Refreshed submission 10 Dec 14

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

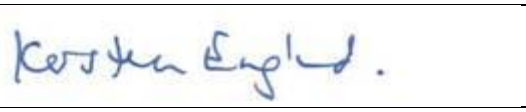
Local Authority	**City of York Council**
Clinical Commissioning Groups	**NHS Vale of York CCG**
Boundary Differences	**The CCG footprint also sits across parts of North Yorkshire County Council and East Riding of Yorkshire County Council.**
Date agreed at Health and Well-Being Board:	**10/12/2014**
Date submitted:	**10/12/2014**

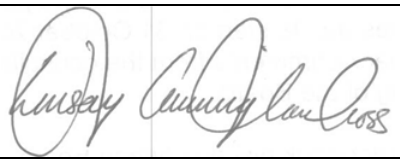
Minimum required value of BCF pooled budget: 2014/15	**£3,354M**
2015/16	**£12,127M**
Total agreed value of pooled budget: 2014/15	**£3,354M**
2015/16	**£12,127M**

b) Authorisation and signoff

Signed on behalf of NHS Vale of York Clinical Commissioning Group	
By	Dr Mark Hayes
Position	Chief Clinical Officer
Date	10/12/2014

<Insert extra rows for additional CCGs as required>

Signed on behalf of the City of York Council	
By	Kersten England
Position	Chief Executive
Date	10/12/2014

Signed on behalf of the York Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Cllr Linsay Cunningham-Cross
Date	10/12/2014

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Improving Health and Wellbeing in York. Strategy 2013-16	H&WB Board 3 year plan
My Life. My Health. My Way. NHS Vale of York CCG Integrated Operational Plan 2014-19	CCG 5 year plan and vision
York Health and Wellbeing Joint	Updated 2014

Strategic Needs Assessment 2014	
North Yorkshire County Council Better Care Fund Plan	32% of Vale of York residents reside in NYCC
East Riding of York Council Better Care Fund Plan	4% of Vale of York residents reside in ERoY
Annual Report of Chief Medical Officer 2013	Public Mental Health Priorities
Gold Standards Framework – End of Life Care	Support and best practice for patients on EOL pathway
York BCF Communications and Engagement Plan	 NHS Vale of York CCG and City ...

2) VISION FOR HEALTH AND CARE SERVICES

a) **Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20**

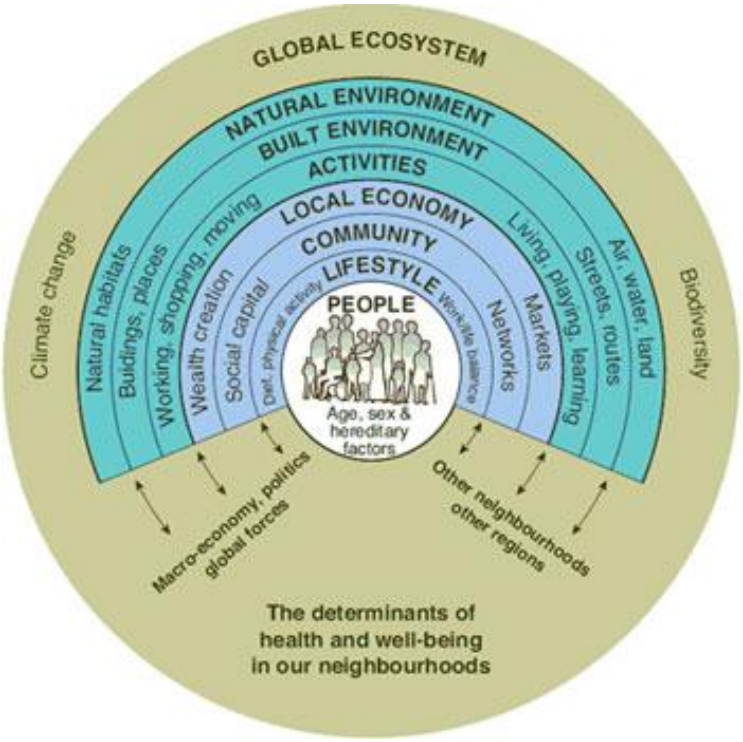
Our joint vision is for a health and social care system that places individuals at the centre with accessible, responsive and effective services built around them:-

"Achieving the best health and wellbeing for everyone in our community" – NHS Vale of York CCG Integrated Operational Plan 2014 – 2019

"York to be a community where all residents enjoy long, healthy and independent lives. We will achieve this by ensuring that everyone is able to make healthy choices and, where they need it, have easy access to responsive health and social care services which they have helped to shape" – York Health and Wellbeing Board Strategy 2013 - 2016

On the whole, people in York have a good standard of life. Most residents can expect to be well educated, have access to good quality employment and, for the most part, live long, healthy and happy lives. However, this is not true for everyone and there are still significant health and wellbeing challenges for the city including the differences in life expectancy between some areas of the city and others, the growing needs of our ageing population and particular challenges around mental health and emotional wellbeing. Based on our understanding of the needs in York (JSNA 2014) our BCF plan sets out our priorities for improving residents' health and wellbeing, and together, as key organisations and as a whole city, what we will do to deliver these priorities. All major providers and commissioners are already signed up to our vision for person centred, integrated health and social care at the highest level via York's Health and Wellbeing Board (H&WB). Our main providers sit on this board. Our integration plan proposed in this submission is absolutely consistent with this vision and the core principles set out in York's Joint Health and Wellbeing Strategy.

Health and wellbeing is about more than illness and treatment. It is about being well physically, mentally and socially, feeling good and being able to live a healthy and fulfilled life. Many factors affect our health and wellbeing, these include: where we live, our housing, the local economy, our income, the environment, our relationship with the local community and the lifestyle choices we make. These determinants of health and wellbeing are shown diagrammatically below:



It is therefore vital that we not only tackle the effects of ill-health but we also address the wider factors and causes. As a Unit of Planning, we will champion good health and wellbeing, identify and harness the determinants that contribute to positive health, building on our strength as a successful and ambitious city.

We recognise that in times of increased demand and additional pressures on budgets and other resources, we need to make sure the health and social care system works as efficiently and effectively as possible. Our joint vision helps us build the necessary programme of work which will take us from our current level of service provision to a new model in 2019 which will ensure:

- Individuals are able to access the right level of care and support in community based settings to help avoid unnecessary admissions to hospital.
- That if individuals do have to go to hospital, we have the right multi-agency teams in place to speed up their journey through the hospital and to make sure they can leave the hospital as soon as it is safe for them to do so.
- Once individuals are discharged from hospital, we have joint teams of health and social care professionals who support them to regain their independence and return to the best level of health possible with a clear focus on effective reablement and enablement.
- That people are able to live in the place of their choice for as long as possible and that when they need to move to a different care setting, this happens quickly and effectively, involving individuals, their cares and families at every step of the way.

The City of York has 3 specific challenges that need to be accounted for in our planning:

- Our JSNA highlights the demographic challenges our health economy faces,

in particular the growth in population aged 85 or over (38% locally, compared with 20% regionally or 23% nationally). This growth has been reflected in our calculations as to how, for example, we will maintain current (13/14) levels of social care provision in the areas that prevent hospital admissions and re-admissions.

- We are also an outlier in respect of the level of "self-payers" within our system" 68% of people in York currently arrange and pay for their own care. This means that in order to develop prevention and early intervention strategies we need to ensure that these residents can receive excellent information, advice and sign-posting at all points in the journey through our health and social care system. It is often the voluntary sector that has the main contact with this cohort and this places particular emphasis on co-design and co-production of services with the voluntary sector.
- Finally, a particular factor we have to take into account in our planning is the extreme pressure put upon the health and care system in York as a result of the "full employment" status of the city. As a city, York has a very low unemployment rate, with JSA claimants at pre-recession levels of 1.3%, compared to 3.4% regionally and 2.4% nationally. This manifests itself within the employment market as a severe skills shortage. This means that we cannot, even if the budget was available, expand traditional service personal care provision exponentially. We need, perhaps more than in almost any other geographical area, to manage down demand so that we can continue to maintain current levels of front-line service provision. It means we must also pay more than average attention to how we use the provision of equipment and assistive technology instead of "care hours". The need to maintain current levels of equipment and assistive technology budgets is reflected within the "Protecting Social Care" element of our BCF submission.

Our vision therefore draws on the findings of our Joint Strategic Needs Assessment (JSNA) and in particular the 4 key points that emerged from the document of:

- Our population is ageing and will place increased demands on health and social care services
- Health and wellbeing inequalities exist in York and must be tackled
- We need to know more about the mental health needs of our population and design appropriate services to meet these needs
- The importance of intervening early and giving children and young people the best possible start in life

b) What difference will this make to patient and service user outcomes?

The success of our vision will be measured by the impact it has on individuals, how it contributes to the sustainability of both health and social care provision and what positive outcomes it has had. Specifically, over the next 5 years we expect to:

- Reduce emergency hospital admissions by 14%. Initial plans indicate a reduction in emergency hospital admissions of 11.7% in 15/16. (See Tab 5 of Part 2 of submission)
- Reduce hospital re-admissions by 2.3%

- Reduce the potential years of life lost from causes amenable to healthcare by 15%
- Improve the health-related quality of life for people with long-term conditions by 1.9% per annum
- Increase the proportion of people having a positive experience of care outside of hospital, in general practice and in the community
- Reduce delayed transfers of care by 6.9% in 15/16. Further modelling required for 16/17 to 19/20 activity based on BCF scheme growth
- Reduce permanent admissions to care homes by 14.8% in 15/16. Further modelling required for 16/17 to 19/20 based on BCF scheme growth

These outcomes will be enabled through the integration of health and social care teams where appropriate and by the implementation of the specific BCF funded schemes outlined in the Annexes. By focussing on the delivery of Care Hubs, supported by additional initiatives such as the roll out of additional Urgent Care Practitioners[1] the expansion of Hospice at Home scheme[2] and the delivery of Mental Health Street Triage[3] we will be best placed to deliver a transformational patient and service user experience as detailed below.

Below is an example of how we see the way in which our residents access and receive care and support change over the next 5 years.

ENID'S STORY

2014	2019
Enid has standard health care reviews with her GP. Social care provision is reactive. She has problems with slowly deteriorating lung function as a result of COPD and she also has mild dementia. Enid begins to feel unwell over a weekend and goes to bed. Her daughter finds her and calls NHS111. She is admitted after a long wait in AE. She is given antibiotics for a chest infection. Like many patients she is at risk of further infection and loss of her normal function. She is discharged back home in the evening after a long stay in hospital. Her GP is unaware of her arrival home until her family call stating that she is struggling and confused. Her medications were altered by the hospital team, including an addition of anti-psychotic medication used to	The Care Hub Team identifies Enid as a risk for admission and proactively assesses and manages her health status with her own case manager. Every opportunity is taken to help her to remain independent in her own home. Enid receives a comprehensive care plan with a named care worker that she and her family can contact for support when necessary. When she contacts the NHS111 and the Out of Hours GP her medical details are available. Alternatively during the week she is seen by her GP or an Emergency Care Practitioner who steps up her care to the local Community Hospital When she is admitted the AE Team has her records and then inform the Care Hub Team that she has been admitted.

[1] Annex 1B – Urgent Care Practitioners
[2] Annex 1 C – Hospice at Home
[3] Annex 1D – Street Triage

control her agitation whilst admitted. She is visited by her GP and a District Nurse who requests Social Care input from the rapid access and reablement teams. She remains at increased risk of admission over the weekend and during the night. The reablement process falters and Enid is referred for placement in a Care Home. Whilst waiting Enid falls and breaks her hip and is admitted back into hospital. The system failed Enid through a lack of continuity of care and a lack of joined up services, working together to meet Enid's needs and aspirations.	They begin her discharge planning within 2 hours of her admission. Her discharge process is fully integrated with the Care Hub Team who signal that they are ready to receive her in the community. She is discharged with a clear emergency care plan and updated Do No Attempt CPR Form. She has social care provision and additional services such as physiotherapy. Enid is assessed as having a risk of falls and is provided with risk mitigation support. The Care Hub Team adjusts her management plan and involves her family to anticipate risks in her disease trajectory. Enid has benefitted from joined up services that fit around her; they support her continued independence through an integrated team of health and social care professionals who share information and involve Enid and her family in decision making.

To do this for Enid and other residents of York, we need to change the way individuals' access services, both in and out of hospital, so we can deliver Right Care, Right Place, and Right Time, and "making every contact count". A true measure of our success will be reduced hospital based activity and a much greater use of community and home based support.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

How future services, both health and social care, are configured and delivered is perhaps the greatest challenge facing the local economy and the level of transformation we want to achieve. Our 8 key strategic initiatives, outlined within the CCG's Strategic Plan, are:

- Integration of Care
- Person Centred Care
- Primary Care Reform
- Urgent Care Reform
- Planned Care
- Transforming Mental Health and Learning Disabilities services
- Children and Maternity Services
- Cancer, Palliative Care and End of Life Care

The activities with most relevance to our BCF submission are described below.

The demographic challenges we face place additional strain on our health and social care services. This is recognised as a key driver in establishing our Care Hub models.

The development and implementation of Care Hubs is a major strand of our vision which will bring together a comprehensive range of health and wellbeing services to provide for local people. Our Care Hubs will:

- Be dedicated to the needs and aspirations of the communities they serve
- Deliver coordinated care and support that is co-designed and co-owned by individuals and communities
- Consistently deliver high quality, successful and cost effective outcomes

Our care hubs in turn will operate within a much wider integration of health and social care including critical factors of success such as a shared care record and single point of contact. These key components are described in more detail below:

Care Hubs – We will develop Care Hubs, whose key responsibility will be to assess, diagnose and activate solutions to enable individuals to remain at home, or return there at the earliest opportunity, following a period of exacerbation or crisis. These hubs will be developed using national and international evidence, ranging from earlier Polysystem models in Redbridge through to fully integrated community models in Canterbury, New Zealand and 'Extensivists' in the USA.

The hubs will be staffed by a multi-disciplinary, multi-agency team who will act as the enablers to ensure care and support packages are put in place as quickly as possible and in the best interests of the individual and their carers. New funding models to incentivise providers to deliver this approach will ensure they truly deliver transformed models of care as alternatives to admissions to hospital or care homes.

We have already established a hub in York, being delivered by Priory Medical Group[4]. Funding for this hub has been made available through the BCF and projections on the efficacy, cost effectiveness and outcomes of this hub are promising. We are putting in place a formal evaluation process in partnership with the University of York and once this initial evaluation has happened (planned for Autumn 2014) we will confirm the additional BCF funding to grow the hub to deliver at pace and scale.

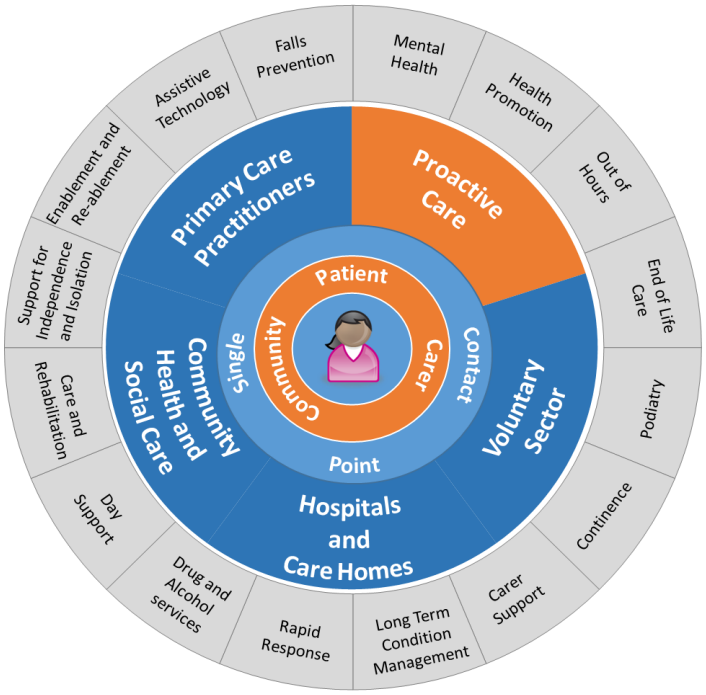
The diagram below shows how we expect our Care Hub model to work, with individuals at the centre, supported by their own networks and community as appropriate through a single contact point. Individuals will access service delivery providers who in turn will ensure individual or joint interventions fit around the individuals' needs.

[4] Annex 1A – Care Hub PMG

WHAT

A range of health and care professionals working together to meet all of the health and care needs of their residents.

Actively liaising with professionals where onward referral for specialist support is needed



HOW

Doctors, Nurses, Social Care, AHPs and Pharmacists

Working from health and care facilities integral to the Hub

Accountable for outcomes and funding across all settings inside and outside the Hub

Shared Care Records – People tell us they "only want to tell their story once". We fully support this and see this not only as one of the greatest impacts the new services can provide it is also one of the greatest challenges we face. We need to join up our different information systems so we can work with partners and the wider business community to look at how we can do this. It will mean new ways of managing data and working across organisations, to share relevant information and we will use the NHS number across both health and social care.

Single Contact Point – we will have one care record, and move to a single contact point for residents to contact us. This could be a GP, a care manager, a district nurse, a community matron, an OT or specialist MH worker or any other health and social care practitioner with whom the person has regular contact. This person will retain accountability for their client and will act as the facilitator to all other services and interventions. Clearly when an individual is admitted to a hospital setting, clinical responsibility will transfer to the relevant hospital clinician but the single contact point will still have an accountable role for in-reach and discharge planning.

The pace and scale of what we are trying to achieve is significant and we have used the principles behind the Better Care Fund to mobilise our local economy into action.

Subject to the Ministerial announcement, we fully expect to be part of the national NHS Accelerate programme. At a recent assessment panel (made up of senior members of the NHS, LGA and Monitor) all commented on the depth and range of the initiatives we are proposing; initiatives and conversations that would have been impossible even 18 months ago, without the catalyst of BCF. By participating in Accelerate we will have access to a range of senior support to help drive our joint initiatives forward at pace.

Implications of Care Act

At present, prior to the implementation of the Care Act, people with the highest levels of need and especially those who are likely to receive public funding, are the most likely recipients of Statutory Social Care Assessment. The implementation the requirements of the Care Act in 2014/15 and 2015/16 will mean that people will be able to access a full social care assessment at a much earlier stage and the assessment will be the same for people who fund their own care as those whose care is funded by the Council.

In addition, as a result of Care Act implementation, people who will not be entitled to funded care will receive greatly enhanced levels of information and advice services to enable them to access care services that complement their healthcare, as well as having a named individual to coordinate their care across health and social care services. Currently in York over 60% of people organise and pay for their own care. The implementation of the Care Act and the move to Community Hubs will provide a coordinated approach for these residents for the first time.

Dementia care

A further challenge for York in respect of its ageing population is the exceptionally high rise in the over 85 population during the plan period and the associated rise in dementia that can be anticipated as a result. York has committed to being a "dementia friendly" city across a whole range of statutory, voluntary and independent sector service provision. The impact is expected to be to help people with dementia to be able to live as long as possible within the community rather than in residential settings. During the BCF plan period we will redesign service provision for this group of residents within the health and social care context. This will include:

- Provision of specialist dementia step-up and step-down beds to avoid unnecessary hospital admission and speed up hospital discharge for this hard-to-place client group.
- The re-provision of residential care homes in the city to provide a dementia friendly model of care. Capital from the BCF will be used to support this re-provision.
- The redesign of extra-care housing provision within the City providing an option to early entry to residential care.
- Increased availability of assistive technology within people's own homes to enable them to retain independent living for longer and to reduce the burden on their carers, thus avoiding carer breakdown.

Mental Health

Finally, in respect of mental health services, there has been a recent and very extensive engagement with the residents of York and the neighbouring area of North Yorkshire about the outcomes they want to achieve from a redesigned of mental health service. City of York Council and Vale of York CCG are currently collaborating to establish which core services can be part of an integrated approach and can be jointly commissioned. This work is moving at pace and key decisions will be made

within the next 6 weeks. It is intended to take this joint plan to a competitive procurement exercise later this year.

- Mental health and the often associated issue of alcohol misuse are also given a prominent place in our admissions avoidance strategy. Two schemes, both of which will be in receipt of BCF funding will significantly contribute to reductions in acute sector admissions. These are our Mental Health Street Triage scheme and out "Together" scheme which targets hard-to-reach individuals whose needs are not being met by traditional services.

Intermediate Care

Another major difference in our local system design in over the plan period will be in respect of our intermediate care services, the services available when people go into crisis in the community and need intensive input to avoid admission to hospital or a residential/nursing home and also when they are discharged from hospital to avoid re-admission. In the Oak Group's Medical Care Appropriateness Protocols (MCAP) this is described on 2 levels:

Intermediate Care (facilities based)

A step-up or step-down unit to initiate or finish a course of treatment where the frequency of complexity cannot be managed at home or where the patient has problems with activities of daily living including transfer, mobility and safety .....interventions can be provided by physiotherapists, occupational therapists or support workers. Medical care is provided by primary care services when required.

Intermediate care (home based)

A service to initiate, maintain or complete a course of treatment that requires supervision but where patients can be safely supported at home. The patient requires MDT input but is safe in the home environment.

We will use BCF funding to provide intermediate care services that prevent avoidable hospital admission and readmission. However, we recognise that the current provision of intermediate care in the City is fragmented. During the latter part of 2014/15 and mainly in 2015/16 we will jointly review our current intermediate care pathway and our current services. We will engage with patients, service-users and their carers as well as our providers. Then we will use this information to jointly commission the optimum range of step-up and step-down services during 2016/17 within a fully integrated approach

A cross-cutting theme for our integration programme is how our systems redesign, our integration plans and specifically our BCF funded activities support urgent care and the acute sector. In this respect the approach we have taken is to understand how each of our BCF schemes will contribute to the following systems objectives:

- Schemes to prevent unnecessary conveyance *to* ED
- Schemes to prevent unnecessary admission *from* ED
- Schemes to support hospital discharge and avoid re-admission

This information is contained in the schedules to our BCF submission.

Evaluation

The formal evaluation of the impact of our Care Hub model will also help redesign service provision, as will our determination to see a reduction in hospital based activity. All of these initiatives will have an impact, in some shape or form, across our unit of planning and we recognise the absolute need to understand this impact early on in our planning processes. We do not currently have a high degree of confidence that we have either the capacity or capability to accurately model these impacts and this is a specific area where we have identified that the NHS Accelerate programme would be able to support. Without additional support, accurately modelling, describing and delivering reconfigured services in a sustainable way will be a significant risk to all partner organisations.

We have also approached the University of York with a view to developing an approach to the evaluation of our BCF funded schemes that will provide us feedback on what interventions deliver the best outcomes for patients and the best return on investment.

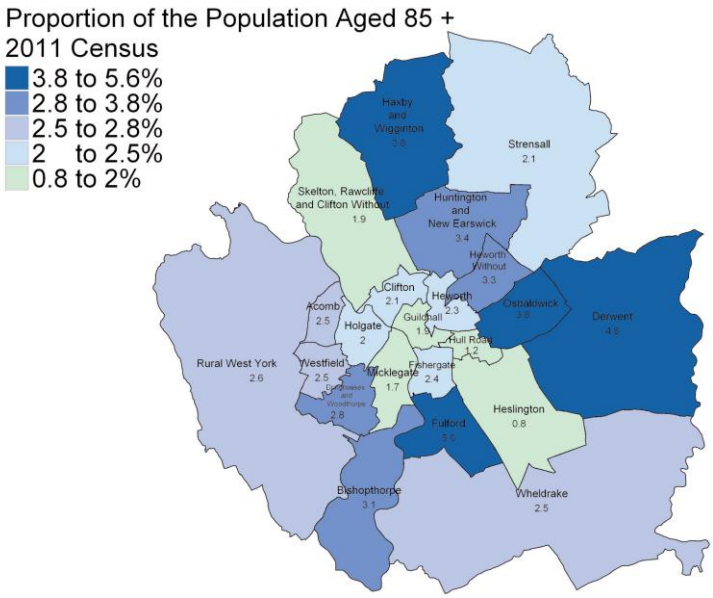
3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this

"We aim to help people to remain healthy and independent in their own communities for as long as possible, by working towards delaying the need for care. Driving greater integration between health and social care is a key commitment. We are exploring jointly commissioning health and social care services from 2015 with the Vale of York Clinical Commissioning Group. The Better Care Fund has been set up to support councils and Clinical Commissioning Groups to deliver their local plans for integrating health and social care and is a vehicle to help us deliver this, which is a core purpose of the Health and Wellbeing Board. People should access personalised support which meets outcomes and is better coordinated, making the best use of resources." Extract from CYC Market Position statement 2014

Local Future Demand

York's population of over 65s is increasing, making up 16.9% of the total population. The most notable growth rate is 38% between 2001 and 2011 for those aged 80 and over, compared to a national rate of 23%. The over 80s are amongst those most likely to be receiving high levels of health and social care services, due to higher prevalence of dementia and likelihood of having more than one health condition or disease. It is predicted that there will be a 44% increase in people in York aged 80 and over between 2012 and 2020. This growth in those aged 80 and over is partly due to increased longevity. There is also evidence that York's higher than average rise may be attributed to the very elderly who often no longer drive, moving out of surrounding rural areas and into York. Cuts in public transport in North Yorkshire and East Yorkshire may have contributed to this, alongside older people wanting to live closer to health facilities. Demand for services and support for older people is expected to rise, with entry in services likely to be later in people's lives.



Mental Health Foundation states that 1 in 4 people in the UK will experience some kind of mental health problem in the course of a year. It is estimated that at any one time there are around 25,000 York residents experiencing mental health problems ranging from anxiety and depression to enduring psychiatric disorders. This figure includes people with dementia. In general we expect demand on services to rise in line with population growth. The Community Mental Health Profile for 2013 records that in York the percentage of adults 18-and-over with depression is 'significantly worse' than the average for England based on 2011/12 data. The percentage of adults 18-and-over with dementia is similarly recorded as 'significantly worse' than the average for England.

The table below highlights the significant challenges facing York in addressing the Mental Health agenda.

Rate per 1,000 population	Period	England Average	Yorkshire and The Humber	York
In-year bed days for mental health	2010/11	193	170	204 (Significantly Higher)
Numbers of people on a Care Programme Approach	2010/11	6.4	6.3	5.6 (Significantly Lower)
Numbers of people using adult & elderly NHS secondary mental health services	2010/11	2.5	2.6	3.1 (Significantly Higher)

Directly standardised rate for hospital admissions for schizophrenia, schizotypal and delusional disorders	2009/10 to 2011/12	57	54	79 (Significantly Higher)
Directly standardised rate for hospital admissions for Alzheimer's and other related dementia	2009/10 to 2011/12	80	81	119 (Significantly Higher)
Directly standardised rate for hospital admissions for mental health	2009/10 to 2011/12	243	221	268 (Significantly Higher)
Percentage of adults (18+) with depression	2011/12	11.68	11.88	13.71 (Significantly Higher)
Percentage of adults (18+) with dementia	2011/12	0.53	0.58	0.66 (Significantly Higher)

The NHS Information Centre - Mental Health Minimum Dataset - http://www.ic.nhs.uk/pubs/mhbmhmds11

Having a clear understanding of this local data has been the first stage leading to the development for our plans, models and programmes for BCF. This has been the baseline we have used to establish which areas we need to concentrate on first to achieve the objectives of BCF. This data has also been used to support our risk stratification approach described in the following section.

Our approach to Risk stratification

To prioritise and help us understand the needs within our resident groups and how these are distributed across the York population we have used the Combined Predictive Model (Kings Fund 2006). We will be applying this method to help identify the top 20% users of health and social care services within our care hubs, this will inform future support options and care planning for those residents and each cohort within our BCF plan. These include: Age-related frailty, levels of economic well-being, behaviour, social connectedness, utilisation risk, presence of a carer, and a person's own caring responsibilities. In addition to people's clinical and social care needs, we recognise these may have a significant impact on a person's capacity and willingness to self-manage and the bearing this could have on their dependency on statutory services.

There are three major reasons why we have elected to take this approach:

1. Similar risk scores do not automatically mean similar needs – two residents may have very high-risk scores, but vastly different needs. For example, someone who is very frail and elderly may have a risk score similar to someone who is middle aged and has diabetes and COPD, but the former may need fall prevention programmes and regular social-care visits, while the latter may need more intensive primary care and regular visits to a specialist for managing their conditions.

2. Utilisation risk only measures risk of a non-elective hospital admission – while this is a useful indicator for needs, many needs are lost by only focusing on one aspect of care.

3. Risk stratification has a low ability to predict non-elective hospital admissions - most of the models we have so far interrogated have only very limited ability to positively predict the people who will be admitted to hospital. By understanding the population of York by their characteristics, we will more accurately be able to identify those at risk of unplanned hospital admissions and enable us to improve our preventative approach.

Risk stratification will be used within each group of residents to understand where the level of need is greatest, and therefore where within each group we should begin our initial focus. Using the grouping around condition type and age combined with the risk stratification approach will give us a more detailed and nuanced view of the residents in York. The former tells us where in the local population the types of needs are similar, while the latter tells us where the magnitude of needs is greatest. The CCG is working with its partners, providers and all BCF schemes to share this knowledge, supporting them to deploy their resources effectively and therefore reduce potential avoidable admissions to hospital and costs.

Understanding people with one or more long term conditions and how this information can help us to tailor the intensity of support an individual may need to help prevent avoidable admissions. This will also help us to identify previously possibly neglected individuals and groups and help us to figure out which groups to work with first. It is important we undertake this to help us understand the needs of our residents and in co-designing with them the new models of support through the care hubs.

We will use the best available data to understand the needs of our residents quantitatively as well as qualitatively, making use of risk stratification and segmentation

Developments resulting from our BCF plan are inline and interdependent with CYC and VOYCCG strategic planning and commissioning priorities, and have been aligned to the JSNA. Both organisations have a clear vision for the delivery of integrated care that is integral within the strategy we are developing for co-commissioning and is also at the core of the CCG's Integrated Operational Plan 2014-19.

Modelling for BCF has been based on the agreed activity targets for VOYCCG, the financial impacts for achieving the minimum statistically significant change across all BCF metrics, the value compared to the requirements of the plan and what level of performance against each BCF indicator needs to be to deliver the BCF plan.
We have also considered what would be the impact of stretching the BCF metrics to a reasonable level and what the combined value of achieving the BCF targets and QIPP is. The practice level tool enables commissioners and practices to test the activity and financial impact of achieving the minimum level and to compare this to alternative scenarios and target stretches.

Where possible, 2013/14 actual activity has been included and used to apportion targets. We recognise the danger of a potential double count with QIPP initiatives and have therefore factored in separation of activity. To help minimise this, the following rules have been applied:

- **Delayed transfers of care.** It is assumed in this model that all delayed transfer days incur an excess bed day charge. As there is a currently a transactional QIPP scheme aimed at reducing non-elective excess bed days, 'Improving length of stay', the 2013/14 actuals shown are the number of excess days remaining after the full impact of the 'improving length of stay' QIPP has been realised. Improving length of stay is estimated to remove £136K of excess bed day activity, approximately 1415 days at average price
- **Non-elective admissions.** Activity as identified by primary diagnoses codes specified in the NHS England guidance 2014/15 **BUT NOT** non-elective activity with a primary diagnosis code for diabetes (ICD 10 codes E10-E14) or primary diagnoses of epilepsy (ICD 10 codes G40, G41). This is because diabetes and epilepsy admissions are expected to be impacted by the diabetes and neurology pathway QIPP schemes respectively.
- **Falls related injuries.** Activity coded as "(ICD10 primary diagnosis in the range S00 through T98X) and external cause (ICD10 code W00-W19) and with an emergency admission code in people aged 65 and over" (Admission method 21-28 including new coding 2B etc.).

The diagram below is an example of a CCG wide report which has been produced from a model developed by the CCG to help inform both QIPP and BCF planning. The model allows impacts of interventions to be measured at a pan CCG level, at a federation level (which feeds the Care Hub model) or at an individual practice level. The CCG has been using the model for 3 months and is anticipating investing in a refresh in late 2014 to ensure the outputs remain current and relevant to national metrics and local demand.

All

Current impact £ 597,521 **Stretch impact** £ 597,521

Better Care fund

	Baseline (BCF)	Actual 2013/14	Full year target	Impact 2014/15			Estimated impact	Stretch Impact 2014/15		Estimated impact	Stretch % as #	Bed impact	Workforce impact
				#	%	Direction	£	#	%	£	#	#	#
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	377.0		47.4	23.7	6.3%	Decrease	£ 188,289			£ 188,289			3.4
Older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	439.2		33.1	16.5	3.8%	Increase	£ 131,413			£ 131,413			2.4
Delayed transfers of care from hospital (EL & NEL excess bed days used as a proxy)	15388.8	19551	553.7	276.9	1.8%	Decrease	£ 26,632			£ 26,632		0.6	0.2
Avoidable emergency admissions (13/14 actuals less Diabetes and Epilepsy activity)	6864.4	47160	360.9	180.5	2.6%	Decrease	£ 100,296			£ 100,296		1.8	0.4
Injuries due to falls in people aged 65 and over	1159.6	1607	330.1	165.0	14.2%	Decrease	£ 149,977			£ 149,977		2.7	0.7
Emergency readmissions within 30 days of discharge from hospital	253.9	213	3.3	1.6	0.6%	Decrease	£ 913			£ 913		0.0	0.0
											TOTAL	5.1	7.0

Avoiding double counting

A number of the 2014/15 QIPP initiatives focus on reducing non-elective admissions and it is important to ensure the monitoring of performance is not double counting with the BCF metrics and with other QIPP programmes. As a guide, it is often best to consider which schemes are most specific and/or most likely to impact patients first and then to consider that broader schemes e.g. UCP will impact only the residual activity.
Table below shows the how 2013/14 activity may be segmented. Excess bed days are not included in the values shown. In addition, it is important to note that the financial values shown have not been adjusted for the 30% Marginal Rate Emergency Threshold (MRET).

Other important considerations:

1. Estimating non-elective savings

In 2014/15, due to the MRET only £42M of the £64M planned non-elective spend (including excess bed days) was paid for at full tariff price: the remaining £22M of activity and non-elective excess bed days was paid for at 30% of tariff.
Based on the average price of a non-elective admission c.£1,800, up to 12,000 non-elective spells of acute activity would need to be removed before the threshold would no longer apply. To put this in context, total annual avoidable admissions at York Hospitals Foundation Trust in 2013/14 were 6,588 and 2014/15, with non-elective QIPP programmes estimated to remove around 2,000 non-elective spells. This means that even if all avoidable admissions activity was removed from the trust and all QIPP non-elective schemes performed as forecast the value of all non-elective activity removed would be 30% of tariff.

2. Sharing potential savings from acute activity

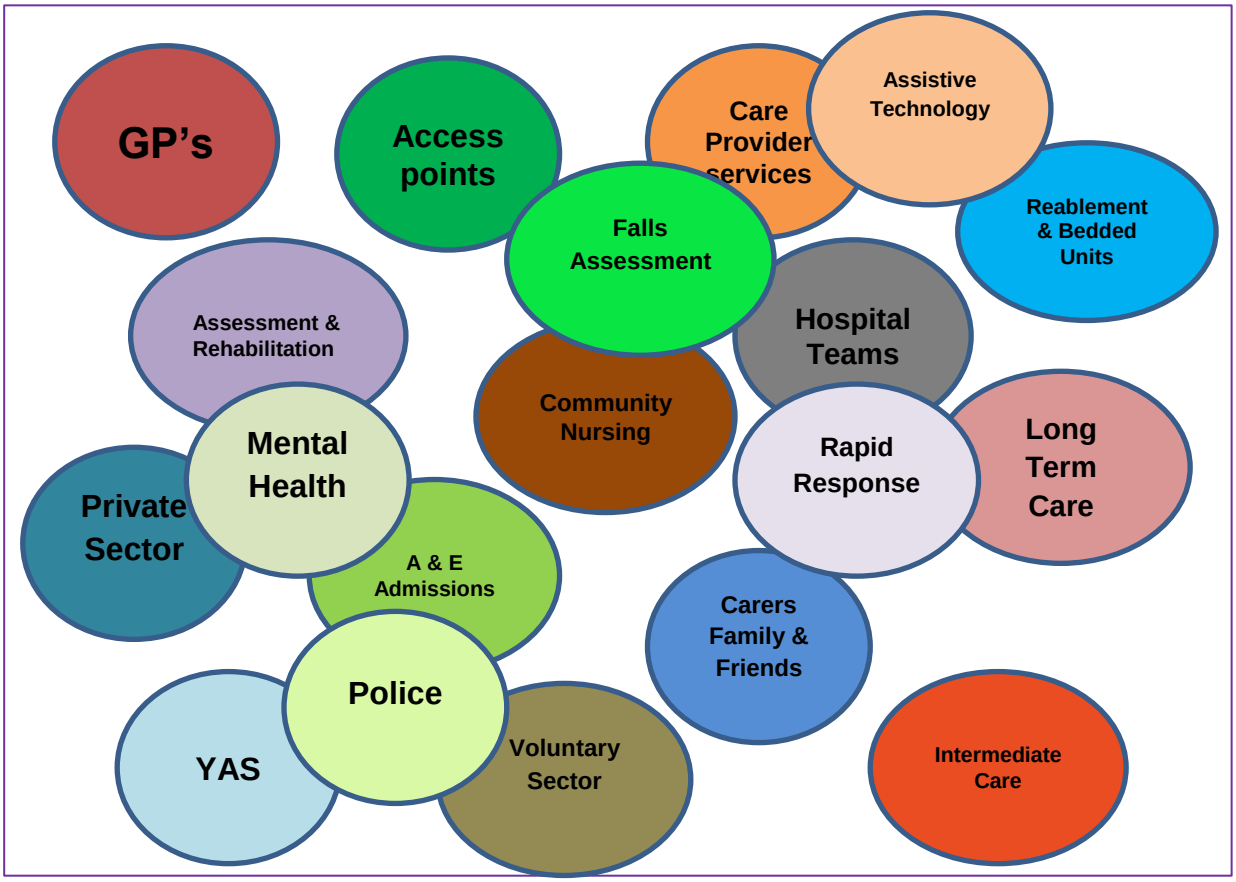
Like all BCF submissions we know there is a dependency related to reducing acute activity that will enable us to transfer funding and deliver our ambition around developing community resources. To support this we will within the next two months develop a section 75 gain share agreement building on the template provided by NHS England.

3. Engaging staff and transforming working practices

We have begun by creating a powerful narrative which is based on improving care for patients, jointly tackling local population health problems and improving working practices. We are creating a joint approach working collaboratively through JDG because we recognise we cannot do it individually.

We are helping our GP practices to focus on the detail of how it will affect their patient base and in particular ‘high demand patients’. We aim to make it easy to engage, designing around practices and moving towards shared MDT meetings to promote consistency and reliability. Making joint working the easy thing to do by removing as much bureaucracy as possible. Using action learning methodology with outside support from University of York. Holding multi-professional design workshops at key stages in the journey and action learning workshops with staff from all professional groups meeting to identify problems and start to problem solve, with JDG acting as a ‘high level problem solving group’. We will involve the voluntary sector at every level (including JDG) to embed awareness of local services across all participating groups and organisations

Our plan will help us to go from this…



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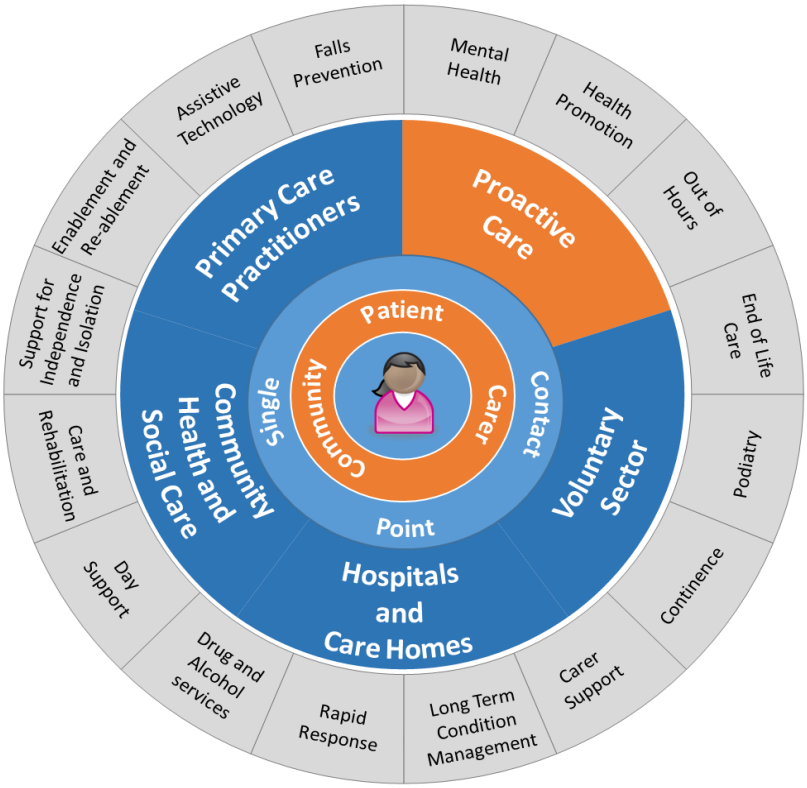


4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

"We have a clear plan of action, agreed across partner organisations, which will help drive our integration plan over the coming months"

	Milestones	Responsible/Accountable	Timescales
	Milestone 1 : Finance		
	Agree pooled budget 15/16	VOYCCG/CYC	Sept -Dec 2014
	Develop Section 75 gain share agreement.	VOYCCG/CYC	Oct - Feb 2015
	Milestone 2: Organisational and Workforce development		
	Carry out a workforce skills and capacity audit.	VOYCCG/CYC	Sept - Dec 2014
	Agree and develop new ways of working – joint assessment/joint care planning, trusted assessor.	VOYCCG/CYC	Sept - April 2015
	Begin planning processes for integration of staffing/ teams, where applicable.	VOYCCG/CYC	Sept – Dec 2014
	Review current provision to ensure sufficient capacity within reablement and intermediate care services including step up/down beds.	VOYCCG/CYC	Sept – Dec 2014
	Milestone 3: Communication and Engagement		
	Develop next stage stakeholder plan Communications and engagement strategy.	VOYCCG/CYC comms leads with support of JDG and relevant partners	Oct - Nov 2014
	Continue to engage with residents and all stakeholders.	VOYCCG/CYC	Sept – Mar 2015
	Develop co-design task and finish groups with residents, partners and stakeholders	VOYCCG/CYC	Sept – Mar 2015
	Culture change – ensure arrangements are in place to address emerging issues and staff concerns so individuals and teams know where to go for support and advice.		

	Milestone 4: Delivery of New models including 7 day services and Data Sharing		
	Implement additional care hubs following successful submissions and recruitment	VOYCCG/CYC	Sept 14 – Mar 16
	Schemes in place and fully operational		Sept 14 – Mar 16
	Review clinical standards for 7 day working to ensure these are included in NHS contracts between CCGs and providers for 2015/16 and 2016/17 Review discharge processes and protocols to facilitate 7 day discharge arrangements are in place	VOYCCG/CYC/Trust	Sept 14 - Mar 15
	Milestone 5: Governance and Assurance		
	Ensure IG protocols are in place that will support data sharing between relevant partners including: Consent principles and arrangements are in place including policy and process that will enable assessments are able to be shared.	JDG All	On – going On – going
	Monitor impacts of BCF developments against agreed performance metrics.	JDG	On- going
	Develop a technical solution that will enable access to both health and social care systems and link data sets where required.	Data sharing task and finish group	July 14 – Apr 16
	Further develop the work stream that will deliver a long-term solution for integrated records.	Data sharing task and finish group	Sept 14 – Sept 15
	TOR for JDG	All	Complete
	Regular dialogue and reports to CTB and HWBB	JDG	On- going

b) Please articulate the overarching governance arrangements for integrated care locally

The York Collaborative Transformation Board (CTB) has been established to progress and govern our integration plan. CTB reports directly to York's Health and Wellbeing Board, who hold ultimate responsibility and governance for integrating health and social care locally. It also provides assurance to both the CCG and the Council for the delivery of the BCF and the wider integrated health and care agenda. The CTB has been running

since May 2013, chaired by City of York Council (CYC) Deputy Chief Executive and attended by senior representatives from commissioner and provider organisations including NHS Vale of York CCG (VoY), York Teaching Hospitals Foundation Trust (YTHFT), Leeds York Partnership Foundation Trust (LYPFT) and CYC Adult Social Services and representatives from the voluntary sector and health watch. Neighbouring Local Authorities who link with the Vale of York CCG are also represented.
YTHFT is fully committed to our plans. As our main provider of acute and community services the Trust has supported our system wide reablement and winter schemes and is playing a strong role in shaping and resourcing our BCF schemes. The Trust is also committed to our vision by running a care hub pilot in Selby and sharing workforce with other 'hub' pilots as well as reshaping its provision to reflect changing demand as our proposed schemes begin to take effect. (See Annex 2 Provider Commentary)

We have also prioritised improvements in mental health services (details of new schemes proposed as part of initial BCF plans are explained later in this submission) as a core part of reforming the care system and Leeds and York Partnership FT (LYPFT) are active partners in helping us re-design and deliver our models of care.

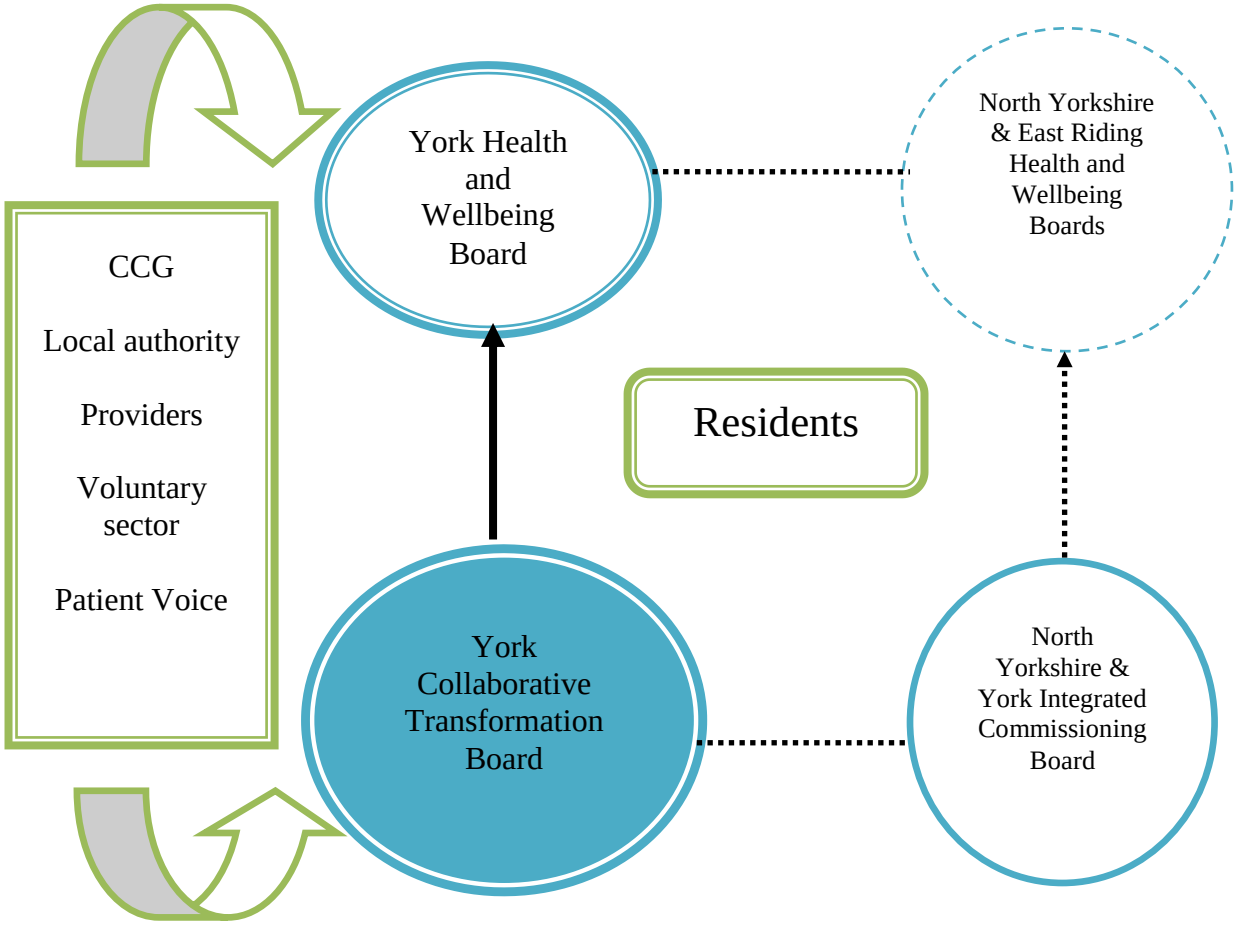
We have established a Joint Delivery Group (a CCG and CYC group which is responsible for driving the delivery of the BCF) which meets monthly and is supported by 2 senior programme leads who work collaboratively across health and social care commissioners and providers; this collaborative approach has allowed significant progress to be made in building sustainable relationships which are translating into joint plans, shared learning and agreed actions.

Joint working groups are being established within our care hub models, consisting of personnel from health, social care teams, providers and the voluntary sector. These have formed into MDT's and the ambition is for these to develop into integrated teams with pooled budgets, consistent processes with the ambition to develop a shared case management record system.

c) **Please provide details of the management and oversight of the delivery of the Better Care Fund plan, including management of any remedial actions should plans go off track**

Because the CCG works alongside 3 Local Authorities, we are actively exploring opportunities to work across geographical boundaries, including working with North Yorkshire and East Riding local authorities, ensuring our plans are aligned across the whole CCG footprint. We have put in place additional service delivery support to help us achieve this.

The diagram below illustrates current governance arrangements for our integration plan.



BCF is a significant component in securing our joint vision for sustainable health and social care, which will be delivered through Care Hubs across the system. We have therefore produced a more detailed delivery framework, driven through a Joint Delivery Group (JDG) which sits below the Collaborative Transformation Board.

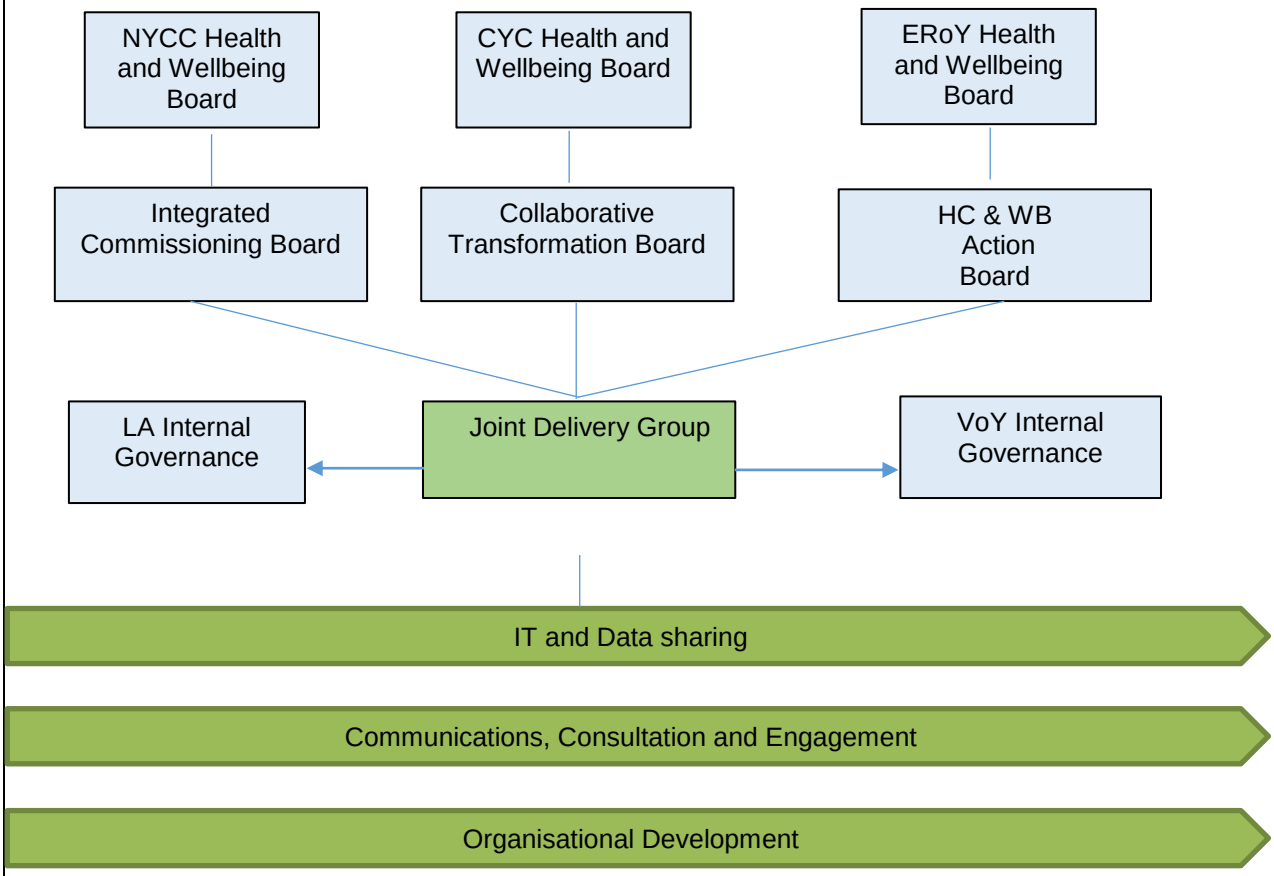
JDG will provide robust and systematic programme management, assurance and scrutiny of proposed plans and all schemes, it will also be the forum for joint learning and problem solving. Project reporting documentation is now in place, each scheme will complete this and report monthly to JDG, through this we are able to measure effectiveness and delivery as well as to chart progress and act quickly should any remedial action be required. An example of this report is included at the end of this section. We are in the process of refreshing both the JDG and the CTB to more accurately reflect the shift in focus from planning to delivery. Part of this refresh will be a change to the current reporting system to focus more clearly on delivery and to help build a more reactive reporting system so that we can see the impact of our schemes and put the necessary actions in place should forecast delivery trajectories not deliver. This will be linked to the HWB Board dashboard and will be the main vehicle for monitoring delivery.

In developing this framework we have taken into account the additional complexities faced by the CCG in having to work with 3 Local Authorities and 3 Health and Wellbeing Boards. We believe our proposed framework represents a pragmatic approach which avoids duplication of effort whilst securing arrangements to deliver the LA accountability

for BCF and providing a realistic level of assurance and challenge to all partner organisations.

We also recognise that there are issues that cut across Local Authority boundaries and we are keen to develop a series of overarching work streams that act as enablers to deliver the overall programme. The diagram below, details these enablers and the new boards and groups now developed.

BCF Governance Structure



d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
Annex1A	Care Hub - PMG
Annex1B	Urgent Care Practitioners (with North Yorkshire)
Annex1C	Hospice at Home (with North Yorkshire)
Annex1D	Mental Health Street Triage (with North Yorkshire)
Annex1E	Pathways Together
Annex1F	Psychiatric Liaison (with North Yorkshire)
Annex1G	Sitting and Crisis Hours Service
Annex 1H	Whole System Review

Example report for Joint Delivery Group

BCF Fortnightly Progress Report: Priory Medical Group

w/e 12th September 2014 — *Overall progress vs. plan:* G

Clinical Lead: Dr. Lesley Godfrey (PMG; GP and Partner)

PM Lead: Martin Eades (PMG Managing Partner)

Key Accomplishments Since Last Report	Activities for the Upcoming Month
• NHS Accelerate programme visit completed - PMG/MDT observed; Feedback expected 09/14 • Business plan for hub development completed (to extend model with additional practices- Unity, Haxby and MyHealth with total hub population of c. 110k); For JDG submission by 30/09/14 • Meeting held with YTH Community Services and Rehab on 21/08/14 held and key actions agreed in supporting caseload reviews, involvement of community allied health professionals in hub/MDTs and utilisation of joint records – YTH teams to support input to SystmOne care plans • Meeting scheduled for 02/10/14 with local stakeholders re. developing a joint electronic shared record • Hub development; New protocols developed for potassium, urine dip testing & antibiotics to include skin/ urine/chest infections.; Syringe driver training circulated to care homes..	• Submit hub expansion business case • Meeting with YAS re. 111 and integration with hub/ use of care plans developed to support admission avoidance • Meeting with providers ongoing re. options for development of community IV service to build on paper provided to CCG SMT; Further exploration of cost-effectiveness and cost case required • Community facilitators to hold clinic at PMG on 24/09/14 – renewed marketing with PMG team to increase clinic impact • Meeting with YTH on 01/10/14 re. community matron/ case manager roles and resource use across hub and expanded hub geography • E-Record meeting on 02/10/14

Progress against deliverables

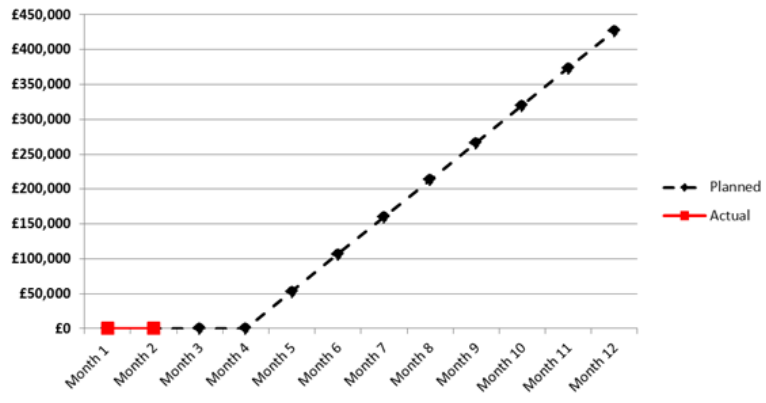
Key Deliverables	Planned Completion Date	Agreed Revised Date	Actual Completion Date	Status / Comments
Hub expansion business case submitted for JDG review	30/09/14	-	-	• Draft completed – on track
Community IV paper to support hub aims to SMT	19/08/2014	-	-	• Paper written and presented to SMT; More detail required and requested from providers in agreeing cost effectiveness case prior to JDG submission (request to complete/ gain further information prior to JDG presentation)
PMG/YTH Meeting re. Case manager/ matron roles and hub interaction	01/10/14	-	-	• Date agreed

Key Issues / Risks	Recommended Actions	Probability[1]	Impact[1]	Status
Issue: Process for agreeing and realising cost savings	Process for agreeing cost savings; Note potential decommissioning/ contracting/ consultation requirements. Hub tracking capacity and activity to support CCG decision-making (monthly report) Update 1/8/14: CCG progressing an evaluation of "hubs" with Uni. Of York to support tracking benefits (proposal expected in September '14)	4	4	CCG QIPP monitoring and impact information sent; Joint approach with providers to agreeing impact on whole-system footprint/bed-base / contract required. Progress with YTH CS contract meetings

BCF Fortnightly Progress Report: Priory Medical Group

w/e 12th September 2014

Metrics (All PMG and all PMG Care Homes against benchmark)	Impact of scheme and supporting evidence
Total acute/social care/ mental health activity and spend (vs. growth)	See Dashboard
Reduction in A&E attendances (vs. GP referred) **(BCF)**	See Dashboard
Reduction in avoidable emergency admissions (average per month) **(BCF)**	See Dashboard
IP Admission (Elec/Nonelec)	See Dashboard
OP (FA/FU/PROC)	See Dashboard
Reduction in delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) **(BCF)**	See Dashboard
Re-admissions 7-day and 28-day (average per month)	See Dashboard
Injuries due to falls in people aged 65 and over per 100,000 population **(BCF)**	See Dashboard
Activity and case management volume of integration pilot	See Dashboard



To adjust values: 1. Double-click on chart 2. Click "convert" 3. Right click on chart area 4. Select "edit data" (an excel chart pops up) 5. Adjust values and click close on excel sheet

Planned Investment YTD (£)	Actual Investment YTD (£)
£65,350 RI1 (To 30 Jun '14)	£22,770 (To 30 Jun '14)
Planned Savings YTD (£)	**Actual Savings YTD (£)**
£0	-
Planned Net Savings YTD	**Actual Net Savings YTD**
£0	-

Return on Investment YTD (%)
- (Actual Savings YTD/ Actual investment YTD) * 100

Completed by: Ryan Irwin

Date: 10/09/14

PMG Overview

Metric	2013/14 Monthly Average	Pre-Scheme Monthly Average (Preceding 12m)	Post-Scheme Monthly Average – YTD (06/14)
1. Acute spend total	£1,953,522	£1, 930, 876	£1, 906, 148
2. A+E Attendances (GP-ref)*	1322 (56)	1306 (53)	1426 (50)
3. IP Non-Elective Admissions* (Care homes)	434 (35)	432 (36)	405 (24)
4. Total New Outpatient Attendances	1068	1059	903
5. 28-Day care-home Re-admissions	9	9	4
6. Over 65-Falls Related Injuries	17	24	20
7. Avoidable emergency admissions	T.B.C	T.B.C	93
8. DTOCs per 100,000	17.8	17.8	T.B.C
9. Avoided admissions**			T.B.C
10. D/C contacted (within 72 hours)			48
11. Number of patients on case management reg.			843
12. Patient Contacts (face to face: non face to face)			427: 227
13. MDTs held (MDT patient reviews)			17 (104)
14. Number of shared care records			389

*Growth has been subtracted in at (the following rates) 3.0% based on last 12 months and acute uplift for 14/15 at x%
**As determined by the use of the hub as opposed to attendance at hospital (audit t.b.c)
Note: Metrics 9-14 reported as in-month actuals (scheme started from June 2014)

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**	**Risk Owner**
Plans may not deliver financial savings necessary to make them sustainable	4	4 £3.5M benefits 15/16	16	• Each element of our planning has an identified exit strategy, should it be necessary to decommission them	• HWB, • Managed through monthly reporting to CTB by JDG
Non Elective Admissions do not reduce in line with expectations	4	4 £978K benefits 15/16	16	• 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 • Develop alternative models of care that provide clear alternatives to admission	• HWB • Managed through monthly reporting to CTB by JDG
Delayed Transfers do not reduce in line with expectations	3	4 £729K benefits	12		

		15/16		• Clear procedures and training • Monitoring of process effectiveness • On-going leadership from the CTB	
Admissions to Care Homes do not reduce in line with expectations	3	4 £263K benefits 15/16	12		
Data analysis, segmentation and benchmarking are constrained by perceived and actual restrictions on data and information governance	4	4	16	• Define and engage support / expertise • Seek legal clarification of acceptability of proposed approaches	• CTB
Agreed system changes between partners are not realised	3	5	15	• Monitoring and reporting processes in place with reporting to CTB and HWB	• HWB • Managed through monthly reporting to CTB
Commissioners not being able to agree clear common objectives with each other that can translate into workable commercial agreements.	3	5	15	• Escalation through CTB and HWB if required.	• CTB • On-going
There might be double counting in the estimates for scheme achievement	3	3	9	• Scheme planning with clear cohorts identified for each scheme • Evaluation of results on a regular basis • Adoption of Improved data segmentation and analysis tools	• CTB • Managed through monthly reporting by JDG
Differing Information Governance regimes prevent opportunities for co-location.	3	3	9	• Organisations will achieve separate compliance for local purposes. • Local agreements will be needed to achieve cross-organisational	• CTB sponsored Information Management and Technology

				compliance. • Workaround is to delivery separate systems on separate devices in the same location.	Programme • On-going
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.	3	3	9	• CTB responsible for managing the conflicts of local directional 'pull' • CTB will monitor delivery • Stakeholder engagement • Programme reporting and evaluation of metrics/data	• CTB through monitoring / reporting • On-going
Financial envelope may not be sufficient to support plans, even with savings identified.	3	3	9	• JDG will continue to monitor delivery, as will CTB, and changes can be made as required	• JDG • On-going
The contractual mechanisms necessary to provide the legal and financial framework to allow new and existing services to be commissioned in partnership may not work effectively enough to enable service change to progress in a timely manner and for providers to be sufficiently confident to properly engage with the process.	3	3	9	• A proper contracting function is established, clearly directed by the CTB, and whose responsiveness and performance is monitored by the CTB	• CTB • On-going
Public may not welcome all changes to system.	4	2	8	• There has been significant patient and public engagement, and it is intended that this will grow as plans develop further	• All partner organisations • HWB oversight • On-going
NHS Number is not used for communication between organisations.	2	3	6	• Organisational development plans including staff training will be monitored.	• JDG • On-going

The outcome of the National ADASS work on Data Sharing / Matching may recommend a different approach.	2	3	6	• The existing DBS tracing service will continue to be used.	• CTB • On-going

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

This plan and the supporting financial template sets out a target for avoidance of Non Elective Admissions of 11.7% or 2,284 spells. This equates to six Non Elective Admissions per day. The associated financial return is calculated on the basis of the saving made at the average actual cost of those admissions, substantially lower than national assumptions, which reflects a threshold level set in 2008 over which all admissions are charged at a marginal rate of 30% of the normal tariff. The risk at the 11.7% level therefore equates to £1,020,725, which is 8.4% of the total BCF.

In following the principles of the Payment for Performance (P4P) process described in the guidance, we have not defined specific scheme spend against the performance pool. Should the planned performance be achieved, the "Performance Fund Contingency", £1m, will be released to further invest in any scheme showing superior performance or as otherwise deemed appropriate by the Health and Wellbeing Board.

There is a total of £1.5m being invested in new schemes, with a further £4.3m of spend on existing services being reviewed and redesigned to ensure they are as integrated and cost effective as possible. These two figures fund the schemes that will deliver the planned level of admissions reductions and represent the level of spend for which there will be commissioning flexibility.

Both the CYC HWB and Collaborative Improvement Board (CIB) have BCF as a standing agenda item, with reports and progress evaluation reported at each meeting. CIB meets monthly and receives reports from the BCF Joint Delivery Group which in turn monitors progress and impact on a scheme by scheme basis.

The City of York BCF benefits from the Vale of York CCG supporting two further BCFs (North Yorkshire County Council and East Riding County Council) which will enable sharing of best practice and rapid redirection of resource, if required, into effective schemes.

It should be noted that the CCG took the opportunity to run a number of the proposed schemes in 2013/14 as part of the Winter Pressures monies received. These were performance monitored and have now been embedded as part of the BCF and therefore commissioners have been able to receive some assurance over their deliverability and impact. The governance and reporting arrangements described above will allow schemes not delivering to be rapidly identified and either changed, stopped or the funding re-directed elsewhere. This should allow for some flexibility with regards to the availability of funds to cover some of the costs should the reduction in emergency admissions not take place as expected.

There is currently no formal risk share agreement in place between the Vale of York CCG, City of York Council or York Teaching Hospital NHS Foundation Trust. All organisations continue to explore a number of alternative models, but this is acknowledged as a priority action point.

As a part of the approach to develop a risk sharing agreement that will include the council, CCG and the provider, the intention will be to meet, as a minimum, the following:

i) It is assumed that, aside from the P4P amounts, funds will transfer to the pool on a monthly "12ths" basis as required, and will be managed under a Section 75 agreement
ii) Quantify pooled funding amount deemed to be 'at risk'
iii) Calculation and modelling of risk amounts for the schemes and the 'payment for performance' (P4P)
iv) Agreement of the principles for investment of released P4P funds
v) Modelling of the impact on the wider system as a result of any failure to meet targets set within this plan
vi) Mitigating actions defined for the risks identified above and contingency arrangements as required
vii) Articulation of the approach to be taken to sharing the risks appropriately across the system

The high-level timeline in place to deliver this agreement is as follows:

Milestone	**Date**
Principles and scope agreed with partners	19 December 2014
Draft agreement developed	28 February 2015
Legal team review and edit process	6 March 2015
Final edits and incorporation to Section 75 Agreement	13 March 2015
Agreement reviewed and agreed	31 March 2015
Finalised and signed agreement	31 March 2015

This remains an area that we recognise we could benefit from support

With regards to any potential risk between the main acute provider and commissioners the position at the moment is that Payment by Results will apply and that the money will continue to follow the patient. The main acute provider is currently significantly above the 2008/09 activity level and therefore only receives payment at the Marginal rate of 30% of tariff for emergency activity. They are fully supportive of any scheme that will reduce non-elective admissions as it currently costs them more to provide this activity than they get paid, but they feel that in continuing to accept the application of the national payment mechanism in this area that this is their contribution to a risk share.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

The BCF plans are completely embedded within the overarching VoY CCG Five year Strategic Plan and form a significant contribution towards the operational programmes of work within the Integrated Care and Urgent Care Strategic Initiatives for 2014/15 and 2015/16. The 5 year vision for the CCG to deliver an innovative Care Hub Model depends on the transformation of acute, community and primary care services into an

integrated model of health and social care delivery and the BCF plans form part of all the integration pilots currently being rolled out in support of the Care Hub model programme.

The BCF plans and the anticipated outcomes and improvements on health outcomes indicators including reductions in avoidable non-elective admissions and again the CCG has identified a local Ambition to reduce emergency admissions over five years by 14% and will provide assurance around this trajectory to NHS England quarterly. Additionally this trajectory contributes towards the CCG's Quality Premium. Most significantly the BCF plans and impact on reducing emergency admissions are critical to delivering the resilience required for the local system as part of the Operational Resilience Plans and to support the CCG in assuring the delivery of NHS Constitution access targets for patients by its providers.

The BCF plans are programme managed and performance managed by the VoY CCG Improvement & Innovation team, supported by a Programme Management Office and PMT Tool Covalent. Assurance around the BCF programmes is then reported to the CCG Governing Body, NHS England as part of the CCG Assurance Framework, as well as through the local Joint Delivery Group for BCF and the emerging System Resilience Group (SRG) for the VoY CCG footprint and its associated Unplanned Care Working Group (was the Urgent Care Working Group).

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

The Council is currently developing the next phase of its Transformation ("rewiring") Programme. The changes towards integrated working and the requirements of BCF implementation are in the process of being reflected within the following transformation work stream documents:

- Corporate customer service transformation
- Corporate ICT transformation (includes use of website and social media)
- Adults transformation communications and engagement strategy
- Adults transformation blueprint
- Adults ICT transformation strategy (including replacement of the care management system and implementation of mobile working)
- Adults Workforce Development strategy
- Adults commissioning strategy
- Adults procurement strategy

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- **For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads**.

NHS Vale of York CCG submitted their proposal for co-commissioning primary care in parallel with the national timescales and were approved to be ready soon for co-commissioning primary care based on the expression of interest submitted (see below).

NHS VoY CCG_Primary Care Cc

The CCG are currently awaiting invitation, after acceptance of the expression of interest request, to develop the proposal defined with the NHS England Local Area Team, which explicitly notes the alignment to the BCF.

The submission document details the timescales and areas for developing co-commissioning to be confirmed with the NHS England Local Area Team and notably the suggestion for joint governance arrangements to develop a co-commissioning programme.

The expression of interest also details the engagement and involvement of primary care and other stakeholders in developing the co-commissioning approach, utilising key local fora to communicate changes and support involvement, for example through;

- PPG steering group and patient groups through “let’s talk health” events
- PPG Forum
- GP Forum
- Council of Representatives
- Primary Care Strategy Group
- Health and Wellbeing Boards and sub-groups thereof
- Stakeholder and provider engagement events

As is noted in the submission, primary care co-commissioning is well aligned to the better care fund plans through the following;

- Developing primary care to reduce variation in services, advance care integration, raise standards and quality of care, contribute to improving whole system outcomes and performance, and cut health inequalities.
- Planning, securing and monitoring primary care in parallel with the CCG’s 5 year strategy and BCF aims and objectives, for example, through providing and monitoring primary care information related to health and social care quality, activity and spend, whilst supporting improvement.
- Ensuring primary care plays a central role in the development of the community care hub model as a defined BCF scheme which is central to BCF delivery; Primary care providers do, and will, also act in some instances as “accountable lead providers” for this model locally working together with other stakeholders and providers.
- Supporting innovation and improvement in primary care that facilitates transition of care from acute to primary and community settings including, for example, the development of new primary care pathways that support admission avoidance and related BCF outcomes.
- Recognising and co-ordinating inter-dependencies between primary care

contracting and enhanced services that will contribute to BCF delivery (e.g. the impact of the admission avoidance enhanced service). The CCG, as is defined through enhanced service guidance, is working directly with primary care providers to support achievement of these related schemes through their internal innovation and improvement team; A named CCG operational lead is assigned to each practice through practice groupings.

- Exploring opportunities co-commissioning brings in improving primary care quality, co-ordinating public and patient communications, engagement and involvement, increasing out-of-hospital capacity and exploring efficiencies in integrated funding arrangements.
- Working through joint governance arrangements with other commissioners, local authorities, providers and stakeholders to join up primary care commissioning and delivery with better care fund plans

The primary risk related to co-commissioning is the conflict of interest posed through GP CCG membership. NHS Vale of York CCG has a comprehensive Business Conduct and Management of Conflicts of Interest Policy, which includes the process for declaring conflicts of interests, the content of which would be applied to any relevant primary care commissioning or co-commissioning, whilst recognising the policies, procedures and processes of any co-commissioner.

It is anticipated that primary care co-commissioning will work within a governance framework that is complimentary to the Better Care Fund plans

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

ii)

In common with councils across the country, the largest budget pressure on adult social care is in respect of meeting increased demographic demand and the increasing complexity, and therefore cost, of care packages for the ageing population.

In order to protect adult social care services we are placing the focus on people's health and wellbeing and how this can best be managed where people live, with only occasional admissions to acute hospital settings when community services are unable to respond appropriately. We need to ensure the full range of adult social care services are available, including those that enable people to navigate a simpler easier to access service model, accessible to all in various formats that people can use either for themselves or with assistance, without which the entire health and social care system will become unsustainable. Adult social care services are fundamental to the delivery of our ambition to deliver the right care and support, in the right place, first time. Protecting adult social care will allow the local health economy to deliver 'care closer to home' and, whenever possible, in people's own homes.

This protection of social care is against a backdrop of an ambitious transformation programme currently underway within the City of York Council 'Rewiring York'. The programme also involves corporate activity to strengthen local community resilience, invest in a digital media Customer Resolution Service, support self-help and increase the Council's ability to generate income via commercial solutions. The programme requires us to substantially change the way people receive information and advice and the ways in which they manage their own health and well-being. This will require substantial numbers of people to have their route through the social care system changed – for example, improving and promoting people's use of digital channels, reducing the number of long term placements to the lowest nationally and investing Public Health resources in Prevention schemes to ensure we can divert or delay demand.

Elements of the programme related to BCF and delivery of the Care Act 2014 within the Health and Adult Services directorate transformation programme are activities including:

- 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 options to support more groups of customers to live independently;
- Increasing current and future capacity within communities and the care market in general, developing our own and the independent sector workforce and prepare for greater public service integration.

It is clear that protecting Social Care is critical to ensuring that the wider systems changes can occur within a safe environment where support is available to those people who do not need acute care but do need support. Without this support Adult Social Care services would need to find additional savings which would have an effect on the whole system.

The recently published ONS Population Projections show that the 65-69 year old population of the City of York expanded by 18.9% (1,738 people) between 2011-2013, while the over 90 year old population expanded by 14.3% (337 people) in the same 2 years. Our JSNA highlights the demographic challenges our health economy faces in future with, in particular, the population aged 85 or over growing by 38% locally, compared with 20% regionally or 23% nationally.

Our local definition of protecting social care services is:

To *maintain* eligibility at "substantial" or "critical" levels Care Act has national eligibility levels as from 1st April 2015.

To *maintain* current (2013/14) levels of service provision through the plan period

Specifically with respect to carers, we intend to:

- *maintain* the current level of support to informal carers in York, taking into account demographic growth
- to enable informal carers to receive care and support in line with statutory responsibilities in the Care Act 2014

to ensure those cared for have plans in place to avoid unnecessary admissions to

hospital, nursing care and/or residential care

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

The main priority in protecting Adult Social Services recognises the severe pressure the department is under and the requirement to provide sufficient funding to support the transformation programme which aims to reduce and delay demand, focus on prevention, self-help, independence and improve performance on delayed transfers of care. The funds will be used to ensure that Social Services can respond to existing and new service users in the context of a known increase in older people and younger adults with very complex needs.

CYC and VoY CCG are committed to the following principles for how people should experience services:

- The promotion of a person's health and wellbeing
- Support is focussed and integrated around the person rather than organisations
- Community and home options are the main focus of care and services
- Parity of Esteem within mental health
- No decision about me without me

Cuts in local authority funding mean that City of York Council has already made £14m savings in other areas of its adult social care budget in the last 5 years. A further £7m of savings need to be found in the next two years. These further savings represent around 1/7 of the total adult social care budget.

There is agreement therefore that it will require support from the Better Care Fund to protect the ability of the Council to meet the needs of those who can be cared for and supported in their own homes, both to avoid an unnecessary hospital admission and prevent avoidable re-admission.

Firstly the plan intends to support social care provision to maintain current eligibility levels and current service levels.

Secondly, and very much at the heart of our plans, is an objective to maintain current levels of prevention services that reduce demand on health and social care services and which specifically support intermediate care provision and our redesign within the plan period of that provision. Details of the protection of prevention services will be finalised through the Whole System Review.

In addition, both the CCG and the Council currently commission preventative reablement services that benefit the health and social care community through prevention of avoidable admissions and re-admissions to both hospitals and nursing/residential care. There will be a BCF contribution to the Council commissioned reablement service in 2014/15. In 2015/16 a similar level of expenditure, not necessarily pertaining to the continuation of the same service model, has been included within the category of NHS commissioned services. This is in line with our stated intention to reshape intermediate care services within the plan period.

Finally, the council is the current (2014/15) provider of a range of step-up and step-down beds, including specialist dementia beds, which divert people from hospital and nursing/residential care provision and permit early supported discharge from hospital for those who are ready to be discharged from an acute setting, but not yet ready to return to independent living at home. The future service model for these beds will be addressed

through the Whole System Review.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

For 2014/15 it would not be possible, given the size of the fund, to secure the requirement for maintenance of adult social care services from BCF. The total underlying requirement for the Council to maintain existing levels of provision of the schemes in the BCF as illustrated in the document, is £5.672m, while the amount that it is possible to fund from BCF is £3.161m. Hence, the burden of maintaining eligibility and maintaining current service levels, within a situation of further funding cuts will predominantly fall upon the Council.

For 2015/16, the requirement from BCF to fund schemes that will contribute to the maintenance of adult social care services at 2013/14 levels is £6.460m, while £5.251m has been agreed as the local contribution.

In addition, the costs of implementing the Care Act (see below) have been calculated using the recommended "Lincolnshire" model. This shows that it will cost the Council £1,818k to implement the Act in 2015/16. Of this, £444k will be funded from BCF in 2015/16.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

The Care Act will mean enhancing general duties and universal provision around well-being, preventing, reducing and delaying needs, enhancing information and advice across the health and social care system, shaping the market and commissioning as well as managing provider failure and other service interruptions.

Specifically around first contact and identifying needs assessments will be available to everyone including carers and for the first time eligible need will be a statutory requirement. Self funders will be entitled to an assessment and we predict this will increase workloads significantly as people want to assess their costs of care pre reaching the ceiling. A national eligibility scheme will be in place with added requirements around portability. Independent advocacy services are enhanced. Charging will change and deferred payment agreements will need to be in place. The Act places new responsibilities on integration and partnership working not only across health and social care but with housing, employment, welfare and other services such as probation and prisons. The Act is coterminous with the Children's Act in relation to transition to adult care and support. The Care Act also puts Safeguarding Boards on a statutory footing. These changes are significant and will mean significant cultural change supported by learning and development for our workforce. IT systems will also need to be revised.

The implementation of the Care Act has been mainstreamed within the Council's Transformation (rewiring) programme. Services are being redesigned in a way that is Care Act compliant as follows:

- Our council customer services response, including elements of our customers

centre, self-service and transactional facilities and e-correspondence
- Our advice and advocacy services so that information and sign-posting is consistent across the council, but also across partner agencies in the statutory and voluntary sectors
- Our transformation of financial services
- Our redesign of care management
- Our market management strategies, particularly in respect of provider failure
- The strengthening of our safeguarding Board
- Our workforce development strategies (internal and external)

Our ICT strategy and the planned replacement of our case management system as part of a joint approach with health partners.

v) Please specify the level of resource that will be dedicated to carer-specific support

York has a relatively high number of informal carers. It also has above average demographic growth in its over 80's population an age group which includes many of these carers who themselves are at increased risk of age-related illnesses and accidents involving falls.

Carer breakdown can result in unplanned admissions to hospital and to nursing and residential care. BCF funding will be used to support carers and prevent carer breakdown.

All carers are currently entitled to request a carer's assessment which is enhanced from April 2015 under the Care Act and to receive care and support for eligible needs found – under the Care Act requirements this will inevitably increase demand for services accelerated through the changes in policy aligned to the introduction of this new legislation giving carers an equal footing and raising volumes of people requesting assessment.

CYC has however recently undertaken a stocktake of its existing provision and anticipated demand resulting from the Care Act. Using the LGA modelling tool, this identified 1,455 carers assessments required and 1,198 requiring information, advice and signposting. Estimated costs are £1,600k in 2015/16 of which £227k will be met by BCF in 2015/16.

York will enhance its assessment service to undertake assessments and its range of care and support services i.e. information and advice, self and supported assessment, support services including respite and help with employment.

The model will work on an integrated health and social care design. It will work to align coproduction principles with voluntary sector partners such as the York Carers Centre and Age UK and it will focus on all carers but will operate on a risk stratification tool to enable proportionate responses and focused interventions to those most vulnerable and in need enabling self-care and support wherever possible to promote staying at home for longer. Specific service elements will include:

- Information and advice
- Advocacy
- Short Breaks
- Emergency Breaks

- Personal Assistant
- Day Activities
- Lifeline Alarm
- Dementia Support through the use of Dementia Bracelets
- Training for carers
- Support for employment and education

York already places a very high priority on carer services and co-production with the voluntary sector in this respect. From a carer perspective, the BCF proposals represent a natural evolution of existing services.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

The total of the schemes initially submitted as part of the financial plan for 2014/15 totalled £4.6m. These were supported by £3.3m funding from NHS England made up of NHS Transfer (£2.7m) and Integration Implementation Fund (£0.6m) plus an aspiration to use £1.3m held by the CCG made up of reablement (£0.9m) and Carers (£0.4m).

The resubmission shows schemes in 14/15 to be funded from the minimum pooled amount of £3.3m; £2.6m for the protection of social care and £0.7m for CCG led integration schemes.

Subsequent negotiations between the CCG and CYC concluded the reablement and Carers money could not be transferred in full in 14/15 and a stepped approach would have to be taken prior to the incorporation of the £1.3m into the BCF in 15/16. Transfers from the CCG to CYC for reablement and carers breaks were £150k in 12/13 and £300k in 13/14. The reablement and carers breaks transfer is no longer part of the 14/15 plan but £600k was agreed to be transferred by the Chief Executives of the CCG, formally confirmed on 18th September 2014 and will be transacted outside of the s256 transfer.

The level of protection of social care available from the BCF is dependent on the success of the schemes that release benefits from health. If the schemes don't release the planned benefits then the protection of social care, alongside other schemes within the BCF, will need to be subject to review. This incentivises both parties to ensure the integration schemes deliver the planned benefits.

The development of the s75 agreement will clearly outline how the financial risks are managed as we implement the Better Care Fund and both parties will work together to agree the parameters of any risk share arrangement.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

VoY CCG is actively working with York Teaching Hospital NHS Foundation Trust, as its main acute provider, to fully understand the requirements and implications of 7 Day Working. For 2014/15 7 Day Working forms a specific element of the contractual agreement between both parties within the Service Development and Improvement Plan (SDIP).

The SDIP is used to detail any service changes or developments that will impact materially on the contract. Progress against the SDIP will be monitored via the Contract Management Board (CMB) as appropriate during the year with quarterly review the minimum expectation. The SDIP is a live document which will continue to be developed and jointly agreed between both parties.

The expected outputs and the consequences for not achieving these outputs will be agreed once the working groups are established. The default consequence is subject to General Condition 9 (Contract Management).

The working groups will be responsible for identifying and cross referencing schemes to the relevant national and local Key Performance Indicators, CQUIN schemes, and quality premium indicators for which achievement will be supported through implementation.

The SDIP includes the following contractual expectations:

A national condition of the Better Care Fund is the requirement to “provide 7 day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.” The CCG wishes to work with the Trust, through the proposed Care Hub models, to identify where changes to current service delivery models are required to support this requirement. It is expected improvements will be required in (but not limited to) areas such as access to diagnostics (including interpretation and resulting care plans), clinical decision making at weekends to support admissions avoidance and discharge, increased liaison with social services and better overall discharge planning.

The progress towards the above and the impact of delivery/non delivery will be measured through the Partnership Delivery Board and existing contract management arrangements.

So far this progress has been made in establishing a working group with Trust and CCG representatives to agree implementation plan and milestones and identifying high priority services, specialties and diagnostics for 7 day working.

Further work is now underway as part of the System Resilience funding for winter 14/15. This consists of additional working hours and clinical lead activity within ED. As well as the developments being put in place to extend the working hours of the RATS (rapid assessment team) based in ED. This will provide increased therapeutic input and social work assessments within ED and ensure those who present at ED after normal working hours will be assessed, triaged and returned home with a package of support in place within 2 hours of their discharge if they do not require admission to an acute bed.

There are also plans in place to increase the number of step up/down beds available within residential and nursing homes in the York area. These will provide an opportunity for clinicians and therapists to carry out a more in depth assessment prior to the person returning to their own home with a reablement package of support.

This will also link to the UCP scheme and provide additional community support that can be called on to avoid unnecessary conveyance for an individual not requiring acute care but unable to be left at home without additional support. Assistive technology will also be deployed i.e. telecare and 'just checking' system to reduce risk and provide comfort to carers that the person is safe within their home environment.

We will evaluate the effectiveness of this initiative, between Jan 14 – Mar 15 learning from which will enable us to determine the right level and type of support people need in order to avoid admissions to acute bed services in the future. We will review the current schemes within BCF to ensure they are aligned with these requirements.

Proactive support planning will then be carried out with through the care hubs for those that are recognised may have further episodes or crisis that may result in admission to acute care, helping to reduce future demand by providing more proactive and efficient long term condition management

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

Partners in our unit of planning have a committed plan for the usage of the NHS number as the primary identifier for correspondence across all health and care services. To facilitate this, the following progress has been made to date:

Identification of clients that do not currently hold an NHS number within CYC ASC clinical system.

An initial audit has been taken to identify clients that do not hold an NHS number. Approximately 4,500 clients within CYC ASC clinical system do not currently possess an NHS number.

Identification of unknown NHS numbers/ Business as usual: Identify how the usage of NHS number as primary indicator will be adhered to.

City of York Council is in the process of procuring a connection to the NHS number tracing system; Demographic Batch Service (DBS). To access the DBS system CYC must attain HSCIC Level 2 IG attainment; work on the application is underway. It is anticipated that the IG toolkit will be completed and ready for review by the HSCIC by 31st December 2014. HSCIC will then need to review and authorise the IG Toolkit - expected turnaround for this would be in the region of 2-3 weeks.

Once we have both the DBS system installed and the appropriate IG toolkit attainment, we shall then commence auditing our ASC system in relation to missing NHS numbers and identify them via the DBS system, then batch load them back into our ASC system accordingly.

In addition a review of missing NHS numbers will also be completed within the children's social care system working along the same timelines ensuring compliance across the LA.

Moving forwards we will work to ensure the NHS number is the primary identifier in

relation to all correspondence across health and care service. Through education and communication and using the NHS number on all our standard forms and documentation, the inclusion of the NHS number will become standard practice, however it is accepted there will be occasions where the NHS number is unknown and unattainable. On these occasions we will continue to utilise the DBS to identify those NHS numbers that are unknown to the service. By continuing to utilise the DBS as a method of identifying clients' NHS numbers on a routine basis, we will also simultaneously be checking the quality of NHS numbers that have been manually input. This process will provide the ability to ensure data quality and assurance by means of auditing existing data and identifying any duplicate/miscellaneous NHS numbers.

It is anticipated we will be in a position to complete the above actions and be using the NHS number as our primary indicator by the end of February 2015.

Communication of change/necessity to adhere.

There is a clear need to ensure the communication of the requirements to identify the NHS number is understood by all those involved, including clients, carers and staff alike. A communication plan detailing strategy and approach will be produced ensuring all those affected are fully informed.

Impact

The practice of using the NHS number as the primary indicator will ensure an efficient and confident linking between primary and secondary care providers, with the provision of assurance that the correct patient has been identified.

Summary of key milestones and priorities

1. Identification and initiation of communication plan – on-going
2. IG toolkit completed and ready for review by the HSCIC by 31 December 2014
3. Gain DBS connection to provide ability to audit NHS number within ASC system anticipated by 30 November 2014
4. HSCIC to review and authorise IG toolkit in view of level 2 attainment; + 2 weeks
5. Auditing ASC system in relation to missing NHS numbers + 3 weeks
6. Identify missing NHS numbers via the DBS system to enable ASC system to be updated accordingly + 3 weeks
7. Weekly on-going audit and associated updates of NHS numbers via DBS by data hub team as part of business operations
8. Any on-going communication, engagement and actions required of stakeholders in relation to NHS number use will be shared and actioned via the joint delivery group to ensure NHS number is embedded in business operations

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

City of York Council, York Teaching Hospital NHS Foundation Trust and NHS Vale of York Clinical Commissioning Group, amongst other local health and care partners, collaboratively agree there is a clear need to share relevant personal information and

data across organisational and professional boundaries in order to ensure effective co-ordination, integration and delivery of services for individuals. A large proportion of the information we need to share involves personal details about the people who use our agencies and their personal needs. By lawfully sharing this information we are able to work better collaboratively, offering a higher level of personalised, joined up care to the person.

Sharing records is a key part of each of the organisations' IT strategies and formal commitment has been given by all parties to investigate the most suitable method of sharing information.

We are currently reviewing our options with regard to interoperability considerations and shall be further completing a comprehensive review of options followed by a clear implementation plan. This includes the following plans and progress to date;

- Investigating the possible replacement options of our current Adult Social Care clinical software, with an integrated system that fully supports the 'one patient, one record' model of healthcare. The right system will be fully interoperable with; primary care, acute and community records. It is understood that SystmOne and EMIS already support Open API's and should this be the route we decide to take, we would work with other providers to ensure that their information systems are technically able to exchange data with other systems.
- A co-chaired CCG and Council group has been initiated with key stakeholders to ensure system interfaces are developed with stakeholders in a collaborative and effective manner; The group has met for the inaugural meeting on 2/10/14 (with the next meeting planned on 22 October 2014) and terms of reference are being developed to ensure accessibility in development of systems interface.
- A task and finish group reporting to the above has been initiated to identify a clear understanding of what information stakeholders wish to share, with whom and when, to develop this work against existing solutions and where these are not appropriate, to develop a pilot of inter-operability solution(s). It is expected that all *relevant* business functionality will be included in any potential open API solution that delivers against the joint stakeholder vision.
- The group will be investigating a number of potential integration platforms, that will provide a holistic shared electronic patient record; from a number of suppliers all of whom we understand have applied to be included in GPSoC Lot 3 (Cross Care Setting Interoperable Systems). This is notwithstanding the procurement obligations and responsibilities of commissioners that may apply in purchasing an open API solution for the purposes described. It is recognised that service user/carer involvement and input will also be a critical component in developing, for example, shared care plans. This need and the approach to address it will be met through the aforementioned group and any commissioning process of new systems

Whichever solution is pursued it will be with the ultimate goal of connecting those that provide a direct provision of care to a patient, enabling community care teams to support the effective coordination and delivery of care between multiple organisations across the health and social care community.

Increased data sharing across providers will reduce cost of service provision, whilst ensuring optimisation of the provision of care provided.

This vision is a shared vision and all parties are committed to working proactively and positively with partners to achieve these aims.

Risks/Issues/Considerations

It is acknowledged that careful consideration needs to be given with regard to the importance of information governance and patient confidentiality, when considering the implementation of Open APIs. However it is felt the vision is substantially in line with the new 7th Caldicott principle:

''The duty to share information can be as important as the duty to protect patient confidentiality"

''Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies''.

Challenges are anticipated in relation to; how we inform patients, provide opt-outs where appropriate, compliance with regard to Data Protection Principles such as- limited use, accuracy, reasonable retention etc however there is shared confidence and commitment that these issues although relevant are achievable.

With regard to intermediate solutions; work has progressed in respect of formalising information sharing and a collaborative Information Sharing Protocol that will provide a clear framework to assist the facilitation of information sharing between those signed to the Protocol has been produced. The Information Sharing Protocol is a joint collaboration between CYC, North Yorkshire Council, York Teaching Hospital NHS Foundation Trust, North Yorkshire Police and the local Fire Authority. The Protocol will be signed by partner SIROs week by 15 December 2014 and then shared wider with an identified group of further key partners inviting them to join the protocol.

Information Sharing agreements have been produced where information is proposed to be shared to as interim measures and the necessary explicit consent will be requested accordingly where appropriate, with the option to opt out at any point.

An application has been made for a Section 251 to enable the sharing of patient data for the purpose of commissioning, including patient segmentation, pathway analysis and risk analysis; This application has made with a group of commissioning organisations facilitated by Monitor and the Department of Health and the submission includes the following;

- Data control and processing arrangements and processes
- Data sources for utilisation of data linkage solutions
- Fair processing and patient objection processes
- Involvement of patients and use organisations in data sharing
- Policies relating to data retention and destruction from all partner organisations
- Data and physical security arrangements

Partners are happy to share this completed application proforma when requested.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

Substantial progress has been made in relation to Information Governance and planned progress will continue, to ensure the appropriate IG controls will be in place and adhered to.

There is a clear City of York Council Information Governance action plan that is governed by the CYC Corporate Information Governance Group, that is continually developing and implementing appropriate IG controls.

Work is currently underway in relation to the production of a collaborative Information Sharing Protocol which has already detailed, will provide a clear framework to assist the facilitation of Information Sharing between those signed to the Protocol.

CYC have two HSCIC IG Toolkits; one of which is now fully compliant to level 2 (however only applies to Public Health) and the other (that covers the remainder of the Council) is in the process of being updated. There is commitment that the overarching City of York Council IG Toolkit will be completed by 31st December 2014. At this point it will be submitted to HSCIC for review in view of level 2 attainment. There will be a clear action plan identified as a result of the completion of the IG Toolkit with regard to any specific areas that require further work, with clear accountability and timescales identified.

City of York Council have two dedicated Caldicott Guardians; Director and Assistant Director level; adult and children services respectively. The Caldicott guardians work to improve confidentiality and security within the council, whilst ensuring the seven principles of Caldicott 2 are strictly adhered to. The council has a well-established corporate information governance group, following the public sector network data handling guidelines which are the core of its overall information governance strategy. Compliance with Caldicott 2 is entirely consistent with the guidelines and the strategy. Both Caldicott Guardians are members of the Corporate Information Governance Group; CIGG, which is chaired by the councils Senior Information Risk Owner (SIRO). Equally, the CCG has a nominated Caldicott guardian at executive level.

New updated online e-learning training with regard to Information Governance is planned for 2014 which all CYC will have to complete as mandatory where a mandatory training programme also exists through the CCG.

In relation to future procurement of Open APIs, a strategic review of IG requirements will be undertaken, including a privacy impact assessment, working in collaboration with the councils Information Governance Manager and associated individuals across partner organisations.

Irrespective of which option is pursued in relation to future interoperability solutions, function access controls will ensure that each partner has access to only those items of

each patient's data proper to its function, taking account of the constraints above and the data protection act. Functionality will allow for consent (or refusal) to open (or close) access to data items for each partner in individual cases.
Explicit consent where appropriate will be gained. Appropriate guidance, protocols and data sharing agreements will be produced in line with the Information Commissioners Office Data Sharing Code of Practice.

A training needs analysis will be completed and appropriate training will be made a mandatory compliance. Dependant on the level of interaction and function access required with the decided Open API, will be reflected in the level of training provided.

As stated privacy impact assessment will be completed to identify all risks related to failure to protect the privacy and confidences of patients, and incorporated into the project plan and risk log.

The principal risk mitigation is careful adherence to the data sharing code of practice which requires the all partners to agree the following:

- what public and individual benefits are expected and why there is not a less intrusive alternative
- what items of personal data are to be disclosed by whom to whom
- how consent is to be managed
- how security will be maintained

It is recognised that the NHS Standard Contract is mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care; The NHS standard contract will be used, as is required of NHS commissioners, in commissioning any healthcare services. The council and CCG recognise that where services are jointly commissioned that the appropriate contract will need to be used and agreed, recognising the current and any emerging legal and policy guidance in this area.

d) Joint assessment and accountable lead professional for high risk populations

i) **Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them**

At the end of June 2014 Vale of York CCG, working in partnership with North Yorkshire & Humber CSU and North of England CS, rolled out the RAIDR Primary Care Dashboard to all Vale of York Practices. This gives all Practices the ability to stratify their individual patient lists by risk of unplanned admission using the Combined Predictive Model Algorithm. Note that the rollout of this system to Practices was delayed due to national Information Governance restrictions pending approval of a Section 251 agreement allowing Hospital and GP data to be linked for the specific purpose of Risk Stratification.

In accordance with the 2014/15 GP Enhanced Service on avoiding unplanned admissions, Vale of York Practices have initially focused on identifying the top 2% of their patients who are at highest risk. Once the work around setting up care plans and supporting MDT meetings is in place to support these patients with their care plans, it is hoped that Practices will start to case find extended groups of patients who would benefit

from more proactive care planning.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

Currently, the unplanned admissions Enhanced Service gives GP's the responsibility of risk stratifying their patient lists – and there is an assumption that MDT meetings will involve a group of care professionals who are involved in providing care (health and/or social) to an individual. The majority of Practices will endeavour to involve representatives from Community Nursing, Social Care and Mental Health in their MDT reviews. Note that currently there is no legal basis for linking health and social care data to assess risk.

From a General Practice perspective, the GP Core contract requires every patient aged 75 and over to have a named, accountable GP, but any appropriate member of the Practice may be responsible for day to day coordination of care and delivery of care plans.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

This is not a metric that is specifically measured via the Enhanced Service agreement, but the aspiration would be for care plans to address patients' holistic needs across health and social care. Through the Enhanced Service, 2% of each Practices' population should now have care plans, but some of these may not require social care input to meet the needs of the patient.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

"Our vision is based on what people have said is most important to them. Over the past 2 years, with the establishment of the CCG and the Health and Wellbeing Board and our first Joint Health and Wellbeing Strategy, both City of York Council and the CCG have engaged extensively with patients and carers, residents, and the workforce across the public, private and voluntary sectors on the vision and priorities for health and social care. York's Health and Wellbeing Board remains committed to this level of engagement and hosts at least two stakeholder events per year. There has been a high level of lay person input into both the initial JSNA and its refresh and this input will continue through the lifecycle of the plan".

Patients, carers and the public are at the heart of our services and we are committed to the philosophy of 'no decision about me – without me'. Delivering sustainable and successful health and social care services in our local area is a collective challenge and we work with our residents to put them at the centre of their care.

We are working closely with Healthwatch in our local area, (and those in adjoining units of planning). Healthwatch have held a number of joint engagement events on a wide

range of health issues and also hosted an engagement event specifically on BCF to raise awareness and encourage resident involvement. A lay member for the CCG Governing Body is currently being co-opted from Healthwatch to further strengthen our focus on empowering our citizens in all our delivery and governance. We are also in the process of adding a member of York CVS to the Joint Delivery Group (see section 4) which will strengthen the role and challenge the voluntary sector has in developing our BCF schemes and plans.

The CCG also has a robust programme of engagement and communications across the Vale of York population to ensure we continue to build on this momentum. We host the Patient and Public Engagement steering group which includes Health Watch and lay members, to ensure we can capture the voice of our patients and residents in our strategic and operational planning.

A number of our General Practices host patient participation groups and as a CCG we are committed to at least two wider open forums per year and a number of engagement events focused on specific projects, i.e. long term conditions.

The CCG have held a series of 'world café' events to work with residents to identify their priorities and their key messages. These events have focussed on how we can develop better together making sure we feedback to those involved and learn how we can improve our engagement programme.

We have also hosted a joint Public and Patient Engagement (PPE) event to focus solely on joining up services and what this means to individuals, their supporters and the wider community. People told us it was important to them to 'tell my story once' and 'to have a joined up system, they could move through easily'. We will continue to build on this as we take our joint plan forward. All the partner agencies have committed to joint communications and engagement events to maintain the focus on working together better. As part of this commitment we are developing a joint communications strategy, led by the H&WB Board, which will ensure we continue to engage and consult across our resident population.

Within York, there is an active voluntary and community sector with partner organisations such as University of York, St John's University and Joseph Rowntree Foundation based here. Such organisations can offer research and evidence that is very valuable to developing our plans for integration. We intend to build on our relationships with these organisations and develop a specific work stream to work on this.

The National Voices research provides us with information for continuing to develop our patient, service user and public engagement. Both the CCG and our partners are committed to doing this and to progress our vision towards joined up, person centred support.

We want to emphasise that our engagement with staff, residents and people who use our services is not a one-off event. We are committed to involving people in planning and designing health and wellbeing services and provision in the long term. Our aim is to 'co-produce' more health and wellbeing services and pathways to care and support. By co-production we mean we want to work with people as equal partners to improve services and respond to challenges, making decisions together. We believe that the people most affected by a service are best placed to help design it. We also recognise that residents and communities already have a range of resources available, both intellectual and physical, and that bringing our resources together we can deliver services *with* rather than *for* people and their families. Early evidence suggests this approach is a more

effective way to delivering better outcomes and more sustainable services, often for less money[5].

We must acknowledge that co-producing health and wellbeing services is challenging, but it is not impossible. We want to learn from others who have achieved this for example the improvements to health care and patient experience in Jonkoping, Sweden. In delivering this strategy we will take every opportunity to co-produce health and wellbeing services, enabling our residents and people who use our services to identify problems and propose solutions, rather than being passive recipients of services. We believe that programmes such as 'Think Local Act Personal' *Making it Real* will help us achieve this by focusing on the way communities can help support each other and by increasing the uptake of personalisation, which is central to communities and their health and wellbeing.

Our Carers

Integral within our BCF planning are informal carers, we have worked hard with partners to ascertain their views. An example from CYC was a review of commissioned services for carers in York in summer 2013. Carers commented on gaps in services especially those providing breaks and emotional support. There was a very clear message that all services need to be more coordinated and joined-up. Generally, carers told us they would like better coordination across organisational boundaries, less demand in terms of assessments and paperwork and a more holistic approach.

Examples of carers comments received:

"There should be better integrated working between adult, children's social services and health"

"Finding the right way into the system and services is the hardest thing"

"Carers still have to support someone with mental ill-health and do so without support themselves"

There are over 18,000 unpaid carers in York; 19% provide 50+ hours of care weekly - these carers are twice as likely to be in bad or very bad health as other members of the population.

To ensure a meaningful voice and influence for carers in the local health and wellbeing system, York Health and Wellbeing Board adopted 'York Carers Charter' in July 2013.

[5] Based on Nesta Lab and the New Economics Foundation co-production research

We will build on this through our care hubs by involving carers in co designing support options and ensuring their voice is heard.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

All major providers and commissioners are already signed up to our vision for person centred, integrated health and social care at the highest level via York's Health and Wellbeing Board (H&WB). Our main providers sit on this board. Our integration plan proposed in this submission is absolutely consistent with this vision and the core principles set out in York's Joint Health and Wellbeing Strategy.

A Collaborative Transformation Board (a sub-committee of H&WB Board) has been running since May 2013, chaired by City of York Council (CYC) Deputy Chief Executive and attended by senior representatives from commissioner and provider organisations including NHS Vale of York CCG (VoY), York Teaching Hospitals Foundation Trust (YTHFT), Leeds York Partnership Foundation Trust (LYPFT) and CYC Adult Social Services and representatives from the voluntary sector and health watch. Neighbouring Local Authorities who link with the Vale of York CCG are also represented.

YTHFT is fully committed to our plans. As our main provider of acute and community services the Trust has supported our system wide reablement and winter schemes and is playing a strong role in shaping and resourcing our BCF schemes. The Trust is also committed to our vision by running a care hub pilot in Selby and sharing workforce with other 'hub' pilots as well as reshaping its provision to reflect changing demand as our proposed schemes start to take effect.

We have also prioritised improvements in mental health services (details of new schemes proposed as part of initial BCF plans are explained later in this submission) as a core part of reforming the care system and Leeds and York Partnership FT (LYPFT) are active partners in helping us re-design and deliver our models of care.

Our Joint Delivery Group (a CCG and CYC group which is responsible for driving the delivery of the BCF) meets monthly and is supported by 2 senior programme leads who work collaboratively across health and social care commissioners and providers; this collaborative approach, managed through our Joint Delivery Unit, has allowed significant progress to be made in building sustainable relationships which are translating into joint plans and agreed actions.

Our GPs are closely involved in developing our plans; we already have plans in place for one GP led care hub in York and another hub which will work across York and North Yorkshire is currently being developed. GPs sit on all of the project teams and also provide clinical input into the JDG.

We also have a number of existing programmes with a range of health and social care providers including our voluntary and community sector, and they too are fully engaged in the development of our plans.

By fully engaging with our health and social care providers we have jointly delivered our

reablement programme over the past two years and this engagement and co-design has been pivotal to the success of this year's sustainability plan over the winter period and our planning for substantial integration going forward.

ii) Primary care providers

Almost every strategic initiative and improvement intervention we are working on has an impact on primary care or requires our GPs and practices to refer or deliver care in a different way in the future. This will require practices to consider extending and expanding the scope of their general and enhanced services and potentially partnering with a range of other stakeholder organisations in order to respond to new service tenders and opportunities such as Care Hubs. The CCG is working closely with primary care to ensure practices understand and can contribute to all transformational initiatives and is working to support any development needs which will help practices to use or deliver future services. Improvement and transformation support is being aligned to groups of practices through the establishment of Improvement Hubs which will support practices with understanding activity and data (see section 3), highlight any variation in practice and allow practices to test and implement new pathways of care. The development of providers and potential future partners to ensure there is sufficient capacity for market readiness is a significant enabler for delivering our integration programme. Ownership of new service models by our community of general practice is critical to the success of our transformation.

We are also working closely with the Area Team to deliver the transformational change programme for primary care reform. The CCG has clearly indicated its interest in co-commissioning primary care with NHS England from 2014-15, including opportunities around community dentistry, community pharmacy and ophthalmic services which would support the delivery of our joint Care Hub approach. This includes the workforce planning and estates infrastructure required to deliver primary care at a greater scale in the future.

Our GPs are closely involved in developing our plans; we already have plans in place for one GP led care hub in York and another hub which will work across York and North Yorkshire is currently being developed. GPs sit on all of the project teams and also provide clinical input into the JDG.

iii) social care and providers from the voluntary and community sector

Healthwatch York held initial discussions about the Better Care Fund with the programme leads in both City of York Council (CYC) and Vale of York Clinical Commissioning Group (CCG). We advertised and attended the Health & Wellbeing Event at Merchant Taylors Hall on Monday 10 March, the first event encouraging members of the public and voluntary sector organisations to get involved in shaping the Better Care Fund. Following on from the event, we discussed the Better Care Fund at our Healthwatch Assembly in April. The Assembly is attended by our volunteers, partner organisations from the Voluntary and Community Sector, and key stakeholders, including CYC and the CCG. At the Assembly, we agreed to hold a public meeting to raise awareness of the Better Care Fund and enable people to help shape local plans. We held an event in May, attended by over 50 people. Lots of excellent feedback was received, which has been shared through

the Collaborative Transformation Board and has shaped our delivery plans.

To reach more people, and help them stay involved with the process, we put an article about the Better Care Fund into our summer newsletter. This was posted to 129 organisations and 231 individuals, emailed to 215 organisations and 459 individuals, and tweeted to our 1,000 followers. We continue to use our place within the Collaborative Transformation Board and the Health and Wellbeing Board to share the views of local residents. We have also attended a stakeholder meeting for one of the schemes the Better Care Fund will support, the Care Hub led by Priory Medical Group. We will continue to support the on-going involvement of local people in shaping these local plans.

York CVS has had on-going dialogue with the sector around BCF developments. A number of consultation mechanisms have been used, although timescales have limited engagement processes. In the initial development of BCF, there was a discussion between CVS and the programme lead regarding the projects and their focus. Following this, a joint consultation event was held between Healthwatch and CVS forums for providers. CVS followed this up with informing the Voluntary Sector Forum Chairs and Elected Sector Representatives on the initial BCF submission. Through the Voluntary Sector Forums and the Partnership Boards, providers and elected sector representatives have been informed about BCF developments and this is on-going, with the Collaborative Transformation Board being a primary conduit for this.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- **What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?**
- **Are local providers' plans for 2015/16 consistent with the BCF plan set out here**?

We have been working closely with our acute providers throughout the development of our Better Care submission. Both York Hospital Teaching Hospitals Foundation Trust and Leeds and York Partnership Foundation Trust are key members of the York Health and Wellbeing Board and the Collaborative Transformation Board and its Joint Delivery Group. York Hospital is delivering a Better Care pilot in another unit of planning.

Please refer to Annex 2 for further detailed information and the table below which summarises the impact of our schemes:

Impact on provider														
	Street Triage		Urgent Care Practitioners		St Leonards Hospice		Priory Care Hub		Whole Systems Review		Sitting Service		Total	
2014/15	York BCF		York BCF		York BCF		York BCF		York BCF				York BCF	
	Activity	£	Activity	£	Activity	£	Activity	£	Activity	£			Activity	£
Reduction in Non Elective (general and acute only)			813	307,314	120	66,770	39	22,090					972	396,175
Reduction in A&E attendances	886	96,166	1,436	155,863	120	13,060	197	21,386					2,639	286,476
Total		96,166		307,314		79,830		43,477						682,651
Total York Teaching Trust Contract with VOY CCG 14/15														175,147,000
% reduction on contract														0.39%

Impact on provider	Street Triage		Urgent Care Practitioners		St Leonards Hospice		Priory Care Hub		Whole Systems Review		Sitting Service		Total	
2015/16	York BCF		York BCF		York BCF		York BCF		York BCF		York BCF		York BCF	
	Activity	£	Activity	£	Activity	£	Activity	£	Activity	£	Activity	£	Activity	£
Reduction in Non Elective (general and acute only)			1,183	447,174	361	200,868	312	173,603			350	156,450	2,206	978,095
Reduction in length of stay									3,650	350,400			3,650	350,400
Reduction in A&E attendances	2,657	288,391	2,089	226,740	361	39,183	1,578	171,276	2,600	282,204	500	54,270	9,785	1,062,064
Total		288,391		673,914		240,051		344,879		632,604		210,720		2,390,559
Total York Teaching Trust Contract with VOY CCG @ 14/15 contract value														175,147,000
% reduction on contract														1.36%

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX A – Detailed Scheme Description

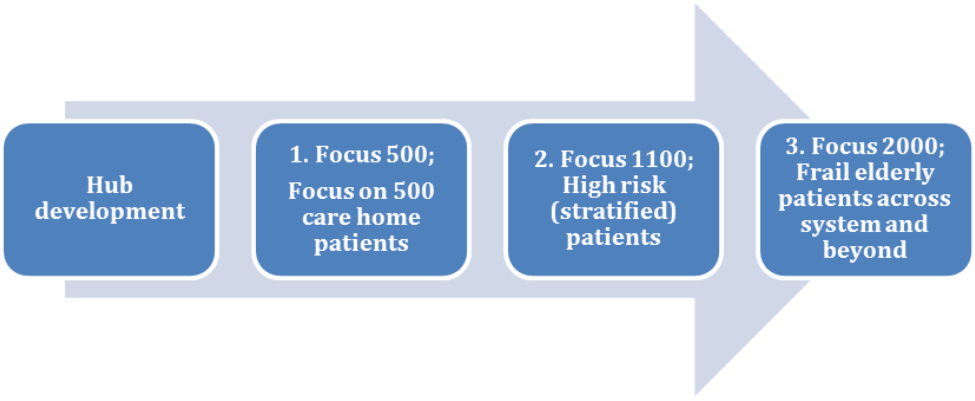
For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
Community Care Hub – Priory Medical Group
What is the strategic objective of this scheme?
Strategic objective: The community care hub will be a proactive and responsive care model for a population of around 100,000 or more that seeks to continually improve health and care outcomes whilst reducing local health and care economy cost per head. Strategic Aims: • To put service users at the centre of hub delivery • To improve defined population-based health and care outcomes, focussing particularly on those most at risk • To reduce population-based healthcare costs, social care costs and associated costs by providing alternatives to hospital admission • To improve the quality and equity of health and care services for the hub population as measured through defined information/outcomes • To provide proactive and preventative healthcare and health promotion through, for example, self-care and measures of patient independence
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted? - How will this scheme support/link to move to 7 day working?
In parallel with local joint strategic needs and plans, and the better care fund strategy and objectives, the CCG and local providers have committed to a “community care hub” model that provides proactive and community-centred care for populations of around 100,000 or more. The community hub model combines all resources from the public sector, the independent sector and existing community assets to deliver joined-up care and improved outcomes for the population it serves. Priory Medical Group are the provider lead for the City of York Community Care Hub and will work with partners to develop the community hub model for their practice population of around 53,000 patients initially, with the potential for working with other practices and providers locally to expand this population reach with time. Phase 2 of this scheme, to incorporate a further three practices and increase the reach of this work up to around 115,000 patients locally, will commence in January 2015. This will initially include the same patient cohorts, with the same MDT model. The community care hub model is seen as essential to reducing acute care demand, increasing and improving primary and community care capacity, and improving health

and care outcomes locally whilst reducing cost to the overall health and care economy.

Model of care and care cohort

The approach will be first to develop the hub structure, primary care-led multidisciplinary team and governance framework, and then focussing care hub attention and delivery on a progressively increasing patient cohort. The below approach and focus areas are anticipated to be delivered over a 24 month period and beyond in line with the BCF development. As demonstrated the model intends to identify vulnerable population cohorts and proactively manage their care through multidisciplinary working in the community setting.



The first three phases highlighted above represent a cohort focus of around 1-4% of the primary care practice population, including those in care homes, many members of which will be receiving multiple health and care related interventions. The cohorts defined above occupy a proportionately higher activity volume and spend of acute care based on data modelling completed prior to scheme initiation. The system benefits of improving care co-ordination and reducing acute demand from cohorts defined has been recognised. Throughout implementation the schemes will flex as there are changes in GP working patterns due to national and local pressures. Phase 2 commencing in January 2015 will encourage horizontal integrated patterns and allow a test of the logistics of working with an expanded team.

The model of care will be scaled in time to include other practices focussing on 5-10% of the patients most at risk of hospital admission or high care utilisation in terms of activity and cost. The model uses principles of;

- Clinical leadership and ownership through an accountable primary care provider
- Risk stratification and daily acute care data alerts for hub patients attending, admitted to, and discharged from hospital. This supports admission avoidance, early discharge and prevention of re-admission
- Daily multi-disciplinary team meetings including health and care professionals through provider agreements
- Care planning and case management supported through technology e.g. electronic care records
- Single point of access for care delivery and management
- Development of new primary care and community care pathways to include voluntary sector support and enhanced sign-posting via existing community facilitators, particularly focussing on alternatives to hospital admission and

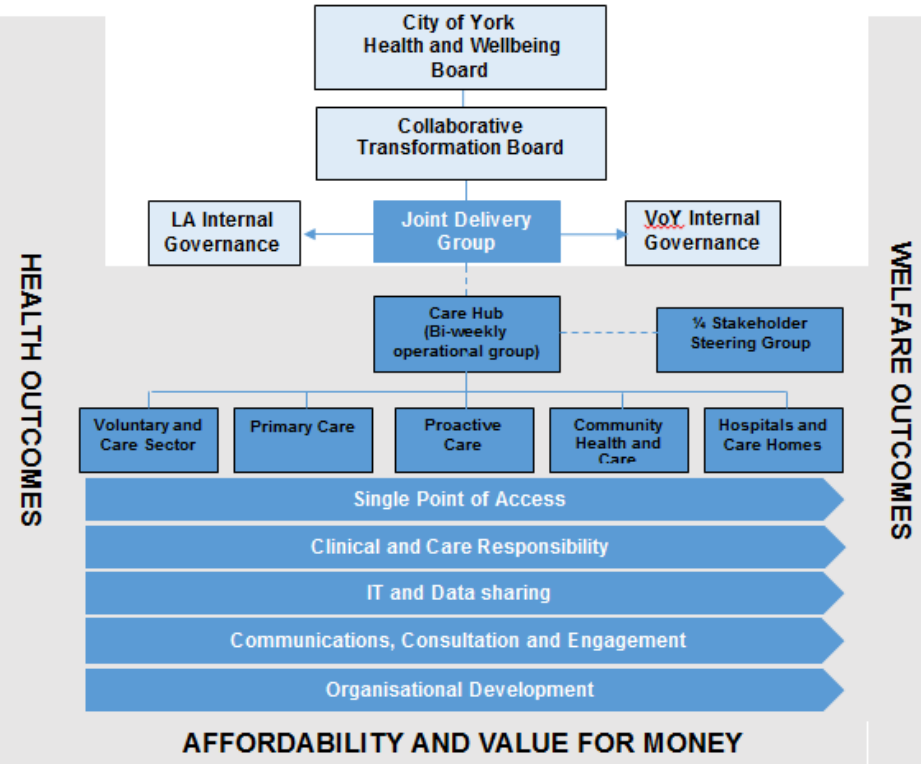
admission avoidance
- Monthly monitoring and reporting through defined better care fund programme governance
- Robust evaluation and adaptation of model responding to impact
- To use principles of ***communication, co-operation, co-ordination and control*** as the basis for the hub delivery

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

A memorandum of understanding, in parallel with commissioning governance and assurance, supports definition of the delivery chain.

An accountable lead provider model has been adopted for the development of the community care hub, initially as a pilot. The accountable lead provider, Priory Medical Group, is commissioned through the better care fund partners and process (invoicing monthly against a submitted business plan and budget), monitored through a joint health and social care delivery group. The memorandum of understanding defines the overall engagement and principles of this arrangement between NHS Vale of York CCG (commissioner), City of York Council (commissioner) and Priory Medical Group (provider). The accountable lead provider however works with multiple other providers and stakeholders to deliver the care hub aims, objectives and deliverables, including local acute services and council provider services, for example.

Governance arrangements for the hub are represented diagrammatically below;



The accountable lead provider is held to account against defined objectives and metrics and a defined plan for the agreed budget, however, there is flexibility for provider

innovation and adaptation to ensure the model is as effective as possible in delivering the aims and objectives sought.

Acute and social care utilisation and metrics are reported monthly. The KPI's are matched against those for other areas within Vale of York CCG that are testing variations of the care hub model. They are also discussed locally and nationally with other networks that are testing out new models of care. Initial data around the effectiveness of the various interventions on-going, and the measures to report them are just starting to be available for analysis.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

In relation to selection and design of the scheme, health and social care data was gained for the c. 53, 000 practice population including activity and spend in acute and social care, with more specific understanding and breakdown of areas of opportunity based on population spend and activity broken down by demographic, gender, age, place of residence, disease area, condition-specific activity and other areas. Similar work is on-going for the practices in Phase 2. This helped to identify patient cohorts and patient characteristics representing a higher proportion of activity and spend in the health system and work since has helped to repeat the process across social care. Additionally, retrospective data on activity and growth has been modelled in addition to formal data modelling supported provided to the CCG and local authority to understand potential impacts further. Subsequent incremental improvement to the schemes objectives is being reviewed to assess if further modelling is required.

Joint strategic needs assessments and public health data has also been available to help prioritise the wider strategy for models and plans, in addition to prior public communications and engagement exercises, and a number of provider market engagement events relating to community services and admission alternatives.

The care hub model also utilises evidence from elsewhere, whilst recognising the need for effective local adaptation, delivery and implementation, the latter being particularly important. The model builds on good experience locally and draws on evidence from national and international exemplars, for example, the Canterbury experience in New Zealand, Caremore and 'Extensivists' in California and 'Polysystems' in London. Additionally, the CCG are linking up with other local and national organisations and networks that are trialling new models of care, to share learning and ideas.

It is recognised, for example through the evaluation of community and integration models through the Nuffield Trust (2013), that models such as those proposed require time and scale. Supply-induced demand can often limit the impact of such models on reducing emergency admissions. It can equally be difficult to prove a negative of avoidable admissions. Where cashable savings are required, commissioners often have to use effectiveness of new models to decommission services not providing value for money which is a dependency to demonstrate cost reduction. However, the model adopted intends to create alternatives to admission and evidence-based delivery, such as risk profiling to target care appropriately to support reducing admissions.

References and an evidence-base being used to inform the model and above statements are highlighted below.

References

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Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

The following overview costings for 14/15 for the care hub are:

Area	Cost (£)	Summary
Senior clinical and operational lead	£88.4k	Senior GP accountable clinical lead and Managing Partner
Care co-ordinator	£45k	Central resource for care planning and navigation
Care worker (generic)	£45k	Central resource for direct health and care in home environment
Administrator	£25k	Single point of access and care planning administration
Technology	£48k	Remote technology/ devices and electronic care plan software
Training	£10k	Developing community/care teams to support admission avoidance skills and pathways

Total	**£261.4k**

The Care Hub expansion plan for 15/16 indicates significant growth across groups of general practices and patient groups. Indicative funding for this growth has been budgeted at £500,000.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

The impact of this scheme is currently being measured by a dashboard of quantitative data as below;

2014-15

Benefit	Organisation	Activity	Unit price	Total saving	Saving value calc.	Monitored
Reduction in permanent residential admissions	Local Authority	5	£6,625	£32,860	64% based on CYC population, of a 6% reduction and an average cost of £250 and an average length of stay of 26.5 weeks	Through the Joint Delivery Group and Collaborative Transformation Board
Reduction in delayed transfers of care	NHS Commissioner	89	£96	£8,527	64% based on CYC population of VoY, of a reduction of 554 XBDs on a weighted average cost of £96.20	Through the Joint Delivery Group and Collaborative Transformation Board
Reduction in non-elective admissions	NHS Commissioner	39	£556	£21,700	4% reduction 156 non-elective admissions using local average NEL cost when applying 30% marginal tariff	Through the Joint Delivery Group and Collaborative Transformation Board
Reduction in ED attendance	NHS Commissioner	197	£109	£21,410	Reduction of 789 A&E attendances pro rata for final quarter at local average A&E attendance cost	Through the Joint Delivery Group and Collaborative Transformation Board

2015-16

Benefit	Organisation	Activity	Unit price	Total saving	Saving value calc.	Monitored
Reduction in permanent residential admissions	Local Authority	40	£6,625	£262,880	64% based on CYC population, of a 6% reduction and an average cost of £250 and an average length of stay of 26.5 weeks. Project will have doubled in size.	Through the Joint Delivery Group and Collaborative Transformation Board
Reduction in delayed transfers of care	NHS Commissioner	709	£96	£68,217	64% based on CYC population of VoY, of a reduction of 554 XBDs on a weighted average cost of £96.20. Project will have doubled in size.	Through the Joint Delivery Group and Collaborative Transformation Board

Reduction in non-elective admissions	NHS Commissioner	312	£556	£173,603	4% reduction 156 non-elective admissions using local average NEL cost when applying 30% marginal tariff. Project will have doubled in size.	Through the Joint Delivery Group and Collaborative Transformation Board
Reduction in ED attendance	NHS Commissioner	1578	£109	£171, 276	Reduction of 789 A&E attendances pro rata for final quarter at local average A&E attendance cost. Project will have doubled in size.	Through the Joint Delivery Group and Collaborative Transformation Board

Current data delivered to date (October 2014):

Metric	2013/14 Monthly Average	Pre-Scheme Monthly Average (Preceding 12m)	Post-Scheme Monthly Average – YTD (06/14)
1. Acute spend total	£1,953,522	£1, 930, 876	£2, 003, 702
2. A+E Attendances (GP-ref)*	1322 (56)	1306 (53)	1373 (49)
3. IP Non-Elective Admissions* (Care homes)	434 (35)	432 (36)	413 (30)
4. Total New Outpatient Attendances	1068	1059	969
5. 28-Day care-home Re-admissions	9	9	7
6. Over 65-Falls Related Injuries	17	24	21
7. Avoidable emergency admissions	T.B.C	T.B.C	69
8. DTOCs per 100,000	17.8	17.8	T.B.C
9. Avoided admissions**			T.B.C
10. D/C contacted (within 72 hours)			38
11. Number of patients on case management reg.			833
12. Patient Contacts			872
13. MDTs held (MDT patient reviews)			21 (239)
14. Number of shared care records			831

*Growth has been subtracted in at (the following rates) 3.0% based on last 12 months and acute uplift for 14/15 at x%
**As determined by the use of the hub as opposed to attendance at hospital (audit t.b.c)
Note: Metrics 9-14 reported as in-month actuals (scheme started from June 2014)
Additionally a patient satisfaction survey is underway at present, and initial results will be available from January 2015.

Meetings are underway in December 2014 to align the performance metrics across the schemes currently being implemented in Vale of York CCG.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand

what is and is not working in terms of integrated care in your area?
Outcomes of the scheme are measured and/or to be measured through the following methods; - Informal regular bi-weekly action-focussed operational development meetings between the core team supporting hub development, progress, challenges, opportunities and delivery - Formal monthly data evaluation against agreed system wide KPI's: using health and social care data across a range of activity and spend and reported through the joint delivery group - Formal evaluation through an academic partner is currently being investigated for formal, quantitative and qualitative evaluation to understand what is working well. Local and national research bodies have been asked to provide a specification for this work and the aim is to provide evidence that evaluates current impact and informs development
What are the key success factors for implementation of this scheme?
A range of broad and recognised factors consistent with any programme delivery are recognised, such as addressing barriers to change and ensuring a clear structure and approach for implementation. Specifically related to the defined scheme and in examining the publications previously referenced key success factors relate to; • On-going provider engagement in delivery • Allowing time (for model development and scale amongst other areas), in parallel with the evidence around integration schemes specifically, for schemes to realise material reductions in admissions and other stated outcomes • Monitoring and adapting scheme delivery, throughout different phases, though real-time and scheme-sensitive metrics (recognising external influences such as population growth, demographic changes and other influences on change) • Utilising decision-making processes to, for example, decommission services in line with increased scheme delivery (to reduce supply-led demand and realise material cost reductions and transfer of care delivery) • To ensure sustainability of the scheme through on-going adaptation and learning

ANNEX 1B – Urgent Care Practitioners

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
Urgent Care Practitioners
What is the strategic objective of this scheme?
Strategic objective: The CCG's Integrated Operational Plan 2013/14 has three local priorities, underpinned by a clear strategic intent "to improve systems for assessing the urgency of care, ensuring an appropriate and prompt response to patient need". The aim for all three is to proactively manage conditions as close to the patients' home as possible thus reducing unnecessary A&E attendances and unplanned hospital admissions. The first and the third priorities come within the Urgent Care Programme and focus on: • Unplanned hospitalisation for chronic ambulatory care sensitive conditions • Reduction in emergency admissions for acute conditions that should not usually require hospital admissions With this in mind, it has been decided within the NHS Vale of York CCG boundaries to change the name of an Emergency Care Practitioner to that of an Urgent Care Practitioner (UCP) so they are able to support the delivery of these priorities in avoiding further growth in admissions, which will reflect a considerable achievement from the 2012/13 experience of 16% increase in unplanned admissions Commissioning the UCP Service will also feed into the vision for health and care services (as set out at the start of this document) by ensuring individuals are able to access the right level of care and support in community based settings to help avoid unnecessary admissions to hospital and in doing so will contribute towards the reduction of emergency hospital admissions. In achieving this it will almost certainly iincrease the proportion of people having a positive experience of care outside of hospital, in general practice and in the community. With the introduction of NHS 111, which is managed by Yorkshire Ambulance Service (YAS) across Yorkshire and the Humber, there are strong links and potential benefits associated with the commissioning of an UCP service delivered by YAS. NHS 111 supports patients with urgent care needs to access the right care, in the right place, first time, which will, if appropriate, involve referral to the UCP Service. Evidence suggests that this form of signposting appears to have the advantage of reducing immediate medical workload through the substitution of telephone consultations and alternative use of clinical skills. Furthermore, this has the potential to reduce costs. (*Leibowitz, (2003))*
Overview of the scheme Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

As part of the 2013 /14 winter pressures projects four members of staff from the Yorkshire Ambulance Service were employed to work alongside regular ambulance crews to attend falls, faints and minor injuries.

The success of this project enabled the CCG to continue and expand the service with funding from the York and North Yorkshire BCF.

They are working on a roving basis around the Vale of York and are called to both emergency calls to improve response times and to less urgent calls where they have appropriate skills. This service aims to see, treat and where required refer onwards individuals in the home or at the scene instead of providing conveyance to hospital.

The use of Urgent Care Practitioners Service that YAS provides for Vale of York CCG is to respond to 999 calls and to accept referrals from paramedics, nursing homes, community matrons and nurses. These referrals include, but are not limited to, falls, COPD, catheter problems, and wound care. UCPs, as independent advanced practitioners, are able to assess patients in their own home and make referrals to the most appropriate agency resulting in reduced ambulance conveyance rates to hospital.

Building on the success of this scheme will be the development of alternative pathways and integration into the community services that offer an alternative to hospital care. This additional funding for UCPs will increase the capacity and coverage of the Vale of York. Also in the rural areas of the locality this enables UCPs to be embedded within general practice. Although their primary role will still be that of an advanced paramedic practitioner responding to 999 calls, their skills and knowledge will be used to manage urgent demand which may be identified within primary care. This will support the move to Primary Care 7 day working.

The CCG have committed to fund this project through the York and North Yorkshire BCF and winter resilience monies and have committed to extend this service.

In 14/15, 4 UCPs are funded non-recurrently through system resilience monies. Recurrently an additional 4 UCPs are funded through North Yorkshire BCF and 4 through York BCF. In 15/16 4 UCPs will be funded recurrently through North Yorkshire BCF and 8 through York BCF. This gives a total of 12 UCPs in each year.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The CCG, with partner organisations and stakeholders, have been working together to manage urgent care. With the national introduction of an Urgent Care Programme the focus has been placed on transformation, improvement of urgent care pathways, integration of existing and new services and close working with care homes. The Systems Resilience Group has been established that underpins the importance of working with key stakeholders to develop ideas, oversee implementation of urgent care plans and monitor the A&E recovery and improvement plans. The approach spans pre-hospital, hospital and post-hospital care.

Following the development of a joint UCP service specification, this has now been

fed into a new contract agreement between the CCG and YAS.

YAS, as the main provider of the UCP service will be responsible for the delivery and implementation of the scheme working closely with the CCG as the contract commences. Currently a strategic meeting is held monthly to review the current levels of activity and address any issues with the scheme. It is anticipated that this will move to a contract management board (CMB) arrangement where YAS will be held account against a defined set of objectives and metrics.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Current Scheme Activity Across North Yorkshire & York.

Below are the latest activity figures for the current service with only 4 UCPs. The additional 8 posts will be in place by December 14. Costs have been estimated against non-conveyance rates, ED attendances and reduction in admissions.

	Total calls to UCP service	No of pts not conveyed to hospital	% of non-conv	1. Non-Conv costs £62	2. ED Atten costs £108	3. 50% reduct in admiss (£1258) at 30% (due to marginal rate effect)	Total
Apr-14	88	50	57%	£3,100	£5,000	£9,425	
May-14	147	57	39%	£3,534	£5,700	£10,933	
Jun-14	100	50	50%	£3,100	£5,000	£9,425	
Jul-14	122	82	67%	£5,084	£8,200	£15,457	
Aug-14	164	91	55%	£5,642	£9,100	£17,342	
Sep-14	210	120	57%	£7,440	£12,000	£22,620	
Oct-14	182	96	53%	£5,952	£9,600	£18,096	
Totals	**1013**	**546**	**54%**	**£33,852**	**£54,600**	**£103,298**	**£191,750**

NB:

1. Ambulance costs are based on a basic two man vehicle at £62 per journey. There are four categories of conveyance costs. YAS car booking if mobility permits - £28, Basic two man vehicle - £62, Fully kitted vehicle, two man support - £288, Frontline 999 ambulance - £288. Based on the patients seen by the UCPs the majority of patients will not require frontline, fully kitted vehicle. Therefore the cost of transport is based on a two man vehicle for most patient seen by the UCP who require ambulance conveyance to ED.

2. Attendance savings are based on 2012/13 data. Number of patients attending A&E divided by the actual cost x by the target reduction of % non-attendance. This is averaging £108 per attendance.

3. Admissions reductions are 50% of the patients attending ED conveyed by ambulance. The percentage conversion from attendance to admission has been identified through YAS experience in other areas. The costs are based on 2012/13 data for emergency admissions that met the criteria discussed above.

Forecast savings

No of UCPs	Month	Total calls	Non convey	% based	1. Non convey £62	2. ED Attend £108	3. Reduct in admiss (incl 30% marginal rate)	
4	Apr-14	88	50	57%	£3,100	£5,000	£9,450	Actual activity
4	May-14	147	57	39%	£3,534	£5,700	£10,773	
4	Jun-14	100	50	50%	£3,100	£5,000	£9,450	
4	Jul-14	122	82	67%	£5,084	£8,200	£15,498	
4	Aug-14	164	91	55%	£5,642	£9,100	£17,199	
4	Sep-14	210	120	57%	£7,440	£12,000	£22,680	
4	Oct-14	182	96	53%	£5,952	£9,600	£18,096	
4	Nov-14	210	141	67%	£8,723	£15,196	£26,592	Forecast
12	Dec-14	315	211	67%	£13,085	£22,793	£39,888	
12	Jan-15	540	362	67%	£22,444	£39,096	£68,418	
12	Feb-15	720	482	67%	£29,884	£52,056	£91,098	
12	Mar-15	720	504	70%	£31,248	£54,432	£95,256	
	Total	3,518	2,246	67%	£139,237	£242,541	£424,447 1,123	£806,224
	Target 2014/15		**2,154**			**£233,795**	**£461,160 1,220**	**£676,560**
	Target 2015/16		**3,133**			**£340,056**	**£670,572 1,774**	**£983,872**

References and an evidence-base have been used to inform the development of this model further.

References

There have been a number of studies that support the implementation of Urgent (was Emergency) Care Practitioners roles. The references below provide an overview of these studies.

Transforming urgent and emergency care services in England First published: November 2013

Urgent and Emergency Care Review, End of Phase 1 Report.
http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

- The challenges facing our urgent and emergency care system are clear, as are the opportunities for improvement. We now need to take action. The report sets out the proposals for the future of urgent and emergency care services in England. There are five key elements summarised in the report, one of which is to provide highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E

Sheffield PCT 2012

- The Sheffield ECP service has a primary role of seeing and treating people at scene, thus ensuring patients do not have to be transported by ambulance to A&E, when this is not the most suitable pathway for them. The service typically sees about 25 patients a day, many of whom have fallen. The service has been successful in reducing the need for people to be taken to A&E for treatment as patients can be treated on scene by an advanced practitioner.

Journal of Paramedic Practice, Vol. 2, Iss. 4, **21 Apr 2010, pp 158 - 168**

- The aim of the literature review was to identify and appraise studies that have compared the effectiveness and decision-making of emergency care practitioners with other health professionals.
- Out of the twenty-nine publications, ten studies were analysed in further detail and three main themes identified: non-conveyance rates, decision-making and admission avoidance.
- The decision-making of ECPs compares favorably with other health professionals when deciding whether a patient can be treated at home, or requires ED attendance or hospital admission.

Measuring the Benefits of the Emergency Care Practitioner: Skills for Health 2007.

- 70% of patients ECPs treated, discharged or referred patients away from hospital

Paramedic Practitioner Older People's Support Trial (PPOPS): A Cluster Randomised Controlled Trial. British Medical Journal, Nov 3;335(7626):919, 2007 (Mason, 2007)

- Controlled study of ECPs in three service settings showed high rates (72.2%) of patients discharged without referral on to other provider

Collaborative practices in unscheduled emergency care. The role and impact of the Emergency Care Practitioner (ECP). Cooper S. et al University of Plymouth (UK) October 2006

- 70% of patients were seen 'in-hours'; 62% were not conveyed; 38% were referred, mainly to A&E

AACE (2014) Future Clinical Priorities for Ambulance Services in England

The Association of Ambulance Chief Executives (AACE) has identified Urgent Care as one of their seven clinical care priorities. AACE recognise a shift from traditional ambulance service delivery ('see and convey') to an increased model of 'see and treat'. This model requires an increase in advanced paramedics and / or nurses equipped with enhanced skills to assess and either treat patients on scene, or refer the patient onwards to appropriate health and social care services.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Investment for 14/15 and 15/16

a. Investment required:

Proposed costs per UCP: £52k pay, £10k equipment, £10k travel and associated costs (£72k)

Year one 14/15:
Four UCPs for 12 months – 4X£72,000 = £288,000
Two UCPs for 6 months – 2X£36,000 = £72,000
Two UCPs for 3 months – 2x£18,000 = £36,000

Total BCF = £396,000
Of which £198,000 is funded from the York BCF.

Year one 14/15:
Four UCPs for 4 months – 4X£24,000
Total SRG = £96,000

Year two 15/16:
12 UCPs for 12 months – 12X£72,000 = £864,000
Total = £864,000

Of which £564,000 is funded from the York BCF in 15/16

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

	14/15 Activity	14/15 Saving (£K)	15/16 Activity	15/16 Saving (£K)
Reduction in emergency admissions	813	307	1183	447
Reduction in A&E attendances	1436	154	2089	223

NB: The above figures are for York BCF only.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Outcomes of the scheme are measured and/or to be measured through the following methods;
- Formal strategic monthly meetings with Yorkshire Ambulance Service and its membership includes CCG and YAS staff from contracting, finance, service improvement and front line clinicians.
- Formal monthly and quarterly data evaluation has been put in place using agreed performance metrics (as per the approved service specification)

What are the key success factors for implementation of this scheme?

It is anticipated that an increase in the number of UCP's commissioned by Vale of York CCG will achieve the following key success factors:

- Increased levels of appropriate non-conveyance due to the enhanced clinical skills of UCPs allowing them to assess and treat, assess and refer and assess and convey to alternative care sites (when clinically appropriate)
- Provide an integrated service, which supports a coordinated approach from health and social care professionals
- Reduction in attendance at A&E for specific patients
- Provide direct referrals to the most appropriate pathway for the patient
- Increased management of palliative care patients at home or at the place they choose to end their life

ANNEX 1C – Hospice at Home

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
St Leonard's 'Hospice at Home' Scheme
What is the strategic objective of this scheme?
Strategic objective: The extended hours operation of the Hospice at Home will be a proactive and responsive care model for the identified population of the Vale of York which seeks to continually improve integrated health and care provision closer to or at service users usual place of residence whilst reducing per head local health and care economy cost. The "identified population" of 2,700 is based on the challenge to primary colleagues from the National Council for Palliative Care to "Find their 1%" of patients aged 18 and over who would be expected to die within the next 12 months. Strategic Aims: • To put service users at the centre of care delivery • To improve access to home-based care and support services to enable more people to die at home or place which has become their home, with dignity • To reduce population-based healthcare costs, social care costs and associated costs through providing alternatives to hospital admission • To improve the quality and equity of access to health and care services for palliative and end of life care service users within the Vale of York.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
In parallel with local joint strategic needs and plans, and the better care fund strategy and objectives, the CCG and local providers have committed to an extended hours hospice at home service that provides proactive and community-centred care for the Vale of York population. The hospice at home model combines resources from St Leonard's Hospice in conjunction with Marie Curie Nursing Services team, York Teaching Hospital Foundation Trust Community Services team and other care providers to deliver joined-up care and improved outcomes for the population it serves both during the working week and also at weekends. The Hospice at Home extended hours service model is seen as essential to reducing acute care demand, increasing and improving primary and community care capacity, and improving health and care outcomes locally whilst reducing cost to the overall health and care economy.

Model of care and care cohort

The approach will be first to look to recruit the additional team members to deliver the extended hours service as there is a pressing requirement for this service given the overwhelming evidence from the Winter Pressures pilot. The recruitment phase should be complete within three months. Primary care colleagues continue their work to identify their palliative care patient population as part of the national "Find your 1%" challenge. These patient cohorts should be proactively managed within primary and community care teams with referrals to the 'hospice at home' service being co-ordinated via St Leonard's Hospice. The referral pathway will be communicated widely as part of the roll-out.

The model of care will be scaled in time to include other practices focussing on the most 5-10% at risk patients of hospital admission or high care utilisation in terms of activity and cost. The model uses principles of;

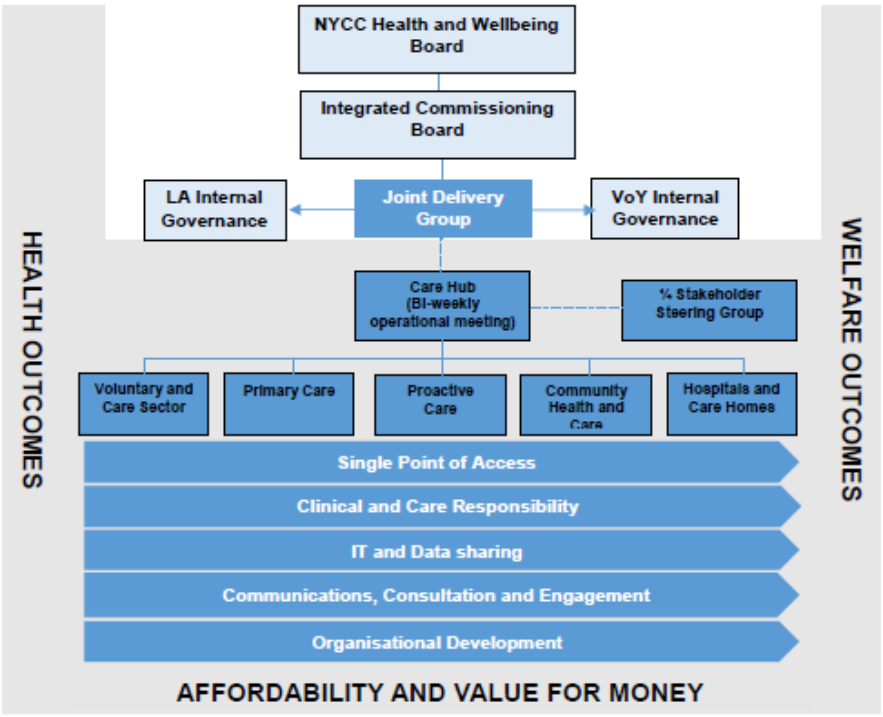
- Clinical leadership and ownership through St Leonard's Hospice
- Daily multi-disciplinary team meetings including health and care professionals through provider agreements
- Where practicable, care planning and case management supported through technology e.g. Electronic care records
- Single point of access for care delivery and management
- Development of new primary care and community care pathways to include voluntary sector support and sign-posting, particularly focussing on alternatives to hospital admission and admission avoidance
- Monthly monitoring and reporting through defined better care fund programme governance
- Robust evaluation and adaptation of model responding to impact
- To use principles of ***communication, collaboration, co-operation, co-ordination and control*** as the basis for the service delivery

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

A Service Level Agreement (SLA), in parallel with commissioning governance and assurance, will support the definition of the delivery chain and demonstrate the collaborative working approach.

The accountable lead provider, St Leonard's Hospice, is commissioned through the better care fund partners and process (invoicing monthly against a submitted business plan and budget), monitored through a joint health and social care delivery group. The SLA defines the overall engagement and principles of this arrangement between NHS Vale of York CCG (commissioner), City of York Council (commissioner), North Yorkshire County Council (commissioner) and St Leonard's Hospice (provider). The accountable lead provider however works with multiple other providers and stakeholders to deliver the care hub aims, objectives and deliverables, including local acute services and council provider services, for example.

Governance arrangements for the hub are represented diagrammatically below:



The accountable lead provider is held to account against defined objectives and metrics and a defined plan for the agreed budget, however, there is flexibility for provider innovation and adaptation to ensure the model is as effective as possible in delivering the aims and objectives sought.

Acute and social care utilisation and metrics are reported monthly.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

From the 'Finding your 1%' initiative around 2,700 adults in the Vale of York will have a palliative care diagnosis. This scheme will work towards reducing the national metric of 25% of all inpatients at any one time in acute hospitals that will die. Similarly from the National End of Life Care Strategy (2008) over 70% of people wished to die at home yet over 50% actually died in acute hospital settings.

Joint strategic needs assessments and public health data has also been available to help prioritise the wider strategy for models and plans, in addition to prior public communications and engagement exercises, and a number of provider market engagement events relating to community services and admission alternatives. It is hoped that this service will wrap around the developing better care fund community care hubs.

References and an evidence-base being used to inform the model and above statements are highlighted below.

<u>References</u>

- National End of Life Care Strategy (2008)

- Health Education England (2014); https://www.eoedeanery.nhs.uk/page.php?page_id=2776
- Health Foundation, The (2011). Getting out of hospital? The evidence for shifting acute inpatient and day case services from hospitals into the community. London. The Health Foundation.
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- Nuffield Trust, The (2012). The anatomy of health spending. London. The Nuffield Trust.
- Nuffield Trust, The (2013). Evaluating integrated and community-based care. London. The Nuffield Trust.
- University of York (2012). http://www.crd.york.ac.uk/crdweb/ShowRecord.asp?ID=12011006375#.U8kq4rnjjIU

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total Investment Required: 14/15 - £135,000, 15/16 - £170,000

This funding comprises staffing costs as well as the costs of recruitment, staff development and travel for the extended hours (6pm until midnight) peripatetic service across the whole of the Vale of York.

The increased levels of staffing comprise: 4 registered nurses, 4 health care assistants, 1 part-time admin officer and an additional management/supervisory resource.

Based on 30% tariff and an average of 7 referrals per week, the total forecast savings would be as follows:

14/15
NEL Admissions reduction - £67k
A&E attendances avoided - £13k

15/16
NEL Admissions reduction - £201k
A&E attendances avoided - £39k

There is a further anticipated saving against ambulance conveyance cost, but as this is on a block contract further work is required to realise this benefit.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

	14/15 Activity	14/15 Saving (£K)	15/16 Activity	15/16 Saving (£K)
Reduction in emergency admissions	120	67	361	201
Reduction in A&E attendances	120	13	361	39

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Outcomes of the scheme are measured and/or to be measured through the following methods;

- Regular monthly action-focussed operational development meetings supporting hub development, progress, challenges, opportunities and delivery
- Formal monthly data evaluation using health and social care data across a range of activity and spend reported through the joint delivery group
- Formal evaluation through an academic partner currently being developed for formal, mixed methods (quantitative and qualitative) evaluation to understand what is working well, evidence that could inform development and evaluation of impact

What are the key success factors for implementation of this scheme?

A range of broad and recognised factors consistent with any programme delivery are recognised, such as addressing barriers to change and ensuring a clear structure and approach for implementation.

Specifically related to the defined scheme and in examining the publications previously referenced key success factors relate to;

- Successfully recruiting sufficient staff resources to safely operate the service
- On-going provider engagement in delivery
- Allowing time (for model development and scale amongst other areas), in parallel with the evidence around integration schemes specifically, for schemes to realise material reductions in admissions and other stated outcomes
- Monitoring and adapting scheme delivery though real-time and scheme-sensitive metrics (recognising external influences such as population growth, demographic changes and other influences on change)
- Utilising decision-making processes to, for example, decommission services in line with increased scheme delivery (to reduce supply-led demand and realise material cost reductions and transfer of care delivery)
- To ensure sustainability of the scheme through on-going adaptation and learning

ANNEX 1D – Mental Health Street Triage

Scheme ref no.
Scheme name
Street Triage
What is the strategic objective of this scheme?

The proposed Mental Health Street Triage Scheme is intended to enable timely and appropriate interventions to individuals at their point of contact with police. It has been successfully trialled in Leicestershire and Cleveland, and other pilots are currently being rolled-out across the country. Leeds Street Triage service has been operational since December 2013 and has seen significant results in relation to increased patient experience and reduced detentions under the Mental Health Act 1983.

Working in partnership with the police, community mental health services, City of York Council and the Third Sector to offer an assertive outreach and follow up service to those difficult to engage following initial contact with the police

Key Objectives –

- Reduce the burden on Crisis Teams, police and health staff, and hence reducing costs
- Mitigate risk and reduce the potential for vulnerable people escalating into crisis
- Significantly enhance inter-agency working in addressing the issues of vulnerable people at the earliest opportunity, with the lowest level of intervention
- Improve the outcomes for those who are detained and also those who are dealt with in the community
- Increased accessibility to Mental Health Service staff beyond normal working hours, seven days a week.
- Reduce the number of inappropriate detentions to both hospital and custody
- Support North Yorkshire Police experiential learning through multi-agency teamwork, leading to greater understanding of the roles of other professionals within mental health service and a greater understanding of mental illness and pathways to support vulnerable people
- Reduce the number of expensive call-outs for Forensic Medical Examiners and Approved Mental Health Professionals within police custody
- Actively contribute to reducing future demand upon services through pre-emptive engagement and action
- Reduce S136 detentions, evidence around the UK with other Pilots is a minimum 25%-30% reduction
- Reduced Emergency Department (ED) admissions (no figures available however above reductions could be replicated with mental health presentations through the ED).

The scheme will achieve this by adding skilled mental health professionals into the existing Crisis Assessment Service in York, the service that currently manages the Cities Health-Based Place of Safety for Section 136 detentions under the Mental Health Act. The team will be available to be deployed by the police to provide an initial assessment of the individual. With various interventions the Mental Health professionals will provide officers with advice, signposting to relevant support packages of care. It will also facilitate information-sharing between agencies at the interface of mental health and service provision, and help to address the subjects issues that lead to the revolving-door cycle of service use. By effective intervention and advice, the scheme will complement the recent investment in the creation of a Health-Based Place of Safety (HBPoS) for MHA detainees in York, and help avoid unnecessary detentions under the Act, thereby improving the patient experience for these individuals and achieving a substantial cost saving for those services.

It is envisaged that the Street Triage Team will see a Registered Mental Nurse (RMN) or an equivalent trained Allied Health Professional and a nursing assistant, on duty between 14:00hrs and 0.00hrs, 7 days a week. Following the model developed for implementation in Scarborough, it is proposed that they will utilise an unmarked vehicle suitable for the discreet assessment of vulnerable people at the scene of incidents in support of the police.

The focus of the service will be directed towards improving the patient experience, with an emphasis on providing a prompt, effective and efficient response to the Police. While not in itself a panacea, the scheme will assist in providing the lowest appropriate level of intervention at the earliest possible juncture.

Purpose of Street Triage

This Service is open and accessible to people of all ages, where it is believed that they may have a mental illness, learning disability, personality disorder or misuse substances, who come into contact with the police outside of custody. The team assesses their mental state in a face to face contact and advises if detention under the Mental Health Act is necessary. The object being to divert people from the Criminal Justice System when appropriate and provide access to community based services thereby ensuring that their health and social care needs are known and provided for by appropriate services.

If the person does need to be detained in a place of safety then the team follows the vehicle being used to transport the person, and once at the place of safety ensures that their health needs are known by staff at the receiving point. The team also where appropriate, provides signposting for all other persons who do not meet the criteria for detention.
The focus of the service is very much towards the front end of the criminal justice pathway, with an emphasis on providing a prompt response to incidents.

The team offers advice, assessment and access to services. They achieve this by offering advice and support to Criminal Justice Staff, checking where appropriate whether someone is known to mental health services and offering advice and signposting to other services.

A face to face triage screening assessment is carried out on persons outside of a custodial setting and risk assessments are completed on all persons seen.

The team also facilitate access to appropriate services in the community where this is appropriate.

Philosophy of Care

The Street Triage team seeks to provide an inclusive service to ensure that persons coming into contact with the criminal justice system receive a high quality, competent and effective range of interventions. The service delivery includes liaison, prevention and ultimately if needed, equitable access to mental health services across the trust.

The service promotes social inclusion and acceptance of service users within mental health provision who may have offended, or are likely to offend or re-offend to enable them to live a more productive, positive and fulfilling life.

The Street Triage service is an integrated part of mainstream services ensuring access to mental health assessment and advice, and creating robust multi-agency working.

The Street Triage service promotes prevention and reduction of offending by working in a flexible, mobile and timely manner with all agencies in the locality.

The street triage team completes follow-up work to promote mental wellbeing and encourage access to appropriate services and offer support.

The street triage team works in partnership with Cleveland Police to provide mental health advice and guidance in an effort to assist the police in their decision making process around managing risk.

The services values are:

To recognise that mentally disordered persons who may also be offenders have the same right to assessment and treatment as any other person. Each person will be treated as a unique individual with dignity and mutual respect, whilst promoting a non-discriminatory service to all. The service will strive to be flexible and responsive to individual needs, responding to requests in a timely manner. Our aim is to establish a therapeutic relationship built on trust and respect. Confidentiality will be maintained within the boundaries of our environment. The service will integrate with the individual's existing systems of support.

Service Definitions

The service is open to persons of all ages with recognition that it will only provide triage screening. There are agreed referral pathways to Child and Adolescent Mental Health Services for persons under 18 years of age and for adults and older adults via the agreed pathways for Adult Services and Mental Health Services for Older People.

If during the triage process a learning disability is suspected then although the team do not have specialist skills in this area they do have a general awareness and would signpost to the most appropriate service.

As part of the triage process Drug and Alcohol Issues will be screened for and help and advice on what services are available will be offered.

The service ensures that the care they provide is culturally sensitive and recognises that cultural differences will not exclude anyone from the service.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

A memorandum of understanding, in parallel with commissioning governance and assurance, supports definition of the delivery chain.

An accountable lead provider model has been adopted for the development of Street Triage, initially as a pilot. The accountable lead provider, Leeds and York Partnership NHS Foundation Trust (LYPFT), is commissioned through the better care fund partners and process, monitored through a joint health and social care delivery group. The memorandum of understanding defines the overall engagement and principles of this arrangement between NHS Vale of York CCG (commissioner), City of York Council (commissioner) and LYPFT (provider). The lead provider is accountable for the effective delivery of the Pilot however LYPFT works with North Yorkshire Police and other stakeholders to deliver all the objectives and deliverables.

Well-established LYPFT Clinical Governance structures will support Street Triage and existing supervision within the Crisis and Access Service will ensure continued delivery of safe and effective high quality Mental Health care to all patients seen on Street Triage.

The accountable lead provider is held to account against defined objectives and metrics and a defined plan for the agreed budget, however, there is flexibility for provider innovation and adaptation to ensure the model is as effective as possible in delivering the aims and objectives sought.

Street Triage development, progress and metrics are reported monthly.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Existing schemes around the UK have been consulted; findings are consistent with reports highlighting their impact on reduced Section 136 Mental Health Act 1983 detentions by Police. There are also reports highlighting the reduced attendance of mental health presentations in custody areas.

Anecdotal reports highlight increased patient experience and describe improvements in working relationships between Health providers and Police Constabularies.

Investment Requirements

Financial resource required to recruit to the following posts:
(The following costs are based on a 12 month secondment or temporary contract)

2.31 Whole Time Equivalents (WTE) Band 6 Mental Health professional
working 7 days a week between the hours of
14.00 and Midnight: £100,809.22

2.31 WTE Band 3 Health Support Worker
working 7 days a week between the hours of
14.00 and Midnight: £60,358.27

Staffing total resource **£161,167.49**

Financial resource other:

Vehicle :
£4,000 Qty 1 Vauxhall Zafira people carrier, with privacy glass and annualised running costs (tax, insurance) for 12 months
£1500 fuel for above
£237 Qty 1 SRH Cradle Car Kit
£20 Qty 1 T Bar Radio Antenna
£17 Qty 1 Fist Mic
£160 Qty 1 Bury 9068 Blue Tooth Kit
£590 Qty 2 days Installation / Resource Costs. (Install of original S Max plus De Install and Re Install into new Zafira @ £295 per day)
Total : £6524

Hand Held :
£1116.20 Qty 2 SRH3900 GPS Radio including all Ancillaries @ £558.10 per radio
£450 Qty 1 Radio Battery Charger
£210 Qty 6 additional Batteries
Total : £1776.20

Security :
£650 Qty 1 CPNI Approved Airwave Radio Safe
£85 Qty 1 Safe Delivery
Total £735

Airwave Access Agreements Revenue:
£2628.32 Qty 2 per year @ £1314.16 each terminal per year
Total £2628.32 per year

Accessories:
£26.80 x4 duty belts
£7.18 First Aid vehicle kit
Total £33.98

Other financial costs **£11,697.50**

Margin	**£25930.00**
Total Costs for 12 month Pilot	**£198,795**

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

n/a

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Outcomes of the scheme are measured and/or to be measured through the following methods;

- Daily Police meetings are planned to support feedback and enable growth in the service
- The pilot will collect data following each Street Triage intervention, this will support the completion of the Department of Health's Incident Pro-forma (see below)
- Formal monthly data evaluation will be sent to all parties including the joint delivery group

Mental Health Triage Pilot Incident Pro-forma

Date of encounter	DD / MM / YYYY
Response officer time on incident prior to triage	HH / MM
Start time of triage involvement	HH / MM
Ref number for individual	
Location of encounter	

What type of issue lead to triage involvement
Nature of triage engagement

Gender of person encountered	
Age of person encountered Date of birth	DD / MM / YYYY
Ethnicity of person encountered	
What mental health issue triggered triage involvement? (tick as many as appropriate)	
First contact with triage car	*if unusual behaviour, please elaborate in open box below*
Action taken by triage	
Conveyed to **1st** place of safety by **If other**, please specify	
Detainee taken to	
Length of time detained in **1st** place of safety	HH / MM
If taken to **2nd** place of safety, conveyed by **If other**, please specify	
Detainee taken to	
Length of time detained in **2nd** place of safety	HH / MM

If taken to **3rd** place of safety, conveyed by **If other**, please specify	
Detainee taken to Length of time detained in **3rd** place of safety	HH / MM
Clinical assessment started within what length of time since start of encounter	HH / MM
End time of encounter	HH / MM
Previous conviction Known to mental health services Known to CAMHS Active care plan Open to services Previously detained under S136 Engagement with and uptake of services Subsequently sectioned under Mental Health Act Subsequent informal admission	
Please note any problems, obstacles, observations or other outcomes (Please capture here any feedback/user experience)	

What are the key success factors for implementation of this scheme?

A range of broad and recognised factors consistent with any programme delivery are recognised, such as addressing barriers to change and ensuring a clear structure and

approach for implementation.

Specifically related to findings in other Street Triage services and the National Pilot the defined scheme key success factors relate to;

- On-going provider engagement in delivery
- Allowing time (for model development and scale amongst other areas), in parallel with the evidence from other Street Triage schemes.
- Monitoring and adapting scheme delivery though real-time and scheme-sensitive metrics (recognising external influences such as population growth, demographic changes and other influences on change)
- To ensure sustainability of the scheme through on-going adaptation and learning

Data and Analysis

The service commenced operating on 10th October 2014.

It started off slow with only 39 interventions carried out in October.

In November there were 82 interventions.

At the end of the referral form there is a question asking officers what would they have done if Street triage had not been available, this question was only asked 47 times out of the 121 interventions however the comments highlight the impact the service is already having across pathways –

12 interventions stopped and ED attendance
6 interventions stopped an attendance into custody
24 interventions stopped a S136 detention
3 felt they would not have done anything but send the individual on their way
2 would have sought mental health advice.

The service receives regular positive feedback from officers, examples of these are –

Supportive, professionals who are able to relay correct clinical information about service users.
Enhancing the knowledge of response officers around mental health presentations,
Officers feel more confident around supporting regular repeat attenders.
Joint risk management allows previous detentions to be supported on different pathways.
Regular attendance to daily briefings and Force Control Rooms allow familiarity to the service which is demonstrated in the increased activity as the service has developed.
Scenario based examples shared in these meetings allow further learning and a better approach to individuals in a mental health crisis.

ANNEX 1E – Pathways Together

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
Pathways Together: York
What is the strategic objective of this scheme?
Objectives allied to the Better Care Fund priorities: - Empowerment of patients to lead their own care and design services to meet their needs - More integrated models of care and better data sharing across agencies - Ensure a joint approach to planning and care and that individuals have a named keyworker Reduction in emergency service use among target cohort - Reduction in preventable use of acute hospital beds among the target cohort - Better identification of mental health needs within emergency service responses - Improved and coordinated responses to mental distress and complex needs by emergency, primary and secondary care, and voluntary services - Increased confidence and competence among agencies coming into contact with individuals experiencing mental distress, in engaging and signposting individuals experiencing distress and complex needs, appropriately - Increased community engagement and access among the target cohort (eg into health, employment, informal networks of support, secondary care where appropriate) - Increased wellbeing, psychological and relationship resilience across the target cohort
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The Pathways project has attracted enough funding to be operational 7 days a week from the outset. It is intended that this service will be operational at least 8 hours a day and this will correspond with service user need and times correlated with high demand. Discussions around co-location have kept this at the forefront of decisions and we intend on co-locating with a service provider who is open ‘out of hours’, 7 days a week. The target cohorts will be: • Those experiencing distress at first contact with emergency services, or at risk of contact with emergency services, aiming to preventatively divert individuals into appropriate resources and strengthen networks, coping and relating skills before problems become entrenched, with referrals by GPs, ASB Units, Safer Neighbourhood Teams, Emergency Care Practitioners, A&E, and the Mental Health Street Triage Team • Those frequently in contact with emergency services who may have longstanding

difficulties, referred by Police, Ambulance, A&E, Fire, Psychiatric Liaison teams, and the Street Triage Team. Individuals experiencing distress in contact with emergency services will also be able to self-refer.

Although the target cohort are individuals with a diverse range of resources, difficulties and presentations, an example may be found in the case study given by the North Yorkshire Police, below.

*"Brian first came to attention reporting he had lost his wallet. His contact with the police steadily increased, coming to police attention 21 times to the end of 2011, either calling (*services) *himself to threaten self harm or suicide, (reporting the loss of his wallet a further three times), or being reported by other concerned people for behaviour including head butting walls and walking through the streets ranting.*

Brian was usually inebriated when making or being subject of these calls. In 2012 police received fifty reports from Brian stating that he was lonely, wanted a chat, or threatening self harm and suicide. A number of calls were received from other public services such as Ambulance, requesting police attendance at calls for help he had made to them.

Brian's number has been blocked by the Samaritans who have refused to deal with him due to the volume of calls he has made to them.

In 2013 Brian made 137 calls for police service, all similar in nature to those above. Many incidents involve multiple calls to the control room. Brian has already instigated 15 police incidents this year (again losing his wallet). Brian has been detained in police cells 5 times using S136 powers."

Classification	**Cost per incident***	**Number of incidents over 3 years**	**Estimated total cost over 3 years**
Ambulance	**£214**	**20**	**£4,280**
Police attendance (no further action)	**£35**	**30**	**£1,050**
Police – action taken	**£500**	**4**	**£2,000**
s.136 MHA in custody	**£2,500**	**5**	**£12,500**
Calls to call centre	**Unknown**	**241**	**Unknown**
A&E attendance	**£214**	**8**	**£1,712**
Alcohol dependence cost to NHS‡	**£1800**	**N/A**	**£5,400**
Employment and Support Allowance (ESA) per annum per individual‡	**£8,632**	**N/A**	**£25,896**
		Minimum total cost of emergency service use	**£21,542 (3 years) (£7, 180 per annum)**
***Marcus, Cox and Morris, [New Economy; 2013]**		**Minimum total cost (including ESA and NHS/ Alcohol)**	**47,438 (3 years) (15,812 per annum)**

The Pathways Together© approach was designed specifically to tackle mental distress in the context of 'complex or multiple needs', for example, people who have experienced mental distress alongside a range of other factors, such as trauma, intergenerational exclusion, drug and alcohol misuse, forensic histories and risks, homelessness and learning difficulties.

Frequently, a lengthy statutory service intervention is not actually what would be most helpful to this group. Our psychologically informed approach takes expertise in understanding of psychological processes and presentations, out of clinics and hospitals, applying it flexibly to people who may never access formal treatment settings, who may have multiple needs, or who may have numerous sub-threshold needs. We pay particular attention to the establishment and maintenance of relational safety[6], in order to effectively engage and support this group.[7] We provide agencies (such as police, mental health services, ambulance and homelessness services) and the people we support, with tools to understand and ameliorate entrenched problematic coping and relating styles – helping address the factors that keep people excluded from networks, communities and services. We use our knowledge to inform and develop interagency information-sharing, working and strategic planning.

We know from our own experience that, although painful, crisis, or times of deep distress, can be starting points for extraordinary journeys of growth, learning, change and discovery – with the right support. Because of this, we aim to facilitate journeys of learning and discovery, about self, others, internal processes, and the world, as well as supporting people to deal with practical problems. This emphasis on learning, planning, understanding and reflecting, is the vital component of our psychologically informed approach.

What is unique about the pathways approach?

- Aimed at people who experience mental distress alongside a range of needs (eg homelessness, substance misuse, relationship problems, worklessness and financial difficulties) that brings them into contact with emergency services and/or the criminal justice system, or leave them at risk of this contact.
- Skilled support workers lead and managed by a clinician (OT, psychotherapist, social worker, CPN, psychologist).
- Robust governance: monthly clinical supervision; clinician led model; on-going specialist consultation, ad vice and training from Together's award winning Criminal Justice Management Team.
- Specialist training in the unique therapeutic support approach.
- Underpinned by a 'learning' approach informed by therapeutic practice: it is as

6 The term 'relational safety' refers to:- I) recognition of the importance of relationships to individuals with significant emotional disturbance II) recognition of the potentially highly charged and challenging nature of relationships for many individuals who experience significant emotional disturbance; III) understanding that many individuals experiencing significant emotional disturbance have experienced relational traumas such as abuse or neglect, and that these experiences may inform future relationships, and understanding of how this may present; IV) using the support relationship as a primary tool to support individuals to repair trust, hope, emotional regulation, and agency, which may include using warmth, nurturance, playfulness, laughter, firmness, setting and reflecting on limits and boundaries, self-disclosure [c.f Young, 2003; 177].

7 The need for attention to relationships is well established for groups deemed by agencies traditionally challenging: for example, NOMS 'Segmentation: Needs and Evidence Tables for Commissioning 2013-14' [November 2012] finds 'positive staff interactions and pro-social modelling' to be the only evidence-based criminal justice intervention reliable for every offence, and every level of risk of harm and reoffending.

important for our workers and the people they support, to *learn about problems, what makes them worse and what makes them better,* as it is to tackle the problems themselves.

- Wholly person-centred – tackling individuals' identified 3 biggest problems on the basis that by alleviating the hardest things, the 'crisis' element of the individual's experience will be eliminated – while not institutionalising people by continuing to offer generic support indefinitely.
- Flexible discharges – as part of road mapping discharge, the service and the client will agree to proactively check in at agreed intervals to ensure things are going smoothly and problems are troubleshot before they become crises.
- Identifying and addressing not just the symptom of the problem (worklessness, distress, homelessness, financial distress) but the causes of problems, for example – relating difficulties, problems managing anger, assertiveness, complex family situations).
- Uses the 'Three Hardest Things' tool – a therapeutic support tool that names the 3 biggest problems explicitly, while reorientating individuals towards values and goals, and identifies and uses individuals' own motivation to effect positive psychosocial change.
- Road mapping discharge: document that tracks what the problem was, what caused the problem, what skills the person will bring to the problem in future, how the person will know if the problem is re-emerging, and what to do about it.
- Services designed in consultation with the people who use them – and people who use the services collaborate at continuous development and improvement at every level – during key working sessions, attending team meetings, and sitting on or attending Strategic Boards, whichever they prefer.
- Sees the person within the context of their network – learns from Multisystemic approaches by shadowing and building links with local teams, while applying the learning to young adults and adults.

Our unique approach blends rigorous interagency and intercommissioning strategic governance with robust clinical governance, to target the 5 key factors in inadequate responses to 'complex' individuals, resulting in costly use of emergency services and preventable crises becoming acute, severe, chronic and intergenerational.

i) 'Individual has too many needs' / 'Individuals' needs lie outside service criteria'

- Practical support based on each individual's identified '3 Hardest Things' – unique triggers of individuals' unique crisis; working with and strengthening individuals' own motivation holistically
- Support not simply based on triaging into services, but also up skilling individuals and families to manage their own wellbeing and relationships – in line with individuals' own priorities.
- Facilitating community reintegration and reducing distress and risks through activities such as increasing uptake of education, training and employment; increasing and building family and friendship links, engagement with drug or alcohol treatment.

ii) 'Individual does not meet criteria for secondary care services'/ individuals unable to access services to which they are entitled

- Clinical expertise to identify and triage needs appropriately
- Strategic partnerships (eg with mental health trusts and police) that facilitate

pathways into appropriate services

iii) 'Individual does not engage'

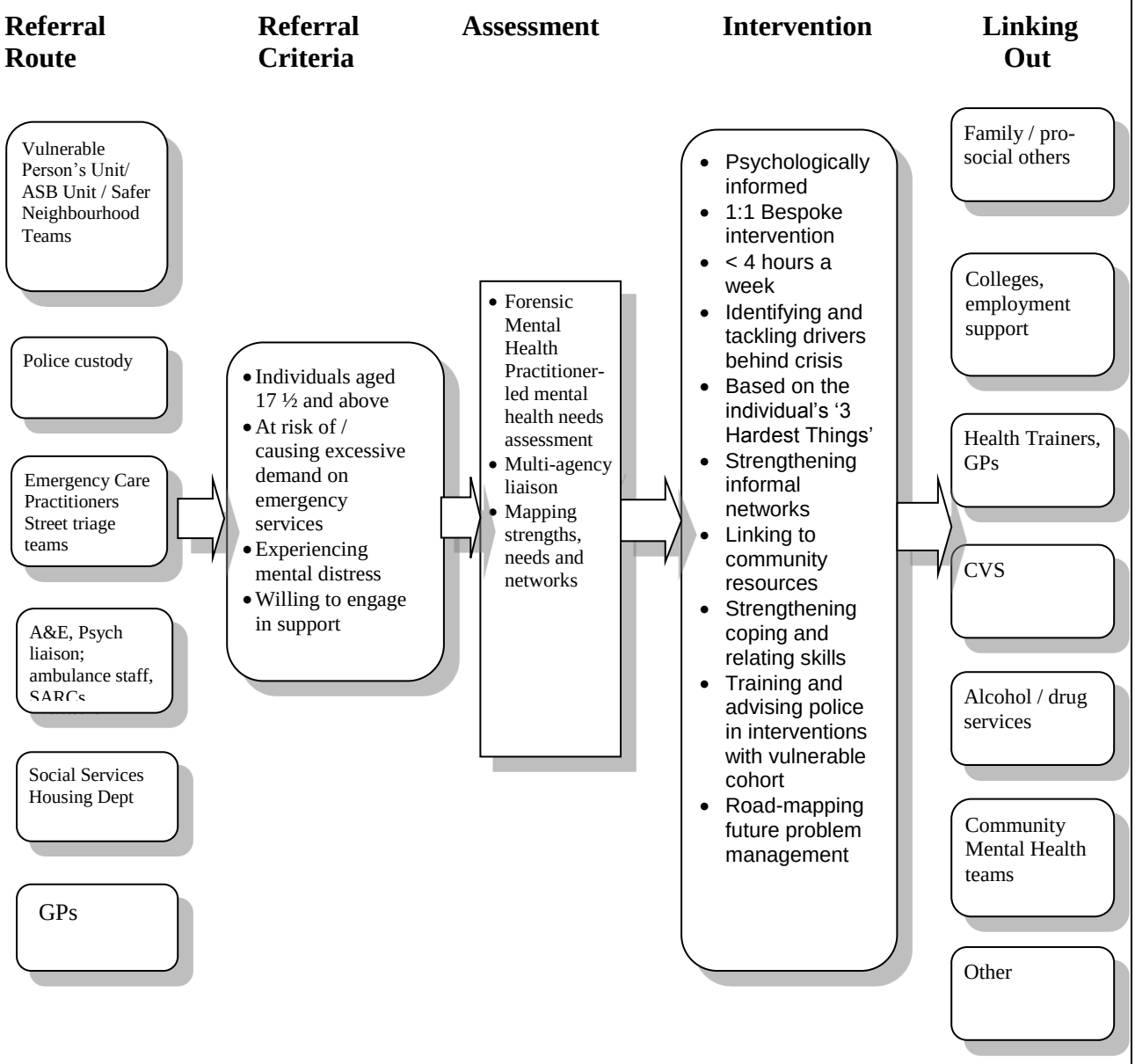
- Psychologically informed approach
- Use of individuals' own motivation to elicit change
- Blending psychological interventions with practical support
- Clinical supervision facilitates practitioners' continual reflective practice, so practitioners continue to intervene with individuals holistically, from a resource, resilience and responsibility-based perspective.
- Relationship, network and carer interventions: Working with and understanding the whole network around the individual, working with individuals and their networks to maintain more effective and prosocial relationships.
- Psychological Interventions: Developing resilience, confidence and competence in emotional regulation, interpersonal effectiveness, managing anger and mood management, so that, having been linked into community resources and networks, individuals have skills emotional regulation, mood management and relationships that will enable them to maintain these links.
- Traditional 'non engagement' behaviour (eg non-attendance, lying, challenging behaviours) used as service feedback, individuals are supported to articulate these verbally rather than behaviourally, and this feedback used to develop and improve systems, service and intervention.

iv) Services lack expertise in understanding and engaging the individual and therefore individuals 'fall out' of services

- Up skilling professionals around the individual: Increasing understanding and effective working with this group across agencies, through providing assessment, training and case consultation around the mental health needs and effective engagement of this client group.

v) **Because individuals' needs fall into a range of categories (eg drugs, alcohol, mental health, housing, family, employment) and services and systems are designed to meet single, acute, severe needs (eg mental health), individuals' needs are neither holistically captured nor met, resulting in repeat presentations, worsening health outcomes, and lack of awareness.**

- Increased interagency and intercommissioning liaison, collaboration, planning and information sharing for this group, through Senior Project Board, comprised of senior decision makers within agencies including Police, Mental Health Trusts, CCG, and Healthwatch, providing strategic and project oversight.
- Working within the Better Care Fund structures, oversight by Joint Delivery Group
- Using demographic information from Project Evaluation and monitoring data to inform the Strategic Board
- Use of service users' feedback to inform systems and system change, including through attendance at Strategic Board meetings and in trainings.
- Use of strategic governance to feed into system development and inform commissioning and interagency liaison and planning.
- Increasing data sharing through sharing best practice from achievements within other areas, engaging in existing multiagency forums, and through the use of the Strategic Board.



The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The CCG will act as the commissioners of the service with additional funding from the Better Care Fund and Lankelly Chase (external grant giving organisation). Additional referring agencies and partners are detailed below:

- North Yorkshire Police (NYP)
- City of York Council including the anti-social behavioural hub
- Yorkshire Ambulance Service
- Leeds and York Partnership NHS Foundation Trust (LYPFT)
- North Yorkshire Fire and Rescue Service (NYFRS)

- Priory Medical Group
- York Centre for Voluntary Service
- York Healthwatch

All the above stakeholders have been invited to join the Strategic Board.

- Increased interagency and intercommissioning liaison, collaboration, planning and information sharing for this group, through Senior Project Board, comprised of senior decision makers within agencies including Police, Mental Health Trusts, CCG, and Healthwatch, providing strategic and project oversight.
- Working within the Better Care Fund structures, oversight by Joint Delivery Group
- Using demographic information from Project Evaluation and monitoring data to inform the Strategic Board
- Use of service users' feedback to inform systems and system change, including through attendance at Strategic Board meetings and in trainings.
- Use of strategic governance to feed into system development and inform commissioning and interagency liaison and planning.
- Increasing data sharing through sharing best practice from achievements within other areas, engaging in existing multiagency forums, and through the use of the Strategic Board.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

In a study describing care and support for people who experience complex needs, The Journal of Integrated Care [2009] notes the importance of both '*highly individualised solutions*', and '*interventions which maximise individuals' opportunities for exercising control'* [8: 2009; Henwood and Hudson]. They note that '*much assessment and care planning remains deficit-based and focused on what people are unable to do rather than understanding individuals with a range of strengths and qualities*'. Moreover, a '*model that focuses on individual pathology…does not always provide the best foundation for longer-term, non-acute conditions, or for promoting social inclusion.*'

While highly individualised solutions, which maximise opportunities for exercising control, and view people from a resource, responsibility and resilience-based perspective, should be the blueprint for all interventions, too often this approach is lost when it comes to those who are experiencing the most complex difficulties, because staff and agencies encountering people who experience multiple or entrenched difficulties can start to feel inadequately resourced, helpless, de-skilled or impatient [Journal for Integrated Care [2009]. At these times, people 'fall out' of services (seen in the case study).

The project has consulted with a number of key stakeholders in the development of this bid to-date, including :

- head of Mental Health Crisis and Street Triage services in York
- lead consultant for York A&E
- mental health lead for the Yorkshire Ambulance Service
- a service-user whose case is detailed below ("Anne")
- City of York Council

- The Priory GP surgeries
- Healthwatch
- Ark light

Identified needs include:-

The North Yorkshire Police note from a desktop analysis of mental health recording in police callouts that 2/3 of incidents recording self harm and suicide did not flag mental health as a factor in the callout, indicating a low level of confidence and awareness in identification and response.
Healthwatch notes the need for 'initial support for anyone that's experiencing issues, before problems become acute or severe', alongside 'support for people who have more complex issues. People don't understand being told they do not qualify for services although they are absolutely desperate. The system is not sufficiently resourced to give people help when they need it so crises occur.'
The Priory Group GPs note a need for interventions ' which will not turn people away because they do not meet service criteria, even though they are really distressed and struggling.'
The lead consultant for York A&E notes, "Historically the ED (A&E) staff often struggle to provide patients with mental health problems with appropriate care which leads to a feeling of frustration for the patient and helplessness / failure for the staff. The problem is addressing the Mental Health care needs of those that tend to fall in between agency support and the ED staff's feeling that there is 'nothing out there' that we can realistically offer the patient: that is where this proposal will help."
One high-volume service-user consulted during the development of the proposal ("Anne") stated: "You don't just fall into crisis and then when 'the immediate crisis [e.g. Section 136, A&E] is over, everything's OK. When services just stop once the crisis is over, you're back there. Back in whatever it was that put you in crisis in the first place. Nothing's changed. You've taken time getting into crisis and it takes time and support to move on. You've got real problems. And if you don't get help to address the underlying problems, you'll be back there. Everyone's unique. And everyone needs a unique approach to get better."
Stakeholders have expressed willingness to support and contribute to the project in a range of ways: offering views and feedback to support development, sitting on the project Strategic Board, or contribution of resources such as office space or mutual agency collaboration and learning.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

This scheme is funded through both the North Yorkshire and the York Better Care Fund.
Funding 14/15 £50k to also include set up costs
15/16 £50k

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme underpins the other BCF schemes and is closely aligned with the Street Triage Scheme therefore the benefits have not been shown separately to avoid possible

double counting of benefits.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

We use a range of outcome measures, Data is collated and disseminated quarterly for our commissioners and key Strategic partners.

- Together's Assessment and Outcome Measure, which is used in all interventions, at treatment start, review and discharge, which measures psychosocial wellbeing, coping, relating, hopefulness, and mood, as well as intermediate factors leading to offending.
- Together's Network and Carers measure, which audits confidence and wellbeing among carers and networks where involved
- Information will feed into monthly team meetings, and into the quarterly Strategic Board via monthly Evaluation and Monitoring returns, and narrative reports, and summaries of this information will be escalated to the Delivery Group (comprised of senior membership from Health, Police, the CCG, the HWB, the Local Authority etc).
- The cost benefit analysis will also be used to measure the impact on service users' lives through analysing changing patterns of emergency service use.
- Key participants at the Strategic Board will be able to use the forum to monitor and report on impacts on services (eg Police, A&E) as a consequence of the Project, and to advise ameliorative action where required.
- Service users' feedback will also be gleaned through a variety of mechanisms unique to the Pathways Approach©. Our approach to feedback is that it is vital to shape our service, and supporting individuals to feedback verbally rather than through challenging or offending behaviours, is an essential component of our work.
- Service users will attend the Strategic Board and input directly to training.
- Service user feedback will be gleaned through key working sessions, discharge and feedback questionnaires, and, most importantly for this client group, non-verbal (challenging behaviour, lying, disengagement) and demographic feedback (eg which populations are not accessing the service, or disengage quickly) will be used to continuously shape service delivery and interventions. For example, For example, a Pathways service user became verbally aggressive at the end of an assessment when the worker tried to forward plan. The incident was explored in supervision, and a decision taken to cease forward planning and spend more time taking pleasure in building mutual interaction before moving forward, with good effect. This was brought to the team meeting, reflected on in correlation with other disengagements, and used as a valuable lesson in slowing down and practising acceptance of the people we support in a variety of ways, before moving towards practical goals. This lesson exponentially increased positive engagement across our cohort of usually deemed 'hard-to-reach'. We fed back to the individual what we had learned from him and reflected on what had happened together, empowering the individual to articulate his values and concerns explicitly (verbally) rather than implicitly (through aggression). The individual has subsequently advised the Strategic Board.

What are the key success factors for implementation of this scheme?

Resulting in positive change for service users

Together: York will use the activities and service model, working closely with partners in

health, the voluntary sector and police described above, to achieve this.

Success will be measured through:

- Together's Assessment and Outcome Measure, which is used in all interventions, at treatment start, review and discharge, which measures psychosocial wellbeing as well as intermediate factors leading to offending
- Together's Network and Carers measure, which audits confidence and wellbeing among carers and networks where involved
- Information will feed into monthly team meetings, and into the quarterly Strategic Board via monthly Evaluation and Monitoring returns, and narrative reports, and summaries of this information will be escalated to the Delivery Group (comprised of senior membership from Health, Police, the CCG, the HWB, the Local Authority etc).
- The cost benefit analysis will also be used to measure the impact on service users' lives through analysing changing patterns of emergency service use.
- Service users' feedback will also be gleaned through a variety of mechanisms (described below).

Involving service-users and being service-user led. Supporting involvement in different ways, at different levels and times.

Principle monitoring mechanisms are:

- Monthly monitoring and evaluation;
- Together's internal auditing and business planning processes.
- The Strategic Board (comprised of Police, local authority, mental health trust, the Yorkshire Ambulance Service (TBC)), and Together: for Mental Wellbeing;
- The Joint Delivery Group.

Service user input will be collated on a monthly basis as part of service evaluation and monitoring. Service users' ideas, feedback and suggestions will be reviewed and monitored by the Project Strategic Board with recommendations for service development incorporated and reviewed on a quarterly basis. Service users will sit on the Project Strategic Board and help to hold the project accountable for its involvement and leadership, as well as for its vision of truly meeting needs responsively. This information feeds into wider business planning and staff appraisals and is reviewed by Together's Head of Criminal Justice Services, helping to feed into Together's wider Criminal Justice Strategy. The Joint Delivery Group will ultimately hold the project to account locally for meeting its aims and objectives with regards service user involvement and leadership.

Remaining strategically and locally relevant.

Principle monitoring and measurement tools are:

- Independent cost benefit analysis of service efficacy to determine impact on cohort and wider local community, and the strategic viability of service intervention for this cohort
- Together's wider organisational business planning objectives and review processes
- Annual stakeholder questionnaires as to where the service is performing well and

how it can be improved, which feed into the Strategic Board and Delivery Group described above

- Service Level Agreements between key partners (e.g. police and health) and quarterly meetings to review joint relationships
- Local and national funders' individual contract monitoring processes.

The cost benefit analysis will identify whether the service has had an impact on local pressures and difficulties and this information will feed into funders and local community planning. Demographical data is collected on a monthly basis within Evaluation and Monitoring processes held in Together. This information, and stakeholder feedback, will be shared and reviewed by the Strategic Board and delivery group and this will be compared with local demographical data (eg found in the JSNA) and action taken to address issues where required. Project data including stakeholder feedback, is reviewed by project managers within Together and is ultimately accountable to service directors. This information feeds into both business and project planning and into individual staff appraisals. Service level agreements and regular review meetings with key partners such as the police and health will ensure that issues arising will be identified and managed within a structured relationship.

ANNEX 1F – Psychiatric Liaison

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
Psychiatric Liaison – Emergency Department Liaison Service
What is the strategic objective of this scheme?

Strategic objective:

To provide a 24/7 Psychiatric Liaison service within the Emergency Department (ED) at York Hospital to manage patients presenting with psychiatric requirements safely and effectively.

Strategic Aims:

1. To provide rapid bio-psychosocial and risk assessment of individuals who present to the ED with deliberate self-harm and acute mental health problems.

2. To collaborate with York Teaching Hospital Foundation Trust (YTHFT) colleagues to facilitate prompt assessment avoiding duplicate contacts ensuring fluent and timely progression through the care pathway.

3. To screen referrals and prioritise them according to urgency.

4. To provide an advocacy role for the service user and carers within the general hospital.

5. Discussing treatment and management options with the service user and safely signposting them to the most appropriate service(s) to meet their individual needs.

6. To facilitate prompt access to mental health intervention for those individuals who have an identified mental illness working closely with the acute care pathway to access in-patient psychiatric admission and intensive community services.

7. To facilitate prompt access to appropriate physical health/emergency intervention for service users where it is identified they have compromised their physical health.

8. To liaise with other services in York, including GP's and primary care workers, community mental health teams, specialist mental health teams, addiction services, crisis services and voluntary organisations.

9. To provide a resource to general hospital colleagues for information and advice on mental health issues.

10. To positively promote mental health in York Hospital.

11. To collaborate with YTHFT in adhering to the Emergency Care standard and auditing adherence outcomes against targets.

12. To provide education and training to the ED with specific objectives to :

    - Promote an understanding of the roles of mental health services in York and the

roles of mental health services that interface with York Hospital.
- Promote an understanding of common mental health problems and the nature of psychosocial crisis and distress.
- Promote an understanding of suicidal ideation and behaviour and self-harm in the context of tension relief.
- Provide an insight into mental health risk assessment and risk management.
- Develop communication skills within the ED in asking questions pertaining to an individual's mental health.
- Develop skills in identifying mental health problems in service users who may have presented with a physical disorder.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

Individuals attend the ED of York Hospital with mental health difficulties and following acts of self-harm. They present with a diverse range of issues and presentation. The Emergency Department Liaison Service (EDLS) team will provide a comprehensive bio-psychosocial assessment.

The EDLS will work in close collaboration with YTHFT on building established working relationships through the Crisis and Access Service (CAS) and link into wider mental health services provided by Leeds and York Partnership Foundation Trust (LYFPT) as the gatekeepers of the mental health acute care pathway.

This interface is seamless in respect of shared assessment format. To manage the transition in implementing the ED service, staff from the CAS will be rotated into the EDLS team. This is to optimise the clinical expertise of the ED team and support the induction of the newly appointed staff.

Service users will be provided with a thorough bio-psychosocial assessment. This assessment should take place within three hours of arriving in the ED of York Hospital for the initial six months of the service. From 1 April 2015 the assessment should take place within two hours. Once their assessment is completed, they will be signposted to the most appropriate service to manage their current mental health and bio-psychosocial difficulties.

There will be an improved patient experience through the ambulatory care pathway for service users with a mental health difficulty or following an episode of self-harm.

Service user groups covered

The service provides mental health and self-harm assessment to individuals age 18 and over who present to the ED department of York Hospital. Service users with mild to moderate learning difficulties can access the services if it is thought that they may benefit from doing so. It may be necessary, to work jointly with Learning Disability or Adult Mental Health Services, on occasions to ensure the best outcomes for the service user.

Exclusion criteria

- Service users under the influence of alcohol or illicit substances should be referred when sober enough to effectively and safely engage in the assessment process. The EDLS team should be informed of these service users at the earliest appropriate time to allow planning of the assessment at the earliest opportunity.
- Service users who are not medically fit for assessment.
- Service users detained under Section 136 of the Mental Health Act.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The driver to provide the EDLS is to improve the quality of service to people who present to the ED with mental health problems, and to reduce the number of admissions to the Acute Medical Unit (AMU) within York Hospital.

From April 2013 – February 2014 there were 1,057 mental health attendance (based on a primary diagnosis of anxiety, bipolar affective disorder, depression, overdose, personality disorder, psychiatric/behavioural, psychosis or schizophrenia).

14% of these attendances breached the 4 hour target, suggesting that mental health related attendances are more likely to breach than attendances for a physical health problem. We expect the rate of ED breaches for patients with a mental health need to reduce as a result of this service.

The table below shows the volumes and costs of non-elective admissions to York Hospital in 2013/14 relating to serious and enduring mental illnesses (SMIs), common mental health disorders (CMDs) and self-harm admissions:

Category	Primary Diagnosis Spells	Final £	Secondary Diagnosis Spells	Final £	Total Spells	Total Final £
SMIs	56	£101,394	261	£422,970	317	£524,364
CMDs	61	£121,197	1,010	£1,961,674	1,071	£2,082,871
Self Harm	767	£445,710	143	£345,244	910	£790,954
Grand Total	**884**	**£668,301**	**1,414**	**£2,729,888**	**2,298**	**£3,398,189**

It is anticipated that these figures will fall as a result of the introduction of the EDLS.

The EDLS will be operational 24/7 seven days a week providing a mental health assessment to the ED department. The target group are service users who have presented with self-harm and acute medical management and interventions are not indicated. It is also anticipated that the service model will provide more timely assessment of those admitted to medical inpatient area of York Hospital, a consequence of which will be a reduced length of stay.

The EDLS will advise YTHFT colleagues on the management of individuals with mental health difficulties who frequently present to the ED. This, where appropriate, will include working with both LYPFT and YTHFT colleagues to devise individually tailored care plans, for implementation to the ED. This is aimed at supporting this group of service users with a consistent approach.

These individuals could be suffering from the range of mental health conditions, commonly described as common mental health disorders and serious mental illnesses. Effective liaison has been shown to be successful in significantly reducing repeat attendances from individuals within these groups by promptly signposting patients to the most appropriate services. Evidence and data will be recorded to ensure the EDLS is meeting the needs of these groups.

The EDLS, as part of CAS, will have well established relationships with a range of community services including home treatment, Community Mental Health Teams (CMHTs) and Section 136 services. They also regularly link with and refer to Social Services, GPs and other voluntary and

statutory services, including housing, employment and education agencies.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The report '*Managing Urgent Health Care In The Acute Trust'*, 2008, is a guide developed by practitioners for managers and commissioners in England and Wales. This report was prepared by the Royal College of Psychiatrists, working in partnership with representatives from the Royal College of Physicians of London, the Royal College of Nursing and the College of Emergency Medicine.

The executive summary highlights that the current provision of mental health services to people attending the emergency departments of general hospitals are extremely variable across the country. These departments have high levels of activity and encounter some of the most seriously ill people at greatest risk. The summary describes this variability in service provision situation as unacceptable.

The summary of the report recommends that liaison services should coordinate the front line responses for psychiatric support to the emergency department and acute wards. This would mean acute trusts working in partnership with mental health services to provide 24/7 services.

This report and the report '*High Quality for all'*, (Department of Health, 2008) both send a strong message about developing care pathways that are easily accessible, and provide timely assessment and high quality care. This translates into a clear single point of access for emergency department staff to refer to mental health services 24/7, seven days a week.

This is also supported within the document '*Healthy Ambitions'* (NHS Yorkshire and Humber) describing of critical importance is single point of access to services which are accessible 24/7.

The need for mental health nurses in emergency departments (ED) is highlighted in the Royal College of Psychiatrists and the British Association for Accident and Emergency Medicine report *CR118* (February 2004). This report recommends that '…mental health nurses should provide the first point of contact from mental health services. Where such professionals are employed they generally develop a close working relationship with the A&E department, and have a role in training and staff support.'

The *National Service Framework for Mental Health* (Department of Health 1999) does acknowledge that EDs can make a valuable contribution when providing access to mental health services particularly for service users who have self-harmed, rough sleepers and those who have not registered with a GP.

The RAID model, first introduced into the City Hospital, Birmingham, has shown the benefits of incorporating psychiatric liaison into a general hospital setting. The service offers consultation and liaison to the ED, the medical assessment unit and the medical maternity and surgical wards with response targets of 1 hour for the ED and 24 hours for inpatients. RAID builds on existing liaison services adding health and social care capacity to the liaison team plus specialist skills in older adults and addictions – as such it is a complete, all age mental health service with an acute trust. As there has been no Psychiatric Liaison service in Vale of York the RAID model is a long term aspirational goal and this initial scheme is part of the pathway to progress to this.

The London School of Economics have recently published an independent economic evaluation of this service, based mainly on a critical scrutiny and re-analysis of data collected by the hospital. The publication concludes that the service generates significant cost savings and is

excellent value for money. The incremental cost was £0.8m versus the incremental benefit, based on conservative assumptions, of £3.55m. These savings relate to a reduction in acute in-patient bed days in terms of reductions in length of stay (LOS) (1.5m), admission avoidance (0.3m) and reduction in readmissions (1.5m). LOS cost savings are derived from annual bed day savings multiplied by the cost of a bed day, purported to be £200.

Admission avoidance and readmission savings multiply the avoided admissions by the marginal rate of an acute admission. The savings are therefore both provider and commissioner related and the London School of Economics report has demonstrated that it can achieve the following outcomes, over and above traditional liaison services:

- Reduce admissions, leading to a reduction in daily bed requirement
- Reduce discharges to institutional care for elderly people by 50%
- Produce a cost-to-return ratio of £1 to £4
- Good service user feedback on holistic care in acute settings
- Staff feedback of improved confidence and capacity in managing service users with mental health issues with improved staff morale
- Waiting times for service users time in A & E has reduced by 70%

The Emergency Department Liaison Service pilot will be used to inform the development of a future psychiatric liaison service. It is envisaged that the service will eventually form part of the wider mental health contracts held by Vale of York CCG if successful at this stage.

References and an evidence-base being used to inform the model and above statements are highlighted below.

References

Applicable national standards (e.g. NICE)

- NICE CG16. *Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care*

Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- RCPsych report, CR158, 2010: *Self-harm, suicide and risk: helping people who self-harm*
- CEM report 6883, 2013, *Mental health in Emergency Department*

Associated policy documents

- Department of Health (2012) *Preventing suicide in England – a cross-government outcomes strategy to save lives*.
- Department of Health (2011) *No health without mental health: a cross-government mental health outcomes strategy for people of all ages*.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

North Yorkshire BCF and York BCF are each providing £25,000 to fund the pilot in 2014/15. 15/16 to be part of the new mental health tender.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

It is anticipated that the EDLS will improve the level of service provided to patients presenting to ED with a mental health need, and reduce the proportion of patients that breach the 4 hour ED target from this cohort.

When the service is fully running we expect it, in conjunction with the other BCF schemes, to enable more efficient management of patients with a mental health need, providing effective alternatives to ED attendances and in-patient admissions.

This scheme is a whole system enabler and is supporting the BCF schemes, therefore no benefits have been specifically identified against this scheme. It is anticipated that as part of the mental health tender in 15/16 this service will be embedded.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The service is being launched in a phased approach, and the first shifts were introduced into the Emergency Department of York Hospital in October 2014.

Outcomes of the scheme are measured and/or to be measured through the following methods;

- Regular informal discussion between stakeholders from the three main organisations: LYPFT, YTHFT and Vale of York CCG.
- Formal monthly data evaluation using agreed metrics against agreed KPI's, reported to main stakeholders and the Partnership Commissioning Unit.
- Formal evaluation through an academic partner currently being developed for formal, mixed methods (quantitative and qualitative) evaluation to understand what is working well, staff and service user evaluation, evidence that could inform development and evaluation of impact.

What are the key success factors for implementation of this scheme?

NHS Outcomes Framework Domains & Indicators:

Domain 4	Ensuring people have a positive experience of care	X
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	X

Reporting specific to this scheme:

Info id	Information to be reported	Frequency of reporting
1.	Number of people referred to EDLS	Monthly
2.	Number of people assessed by EDLS	Monthly
3.	Time taken from booking into ED reception to referral to EDLS	Monthly
4.	a) Number of people assessed by EDLS within the set target. b) Number of people assessed by EDLS outside of the set target. When the target has been missed, reasons should be recorded.	Monthly
5.	Number of EDLS assessments delayed because the service user was intoxicated from alcohol or illicit substance misuse	Monthly

6.	Number of people assessed requiring MHA assessment	Monthly
7.	Number of people referred to EDLS who meet the 4 hour ED target	Monthly
8.	Number of people referred who self-discharge prior to assessment	Monthly
9.	Number of people assessed who self-discharge prior to completion of EDLS involvement	Monthly
10.	Destination following assessment and treatment. Number of people assessed who are: ▪ Admitted to AMU ▪ Admitted to inpatient bed within York Hospital ▪ Admitted to inpatient bed within LYPFT ▪ Referred to community based MH services ▪ Referred to primary care ▪ Discharged back home ▪ Self-discharge	Monthly
11.	Number of patients who attend community based mental health services when referred from ED	Monthly
12.	Length of stay for patients: ▪ Admitted to AMU ▪ Admitted to inpatient bed within York Hospital	Monthly
13.	Number and % of re-attendance within: ▪ 7 days ▪ 28 days	Monthly
14.	Number of ED staff who have received appropriate training to equip them to understand and care for people who have self-harmed or who present with mental health needs	Monthly
15.	Service User Experience data	TBC
16.	Staff experience data	TBC

Key performance indicators (KPI)

KPIs should be reported on a monthly basis from the full launch of the pilot service. Levies as a consequence of a breach will not be enforced for the first 6 months of the pilot.

KPI id	Requirement	Threshold	Method of measurement*	Trust responsible
1.	% of appropriate patients being referred to the EDLS team within target	Target is 2 hours between 1st Oct 2014 – 31st Mar 2015, and 1 hour between 1st Apr – 30th Sep 2015	N – number of patients referred to EDLS team within 1 hour D – number of patients referred to EDLS team	YTHFT
2.	% of EDLS assessments carried out within target	Target is 3 hours between 1st Oct 2014 – 31st Mar 2015, and 2 hours between 1st Apr – 30th Sep 2015	N- number of EDLS assessments carried out within target D – number of EDLS assessments carried out	LYPFT

	3.	Reduction in the % of patients attending the ED with a mental health (MH) problem, who breach the 4 hour target	Use Q1 data to set baseline *Current breach is 14%*	N – number of patients who attend ED with MH problem and meet 4 hour target D - number of patients who attend ED with MH problem	To be established	
	4.	% of patients who attend when referred to community based MH services (CMS)	Use Q1 data to set baseline	N - number of patients referred to CMS, and attend services D - number of patients referred to CMS	LYPFT	
	5.	Reduce the number of patients who re-attend to EDLS within 28 days of previous attendance	Use Q1 data to set baseline	To be agreed	LYPFT	
	6.	Increase levels of service user satisfaction	Use Q1& Q2 data to set baseline	To be agreed	LYPFT	
	7.	Increase levels of staff satisfaction TBC	Use pre service evaluation to set baseline	To be agreed	LYPFT	

ANNEX 1G – Sitting & Crisis Hours Service

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name:
Sitting & Crisis Hours Service
What is the strategic objective of this scheme?
To prevent unnecessary conveyance to hospital of York residents who are assessed by ambulance service personnel, UCP's, the Lifting Service, the social care out-of-hours emergency duty team *or* GP's as not being fit to be left on their own immediately after a crisis, e.g. a bad fall, but do not have a medical need to be conveyed to hospital and admitted, as well as supporting other elements of the transitional care and support pathway such as the RATS & hospital discharge teams to ensure there is always care available to get people home safely, and to provide a strictly time limited (72 hours maximum) domiciliary support service providing adult social care as necessary.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
It is widely accepted that many people are conveyed to hospital or subject to a GP referral for admission, because, immediately following a crisis it is not safe to leave that person, (usually a frail older person), on their own however, often, there is no service to which such individuals can be referred and therefore they are admitted to hospital. This service would be part of a coordinated and integrated transitional care and support pathway to provide a rapid response care and support offer to those in crisis in their own homes but who do not have a medical need to be conveyed/admitted to hospital. Referrals would be taken by the sitting and crisis hours service control room and sitters/ carers dispatched within a target response time of 1 hour. They would then either sit with the person until 8 am in the morning, for an overnight call, or for up to 6 hours for a daytime call-out, or they will offer an appropriate number of visits to provide care and support over a period of up to 72 hours. The tasks that the sitter or care provider carried out would vary in response to individual need but as a core would comprise one or more of the following: • Reassurance • Assistance with hydration and nutrition • Support with hygiene • Personal care provision • Making contact with family/friends • Providing a comprehensive list of key phone numbers they might need in the future, including all local alternatives to 999. • Advice with regard to maintaining safety

There is a commitment between health and social care to work this scheme up in more detail over the coming weeks.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This would be an NHS commissioned service provided by the existing provider of out of hours response services as well as an appropriate registered domiciliary provider agency..

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

This service forms a part of a wider system of interlinked schemes to deliver a transitional care and support pathway from low level prevention and early intervention, to more specialised and intense services designed to prevent hospital admission, coupled with a joint reablement and support offer to engage with those coming out of hospital or recovering from an illness, accident or fall etc. There will be a very strong links with services such as Urgent Care Practitioners and the Care Hubs. This is due to the fact that when an individual is seen by a UCP following a fall, and the UCP feels the person, although medically stable is not quite ready to be left alone, then the UCP can call on the sitting or crisis hours service (depending on the level of need) to provide support, care and reassurance etc. There is evidence that an integrated approach to prevention and re-ablement can significantly improve the health and wellbeing of the person accessing the services.

http://www.scie.org.uk/publications/guides/guide49/ from the Social Care Institute of Excellence (SCIE) gives an overview of the benefits of reablement & early interventions in social care..

https://www.nice.org.uk/guidance/cg161/chapter/1-recommendations lays out NICE guidelines on falls prevention and management in older people.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf Outlines the Care Act 2014 and the duty of Local Authorities and their health partners to Prevent, Delay and Reduce the need for on-going care and support.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Cost:

Sitting & Crisis Hours Service	
Sitting Service	£70,000
Crisis Response Service	£94,000
Total	**£164,000**

Benefit:

Sitting & Crisis Hours Service Benefits			
Area of activity	**Number reduced by**	**Unit cost**	**Total**
Ambulance Conveyance	500	£154	£77,000
ED Attendances	500	£109	£54,500
Non Elective Admissions	350	£447	£156,450
	Total Savings for Scheme		**£287,950**

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

A small team of sitters would need to be recruited by "Be Independent". Payment would be on a "per episode" basis. There would also need to be a dedicated care response team employed by the domiciliary care agency provider who takes on the "crisis hours" element of the service. There would be an expectation that the care agency would need at least some of the care hours guaranteed to ensure that there is care staff time available when required.

Be Independent would recruit a team of relief staff who would agree to be called at short notice to provide overnight or short term support. These staff would only be paid as and when they were called to work.

The outcome that we would seek is to ensure elderly customers who have suffered a fall or experienced a similar episode at home to have access to low level reassurance and support to help them regain their confidence at home.

The provision of information regarding services to contact rather than the NHS services will also reduce the pressure on out of hours GP services and the ambulance service.

The deliverable benefits of this scheme include at least 1 non elective acute admission per day (365 annually).

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

To ensure that the outcomes of this service are actually helping to reduce the need for admissions to acute and short term residential/ nursing care, we will agree a complete suite of management monitoring data that will include, but not be limited to:

- Details of service users (Name, Address, Date of Birth, NHS No)
- Dates & times of activations.
- No & type of service activations (i.e. sitting or crisis hours).
- Amount of hours used per incident
- Referral source
- Presenting needs
- No of staff employed on each incident
- Outcome at the end of service

- Referrals onto which other services

What are the key success factors for implementation of this scheme?

Clear eligibility criteria.

Awareness of all referrers of the service and how to access it.

Good coordination between ambulance control room/social care out-of ours service/GP out of hours service, Be Independent control room out-of-hours & care providers supervisors/ managers..

Good coordination between proposed new single point of access, “Crisis Hours” care provider(s) and Be Independent control room in normal daytime hours.

Clarity about 7-day working arrangements.

Very clear arrangements for liaison with social care to ensure that assessment can be prioritised for any of these residents who appear to be in need of on-going social care, including those not currently in receipt of such care.

Further reduction in the number of non- elective admissions to acute care. An increase in number of people who can have their presenting crisis dealt with by an early intervention with long term social & health care &/or support either prevented all together, delayed or reduced.

Demand management processes to ensure scheme is used appropriately and costs do not escalate.

Annex H - Whole Systems Review

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme name:
Whole Systems Review of Community Health & Social Care Services
What is the strategic objective of this scheme?
To carry out a joint review on the community based services that are at present commissioned by the Vale of York CCG and the City of York Health & Wellbeing Directorate. Working within an integrated Health & Social Care commissioning structure we will design the structures needed to provide a truly joined up transitional care and support pathway that provides support and care commensurate with the needs of the individual with identified needs, as well as their carers, delivered as close to home as possible. As well as joining up and integrating community services to reflect the aims & objectives of the Better Care Fund, the services included in this review will be designed to conform with the aims of Prevent, Delay and Reduce (the need for care and support services) laid out in the Care Act 2014.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?

The Whole System Review will be carried out in an integrated way to ensure that the community services across health, social care and social housing are joined in a way that provides a coherent transitional care & support pathway for the patient/ service user, that is efficient, effective and avoids duplication of any elements of the pathway. The scope of the review will include:
 	
• **Reablement:** National evidence (CSED, SCIE, and DoH) demonstrates that well delivered reablement services do improve health and wellbeing and have the potential to reduce the size and cost of long term packages of care through promoting independence and the regaining of skills needs to carry out tasks associated with daily living. we need to develop an integrated reablement service that can help to;
  • reduce delayed transfers of care,
  • prevent or reduce the need for social care packages,
  • provide therapy and reablement assistant/carer support as part of the same package.
  • reduce the incidence of readmission to acute care

- reduce the number of admissions to long term residential/nursing care.

- **Dementia Step Up & Step Down Beds**: There will be an increasing need to provide elements of the transitional care & support pathway that are appropriate and needed by people with dementia and their carer(s). The step up and down beds are a way to support a person with dementia and/or their carer(s) during a short term crisis episode in order to:

    - Avoid the need for an admission to acute care. Non dementia specific hospitals can be confusing to someone with dementia, so exacerbating the episode of crisis. There is also the real possibility of the person with dementia disrupting the smooth running of an acute ward, as well as disturbing other patients.

    - Support the carer(s) in times of crisis, or during difficult periods, when they feel unable to cope. Research has shown that carers that feel supported and able to access respite and "sitting" type services feel able to carry on providing the support required to keep the cared for person in the community for longer.

    - To support early supported discharge from acute beds and prevent delayed transfers of care episodes due to lack of dementia appropriate care being available in a community setting.

- **Step up & Step Down Beds;** As part of any transitional care & support pathway there must be an availability of short term residential beds that can work in a re-enabling way in order to:

    - Support people (without a medical need to be in hospital) being stepped down from an acute bed, who are not quite ready to return home for whatever reason.

    - Help people regain confidence to carry on living in their own homes by regaining the skills and activities of daily living, such as food preparation, washing, dressing, moving etc.

    - Reduce the number of admissions to acute care by allowing the stepping up to a residential bed when there is no medical need for admission to a hospital bed.

- **Falls & Lifting Service;** falls are by far the largest reason for people over 65 years to be conveyed and admitted to hospital. Falls also have a detrimental effect on the general health and wellbeing of a large number of older people,

eroding confidence in their own ability to remain independent and in their own homes, as well as being the leading cause of fractures (especially hip) in those over 60. NICE Guidance 161states that all people over 65 have a 30% chance of falling each year, this rises to a 50% chance of a fall each year in those over 80. In order to make a positive difference to the older population of York we need to ensure that there is an integrated vision and adequate services in place to prevent falls and to limit the damage caused by falls wherever possible. An integrated falls management service coupled with a dedicated lifting service is recommended in the NICE guidelines in order to;

- Reduce the number, as well as the damaging effects of falls in older people. By adopting a multi factorial risk assessment and implementing appropriate prevention and protection measures.

- Reduce the number of emergency ambulance call outs attending older people who fall through the use of a dedicated falls lifting & assessment service. Supporting the UCPs to deal with older fallers.

- Reduce the number of older fallers who are conveyed to accident and emergency departments, as well as reducing the number of older people admitted to hospital following a fall.

- **Safely Home Service:** Older and vulnerable adults, especially those over 85 that are discharged directly to their own homes from hospital are at a greater than average risk of readmission to an acute setting through a variety of factors such as, falls, non-compliance with medicine treatment regimes and the temporary loss of daily living skills often brought about by the inactivity inherent in a hospital stay. The Safely Home Service is designed to;

  - Engage with the potential service user whilst they are still in the acute bed to explain the services they offer. If the patient/service user is suitable and wishes to engage with the services then they can begin to be familiarised with appropriate pieces of technology such as automatic medication dispensers prior to discharge. Experience has shown that familiarity with the equipment aids the safe transition home and into sustainable routines.

  - Reduce the incidence of delayed discharges, and delayed transfers of care from acute hospital beds.

  - Ensure that the home environment is safe and suitable for the service user to remain with an appropriate level of care and technological support. This will be done by initial visits on discharge as well as follow up phone calls/ visits, at the 3 days, 1 week, 2 weeks, 4 weeks & 6 week post discharge points.

- **Community Equipment Provision;** Low level and simple equipment known as Simple Aids to Daily Living (SADLs) such as walking aids, bath boards, grab rails and raised toilet seats are vital elements in ensuring the continued independence and safety of a large number of older people both with and without mainstream packages of health or social care. The larger and generally more expensive Complex Aids to Daily Living (CADLs) include more specialist items such as bespoke seating solutions and mobile hoists etc. The effective and efficient provision of community equipment is vital to the safe discharge of patients from hospital as well as being a main cornerstone of any effective offering of prevention services within a community setting. The Community Equipment Service will:

    - Support the prevention agenda.

    - Aid safe and timely hospital discharge through the speedy provision of equipment available 7 days a week.

    - Support the journey through the transitional care and support pathway both upwards from the community through step up to acute care, and down from acute through reablement beds and domiciliary based reablement services onto independent living or the minimum support needed to remain independent.

    - Operate in an efficient manner, ensuring that procurement of equipment and service is carried out in a manner that represents best value for money

    - Have the facility to provide SADLs such as walking aids etc direct to the public as required.

- **Home Adaptations (Top Ups):** Adaptations to peoples' homes can be vital in enabling them to remain independent and living in the community. The adaptations provided range from relatively simple and inexpensive items such as grab rails and bannister rails, through to more complex and expensive projects such as level access wet rooms and rising ramps to raised front doors etc. The original funding for these adaptations comes to the council from the Disabled Facilities Grant (DFG). The amount of DFG has not matched the growing demand both in the higher numbers of older people, but more specifically the increasing number of people that are choosing to remain in their own homes with serious and limiting long term conditions. In order to ensure that the adaptations service can continue to deliver services in an acceptable time frame without developing long waiting lists, City of York Council have instigated a top up to the DFG grant to allow the service to keep

pace with growing demand.

- **Telecare & Assistive Technology;** The DoH Whole Systems Demonstrator study has provided evidence that Telecare when properly used and integrated with other "hands on" health and social care support and services, can deliver;

    - Reductions in non-elective admissions to acute care.
    - Delay admission to long term residential/nursing care.
    - Reduce the number and size of domiciliary care packages.
    - Support informal carers to carry the caring role for longer.
    - Increase the health & wellbeing of the service user.
    - Reduce the number of and negative consequences of falls.

CYC presently commission a Telecare service with Be Independent.

This service provides community alarm "pendant "services to approximately 2,900 older people in the city. Of these around 300 also have wider Telecare equipment packages such as, heat detectors, door monitors, automated pill dispensers, bed occupancy monitors etc. Arguably the most important aspect of the Telecare service is the response once an alarm is activated. The York be independent service operates a 24 visiting response service that can reach any service user within 1 hour of the alarm being received.

- **ED Diversion Service;** In order to provide the nationally mandated 7 day working across the health and social care economy in York, we have arranged extra capacity within the existing Rapid Assessment Team (RATS) based in the York Teaching Hospital Foundation Trust (YTHFT) building. The RATS team is multi-disciplinary and includes Social Workers as well as Occupational and Physiotherapists. They presently work 08.30 to 18.00 hours Monday to Friday only. The extension of the hours under this scheme will see the service operate from 08:00 hours to 20:00 hours 7 days a week. The social worker will work from 11:00 to 20:00 hours on Saturdays and Sundays. The main function of the RATS team is to take people from the Emergency Department that have no real medical need to be admitted to an acute bed, but who are likely to require some support to return home safely. The RATS team are capable of carrying out a basic assessment of needs and then referring the person into a service appropriate to their needs (home care, reablement etc). The service supports several outcomes and KPIs including:

    - Reducing the number of non- elective admissions to hospital

    - Maintaining a smooth patient flow through ED

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The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Currently the majority of the projects above are commissioned by the City of York Health and Wellbeing directorate. There is also significant funding from the Vale of York CCG to support the community services offer.

Taking these schemes forward there will be an integrated commissioning approach over the medium to longer term with VoY CCG and CYC planning, commissioning and delivering these services jointly to provide the best community support and care offer possible for the people of York.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Evidence in favour of reablement including positive impact on hospital admissions/readmissions (from policy and performance).
Local: Study commissioned by Social Policy Research Unit from University of York Home Care Reablement Services: Investigating the longer-term impacts
here: http://php.york.ac.uk/inst/spru/pubs/1882/

as well as at SCIE here; http://www.scie.org.uk/publications/ataglance/ataglance52.asp

http://www.scie.org.uk/publications/briefings/files/briefing36.pdf

Detail on the rise in dementia diagnosis & the efficacy of specialist dementia intermediate care services can be found at;
:
Quality Outcomes Framework, Recorded Dementia Diagnoses - 2013-14.
:http://www.rcn.org.uk/development/practice/dementia

Step Up Step down beds are discussed in the National Audit of Intermediate Care Services here:
http://www.nhsbenchmarking.nhs.uk/partnership-projects/National-Audit-of-Intermediate-Care.php

Real benefits of a lifting service for older people can be found on page 7 of:
http://www.vitaline.org.uk/Annual%20Report%202013.pdf
The NICE guidance for falls management & pathways is at:
https://www.nice.org.uk/guidance/cg161

Evidence on the effectiveness of Safely Home type Services can be found here:
http://www.housinglin.org.uk/_library/Resources/Housing/H2H/H2Hfactsheet1.pdf

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB

Expenditure Plan

Whole Systems Review Costs		
	2014/15	2015/16
	£577,000	£4,313,000

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Area of activity	Number reduced by
Ambulance Conveyance	2,600
ED Attendances	2,600
Length of Stay (Days)	3,650
Delayed Transfers of Care(Days)	3,232

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The outcome of this scheme will be measured primarily in how effectively we can integrate the services described above between health and social care, and how we can agree joint targets that can support the longer term integration agenda.

Specific success measures and KPIs will of course be jointly identified for each of the different projects/ services.

What are the key success factors for implementation of this scheme?

This scheme will be considered successful if we can demonstrate an integrated and truly joined up vision, planning and delivery process for the above projects. Working together and with partners to ensure the best possible transitional care and support pathway across the City of York that is effective in ensuring access to the right support and services as close to home as possible, whilst avoiding unnecessary duplication of any service elements.