of ideas that support delivery of the 'Five Year Forward View'.

The BCF plan and the Harrogate Vanguard - New Care Model (NCM) represent two of West Yorkshire & Harrogate STPs five priority areas and are core elements of the 2017/19 CCG Operational Plan. Dependencies are recognised and plans will ensure that priorities are aligned with other projects and business as usual. The NCM is in its final year of implementation and is testing a radical new model of integrated delivery between primary care, community health, social care, mental health and voluntary care sector. The new model is still at early stages of implementation, but planning is underway to assess the viability of scaling and adopting the integrated model across Harrogate during 2018-2019.

The focus for 2017-2019 is to transform and strengthen the primary, community and local urgent care offer:

- making it simple for people to navigate and access the right care at the right time
- reduce activity and spend in the acute sector, and rebalance investment in those services that support people to live independently
- reduce non-elective admissions
- improve flow through hospital
- reduce delayed transfers of care.

This work will be developed and assured through a number of joint planning forums including the Accident and Emergency (A&E) Delivery Board, the Harrogate Health Transformation Board, in addition to CCG business as usual committees.

HaRD CCG will continue to work as part of the North Yorkshire Commissioner Forum, to develop and implement integrated commissioning where evidence supports the value of commissioning across a wider geographical footprint.

Activities for 2017-19

HaRD CCG's integrated plan for delivery recognises a number of work programmes which include the Urgent and Emergency Care Delivery Plan, New Care Models programme, the Better Care Fund and commitments as part of the West Yorkshire and Harrogate Sustainability

Partnership. These are all described in the HaRD CCG Operational Plan. Projects, schemes and initiatives will be further developed in 2017/18 to ensure resources and planned outcomes are aligned to support an integrated delivery model. The overlapping themes of partnership, prevention, empowerment, early intervention and choice are present.

The three key planning and delivery areas where system partners are working to develop and implement joint plans that improve access and outcomes for Harrogate communities are:

1. Urgent and Emergency Care Delivery Plan

The Urgent and Emergency Care (U&EC) Delivery Plan is a local system wide plan which contains programme of work under which initiatives have been implemented or are planned to enable us to meet the eight national priorities. The objective is to deliver a coherent urgent care offer to the population of Harrogate and Rural District.

This plan includes testing innovative new models of service:

- Access to evening and weekend appointments with general practice
- Streaming of appropriate patients to a GP led service co-located with A&E
- Ensuring discharge assessments and funding decisions are taken outside of the acute care setting

This includes:

- Use of a Trusted Assessor model
- Discharge to assess process
- Use of SAFER model
- Implementing planned discharge dates
- Prioritising additional social care funding to support reduction in delayed transfers of care (DToCs)

2. New Care Models

Under the banner of 'What Matters To Us', the development of a new care model is an ambitious three year partnership programme involving NHS Harrogate and Rural District Clinical Commissioning Group, Harrogate and District Hospitals NHS Foundation Trust, Tees, Esk and Wear Valleys NHS Foundation Trust, Harrogate Borough Council, North Yorkshire County Council and Yorkshire Health Network.

The programme's aim is to deliver joined up, community-based health and care services that enable people to regain and maintain their independence, health and wellbeing and to avoid hospital admissions unless there is no safe alternative. The programme, now in year three, is honing the delivery model through intensive testing of a new approach focused on three GP practices, representing 30% of the population. The following approach includes:

- Intensive operational and quality improvement support across the partnership

- An **Integrated Response** team working with 3 practices and developing the role of the GP and other primary care staff
- Implemented Tees, Esk and Wear Valleys NHS Foundation Trust's **Purposeful and Productive Community Services** quality improvement system including close daily monitoring
- Development of a local algorithm to supplement predictive risk stratification tools and the electronic Frailty Index to better find people at risk of admission
- Focused on finding people approaching crisis, not in crisis, and
    - Providing intense integrated support that will stop or delay people reaching crisis and being admitted to hospital
    - Change the pattern of utilisation of health and care services from unplanned to more pre-emptive, controlled and planned
    - Achieve better outcomes for people focused on their priorities and goals

3. Better Care Fund

Our Better Care Fund (BCF) programme spans the NHS and local government and voluntary sector partners and seeks to join-up health and care services so that people can manage their own health and wellbeing and live independently in their communities for as long as possible.

The BCF will improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them with integrated health and social care services, resulting in an improved experience and better quality of life.

In its third year of delivery, multiple projects and schemes have been joint-funded by the CCG and Local Authority across the sectors of acute, primary care, mental health, social care and voluntary sector. Projects and schemes supported range from mental health crisis service, befriending and EMI respite to support for carers, home from hospital support and a dementia service.

The goals and activities described in our BCF locality plan derive from and are an integral part of the HaRD CCG operational plan.

Ensuring delivery

Our model recognises the complexity of local systems and the transformation required to shift and rebalance how people receive care. This will mean that more people will be supported in the community than in hospital and people will be an active participant in their own wellbeing. We will coordinate our activities to meet the individual programme goals and align delivery of services, whilst identifying gaps and duplication so resources can be appropriately deployed.

Local delivery is managed through HaRD CCG commissioning team under the leadership of the Director of Transformation and Delivery. Individual schemes will be delivered through relevant responsible groups, for example A&E Delivery Board for reducing delayed transfers of care and establishment of the Trusted Assessor process; CCG Transformation and Delivery

Board for GP Extended Access, Harrogate Health Transformation Board for New Models of Care.

Performance, delivery and risks related to system transformation are reported through organisational governance frameworks and where appropriate to Harrogate Health Transformation Board (HHTB) and the North Yorkshire Health and Wellbeing Board.

4.4iv Scarborough and Ryedale locality – 'Ambition for Health'

Goals

Scarborough and Ryedale is part of the Humber Coast and Vale STP (HCV) along with five other NHS Clinical Commissioning Groups and six local authority boundaries representing communities in Hull, East Riding, York, Scarborough and Ryedale, North Lincolnshire and North East Lincolnshire. The HCV STP has six priorities which will be embedded within the change it is striving to achieve. These are:

- Helping people stay well.
- Place-based care.
- Creating the best hospital care.
- Supporting people with mental health problems.
- Strategic commissioning.
- Helping people through cancer.

Our local transformation programme, Ambition for Health, forms the basis of the SRCCG placed based plan within the HCV STP. The BCF is a crucial component of this programme. The aims of the programme are:

- Healthy lifestyles – an ambition to help people lead healthy lifestyles, supporting them to take control of their own health to prevent illness.
- Care closer to Home – an ambition to improve out of hospital services through integration across community services, social care, mental health services and primary care services with the aim of supporting people at home and preventing people needing treatment in hospital.
- Sustainable services – an ambition to ensure that acute and mental health hospital services are financially and clinically sustainable.

Activities for 2017-19

Our out of hospital care will be transformed by the procurement of a Multi-Specialty Community new model of care to facilitate integrated adult health and social care services, bringing together social care, community and primary care to deliver service models that will ensure:

- Improved prevention through single contact system of advice, guidance, signposting and direction into community support.

- Rapid access to community response for those in crisis or stepping down from acute care
- Combined integrated care teams, based around practice populations, to provide planned care and proactive management of chronic diseases.

This new model of care will develop in phases and will ultimately shift elderly sub-acute care from being primarily hospital bed-based, to that of a 'Home First' approach delivering care into patients' own residence.

SRCCG will take forward procurement for a Multi-speciality Community Care Provider. A number of community services are included in Phase One of this (18/19), further services in Phase 2 (18/19) and there is opportunity to include further services in the scope of the MCP, including significant parts of Social Care delivery at a later date. Elements of some of these services are currently included in the 16/17 plan as BCF schemes.

Ensuring delivery

Delivery of the Ambition for Health programme and BCF schemes falls within the governance of the CCG as whole, and schemes' performance is considered as part of the overall CCG performance system, measured and reported to the CCG Governing Body and it's sub committees where required. Since Integration and the metrics outlined in the BCF plan are key components of both the CCG strategic plan and the HCV STP, the CCG no longer has separate governance structures for the BCF schemes.

There is a current work stream to develop further integration between the A&E Delivery Board planning process and the Health and Wellbeing Board planning process, both at strategic level and also at operational delivery level (Local Transformation Plans).

All BCF Schemes are monitored and reported through established CCG governance processes, "where they lie", in order that they are fully integrated as part of the wider CCG plan. For example, IAPT and Psychiatric Liaison are managed as part of the Mental Health work stream; the Integrated Palliative Care Scheme is managed as part of the Palliative and End of Life work stream.

This will ensure that the individual schemes are managed appropriately within the overall CCG and STP plans, which are designed to be integrated with the aims and objectives of the HWB plan.

In addition, some of the schemes are included in the CCG Quality, Innovation, Productivity and Prevention (QIPP), Programme. These schemes are therefore also scrutinised for their productivity against an agreed financial target. They are measured and reported monthly to the Governing Body or its sub committees, and where appropriate issues are escalated for decisions on performance management.

4.4v Vale of York locality

Goals
The York Better Care Fund plan for 2017/19 includes existing BCF schemes, system wide pilots that require on-going funding and new schemes to address areas that require greater focus as part of the integration agenda locally.

Vale of York CCG is currently operating under the special measures regime and legal directions from NHS England, put in place effective 1 September 2016. The CCG was required to produce an Improvement Plan outlining how it would improve the capacity, capability and leadership in the CCG alongside delivering the changes needed to recover the financial position to one that is sustainable for the future. Building on this, the CCG has developed and approved a Medium Term Financial Strategy (MTFS) which has been shared widely with partners and sets a course for financial balance by 2020/21.

To address these challenges, we want to harness our shared assets to create a different response to managing demand. We will do this by developing whole community, whole system solutions. Partners recognize the difficulty in meeting individual organizational pressures whilst working collaboratively but understand that sustainable solutions to the challenges we face requires partners to work together to address the health and social care pressures in the local system.

Activities for 2017-19
There is a high level of consensus about the characteristics of an integrated health and social care system for York. We believe that the progress made to date from the existing BCF arrangements gives us a platform to build on. The areas that we would like to see strengthen include the reablement services, integrated place based commissioning, local area co-ordination, focus on wellbeing and more emphasis on self-management.

Ensuring delivery
A Joint Commissioning Strategy was approved by the York HWB in 2017. This is a high level strategy which sets out why and how we will work together in the period to 2020 to commission health and social care services for children, young people and adults. It is designed to provide a framework within which specific strands of joint commissioning work will take place, including the schemes linked to the BCF.

Our local definition of joint commissioning refers to the ways in which the organisations which form part of system of health care, social care and public health work together and with the local community to make the best use of the resources available to them in designing and delivering services and improving outcomes for local people of all ages.

Commissioners will work together to specify and agree an integrated approach to needs assessment, service specifications, funding and financial management, governance, contracting, performance management, community engagement and risk management.

The first annual joint commissioning plan, currently in development to align with the usual business planning cycle, will set out priorities for joint commissioning work, with specific plans for the actions to be taken to deliver the plan. Identifying key actions, agreeing individual lead commissioning responsibilities, engaging with providers and the community, and setting timescales for action in relation to these strands of work is the immediate focus for the Head of Joint Commissioning.

During 2017/19 the BCF plan figures prominently in the wider integration agenda underpinned by robust governance arrangements to support delivery. A high level review of current governance arrangements across the system has been undertaken, which has resulted in a clear understanding of the partnership arrangements that are in place to support the different levels of system change required. Commissioners are clear that the HWB is statutorily responsible for oversight of the BCF with a need to manage any resource effectively through shared commissioning and programme management functions. This is a shared strategic intent and is being progressed at pace to support delivery in-year.

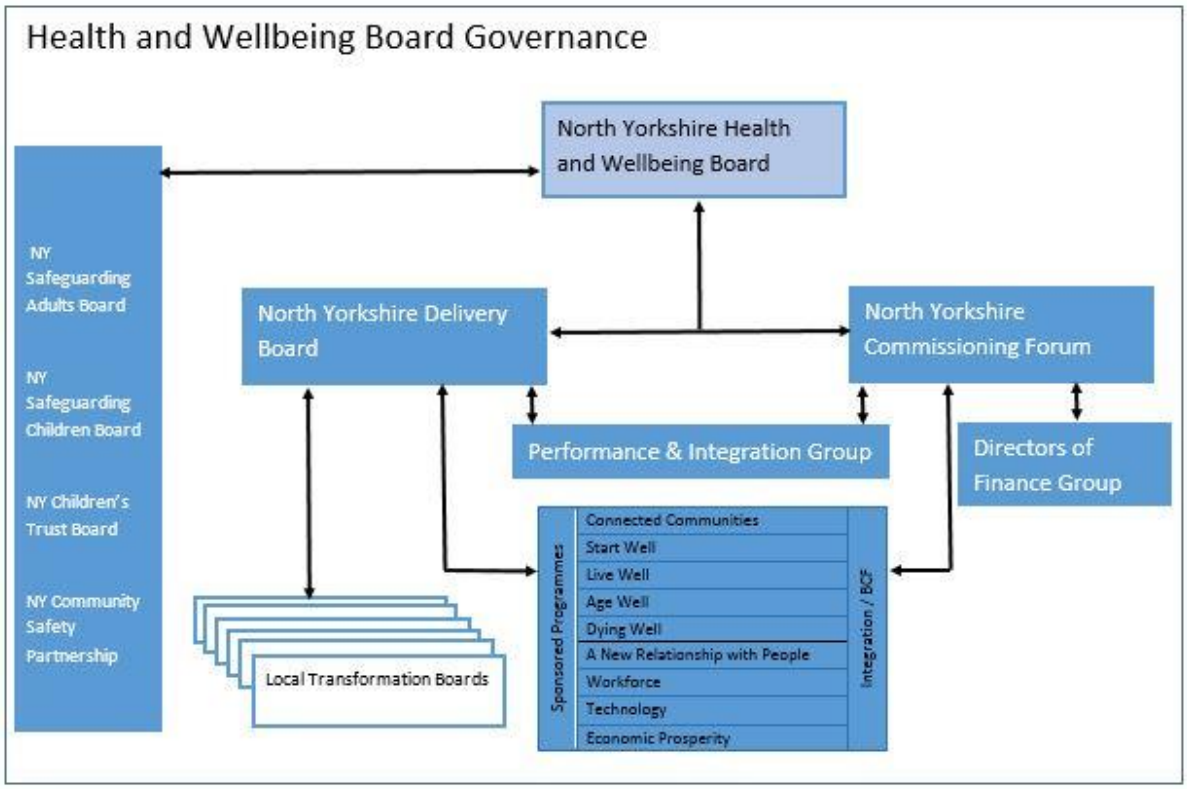
The BCF Performance and Delivery Group was established in 2016 and remains in place as the 'engine room' for the BCF plan. Other groups are a critical part of the wider system such as the Complex Care Discharge Group which sits within the A & E Delivery Board architecture and the Central Locality Delivery Group.

Regular reports on progress in relation to metrics and performance have been provided to the HWB over the last year with agreement by the Board in May 2017 to extend the performance dashboard to include greater detail on the impact of schemes within the wider system for 2017/19.

4.5 Overall governance

The overall governance and accountability arrangements remain in place for 2017/18 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 the current HWB governance structure. The Commissioner Forum has been reviewed and strengthened 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 the Forum also oversees implementation of key projects and ensures a continued focus on health and well-being priorities. This Forum remains actively involved in the North Yorkshire Integration and BCF plan and its links to local operational plans and STPs.



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

As described already Transformation Boards and A&E Delivery Boards also operate in each locality with responsibility for developing new models of care that will support graduation from the BCF. These 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 Councils and acute trusts is evidenced primarily through the HWB, Local Transformation Boards and A&E delivery boards with wider engagement opportunities feeding in as appropriate.

4.6 Risk Log

The 2016/17 risk log has been updated to better reflect plans for 2017-19 and is attached as appendix 1.

5. Delivering the BCF National Conditions

5.1 Jointly Agreed Plan

Commissioners and local providers including housing authorities and the voluntary and community sector are involved in the plan through representation on the Health and Wellbeing Board, locality transformation boards, A&E delivery boards and other forums and meetings designed to engage partners in specific aspects of the plan. The North Yorkshire Health and Wellbeing Board has been updated throughout the process of establishing agreement to and developing the plan.

5.1a Improved Better Care Fund

Given the timescales involved and the complexity of the North Yorkshire system there has been a good level of engagement and cooperation between partners to agree priorities for investing the IBCF. A long list of proposals were discussed with the CCG Accountable Officers in the first instance and further work with them and their teams to refine the proposals. There has been dialogue with A&E delivery boards and draft proposals have been presented to and discussed at each of the four Boards.

The proposals and priorities were presented to and supported by the Health and Wellbeing Board at a meeting on the 21st of July.

5.1b Disabled Facilities Grant.

District Councils continue to be engaged in the development and implementation of the Plan through representation on the HWB (Chief Officer and Council Leader rep) and on Locality Transformation boards. Since submission of the 2016/17 BCF plan, work with District Council housing officers has been ongoing in order to develop a more strategic and joined-up approach to improving outcomes across health, social care and housing through the DFG and BCF programme. A working group involving officers from the county council and district councils has developed a draft Memorandum of Understanding which seeks to improve collaboration and the integration of health, social care and housing and to support joint local decision making in relation to the DFG. The Memorandum of Understanding will be finalised over the coming months and provides the basis of the approach to DFG spend over the next two years as described in section X

District Councils were notified by letter in June of the intention to cascade the grant to them in full for 2017/18 as per the guidance.

5.2 Maintaining the provision of social care services

Acknowledging the issues faced by the North Yorkshire system in agreeing the 2016/17 BCF, early discussions between the County Council and CCG Directors of Finance established an agreement in principle regarding funding for the maintenance of social care. This agreement is consistent with the uplift of 1.79% in 2017/18 and 1.90% in 2018/19 using the 2016/17 figure as the baseline.

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' and we are committed to continued 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 continues to be delivered with funding used to support the following:-

- 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 inequalities, 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.

5.3 NHS commissioned out of hospital services

Out of hospital care is central to our ambition for integrated commissioning and delivery on both a North Yorkshire wide and locality footprint. New models of care and transformation plans are, and will continue to ensure patients are cared for as close to home as possible with plans around for example urgent and emergency care, community and primary care and mental health, built on this concept. This is described more fully in sections 2 and 4.

There have been some key successes particularly where efforts have been targeted towards specific populations highlighted in the review of progress shown in section X and appendix X progress review by locality

Good practice has been shared which has resulted in localities learning from and in some cases adopting similar approaches.

Across North Yorkshire as a whole the 2016/17 emergency admissions reduction target was not met but there is evidence that schemes managed growth in non- elective activity. For 2017-19, each locality has determined how it will use its share of funding in line with its performance against the 2016/17 target.

5.4 Implementation of the High Impact Change Model

Table x below shows an initial self-assessment against the High Impact Change Model for each of the four A&E Delivery Boards covering North Yorkshire.

This shows good progress across a number of the change areas with some clear areas to progress - Trusted Assessor being the obvious area for more focussed work.

Each A&E delivery board has a rationale and evidence for the self-assessment along with action plans to address, though recognising that in some areas more work is needed to shape and develop these plans across health and social care. The work in Hambleton, Richmondshire and Whitby to develop and agree the three Discharge to Assess Pathways and test a Trusted Assessment model across acute services for pathway 2 will be helpful in supporting other areas to progress this change.

The goal to implement a discharge to assess model and trusted assessors across North Yorkshire will be critical to improving outcomes for people and to support improved hospital flow.

Partners acknowledge that there is no 'one' model that will deliver discharge to assess. What is required is described as working as a 'complex adaptive system' which involves simple rules in order to function rather than rigid inflexible criteria.

Based on good practice and acknowledged by all partners - the 'rules' set out below alongside a set of common design principles can form the basis of developing discharge to assess model and trusted assessors across North Yorkshire.

- It is widely recognised that nobody should remain in hospital if they do not have a clinical need to be there – it is not good for them nor for the person who may need the bed, however neither of those statements mean that a discharge should be effected that is not safe for the person
- People must not be discharged from hospital before they are clinically ready.
- A return home should be the first choice, though it is recognised that this may be via a 'step down / other' setting if recuperation / rehabilitation is required in order to effect a safe return home for the person.
- It does not remove the need for appropriate assessment to establish any support required to effect safe transfer home from hospital.
- A person must not be transferred from hospital without the appropriate support being in place and with their consent / best interest decision in place.
- Discharge to Assess should improve the customer journey with less hand off's if set up correctly.
- Discharge to Assess can be applied to people with low and complex needs – providing the support is there.
- It does not deny the person's right to a CHC assessment where they meet the checklist.
- A person must not be charged for services that they should receive free from the NHS.
- Nor should there be 'cost shunting' between NHS and LA's.

- If implemented well it should reduce the number of people being admitted to permanent residential care.

Include Schemes funded through the IBCf

Table x High Impact Change Model Self - Assessment

	1) Early Discharge Planning					2) Systems to Monitor Patient flow					3) MD MA Discharge Teams					4) Home First					5) Seven-Day Services					6) Trusted Assessors					7) Focus on Choice					8) Enhancing Health in Care homes				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
York and Scarborough																																								
Harrogate																																								
Hamb, Rich & Whitby																																								
Aire , Wharf & Craven																																								

Key
1 Not yet est.
2 Plans in place
3 Established
4 Mature
5 Exemplary
As is
Ambition

National Metrics
6.1 Non elective admissions

Whilst there were some areas of relatively good performance in 2016/17 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
TBC

6.3 Reablement

TBC

6.4 Delayed transfers of Care
6.4i Ambition
The metric for DToC across the NY HWB area for 17-18 has been largely set on the basis of the targets agreed by CCGs with NHSE in June 2017 and the expectations set out in the DToC template circulated in July.

There are variations to the expectation set which are based on some CCGs not recognising the figures within the July template, namely York and Scarborough and the expectation for social care being considered by the Council to be unrealistic.

In the absence of a clear steer about whether the figures could be corrected, concern about the basis of the figures and the expectation, and no formal feedback from the provisional submission, targets have been set that are considered to be more realistic.

Based on the current position, partners acknowledge that the target will be a stretch to deliver. Notwithstanding this there is 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.

This plan demonstrates that partners are fully committed to ensuring people are cared for out of hospital and as close to home as possible and that a system wide approach will be needed to make the necessary improvement.

6.4ii Local Target

Table X below shows historic performance based on outturn data and the target for 2017/18 – 2018/19 (TBC)

Table X

							Target	Target
Year	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Annual DToC days	10,970	13,939	12,004	13,225	14,290	25,576	12,153 TBC	TBC
Monthly average	914	1161	1000	1102	1191	2131	1013 TBC	TBC
Population Base	484,100	484,432	487,301	489,218	486,577	487,856	489,150	490,259
Rate per month	188.8	239.8	205.3	225.3	244.8	437.1	207.1 TBC	TBC

6.4iii Rationale

The expectation for social care would require a reduction from an average of 1173 delayed days per month (39 delays per day) using February 17 as the baseline (7.9), to an average of 396 days per month (13 delays per day) within a very short timeframe.

This is considered unrealistic in the context of performance trends over the last year, the impact of current social work vacancies and the fragility of the market. 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.

As a result of the above considerations, coupled with further work to better understand the data, the impact of planned activity across the whole health and care system and the time needed to effect change within a complex system such as North Yorkshire, a more realistic target has been set. While this target does not meet the national expectation within the prescribed timescale, it does along with focussed action to address delays, demonstrate a genuine commitment to continued improvement over the period of the plan and beyond.

For the Vale of York the indicative plan for delayed days attributable to the NHS in the DToC template was zero. This was recognised locally to be incorrect. Without a clear steer about whether the "zero" figure could be corrected, and because the derivation of the NHSE indicative plans could not be replicated, an exercise to estimate what the plan to reflect the York HWBB footprint should be was undertaken resulting in a revised target.

The revised CYC target is based broadly on two principles: firstly, that the number of delayed days for NHS:ASC:Joint are split 52:45:3. Secondly, the target level replicates the best

performance seen over the past 9 months. The average monthly delayed days attributed to NHS between November 2017 and March 2018 is 307; this is 29% lower than the 433 days per month for VoY patients in CYC measured over Q4 2016-17, but needs to be looked at in the context of time as DTOCs vary greatly from month to month and recognising seasonal pressures that need to be considered in planning. The same zero figure appeared in the North Yorkshire Template and so the same methodology was applied to the proportion of delayed days falling within the North Yorkshire footprint.

For Scarborough it was unclear form the DToC template what the correct plan for NHS attributable days should be since the NHSE indicative plan of 0.57 delayed days per day - equivalent to approx. 17 per month - from a Q4 baseline of 191 per month, or 6.38 per day was neither recognised nor considered realistic. This is possibly linked to the use of a "zero" figure in relation to the York area. Again in the absence of a clear steer about whether the figure could be corrected a more realistic target was agreed for Scarborough.

6.4iv Improvement Plans

The County Council has been working to identify the causes for delay which are reported as specifically attributable to social care only, and making plans to address these to facilitate more timely transfers of care.

Links have been made with areas who perform well (e.g. Nottinghamshire) to learn from best practice and the Council is making use of the BCF support offer via the Local Government Association to provide an independent view of the effectiveness of practice and process relating to delayed transfers of care.

There has already been an analysis of available information which has generated a number of ideas for change categorised into seven workstreams and linked to the High Impact Change Model.

With the full support of TEWV, a similar exercise has commenced in Mental Health where there has been a substantial increase in reported delays attributable to social care.

The Council will progress where it can with improvements to its own processes and work more jointly with partners across the health system to address delays.

Within localities improvement plans are allied to wider system transformation plans through transformation boards and operationally through local A&E Delivery Board structures. Further development and delivery of new models of care will also be a key factor in addressing delays.

This approach recognises that each locality within North Yorkshire has different Patient Flows and STP footprints. Individual DToC plans 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, for ensuring that progress is monitored, understood and shared, including barriers and lessons learned.

Actions to improve delays are strongly linked to implementation of the High Impact Change Model and include:-

- Implementation of discharge to assess pathways including provision for people who are medically optimised but suffering with a delirium. There is a requirement to commission a number of discharge to assess beds to support this work.
- Action plan to reduce the number of DST assessments being completed in an acute setting to under 15%.
- Trusted Assessment: A pathway to community services that enables intermediate care and community-based services to proactively "pull" patients back home based on trusted assessment
- Discharge planning in A&E for emergency admissions
- Staff training in place to ensure understanding of the need to increase senior clinical capacity
- Nursing Capacity in community to do complex assessments in the community.
- Draft pre-admission information for patients
- Identification of high referring care homes and plans in place to support

Investment has been agreed through the IBCF that increases social care capacity and helps stabilise the market. It is clear from the reasons for delayed transfers of care locally that this investment will have a beneficial impact on delays. Analysis shows that 70% of delays attributable to social care in North Yorkshire are due to a wait for capacity in either the domiciliary care market or residential and nursing market and 10 % have been due to delays in assessment processes.

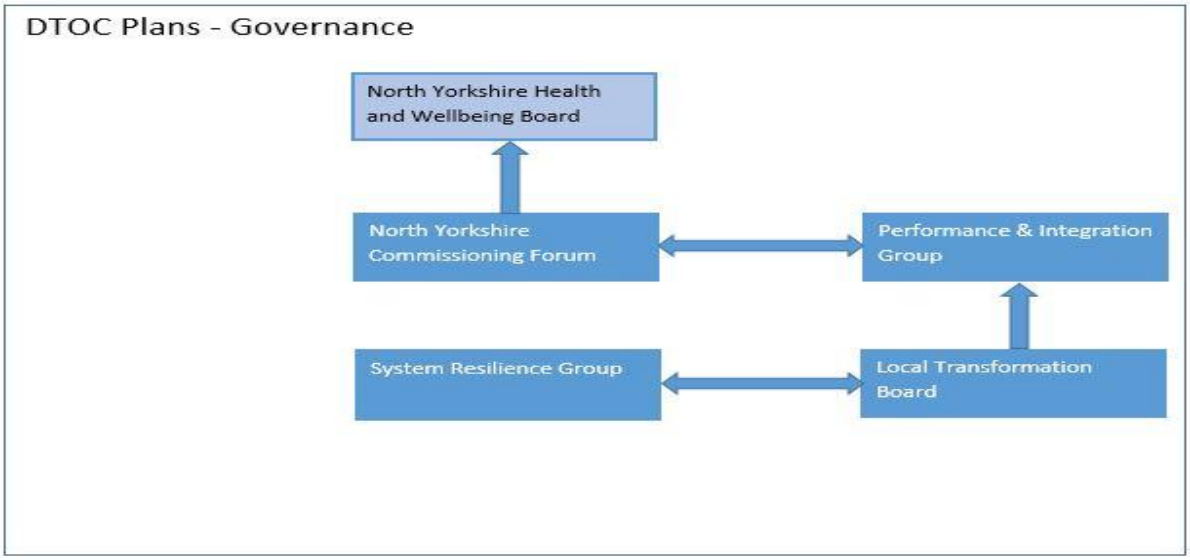
6.4v Governance

Ownership and management of DTOC is through the local A&E Delivery Board structures.

Performance against DToC will continue to be reported to the HWB quarterly via 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 X below shows how DToC is reported to the HWB

Chart x DToC Governance


DTOC Plans - Governance
North Yorkshire Health and Wellbeing Board
North Yorkshire Commissioning Forum
Performance & Integration Group
System Resilience Group
Local Transformation Board

Appendix 2 2016/17 Progress review by locality

A summary of performance, activity and successes in each locality includes:-

Locality	Review of progress in 2016/17
Airedale, Wharfedale and Craven	Our work around new models of care is integral to transformational change and the BCF schemes all support the overall shift to pro-active care. All schemes contribute to our overall position and it is difficult to attribute with any confidence system/position changes to a specific scheme. NEL activity is reducing however costs are increasing, this could be as a result of the increasing complexity of our population and that the new models of care and wrap around services are supporting a reduction in avoidable admissions, those who are more acutely ill still require specialist care and so more expensive admissions Examples: **The Quality Improvement in Care Home Scheme:** NHS Digital have prevented monitoring at post code level which means that since August 16 we have been unable to evaluate impact. These issues are expected to be resolved soon. High level summary follows • Advanced care plans in place- 371 now completed since start of service. Ensuring patients being cared for and ultimately dying in their preferred place. • Ward Rounds- all homes seen every 2 weeks with Residential Homes seen weekly. This also includes post A&E attendance and admission reviews as routine SOP. • Electronic resource aid- In development • Quality Improvement- Through liaising with CCG homes struggling have been identified. For these homes we have worked alongside staff, working shifts with health care staff, providing on the spot support and training. Clinical lead has worked with staff at embargoed home to improve care standards, documentation and basic care – embargo now lifted • Integrated working- improved relationships. Multi disciplinary working home managers, District nursing & Social care teams- regular contact and support with safeguarding teams, and CQC. Assistive technologies: Telemedicine activity has been reviewed and action taken to improve utilisation where activity less than expected. AFT are a Care Home Vanguard so we expect robust independent evaluation to provide evidence of the impact and support future commissioning decisions **Enablement and rehabilitation** Work to further integrate services with community services continues. This will enable a fully responsive community 'wrap around' response

	Enhanced primary care scheme Has shown encouraging results & learning has informed the 17/18 scheme which will be a CCG wide with four key components: 1. Care Navigation and Social Prescribing – A team of social prescribers and care navigators will be put in place across the CCG (1 FTE per 10,000 patients). The team will be located within practices. They will review hospital discharges, track complex care patients conduct weekly MDT huddles which will include EPC GP leads, ANP and Physician Associates (PA's) supporting the service. In addition there will be biweekly whole scheme EPC MDT meetings at a locality level to offer mutual support and discuss more complex cases. 2. Physio First – 1 FTE Physiotherapist per 25,000 patients. Patients will receive 30 min assessment and onward referral as necessary. Verbal and written advice and guidance will be provided and receptions staff training and support to triage relevant patients contacting practices with MSK problems. 3. Chronic pain and medically Unexplained Symptoms (MUS) – Support groups (12- 18 patients) will be established in practices to provide peer support and ongoing pain education, help to manage flare ups and avoid future unnecessary investigations. EC Scheme will facilitate roll out of this across the CCG via 'teaching enabling' model. It is anticipated that groups of practices/patients will run groups themselves with supervision and support from team of expert patients, a clinical psychologist, GP and physiotherapist. 4. Frailty Care – Provide an enhanced frailty service which will holistic care approach including detailed care planning, educate and involve families, increase links with Goldline, and advanced care planning. Pharmacists will deliver comprehensive medications reviews, providing staff education and patient sessions to rationalise repeat ordering to reduce wastage. Exercise and falls prevention advice and risk assessment and support for patients and families. Partners are actively engaged in activities to implement the high impact change areas and further improve DTOC position All schemes also contribute to reduce A&E attendances, AFT benchmark favourably across Yorkshire for A&E performance

Locality	Review of progress in 2016/17
Hambleton, Richmondshire and Whitby	Our Fit 4 the Future strategy culminated in the 'Transforming Our Communities' consultation in 2016 and the current Transforming Mental Health Services consultation and is paving the way for integrating services across health and social care, physical and mental health and primary and community services. The new models of care are predicated on the further development and sustainability of primary care services, we are therefore working with our 22 practices to develop the 'out of hospital' basket of extended primary care services and through the extended access schemes leading to the creation of an MCP model.

	Our strategy provides a formal pathway structure to new models of care established in 16/17, these include a new Community Bed Base, Discharge to Assess, the introduction of Telemedicine and integrated locality teams and an Integrated EOL service we are further developing these as part of a wider frailty pathway as a key enabler to the development of an MCP. The success of the frailty pathway requires genuinely integrated models of care bringing all care sectors together, which will maximise the benefits of a cohesive frailty pathway. **Community Bed Base** Implementation of 8 Step Up/Down Beds across Hambleton, Richmondshire to actively support discharge out of the acute and prevent avoidable admissions through providing a flexible community bed base within a patient's home community, supported by an Integrated Locality Team. Ongoing work to extend the scope of this bed base to support the wider system. **DTOC and Discharge to Assess** Performance on delayed transfers of care continues to be closely monitored and activity is taking place across all CCG areas to identify and improve patient flow. Local escalation pathways and daily reporting has been reviewed against the requirements of the High Impact Change Model to inform our local DTOC Action Plan. Implementation of discharge to assess pathways to ensure patients are not assessed in acute hospital settings. This will includes provision for patients who are medically optimised but are suffering with a delirium. Three Discharge to Assess Pathways have been developed and agreed through the DTA strategic working group and there is a commitment to jointly commission a number of discharge to assess beds to support this work. An action plan has been developed. **The Introduction of Telemedicine (Immedicare) in Care Homes and Extra Care Housing Facilities** 26 Telemedicine units have been fully implemented across Hambleton, Richmondshire & Whitby across 25 sites. The service is being provided by "Immedicare" which is a partnership between Airedale NHS Foundation Trust and technology experts Involve, Airedale NHS FT have been delivering the service since 2009 and recently became one of NHS England's Vanguards for the future delivery of healthcare in Residential Care & Nursing Homes. The telemedicine service provides care home staff and patients with immediate access to expert clinical advice that in many cases means that a trip to the hospital can be avoided. The hub is staffed by specialist nurses who can assess and triage patients as well as support nursing home staff to provide any additional care. Feedback from Care and Residential homes has been positive and we are averaging 50 calls per month. All Extra Care Housing sites where there is a commissioned NHS Step Up/Down bed now have the service in place. **Integrated Locality Teams**

	The establishment of integrated locality teams has facilitated new ways of working with specialist services; both community and hospital based, to offer patients and much more complete and less fragmented care and support. The ILT will form the basis of the Multi Community Specialty Provider (MCP) model. This aims to develop integrated care by creating a simple pattern of services based around primary care and natural geographies and with a multi-disciplinary team. A specification have been developed to re-engineer health and social services in the community through the creation of integrated Multi Professional Teams with a more flexible approach to delivery of care, 24 hours per day, 7 days per week. The teams have been mapped and will be based and work within specific localities centred upon GP clusters and will be a natural extension of current Multi Agency Meetings (MAMs). The teams will incorporate and take advantage of advanced nursing practitioners within the community. **Dementia** Local action plans to deliver the North Yorkshire strategy are being developed with Dementia Collaboratives and will include areas such as improved dementia diagnosis rates in primary care, shared care processes, better support post diagnosis with greater signposting and navigation to support services for patients and carers. In Q1 2017-18 this includes commencing a pilot Dementia Navigation Service in the Richmond locality with a dedicated post working as part of the GP locality cluster. **Integrated End of Life Service** An integrated end of life care pathway has been established in Hambleton and Richmondshire to replace the fast track system. This service, working with the integrated locality teams allows patients who wish to die at home to do so knowing they will receive the best possible care and support. The service is also preventing unnecessary hospital admissions for patients at end of life. **NEL** Non elective admissions remains a significant issue for the CCG, particularly for the ageing population for conditions such as pneumonia, heart failure, COPD, UITs, abdominal conditions and diabetes. In 2017-18 the frailty pathway will address this issue by ensuring resilient services which are joined up and based in the community and primary care to prevent the instances of NEL admissions. A number of frequent A&E attenders and NEL admissions contribute to this issue and practice clusters are working with the wider ILT to ensure proactive identification, care planning and support is in place

Locality	Review of progress in 2016/17
Harrogate and Rural District	BCF and the New Care Model (NCM) represent two of Harrogate STPs five priority areas and are core elements of the 2017/19 CCG Operational Plan. Dependencies are recognised and work to align both priorities with other projects and business as usual provision is underway. The next phase of NCM will test out genuine integration of primary care, community health, social care, mental health and voluntary care sector. Examples of progress in 16/17 include; • Patient flow – continued focus on delivering a shift in patient flow in the healthcare system, such as targeted reductions in emergency admissions and ED attendances. • Care home visits - GP practices continue to provide weekly/fortnightly visits to care homes. • Telemedicine – telemedicine is currently being trialled in 11 care homes and an audit review is due to identify the impact on care homes and out of hours services. • ETTF – the bid to implement Systmone in Care Homes across Harrogate will allow greater access for care home staff to patient records and GP advice. It is anticipated that this project will reduce unplanned admissions from care homes. • Transformation site - consultation is underway to deliver Extended Access by September 2017. • Senior leadership through the A&E Delivery Board to develop plans that reduce DTOC, ED attendances and emergency bed days and implement trusted assessor models. • Voluntary Sector - Harrogate and Ripon Centres for Voluntary Service (H&RCVS) host an online community directory, 'Where To Turn', with information on 100s of community activities and services in the Harrogate District. • Falls and Frailty – a review of pathways is currently underway.
Locality	**Review of progress in 2015/16**
Scarborough and Ryedale	SRCCG and NYCC continue to move ahead with the plan implement an integrated multi- disciplinary team structure (called a Multispecialty Community Provider - MCP) by Apr 2018. This is in the early stages of a Procurement process. **Integrated Palliative Care Scheme** Based on the current data and quality reports, The Integrated Palliative Care Service is achieving well against the original targets set as part of the BCF programme. The KPIs set as part of the 2015/16 planning round and embedded in the contract with St Catherine's Hospice are all being met, and in some cases exceeded**.** **Psychiatric Liaison** The scheme as original designed was to contribute to the BCF goals of; a reduction of Non Elective admissions; an improvement in quality of care.

	While it is clear from the data that there has not been a reduction of emergency attendances and only a very small reduction in non-elective admissions for patients with a mental health diagnosis, there is significant anecdotal evidence from the Acute trust staff that the liaison team are contributing significantly to improvements in quality of care for patients with a mental health diagnosis. In particularly, support and training for staff in managing patients with dementia has been noted as important. Patient satisfaction has been largely very positive with an overall satisfaction rate of 88% for the year. **Ryedale Community Response Team** The Ryedale Community Response Team has now completed its second full year of operation, during which the population covered was expanded to include the populations of West Ayton and Eastfield Practices. Despite this increased population, the year has seen an increase in both Non-Elective admissions and readmission rates. Whilst the increases are smaller than that seen in the practices not covered by the Hub, the difference is small and has not been accompanied by a significant reduction in costs. **IAPT Service** The IAPT service has continued to improve performance throughout FY 16/17, finally achieving the targets in both access and recovery in Month 12. This is likely to be attributed to some of the service changes planned by TEWV in FY 15/16, and some of the rapid improvement actions carried out following the IST review. The IAPT IST review recommended an uplift of funding from current levels. Whilst the cause and effect relationship between increased funding and increased performance is not clear, better funded IAPT services do tend to perform better. The performance of the service has improved since the implementation of a number of the recommendations of the IST report, but it is too early to assess the full effect.
Locality	Review of progress in 2016/17
Vale of York	**Vale of York: Examples of progress in 16/17 include:-** **Selby Care Hub** Between April 16 and March 17, the CRT received 741 referrals of which 55% were for patients who 'stepped up' from the community avoiding the need for a hospital admission. This included 185 referrals directly from practices, 116 from the ambulance service and 82 from ED/RATS. These referrals generated 20,002 contacts from the team between April 16 and March 17. A contact can include a comprehensive assessment and care planning with one or more registered professionals or sessions undertaking therapeutic exercises with one or two generic support workers. 81% of these contacts were undertaken by unregistered staff. Impact As with the Care Home in reach there have been difficulties in accessing information through the CCG provider on the impact on non-elective admissions. Again, Trust internal data has been used to compare activity from Selby and District practices to Nimbus

practices, taking April 2013 – February 2014 as a baseline (and comparing this to April 2016 – February 2017). For those aged over 85 years, it is possible to see that there has been a growth of 15% for practices from Selby and District compared to a growth of 32% for Nimbus practices. For those aged 75-84 years, there has been a growth of 18% in Selby and District compared to a growth of 34% for Nimbus practices.

In assessing cost effectiveness of the CRT, the price for April 2016 – March 2017 will be £994k. Based on an expected full year effect of 739 referrals this equates to £1,345 per referrals. The cost of alternative services providing care in a crisis or rehabilitation is shown below as a comparison.

• The 2015 National Audit of Intermediate Care (NAIC) finds an average cost of £5,672 for bed based intermediate care;

• A non-elective admission – whilst the actual tariff is based on what the patient is admitted for, a typical cost of would be £2k;

• An extended stay in hospital for rehabilitation – the average length of stay on the Selby and District Community Response Team (as at February 2017) was 15.5 days – at an excess bed day cost of £200 this would equate to £3,100 (it should be noted that if the stay was provided in a rehabilitation unit the daily rehabilitation tariff is £301).

• This does not factor in the long term cost implications associated with bed based care – the Emergency Care Improvement Programme highlight studies showing 10 days bed rest can cause the equivalent of 10 year of aging in the muscles of older people together with a loss of function through deconditioning increasing the need for long term support from health and social care services. The 2015 NAIC found the 72% of patients in home based intermediate care improved their dependency levels with a further 21% maintaining these despite their crisis.

The service is included in the Trust programme to understand if patients would make a recommendation to their friends and family based on their experience. Between September 2016 and January 2017, 96% of patients would have been extremely likely to recommend the service (the remaining 4% would have been likely to recommend).

Hospice at Home

During 16/17 the H@H service supported 495 people to be cared for in their own homes, of these, 150 (30%) were cared for during the extended hours of the H@H service.

For the duration of the extended H@H service to date (Jan 15 – Mar 17), 281 crisis intervention cases were identified (over 56% of the 495 patients seen during that period), and it is likely that these crisis intervention referrals avoided a call out of other services such as ambulance and OOH GPs.

Urgent Care Practitioners

During 16/17 the following Urgent Care Practioner scheme has continued to develop. From April 16 to March 17 UCP activity stands at 4,981 cases. Of that number 1,544 have avoided A&E as a direct result of UCP activity. Of the overall conveyance rate of UCP 55% it is estimated that 30% would have avoided admission making an estimated saving of £789,000.

	The following are also of particular note: • Additional Fulford Step-up beds are now accepting referrals for patients requiring intensive rehabilitation which has avoided an A&E attendance • Care homes are now regularly using the UCP team rather than asking for patients to be admitted • Social prescribing has been supported and integrated into the work with the UCPs • UCPs are accessing the existing GP call back scheme to get GP advice or have the ability to refer patients directly to their GP if necessary • Within the acute sector UCPs now have a direct pathway into the hospital either via Bed Managers or directly to the Ambulatory Care Unit

Appendix 3 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
Additional contributions towards the protection of social care do not materialise in full and a budget shortfall results.	Signed Plan is produced. Maintain level of spending on social care services	4	5	20	• Monitoring of activity and metrics to seek early signs of budget pressures.	• HWB • • Managed through monthly reporting by Chief Finance Officers Group
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 by Chief Finance Officers Group
Non Elective Admissions do not reduce in line with expectations.	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	• HWB • Managed through monthly reporting to NYCF by Chief Finance Officers Group
Delayed Transfers do not reduce in line with expectations.	High Impact Change Model for ToC's	4	5	20		
Admissions to Care Homes do not reduce in line with expectations.	NHS commissioned OOH services	3	3	9		
There is a lack of availability of providers of support for carers.	Progress towards seven day services	4	4	16	• Market development including with voluntary sector providers	• HAS Commissioning Team

	Impact of changes on 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	
Data analysis, segmentation and benchmarking are constrained by perceived and actual restrictions on data and information governance.	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
Agreed system changes between partners are not realised.	High Impact Change Model for ToC's NHS commissioned OOH services	3	5	15	• Monitoring and reporting processes in place with reporting to NYCF and NYHWB	• HWB • Managed through monthly reporting to NYCF
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.	All	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
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

There is a lack of joint working between partners, resulting in duplication of effort.	All	2	4	8	• Locality Boards and NYCF monitoring the implementation and management of on-going services	• Locality Boards / NYCF
Delays in delivery of Local Digital Roadmaps impacts on improved interoperability of systems, consent management & and sharing of data between partners.	Better data sharing between health and social care	3	3	9	• Rollout of Countywide Information Sharing Framework (ISF) and subsequent Information Sharing Agreements (ISA). • New consent management approaches required. New GDPR coming into force. • Monitor and respond to guidance from the NHSE Interoperability Programme, NHSD and other national bodies.	• Partner IM&T Leads • Partner IG 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 (£208k net in 17/18) 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