Appendix 2

Integration and Better Care Fund

Narrative Plan Template 2017/19
Better Care Support Team

Area	**York**
Constituent Health and Wellbeing Boards	**York Health and Wellbeing Board**
Constituent CCGs	**Vale of York CCG**

Action/ amendment	**Who By**	**Date**
Blank template updated with VOY details/existing narratives	Elaine Wyllie	21/8/17
Updated template with info from CYC colleagues	Elaine Wyllie	28/8/17
Updated template with further revisions from CYC colleagues	Elaine Wyllie	30/8/17

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Introduction / Foreword

The Better Care Fund (BCF) 2016/17 plan focused on the move to jointly commissioned activities contributing towards a set of shared strategic objectives. The plan for 2017/19 continues this intent and 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.

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 want to see strengthen include:

- ✓ York Integrated Care Team
- ✓ Reablement services
- ✓ Integrated place based commissioning
- ✓ Local area co-ordination
- ✓ Focus on well-being
- ✓ More self-care, self-management

Delivering this is not without challenge – the current key features of the York HWB health and social care landscape are:

- A long standing challenging financial picture across the commissioner and provider base
- A high level of reliance on hospital based services by the public
- An acute trust provider that has historically delivered good performance but is now facing significant financial challenge and deteriorating performance
- A high level of self-funders using care home services
- A vibrant retail and tourism sector which impacts on the available workforce
- An articulate and well-informed population who demand access to statutory services

Despite adult social care being one of the largest spending areas of the council (£73.1m gross and £47million net, which is 39% of total net budget for the council), spend per head of population is low (bottom quartile) compared to statistical neighbours. Demographic, demand and cost pressures are reaching critical levels. Workforce and provider cost pressures are particularly having an impact during the current financial year (2017/18). Plans are in place to achieve £1.783m efficiency savings in current financial year. These savings, in addition to use of the Adult Social Care precept and funding from iBCF will go some way to assisting with these pressures. Most importantly however is the work to transform the nature of care and support within York and manage demand by tapping into the assets of the local community and promoting approaches based on early intervention and prevention.

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.

Our local vision and approach for health and social care integration?

Our local vision is embodied within the Joint Health and Wellbeing Strategy which has been reviewed and updated for the period 2017 to 2022 [***insert hyperlink to the document off CYC website]***. The review has taken into account the views of local residents, intelligence from the Joint Strategic Needs Analysis (JSNA); local plans and wider system plans.

Our ambition is for every single resident of York to enjoy the best possible health and well-being throughout the course of their life: by promoting greater independence, choice and control, building up community support; by supporting self-care and management; with greater use of early help through targeted/short term interventions; by imaginative use of new technology; with fewer people using statutory services.

Ref: Joint Health & Wellbeing Strategy (2017-2022)

The Joint Health and Wellbeing Strategy concentrates on four themes: mental health and wellbeing plus three life stages. Within each theme a top priority has been set out with additional key priorities under each theme (see Table 1).

The York BCF is based on shared system outcomes overseen by the York Health & Wellbeing Board (HWBB) within the wider context of the Vale of York population from a CCG perspective; and neighboring authorities (North Yorkshire and East Riding) from a social care perspective. The York BCF sits within the emerging footprint of the Humber, Coast and Vale Sustainability and Transformation Plan.

The vision for the Humber, Coast and Vale Sustainability & Transformation Plan

(STP) [***insert hyperlink to relevant document]*** reflects similar themes to that of the local HWB strategy: To be seen as a health and care system that has the will and the ability to help people 'start well, live well and age well'. To achieve the STP vision we aim to move our health and care system from one which relies on care delivered in hospitals and institutions to one which helps people and communities proactively care for themselves. The STP plan focuses on the wider determinants of health in our footprint, with all public services working together to support people to take more responsibility for their own health.

The wider system (STP) approach is to develop new models of care across the constituent population, supported by strategic commissioning across the acute health system. This builds on the ideas put forward in the Five Year Forward View and best-practice national and international examples of whole population management and outcomes-based commissioning for health and social care.

Mental Health and Wellbeing	Starting and Growing Well	Living and Working Well	Aging Well
Get better at spotting the early signs of mental ill health and intervening early	Support for the first 1001 days, especially for vulnerable communities	Promote workplace health and remove barriers to employment	Reduce loneliness and isolation for older people
Focus on recovery and rehabilitation Improve services for young mothers, children and young people Improve the services for those with learning disabilities Ensure that York becomes a Suicide Safer city Ensure that York is both a mental health and dementia friendly environment	Reduce inequalities in outcomes for particular groups of children Ensure children and young people are free from all forms of neglect and abuse Improve services for students Improve services for vulnerable mothers Ensure that York becomes a breastfeeding-friendly city Make sustained progress towards a smoke-free generation in York	Reduce inequalities for those living in the poorer wards and for vulnerable groups Help residents make good choices Support people to maintain a healthy weight Help people to help themselves including management of long-term conditions Work with the Safer York Partnership to implement the city's new alcohol strategy	Continue work on delayed discharges from hospital Celebrate the role that older people play and use their talents Enable people to recover faster Support the vital contribution of York's carers Increase the use of social prescribing Enable people to die well in their place of choice

Table 1: Four Themes for Health & Wellbeing in York 2017- 2022

Moving towards fuller integration by 2020

A priority for the York footprint `is to deliver improved outcomes for the population

within the context of the demographic, cost and demand pressures faced by the health and social care system. There is recognition that these pressures, together with the financial context of the statutory agencies requires a whole system approach to transformation and the development of a single medium term financial strategy (MTFS) for the system. The York HWB operates in the context of significant community assets supported by a strong and vibrant third sector presence.

How will our local vision be achieved?

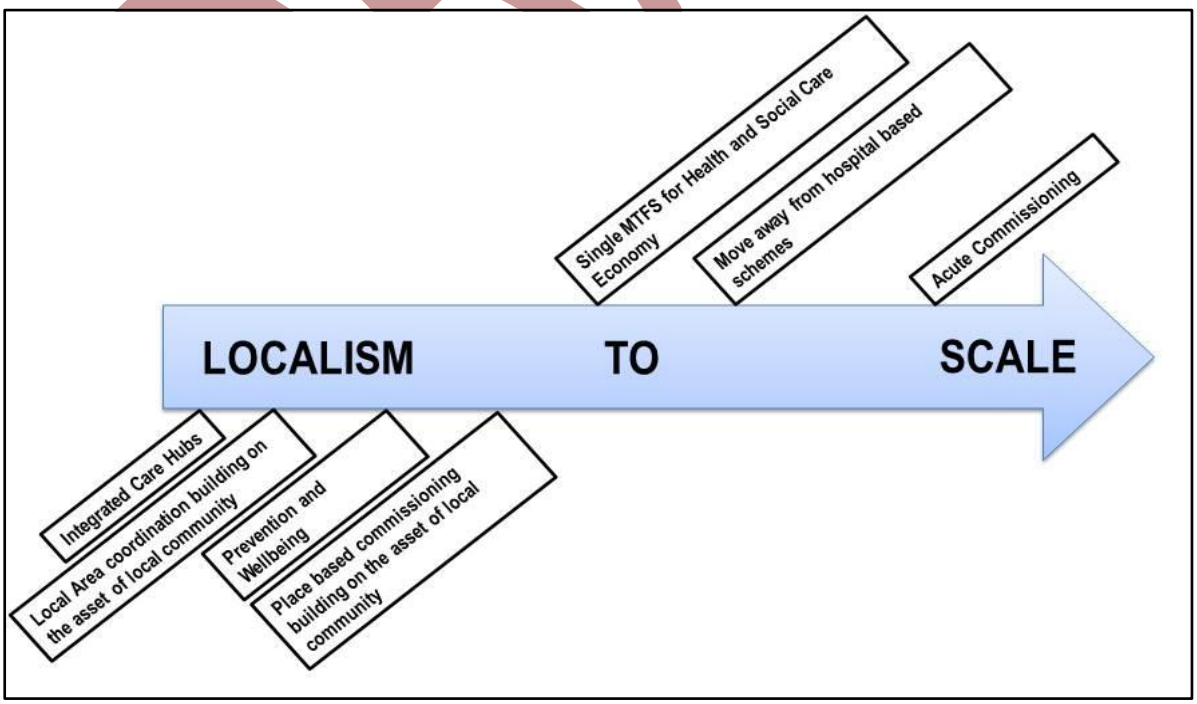
System first, organisation second

The Better Care Fund continues to influence how we join-up health and social care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.

However we cannot rely on the BCF on its own to resolve some of the complex pressures facing our joint health and care system. A whole system approach is needed if we are to deliver our vision for 2020. The most fundamental change facing the system requires a shift away from statutory agencies meeting needs through the provision of services and medical interventions, towards working with individuals and communities to support self-help and self-care. This will require all agencies to shift the focus of commissioning activity upstream towards early intervention and prevention.

Combining the benefits of scale and localism

We want to use the resources available to us in the most effective manner possible. This means that we will use our assets at scale or locally, depending upon the outcomes we are trying to achieve. Graphic1 sets out the approach we will take across this continuum for different aspects of health and social care.



Graphic 1: Localism to Scale

Prevention through self-care and self -management
Insert text

Background and context to the plan
York's population is now estimated to be just over 200,000 people. By 2025, it is estimated that:

• the 65+ population in York will have increased by 16%
• the 85+ population in York will have increased by 32%
• the 0-19 population will have risen by about 9%

York's population is, on the whole, healthy (in a recent survey, 83.9% stated that they are in very good or good health compared to 80% regionally and 81.2% nationally). But this is not true of all communities and groups.

The city has become more culturally and religiously diverse with a Black and Minority Ethnic (BME) population of 9.8% (non-White British) compared to 4.9% in 2001.
If we look at 'York in a nutshell' (see Graphic 2) we can illustrate what the composition of York would be like if it was a village of 100 people based on available data. (October 2016). ***[insert ref: Page 5 of HWB Strategy]***

This shows that the York HWB population is generally well with a high proportion of people reporting 'good' or 'very good' health and wellbeing; a good number of people being physically active and using outdoor space; very low unemployment levels and a high number of the population working between the ages of 16 and 64 years.

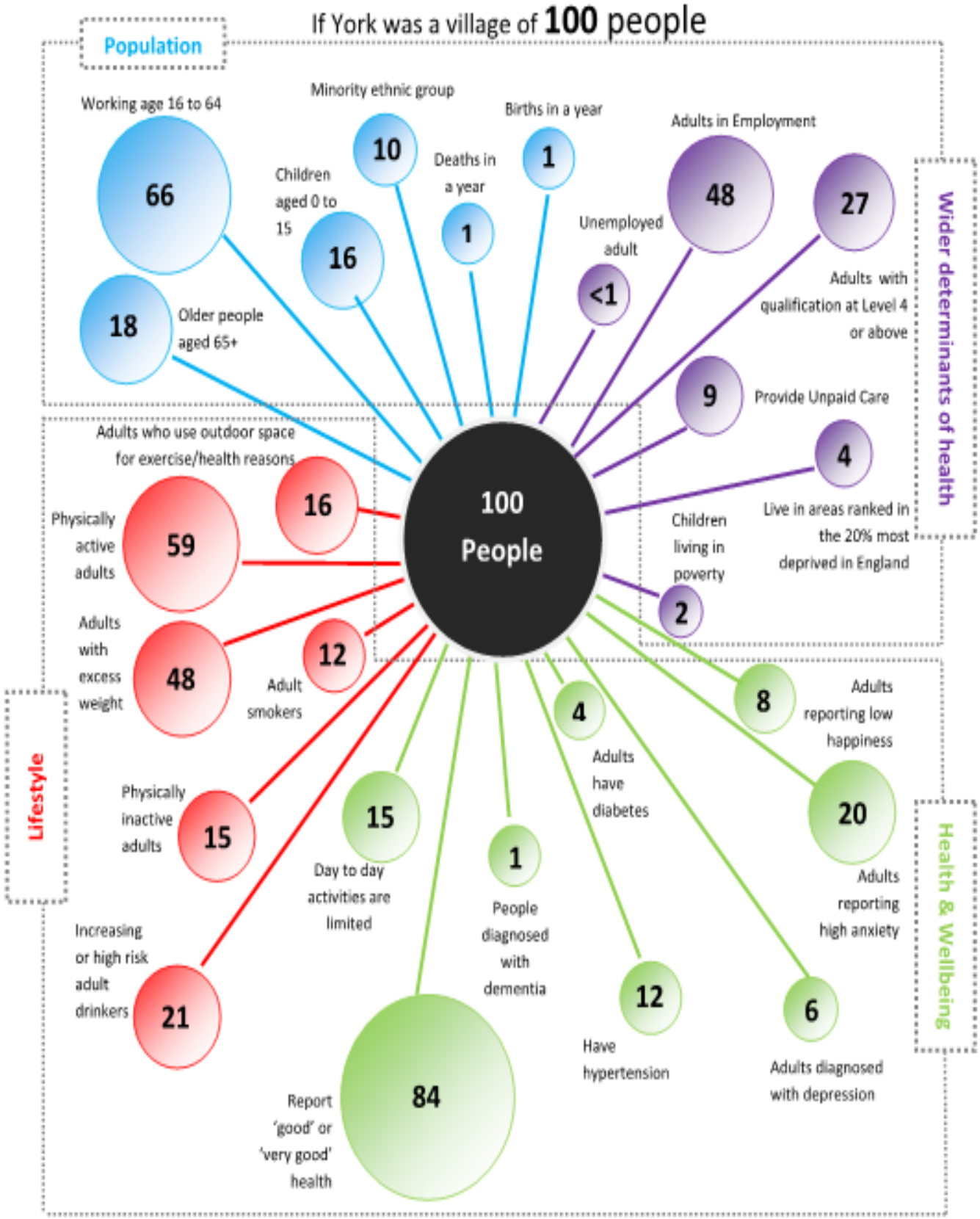
Despite this picture the following challenges remain:

a) **Health inequalities exist** and there are communities for whom health and wellbeing fall short of those enjoyed by the majority. The difference in life expectancy between the most and least deprived is 7.7 years for women and 5 years for men.

b) **People who experience mental ill health are still not consistently getting the services they need.** A new mental health/dementia strategy is in draft stage to steer the development of services that meet people's needs going forward. This strategy will recognize the need for physical and mental health services to be more closely aligned than they are currently.

c) **A high level of reliance on hospital based services by the public.** The 26 GP practices that deliver primary care in the locality have been assessed as 'good' and there has been a focus on integrated care solutions wrapped around primary care models of delivery.

Graphic 2: 'York in a nutshell'



The graphic above illustrates what the composition of York would be like if it was a village of 100 people based on available data. Produced November 2016.

d) An **acute trust provider that has historically delivered good performance but is facing significant financial challenge and deteriorating performance**. The development of the accountable care system, underpinned by the Accountable Care Partnership Board, is demonstrable progress towards integrated commissioning arrangements and joint delivery models across health and social care partners.

e) **Significant financial challenges faced by both the CCG and the council**. The focus on early intervention and prevention is a helpful driver for aligning CCG and CYC financial plans. The role of public health is pivotal in this regard, alongside the opportunity gained from developing existing forums within the third and voluntary sector.

BCF - Local Context

In terms of hospital services, York Teaching Hospital NHS Foundation Trust (YTHFT) is the acute trust and community service provider for the local population, with the main hospital being sited within walking distance of the city centre. The trust also provides services to the neighbouring population of Scarborough and Ryedale CCG and has an acute and community base in these localities. An over-reliance on acute care has necessitated a jointly owned and managed strategic plan to move the public's mind-set to more self-care and personal resilience in order to reduce the demand for public services.

Mental health services are provided by Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) who were awarded the contract in October 2015. A significant focus over the last two years has been the development of the capital estate across services and transitioning systems and processes to support new ways of working in both acute and community mental health services. Following a public consultation in 2016, plans are on track to deliver a new mental health hospital by December 2019.

Workforce pressures are of significant concern in the York locality with full employment in the local area; this is kept constant as a result of the competitive opportunities in the tourist and retail industry which is strong in the historic city centre. A multi-agency Workforce Development Group has been established and is part of the solution.

There is also a large student population which, although transient, has physical and mental health needs that are unique to this segment of the population.

The general population is relatively affluent, with high levels of employment. The care home market is buoyant in terms of self- funders. The uptake of personal health budgets in the community remains low.

The context of the broader health and social care economy is, therefore, one of significant financial pressure with a local population that has a history of high dependency on hospital services and dependency on residential care provision.

Although challenging, this context provides a significant opportunity for agencies to

tap into the assets that exist with the local population and wider community. York has a demonstrable history of community benevolence with over 1000 voluntary sector agencies operating across the population.

Integration: Progress to date

A Joint Commissioning Strategy was approved by the York HWB in January 2017 [***CHECK DATE and INSERT HYPERLINK TO DOCUMENT***] 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.

Key outcomes include:

- The integration of community based health and care services and delivery through local care hubs including mental health care support
- The development of integrated assessments and care plans for vulnerable adults
- A single pathway and pooled budget for reablement and intermediate care
- Integrated personal budgets for health and social care, to promote choice and personalisation
- Development of a single integrated pathway for Continuing Health Care
- Creation of a pooled budget and joint commissioning arrangements for mental health and learning disabilities
- Agreement on, and implementation of, an approach to incrementally shift funding towards early intervention and prevention

Governance and leadership arrangements in place to support the development of joint commissioning can be found in Appendix x.

Joint delivery of services or wider partnerships to date can be evidenced by:

- Archways - relocation of social work teams to a shared facility with community service staff is proving beneficial and increasing integration at service delivery level

- Prevention Partnership – Although early days, a forum to bring third sector providers together has been established which will allow commissioners and providers to develop ways to further increase partnerships, look at new ways of working across partners and identifying further opportunities to develop the community assets available in York

- Integrated teams – the York Integrated Team, funded from the BCF initially as a pilot across one GP practice population, has now been rolled out to cover the full population registered with GP practices within the City. This service works directly with practices and A & E to support case management of those at high risk of readmission in order to reduce non-elective admissions and speed up discharge.

How has the BCF helped with integration?

It is important to recognize that the BCF plan/funding is one slice of the wider health and social care system and, as such, a direct correlation between a

The appetite for whole system transformation has been steadily gaining momentum over the last 18 months and there is a clear recognition within the CCG, the Council and the York HWB wider membership that the BCF provides a platform on which to build sound strategic transformation that will deliver better outcomes, better value for money and person–centered coordinated care in the context of the financial risks and service pressures across the system.

System leaders are resolved to work through the financial, operational and political challenges jointly and collectively with HWB partners in order to manage the financial risk and to identify further opportunities to transform services that can be delivered sustainably.

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. The connections between these groups are described in more detail in Section XXX.

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. Table XXX sets out the final year end performance for 2016/17 which shows that the majority of the indicators did not achieve the target set in the plan showing that further improvement is required.

Metric type	Metric description	Target	Q1 position	Q2 position	Q3 position	Q4 position	Year End Position	Performance
National:	Reduction in non-elective admissions (General & Acute)	20,781	5,530	5,639	5,739	5,731	22,639	Deteriorating/ Missed target
*Local metric (outwith routine reporting framework)	Reduction in non-elective admissions (General & Acute) *National data adjusted for Ambulatory Care Recording issues	20,781	5,063	5,220	5,317	5,319	20,919	Static/ Missed target
National:	Delayed Transfers of Care: Number of bed days per 100, 000 of population	9,837	2,497	2,889	3,117	2,032	10,535	Deteriorating/ Missed target
National:	Long-term support needs met by admission to residential and nursing care homes, per 100,000 population	657.8	189	184	143	153.6	669.6	Improving/ Missed target
National:	Number of permanent admissions to residential & nursing care homes for older people (65+)	238	70	68	53	57	248	Static/ Missed target
National:	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	0.758	NO DATA	NO DATA	NO DATA	0.793	NO DATA	Improving/ Above target
Local:	Injuries due to falls in people aged 65 and over per 100,000 population	2,454.7	591	641.6	588.4	665.6	248.6	Static/ Missed target
Local:	Injuries due to falls in people aged 65 and over (actuals)	922	222	241	221	250	934	Static/ Missed target
Local:	Overall satisfaction of people who use services with their care and support	0.664	NO DATA	NO DATA	NO DATA	0.62	NO DATA	Deteriorating/ Missed target

Table XXX: Summary of 2016/17 Performance Metrics

Evidence base and local priorities to support plan for integration

The changes in demographics in York means that the Council has to take a pro-active approach and has already started a process to re-design their operating model focusing on prevention, reducing and delaying the need to access statutory care and support provision. The Council is focused on meeting locally identified need by listening to the voice of local people and providing the means by which local groups can develop and flourish. Demographics show that there are 2,700 older people in York with dementia, this is set to grow to around 3,500 in the next 10 years, across York 14,000 live alone, this is set to grow to 16,000 by 2027 and there are an estimated 2,500 people over 65 providing 20 hours or more unpaid care each week. By 2025, it is estimated that that this level of care provided by older people will increase by 16%. These are just some of the challenges that the social care market faces in York.

The Council is currently revising their Market Position ***Statement [INSERT HYPERLINK TO CURRENT MPS]*** but there are a number of key messages emerging;

- There is an ongoing and continued pressure on providers to recruit and retain paid carers in a "full employment city"

- The Council's commitment to maximising independence to prevent, reduce and delay access to care services

- That information and advice provision needs to be well developed to meet the cities aspirations of promoting independence, choice and control

- That we need with partners to greater understand the needs of self-funders which present a challenge to the City in terms of numbers and service requirements

- That York has a strong established process for monitoring the quality of service provision and supporting providers that may be struggling

From a health and wellbeing perspective we know that:

- York has a higher rate of emergency hospital admissions for intentional self-harm than the national average

- 3.8% of York's population live in areas that are among the most deprived in the country. Childhood obesity affects more children in our most deprived wards. There are also poorer health and wellbeing outcomes for certain vulnerable groups, e.g. the gypsy and Roma community and the lesbian, gay, bisexual and transsexual (LGBT) population.

As a system we have recognised the financial pressure that faces individual organisations which, in turn, impacts us collectively. For 17/19 we believe we have developed a set of investments that maintain existing services as well as looking to new opportunities that contribute to shared strategic plans.

Evaluation of 16/17 schemes

16/17 schemes were evaluated using agreed metrics and key performance indicators against their individual aims that reflect the focus on reduction of non-elective admissions in accordance with the Better Care Fund grant determination for 16/17.

Challenges

- Recruitment and Retention of staff across the care sector in a city which has full employment
- High costs of care due to local economy
- Increased needs of customers resulting in higher average levels of care packages
- The care home market is 70% self-funded leaving the local area with an underdeveloped and under-stimulated provision of care homes

Successes

Reablement – The service has been recently re-commissioned and a revised specification developed. This will include a pathway for people to be assessed at home following a stay in hospital facilitating discharge and supporting the reduction of delayed transfers of care. The service currently provides around 400 hours of direct care to customers, this will increase to a maximum of 612 hours during the next two years which will enhance capacity and will be achieved through the development of an integrated approach via the "One Team" and a revised, challenging specification.

The service currently reduces support levels by approximately 53% with around 25% of customers receiving no service following their period of reablement. This, however, needs to be seen in the context that the service in York has high numbers of people with intensive packages of support in comparison to similar services. The new specification challenges the provider to achieve targets of 40% of all completed cases have no on-going care by 2019 and 90% of all completed cases to have a reduced care package by 2019, alongside developing collaborative working, onward referrals, outcomes measures such as the customer experiencing flexibility, choice and control and a requirement that 80% of all Rapid Response referrals, which are 20% of all referrals, are commenced within one day of receipt. These will support both the increase and effectiveness of our Reablement approach and ensure customers remain independent; facilitates discharge from hospital and supports a reduction in delayed transfers of care.

York Integrated Care Team - Analysis of the York Integrated Care Team scheme is positive and shows that: ***[CHECK DATA]***

NEA are down by 2.1%, admissions are holding static and where patients are admitted their excess bed days have decreased by 25%

Reduction in York Acute Delayed Transfers of Care from 2016 to 2017(

Reduction in the numbers of people entering Residential Care –

A 10% growth in the number of new registrations with Carers Services

Targets for the number of new referrals into the Hub have been exceeded by 12% since May 2016.

The target for Carers Assessments of Need has been exceeded by 17%

Case studies show that a complete breakdown of the care giving role has been avoided for at least 207 households in the 11 month period May 2016 to March 2017.

Approximately 19,000 equipment deliveries in 2016/17 with 98.5% delivered within 5 working days.

Overview of funding contributions

An assessment of the investments in 2016/17 has been used to inform the funding plan and detailed list of schemes for 2017/19 (see Table 1.4). The 2017/19 BCF plan has been jointly agreed by partners, including the level of maintenance for social care, funding for reablement and carers breaks as set out in summary in Table 1.3.

Funding Contribution	15/16 Actual	16/17 Actual	17/18 Proposed	18/19 Proposed
LA Minimum (DFG)	0.951	1.003	1.101	1.101
LA Additional (iBCF and iBCF supplementary funding)	0.000	0.000	2.847	3.735
CCG Minimum (includes reablement and carers breaks)	3.354	3.412	3.473	3.539
Care Act	0.444	0.454	0.454	0.454
CCG Additional	7.378	7.334	7.473	7.624
Total pooled fund (£M)	**12.127**	**12.203**	**15.348**	**16.551**

Table 1.3: 2017/19 Funding Plan

A number of schemes have been maintained going forward for 2017/19 alongside a commitment to invest in new schemes. An agreed methodology was used to build up the investment schedule as follows:
Step 1 – Existing schemes maintained (following high level review)
Step 2 – Full year effect (FYE)/recurrent commitment costs applied
Step 3 – Risk share costs absorbed
Step 4 – Inflation/growth applied if applicable
Step 5 – System wide schemes identified and added
Step 6 – Additional new schemes agreed and added

This methodology supports the following investment profile**:[CHECK FIGURES]**

Investment Profile	16/17 Actual	17/18 Proposed	18/19 Proposed
Existing schemes maintained	12.203	12.159	15.196
FYE/Recurrent commitments	0.000	723	658
Risk share costs absorbed	0.000	1.227	0.000
Inflation/growth applied	0.000	104	126
System wide	0.000	863*	0.000
Additional new schemes	0.000	272	571**
Total pooled fund (£M)	**12.203**	**15.348**	**16.551**

*£863K includes £152K potentially available following detailed review in 2017/18 of schemes

**£571K includes funding potentially available following detailed review in 2017/18 of schemes

Table 1.4: 2017/19 Investment Profile

The full amount of the DFG allocation has been used within the BCF for 2017/19.

The iBCF monies have been used to stabilise existing system wide commitments across health and social care as well as support new investments with a priority on supporting delayed transfers of care across seven working days.

A summary of the services funded in 2016/17 and proposed for 2017/19 is given in Table XYZ. **:[CHECK FIGURES]**

Scheme	2016/17 current	2017/18 plan	2018/19 plan
Disabled Facilities Grant	1,003	1,101	1,199
Care packages (demographic change impact)	2,174	3,115	3,208
Contribution to social work post	137	138	139
Carers support	655	655	655
Care Act implementation	454	454	454
Community facilitators	40	40	40
Reablement services (Human Support Group contract)	1,099	1,099	1,099
Step up/step down beds (inc dementia)	300	303	312
Telecare and Falls lifting	192	192	192
Community equipment	180	180	180
Home adaptations	75	75	75
York Integrated Care Hub	625	750	758
Urgent Care Practitioners	569	526	526
Hospice at Home	170	173	176
Street Triage	150	150	150
Out of hospital services (commissioned by CCG)+	4,380	5,262	5,408
Arc Light – A Bed Ahead	0	81	83
Age UK – Escorted Transport	0	91	93
Fulford Nursing Home beds & OT support (6 months funding pending review)	0	152	0
Rapid Assessment & Treatment Service extended hours and social worker	0	207	207
Priory Outreach	0	180	182
Increased reablement capacity (7 months in 17/18)	0	97	168
Self support champions (4 months in 17/18)	0	33	98
Social prescribing/ways to wellbeing (8 months in 17/18)	0	101	152
Expanded handypersons service (4 months in 17/18)	0	10	30
Information and advice (4 months in 17/18)	0	16	49
Alcohol prevention (5 months in 17/18)	0	15	47
7 day working: multi-agency project	0	0	300
Uncommitted/contingency funds*	0	152	571
Total	**12.203**	**15.348**	**16.551**

+includes: specialist nursing, integrated community teams, community therapies, community equipment & wheelchair services)

*Uncommitted funds includes £152K (2017/18) and £571K (2018/19) potentially available following detailed review in 2017/18 of schemes

Table XYZ: Summary of 2017/19 schemes

Risks

Risks to delivery include:

Main market /delivery risk and current market position – include likelihood vs severity/impact

Financial risk – approach to mitigation of risks, including risk shares – use risk approach from 16/17

[INSERT RISK LOG AS AN APPENDIX]

There is no risk share in place for 2017/19.

Target setting for 2017/19 has considered wider whole system impacts and a risk impact analysis has been undertaken to try to identify unintended consequences of any actions.

National Conditions

The York BCF is based on shared system outcomes overseen by the York HWB within the wider context of the Vale of York population from a CCG perspective.

The York HWB is a statutory committee of CYC and is chaired by the elected member with a responsibility for health and social care. The Board meets bi-monthly and, along with its wider health and wellbeing duties and exists to consider and make recommendations to the Council's Executive and the CCG on the use of BCF funding based upon jointly agreed plans. The Board covers the City of York Council population boundary and has a membership covering a broad range of partners as set out in Table 3.1.

HWB Partner Agencies	
City of York Council	York Council for Voluntary Services
NHS Vale of York CCG	Healthwatch York
York Teaching Hospital NHS Foundation Trust	Independent Care Group
Tees, Est & Wear Valleys NHS Foundation Trust	North Yorkshire Police
NHS England	

Table 3.1: HWB and ACS/ Central Locality Partners

The York HWB has received regular updates on the BCF Plan throughout 2016/17 and, at the May meeting agreed to delegate authority to the Chair and Vice Chair of the Board ***[INSERT HYPERLINK TO MAY MINUTES]*** to act as signatories to the plan should the submission timetable fall outwith the Board meeting cycle.
A draft version of the BCF narrative was considered by the HWB on 6 September 2017 in advance of the final submission by 11 September 2017.

Implementation of Care Act
This element of the BCF supports activities and services resulting from new statutory duties imposed on local authorities by the Care Act 2014. Key services provided through this scheme include Care Act Advocacy Services, online counselling support, financial assessment/personal accounts and information/advice services. The outcomes we are expecting include services which intervene at an earlier stage, improvement in the wellbeing of the population, provision of information and advice, advocacy support, increased numbers of carers assessments and customers being reviewed in an appropriate and timely manner.

Key performance measures include the number of financial assessments completed, number of carers accessing online support, the number of people with personal accounts and that undertaking self- assessment.

Managing Transfers of Care

[Add narrative once National Metrics section complete]

Overview of funding contributions

An assessment of the investments in 2016/17 has been used to inform the funding plan and detailed list of schemes for 2017/19. The 2017/19 BCF plan has been jointly agreed by partners, including the level of maintenance for social care, funding for reablement and carers breaks as set out in summary in Table 1.3.

Funding Contribution (£M)	15/16 Actual	16/17 Actual	17/18 Proposed	18/19 Proposed
LA Minimum (DFG)	0.951	1.003	1.101	1.101
LA Additional (iBCF and iBCF supplementary funding)	0.000	0.000	2.847	3.735
CCG Minimum (includes reablement and carers breaks)	3.354	3.412	3.473	3.539
Care Act	0.444	0.454	0.454	0.454
CCG Additional	7.378	7.334	7.473	7.624
Total pooled fund	**12.127**	**12.203**	**15.348**	**16.551**

Table 1.3: 2017/19 Funding Plan

A number of schemes have been maintained going forward for 2017/19 alongside a commitment to invest in new schemes. An agreed methodology was used to build up the investment schedule as follows:

Step 1 – Existing schemes maintained (following high level review)
Step 2 – Full year effect (FYE)/recurrent commitment costs applied
Step 3 – Risk share costs absorbed
Step 4 – Inflation/growth applied if applicable
Step 5 – System wide schemes identified and added
Step 6 – Additional new schemes agreed and added

This methodology supports the following investment profile:

Investment Profile	16/17 Actual	17/18 Proposed	18/19 Proposed
Existing schemes maintained	12.203	12.203	15.348
FYE/Recurrent commitments	0.000	723	658
Risk share costs absorbed	0.000	1.227	0.000
Inflation/growth applied	0.000	104	126
System wide schemes	0.000	667	0.000
Additional new schemes	0.000	424*	571**
Total pooled fund (£M)	**12.203**	**15.348**	**16.551**

*£424K includes £152K potentially available following detailed review in 2017/18 of schemes
**£571K includes FYE of £152K potentially available following detailed review in 2017/18 of schemes

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	**Total 17/18**	**Total 18/19**
HWB Non-Elective Admission Plan	**5,439**	**5,429**	**5,579**	**5,435**	**4,720**	**4,711**	**4,841**	**4,716**	**21,882**	**18,989**

Admissions to residential care homes

Reduced admissions to care homes will be achieved through the protection of domiciliary care, alongside an enhanced and better integegrated reablement offer. These schemes are closely linked to the development of more extra care housing as an alternative to residential care and the transformation of assessment and care management services to ensure people are able to access this.

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	683.1	633.6	638.4	616.4
	Numerator	253	238	243	238
	Denominator	37,037	37,561	38,067	38,611

Reablement

One of the key actions during 2017-19 will be to build on the successful approach adopted for re-ablement and improve performance both against the "customers remaining at home after 91 days" indicator and outcomes in relation to reduced support following a period of re-ablement. The service has been recently re-commissioned and a revised specification developed. This will include a pathway for people to be assessed at home following a stay in hospital facilitating discharge and supporting the reduction of delayed transfers of care. The service currently provides around 400 hours of direct care to customers, this will increase to a maximum of 612 hours during the next two years which will enhance capacity and will be achieved through the development of an integrated approach via the "One Team" and a revised, challenging specification.

The service currently reduces support levels by approximately 53% with around 25% of customers receiving no service following their period of reablement. This, however, needs to be seen in the context that the service in York has high numbers of people with intensive packages of support in comparison to similar services. The new specification challenges the provider to achieve targets of 40% of all completed cases have no ongoing care by 2019 and 90% of all completed cases to have a reduced care package by 2019, alongside developing collaborative working, onward referrals, outcomes measures such as the customer experiencing flexibility, choice and control and a requirement that 80% of all Rapid Response referrals, which are 20% of all referrals,are commenced within one day of receipt. These will support both the increase and effectiveness of our Reablement approach and ensure customers remain independent, facilities discharge from hospital and supports a reduction in delayed transfers of care.

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	75.7%	75.8%	86.0%	86.0%
	Numerator	106	138	43	43
	Denominator	140	182	50	50

Delayed transfers of care

		16-17 Actuals				17-18 plans				18-19 plans				
		Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Comments
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	Quarterly rate	1454.4	1682.7	1815.5	1173.6	1094.4	1211.1	1095.0	991.8	991.8	991.8	991.8	986.4	
	Numerator (total)	2,497	2,889	3,117	2,032	1,895	2,097	1,896	1,729	1,729	1,729	1,729	1,729	
	Denominator	171,684	171,684	171,684	173,149	173,149	173,149	173,149	174,327	174,327	174,327	174,327	175,281	

High Impact Change Model – Self Assessment [ADD NARRATIVE]

Impact Change	Where are you now	Actions to address challenges
1) Early Discharge Planning	Elective: a) **Plans not established**: *Early discharge planning in the community for elective admissions is not yet in place*. Emergency/ unscheduled: b) ***Plans in place****: Plans in place to develop discharge planning in A&E for emergency admissions*	• Pre assessment focus is on the anaesthetic risk assessment of patients having surgery (POPs Model for elderly). There is no proactive management of potential complex discharge management, there is a strong drive at pre assessment to ensure no day case patients are admitted for social reasons and the onus is on the patients to identify support. Pre assessment can occur on the day of or day before surgery and not all patients are pre-assessed. Patients being referred in should have this discussion with the primary care. • SAFER , bundle includes EDD set within 48 hours - RATS identify/assess patients on admission to ED and aim to turn get them home from ED. York have a social worker attached and have links to York ICT team to support discharge. EDD not set in ED - AAU /AMU/B –EDD set for todays and tomorrows discharges
2) Systems to monitor patient flow	*a)* **Not yet established:** *No relationship between demand and capacity* *b)* **Not yet established:** *Capacity available not related to current demand* c) **Plans in place:** *Analysis of causes of bottlenecks underway and practice changes being designed* d) **Plans in place:** *Analysis of admissions variation on going with capacity increase plans being developed* e) **Plans in place**: Staff training in place to ensure understanding	• Discharge levelling and golden patient work implemented across both Acute sites • Capacity and demand work required for community teams • Support has been requested from NHSI for demand analysis across the system. • Stranded patient reviews planned 17 August to identify delays /escalation • SAFER/ Stranded patient escalation

	of the need to increase senior clinical capacity	
3) Multi-disciplinary, multi-agency discharge teams including voluntary and community sector	a) **Plans in place:** *Discussion on going to create integrated health and ASC teams* *b)* **Plans in place**: *No daily multidisciplinary team meeting in place* c) **Not yet Established:** Continuing Healthcare assessments carried out in hospital and taking "too" long	• Integrated Complex Discharge planning project and the one team • Board rounds SAFER in acute and community units ASC team and community DLT attend the weekly Community MDTs. Integrated complex discharge planning model • Pathway 3 yet to be established for discharge to assess
4) Home First Discharge to Assess	*a)* **Plans in place:** *Nursing Capacity in community being created to do complex assessments in the community.* b) **Established :** People usually only enter a care/nursing home when their needs cannot be met through care at c) **Not yet Established:** People wait in hospital to be assessed by care homes	• Expansion of Scarborough CRT has increased capacity in Scarborough pathway 1.York pathway 1 has been supported by CRT however the One team integration will develop pathway 1 to be supported by intermediate care and reablement. Complex discharge to identify pathway capacity. • CYC numbers show that there is a reduction in the number of people entering care/nursing homes • There is currently no evidence to support the current time to assess, local audit would need to be developed
5) Seven day services	*a)* **Not yet Established:** *Discharge and social care teams assess and organise care during office hours five days a week* *b)* **Not yet Established:** *OOH'S emergency teams provide non office hours and weekend support* c) **Not yet Established:** Care Services only assess and start new care Monday- Friday d) **Plans in place:**	• CRT and RATS 7 day service 8-8pm. SW attached to RATS does not cover the full hours • Care Services will restart existing care but not new POC. Wards can request the restart of existing POC within 2 weeks of admission. • Pharmacy, diagnostic and transport available evenings and weekends Age UK home form hospital operate 7 days a week and into the evening. New patient transport contract due to commence April 2018

	Hospital Departments have plans in Place to open in the evening and weekends	
6) Trusted Assessors	a) **Not yet Established:** Assessments done separately by health and social care *b)* **Not yet Established:** Multiple assessments requested from different professionals c) **Not yet Established:** Care providers insist on assessing for the service or home	• One Team does have plans to develop trusted assessment but these are not yet in place. This forms the 2nd phase priority for the team who will be analysing and developing the internal referral processes between the teams and the training of the workforce. • Care home providers still come into assess although there some occasions when assessment is accepted for example fast track patients. CYC SW assessments accepted by care provider. Work to be developed through care home project.
7) Focus on choice	a) **Plans in place:** Draft pre-admission leaflet and information being prepared b) **Plans in place:** Choice protocol being written or updated to reduce seven days c) **Not yet Established:** *No Voluntary sector provision in place to support self funders*	• Admission and discharge leaflet "Planning your Discharge from Hospital" available, no reliable process to ensure every patient receives. Plans in place with DLO to build a sustainable process add to the complex discharge project Workstream 3 • Joint Protocol to be reviewed as part of the Complex discharge project Workstream 3 • No plans in place to involve voluntary sector we have an example where CYC social work team provide this support for self funders.
8) Enhancing health in care homes	a) **Plans in place:** CCG and ASC commissioners working with care home providers to identify need. b) **Plans in place:** Specific high referring care homes identified and plans in place to address c) **Established:** Quality and safeguarding plans in place to support care homes	• Care Home project- Lead nurse for quality and safety appointed to work with care homes. • Care Home project: High referring homes known and plans in place with the care home project to work with these areas • The CQC inspections- the data shows that we do not currently have any inadequate homes in our area and we are actually above the national average for ratings. • Local authority homes have improvement plans in place.