ANNEX A

INTEGRATION & BETTER CARE FUND NARRATIVE PLAN 2017/19

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Introduction

We start this year in a great place…

- ❖ We have a jointly agreed plan
- ❖ We have a balanced plan
- ❖ We have had some successes in 2016/17 and are building on these
- ❖ We have better partnerships that are more resilient
- ❖ We are collectively committed to integrating services and removing obstacles
- ❖ We recognize the connections across the different parts of our local system and continue to try and work through barriers

These are great achievements for any system but are especially significant given the position we started from last year. We intend to carry on building on our success to make things better for people living in the footprint of the York HWB.

The Better Care Fund (BCF) 2016/17 plan focused on the move to jointly commissioned activities contributing towards a set of shared strategic objectives. The plan for 2017/19 continues this intent and includes existing BCF schemes, system wide pilots that require on-going funding and new schemes to address areas that require greater focus as part of the integration agenda locally.

There is a high level of consensus about the characteristics of an integrated health and social care system for York. We believe that the progress made to date from the existing BCF arrangements gives us a platform to build on and move towards fuller integration by 2020. The areas that we are already working on but would want to see strengthen include:

- ✓ Integrated place based commissioning
- ✓ Integrated service delivery teams
- ✓ Local area co-ordination
- ✓ More self-care, self-management
- ✓ A greater focus on well-being, emotional and mental health

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

- ➢ A long standing challenging financial picture across the commissioner and provider base
- ➢ A high level of reliance on hospital based services by the public driven by historic underfunding of community-based alternatives
- ➢ An acute trust provider that has historically delivered good performance but is now facing significant financial challenge and deteriorating performance

- A high level of self-funders using care home services
- A fragile domiciliary and home care market
- A vibrant retail and tourism sector which impacts on the available workforce in the health and social care sector
- An articulate and well-informed population who demand access to statutory services

Despite adult social care being one of the largest spending areas of the council (£73.1m gross and £47million net, which is 39% of total net budget for the council), spend per head of population is low (bottom quartile) compared to using statistical neighbours[1] as a benchmarking tool. Demographic, demand and cost pressures are reaching critical levels. Workforce and provider cost pressures are having an impact during the current financial year (2017/18). Plans are in place to achieve £1.783m efficiency savings in current financial year. These savings, in addition to use of the Adult Social Care precept and funding from iBCF, will go some way to assisting with these pressures. Most importantly however is the work to transform the nature of care and support within York and manage demand by tapping into the assets of the local community and promoting approaches based on early intervention and prevention.

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

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

[1] Local authorities that Chartered Institute of Public Finance and Accountancy (CIPFA) have grouped together as sharing similar characteristics therefore providing a cohort that can benchmark against each other.

Our local vision and model of delivery

Our local vision is embodied within the Joint Health and Wellbeing Strategy which has been reviewed and updated for the period 2017 to 2022 (***https://www.york.gov.uk/downloads/file/12806/joint_health_and_wellbeing_strategy_2017_to_2022***). The review has taken into account the views of local residents, intelligence from the Joint Strategic Needs Analysis (JSNA),local plans and wider system plans.

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

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

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

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

The vision for the Humber, Coast and Vale Sustainability & Transformation Plan (STP) reflects similar themes to that of the local HWB strategy:

To be seen as a health and care system that has the will and the ability to help people 'start well, live well and age well'

To achieve the STP vision we aim to move our health and care system from one which relies on care delivered in hospitals and institutions to one which helps people and communities proactively care for themselves. The STP plan focuses on the wider determinants of health in our footprint, with all public services working together to support people to take more responsibility for their own health.

The wider system (STP) approach is to develop new models of care across the constituent population, supported by strategic commissioning across the acute health system. This builds on the ideas put forward in the Five Year Forward View

and best-practice national and international examples of whole population management and outcomes-based commissioning for health and social care. (*https://www.hey.nhs.uk/wp/wp-content/uploads/2016/11/stp.pdf*)

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

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

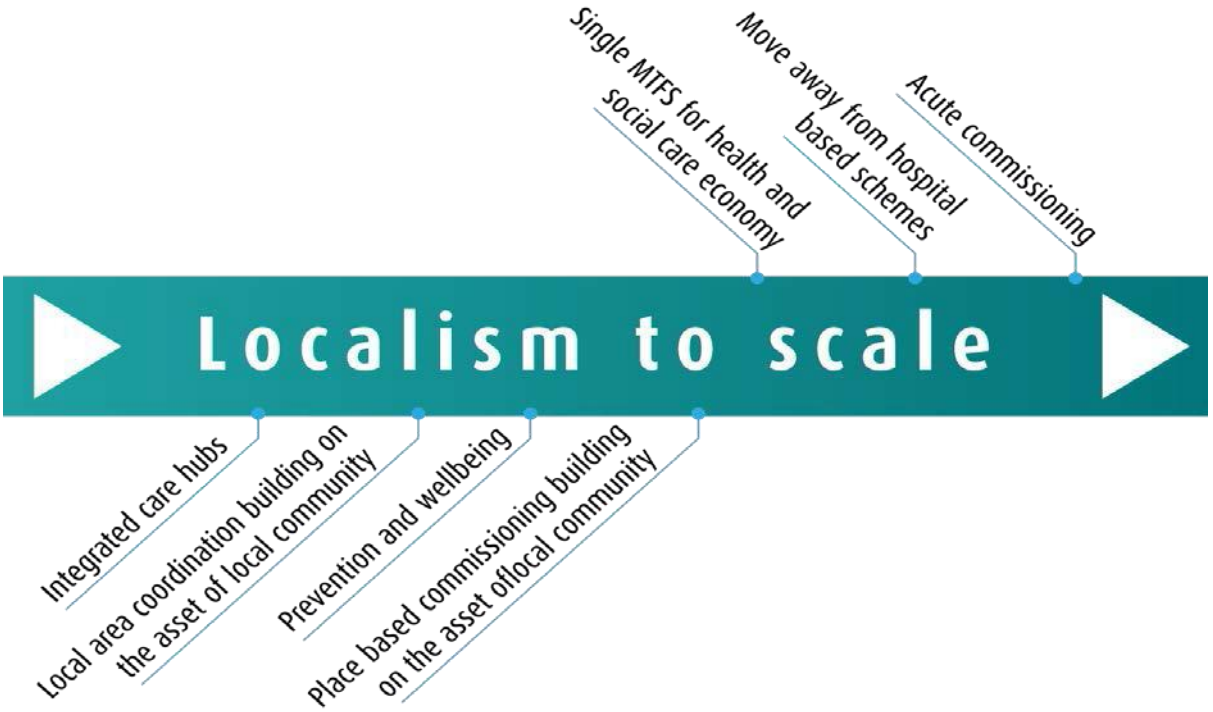
How our local vision will be achieved

System first, organisation second

The Better Care Fund continues to influence how we join-up health and social care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible. However, we cannot rely on the BCF in isolation to resolve some of the complex pressures facing our joint health and care system to deliver our local vision for 2020. The most fundamental change facing the current system requires partners to work together to shift away from statutory agencies meeting needs through the provision of services and medical interventions, towards working with individuals and communities to support self-help and self-care. This will require all agencies to shift the focus of commissioning activity upstream towards early intervention and prevention.

Combining the benefits of scale and localism

We want to use the resources available to us in the most effective manner possible. This means that we will use our assets at scale or locally, depending upon the outcomes we are trying to achieve. Graphic 1 sets out the approach we will take across this continuum for different aspects of health and social care.



Graphic 1: Localism to Scale –JHWS Vision

Integrated service delivery

We will continue to develop and deliver integrated models of service to improve the experience and outcomes of people who we support. This is based on the consistent messages from local people about only wishing 'to tell their story once' and the challenges of navigating the 'system'. Local providers are committed to working together to improve the efficiency and effectiveness of their services.

Prevention through self-care and self -management

Empowering people with the confidence and information to look after themselves when they can, and access statutory services when they need to gives people greater control of their own health and encourages behaviours that help prevent ill health in the long-term.

More cost-effective use of statutory services allows money to be spent in local priority areas to focus on improved health and care outcomes. Furthermore, increased personal responsibility around healthcare helps improve people's health and wellbeing and better manages long-term conditions when they do develop. There is a significant opportunity for us to more closely connect the support available through community assets and third sector provision in the York HWB.

Background and local context

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

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

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

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

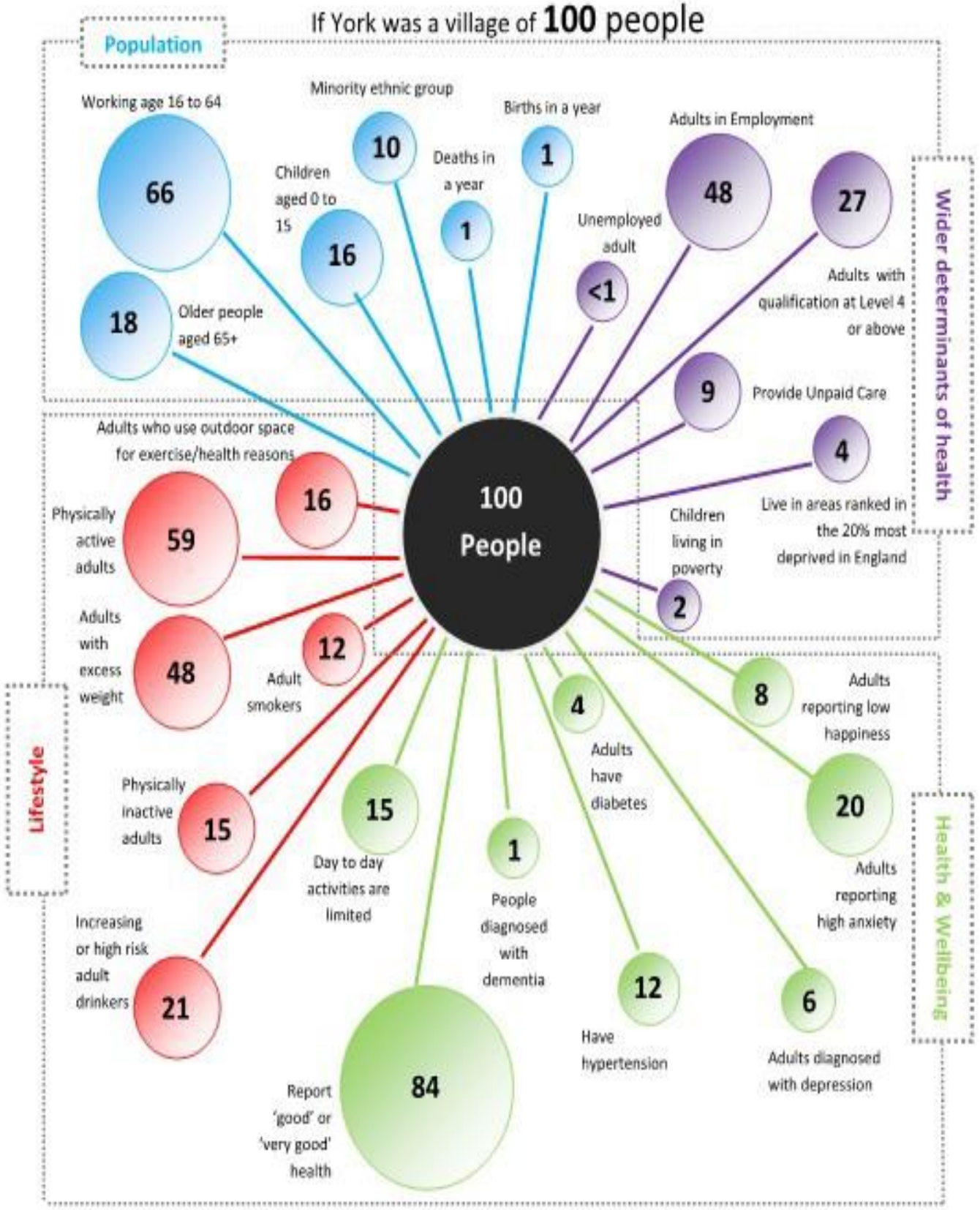
This shows that the York HWB population is generally well with a high proportion of people reporting 'good' or 'very good' health and wellbeing; a good number of people being physically active and using outdoor space; very low unemployment levels and a high number of the population working between the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

Despite this picture the following challenges remain:

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

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

c) **A high level of reliance on hospital based services by the public.** A recent Utilisation Management review commissioned by the CCG found the system to be 'hospital centric'. In part, the review found this was due to limited community-based alternatives. However, the CCG MTFS shows that the Vale of York CCG spends 9% less on acute care per head than the STP average. The 26 GP practices that deliver primary care in the locality have been assessed as 'good' and localities are progressing integrated care solutions wrapped around primary care models of delivery.



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

Graphic 2 'York in a nutshell'

d) An **acute trust provider that has historically delivered good performance but is facing significant financial challenge and deteriorating performance**. The development of place based commissioning through the locality delivery model is demonstrable progress towards system wide solutions to try to reduce demand on hospital services.

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

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

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

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

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

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

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

Although challenging, this context provides a significant opportunity for agencies to benefit from the assets that exist with the local population and wider community. York has a demonstrable history of community benevolence with over 1000 voluntary sector agencies operating across the population.

Moving towards fuller integration by 2020

A priority for the York BCF footprint is to deliver improved outcomes for the local population within the context of the demographic, cost and demand pressures faced by the health and social care system. There is recognition that these pressures, together with the financial context of the statutory agencies, requires a whole system approach to transformation and the development of a single medium term financial strategy (MTFS) for the system.

There has been a significant commitment in system leadership in York over the last 18 months and the 2017/19 Better Care Fund (BCF) Plan has been developed by a multi-agency group based on a common understanding of the issues that must be addressed to deliver high quality, co-ordinated care in the locality.

There is a shared commitment to place based commissioning and a high level of consensus about the characteristics of an integrated health and social care system for York. This has allowed organisations to work through challenges and gain a greater understanding of each other's drivers and perspectives. There is still work to do to make sure delivery follows through from plans but there are mechanisms in place to support this.

From within the system discussions and debate, a locality approach has now become the established model for delivery. This is reflected in the health footprint and across social care in the form of Local Area Co-ordination. Geographically, the Vale of York CCG has a population that spans the York HWB footprint whilst also falling within the even wider geography of the STP. To support the locality delivery model across the CCG's full population three locality delivery groups have been established in the North, Central and South geographies of the CCG.

The Central Locality Delivery Group is co-terminus with the York HWB population. This group is multi-agency in nature and has representatives from the Clinical Commissioning Group (CCG), City of York Council (CYC), GP practices, Community Voluntary Service (CVS), York Teaching Hospital Foundation Trust (YTHFT) and Tees, Esk & Wear Valleys Foundation Trust (TEWV).

As part of its financial recovery plan, the CCG has developed an Unplanned Care Programme with system partners. The programme provides an overarching approach across each of the CCG localities to improve the independence and resilience of local people, reducing the need to access secondary care. Each Locality Delivery Group is using the programme as a framework to identify local priorities for action.

The partner organisations represented in the Central Locality Delivery Group have agreed that their immediate focus is on the following three workstreams:

- ✓ **Urgent/same day access in primary care** to provide alternatives to secondary care and to free up GP time to deliver different models of care

- ✓ The development of **more integration across services at a team level** to manage frail/elderly people in a different way in care homes and their own

homes

- ✓ Support to **help people self-care/manage their health and social care needs** to maintain independence and make best use of the community assets available to the local population. The methodology we propose to adopt is:
  1. Review existing models which are working well in other areas such as the Manchester Choose Well campaign *(http://www.choosewellmanchester.org.uk/)* and the joined up approach being taken by Windsor, Ascot and Maidenhead: (*http://www.windsorascotmaidenheadccg.nhs.uk/wp-content/uploads/2015/05/talkbeforeyouwalkwamfinalweb.pdf).*
  2. Contact the local authorities who are doing this well to understand three things; how embedded the model is locally, what difference has been made and how that's known.
  3. Undertake local research to find examples of 'self-care' activities, and explore how they are working in York with health and care providers, and present findings to the Central Locality Delivery Group.
  4. Set up a cross sector steering group to develop and deliver an action plan to test this.
  5. Develop a simple model for York, agree testing conditions and basic metrics to measure outputs and outcomes.
  6. Use agreed metrics to review outputs, outcomes and overall effectiveness.

These three programmes of work are not stand alone but have been agreed as the initial areas that partners wish to focus on collectively to support system change. They are augmented by other workstreams that are critical to changing the way services are currently delivered.

Progress to date

Integrated commissioning

Partners have found the Better Care Fund to be a useful construct driving integrated working and joining services together to achieve better outcomes. We have used the process to further identify opportunities for integration as evidenced by progress made through the development of a Joint Commissioning Strategy and the appointment of a jointly funded Head of Joint Commissioning.

A Joint Commissioning Strategy was approved by the York HWB in January 2017. This is a high level strategy which sets out why and how we will work together in the period to 2020 to commission health and social care services for children, young people and adults. It is designed to provide a framework within which specific strands of joint commissioning work will take place, including the schemes linked to the BCF.
(http://democracy.york.gov.uk/documents/s112190/Annex%20A-yesitb%20joint%20commissioning%20strategy%20final%20draft.pdf)

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

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

The first annual joint commissioning plan, currently in development to align with the usual business planning cycle, will set out priorities for joint commissioning work, with specific plans for the actions to be taken to deliver the plan as part of the broader integration agenda.

Joint commissioning outcomes include:

- The integration of community based health and care services and delivery through local care hubs including mental health care support
- The development of integrated assessments and care plans for vulnerable adults
- A single pathway and pooled budget for reablement and intermediate care
- Integrated personal budgets for health and social care, to promote choice and personalisation
- Development of a single integrated pathway for Continuing Health Care
- Creation of a pooled budget and joint commissioning arrangements for mental

health and learning disabilities

- Agreement on, and implementation of, an approach to incrementally shift funding towards early intervention and prevention

Identifying key actions, agreeing individual lead organisation responsibilities, engaging with providers and the community and setting timescales for action in relation to these strands of work is an immediate focus for partners.

Governance and leadership arrangements in place to support the development of joint commissioning can be found in Appendix 1 of the Joint Commissioning Strategy.(http://democracy.york.gov.uk/documents/s112190/Annex%20A-yesitb%20joint%20commissioning%20strategy%20final%20draft.pdf)

Integrated delivery

It is important to recognize that the BCF plan/funding is one slice of the wider health and social care system and, as such, a direct correlation between individual schemes and a particular impact is difficult to evidence. However, the effect of various strands of work across system partnerships can be evidenced in the following ways:

- Archways Intermediate Care Unit – In 2016, system partners worked together to reprovide a 22-bedded Intermediate Care Unit through a home based model. Through our 'One Team' project we have brought together intermediate tier services (health provided intermediate care, local authority provided reablement and voluntary sector provided 'home from hospital'). These teams are now co-located in the Archways building together with the Hospital Social Work team and Community Discharge Liaison Service.

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

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

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

Partnership arrangements

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

During 2017/19 the BCF plan figures prominently in the wider integration agenda underpinned by robust governance arrangements to support delivery. A high level review of current governance arrangements across the system has been undertaken, which has resulted in a clear understanding of the partnership arrangements that are in place to support the different levels of system change required. This is a shared strategic intent and is being progressed at pace through mechanisms including the:

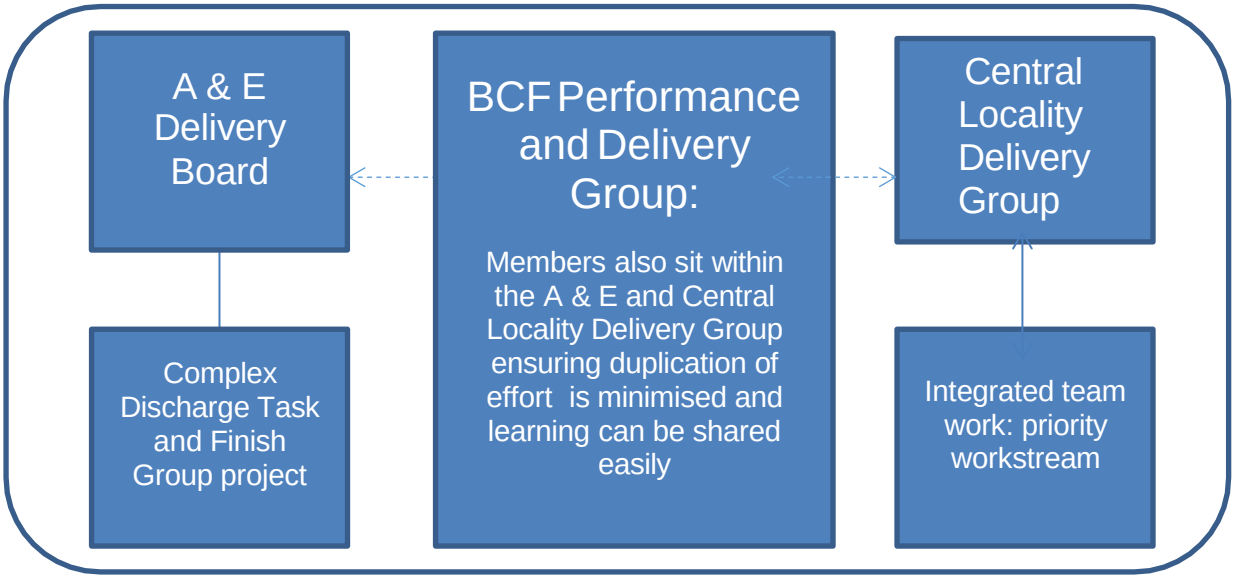
- Central Locality Delivery Group
  One of the three locality groups that sits within the Accountable Care Partnership Board arrangements. This group focuses on systematic change at a locality level and is working on three priorities (see 'Moving towards fuller integration by 2020' for more information).The partnership is co-terminus with the York HWB footprint.

- Complex Discharge Programme Task and Finish Group
  This forum is a sub-group of the A & E Delivery Board arrangements and has a work programme to reduce the number of stranded patients in acute hospital beds, improve the quality of assessments of long term care needs and reduce duplication and variation in decision making through the integration of teams. There is a clear connection in the work of this group to the Delayed Transfers of Care (DTOC) targets set within the BCF (see 'Managing Delayed Transfers of Care') . The membership of this group is based on the local acute hospital footprint and therefore has a wider system focus.

- Better Care Fund Performance and Delivery Group
  This programme of work connects into individual health and social care arrangements as well as drawing on the above groups to deliver the requirements of the BCF plan. The BCF Performance and Delivery Group forms part of the governance arrangements linked to the York HWB and was established in 2016.
  Commissioners are clear that national conditions for the BCF require oversight and sign off by HWB. HWBs have a duty to promote greater integration and partnership working, including joint commissioning, integrated provision and pooled budgets.

We use matrix working to co-ordinate governance between the complex systems but the BCF Performance and Delivery Group brings the systems together working closely with the Central Locality Delivery Group and the Complex Discharge Programme Task & Finish Group to deliver the BCF plan.

The BCF partnership recognizes the complex system that is already in place with governance arrangements connecting to formal arrangements such as the A & E Delivery Board and the Central Locality Delivery Group. Individual relationships and a commitment to improve services for people allow progress to be made despite this complexity. An example of this is given as a 'case study' in Graphic 3.



Graphic 3: Case Study on work relating to Care Homes

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

2016/17 Performance

An end of year position was reported to the HWB in September 2017 as set out in Table 2. Some measures have not delivered the anticipated target but there is evidence of success within non-elective admissions (NEA) and Delayed Transfers of Care (DTOCs) and Reablement as described below:

NEA - Using national activity data, NEA measure fails the BCF target by 1,858 admissions (which is 8.9% above plan). However, the introduction of the YTHFT Ambulatory Care unit accounts for around 250 spells per month, which are recorded as NEA activity in the national return.

This new model of service delivery which centres around providing expert advice, avoiding admissions to acute wards, and sending patients home safely, usually on the same day. When taking this local context into account, NEA performance is very positive at just above target by 0.7%, which equates to 130 admissions above plan, which was originally based on 1% growth. We recognise that managing to a level of 1.7% growth in acute admissions would place the system within the Vanguard performance nationally compared to a national level of around 3% growth as referenced in the 'Next Steps 'document.

This is a significant achievement given the system challenges described in the earlier sections of the BCF plan.

DTOC - Although the year end position is above the plan for 2016/17, Q4 shows a significant improvement. In-year monitoring shows a continued improving trajectory for acute DTOCs which has been considered in setting the plan going forward. Another factor that needs to be considered when assessing performance is the change in reporting of mental health DTOCs in July 2016 which was not considered when the 2016/17 plan was set. Although this change in process created some challenges for partners, the resulting governance and revised systems and process has created a transparent, more robust set of arrangements between partners.

Reablement – The Q4 position shows a positive improvement against the target set at the start of the year showing more people were still at home 91 days after discharge from hospital into these services. This type of support has been further invested in for 2017/19 as set out in the 2017/19 Plan section.

Metric type	Metric description	Target	Q1 position	Q2 position	Q3 position	Q4 position	Year End Position
National:	Reduction in non-elective admissions (General & Acute)	20,781	5,530	5,639	5,739	5,731	22,639
*Local metric (outwith routine reporting framework)	Reduction in non-elective admissions (General & Acute) *National data adjusted for Ambulatory Care Recording issues	20,781	5,063	5,220	5,317	5,319	20,919
National:	Delayed Transfers of Care: Number of bed days per 100, 000 of population	9,837	2,497	2,889	3,117	2,032	10,535
National:	Long-term support needs met by admission to residential and nursing care homes, per 100,000 population	657.8	189	184	143	153.6	669.6
National:	Number of permanent admissions to residential & nursing care homes for older people (65+)	238	70	68	53	57	248
National:	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	0.758	NO DATA	NO DATA	NO DATA	0.793	NO DATA
Local:	Injuries due to falls in people aged 65 and over per 100,000 population	2,454.7	591	641.6	588.4	665.6	2,486.6
Local:	Injuries due to falls in people aged 65 and over (actuals)	922	222	241	221	250	934
Local:	Overall satisfaction of people who use services with their care and support	0.664	NO DATA	NO DATA	NO DATA	0.62	NO DATA

Table 2: Summary of 2016/17 BCF Performance Metrics

Evidence base and local priorities

The changes in demographics in the York HWB footprint (see Background and local context section for more detail) means that the Council has to take a pro-active approach and has already started a process to re-design their operating model focusing on prevention, reducing and delaying the need to access statutory care and support provision. The Council is focused on meeting locally identified need by listening to the voice of local people and providing the means by which local groups can develop and flourish.

Demographics show that there are 2,700 older people in York with dementia, this is set to grow to around 3,500 in the next 10 years, across York 14,000 live alone, this is set to grow to 16,000 by 2027 and there are an estimated 2,500 people over 65 providing 20 hours or more unpaid care each week. By 2025, it is estimated that that this level of care provided by older people will increase by 16%. These are just some of the challenges that the social care market faces in York.

The Council is currently revising their Market Position Statement but there are a number of key messages emerging;

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

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

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

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

- That York has a strong established process for monitoring the quality of service provision and supporting providers that may be struggling *(https://www.york.gov.uk/downloads/file/3740/shaping_care_for_york_%E2%80%93_market_position_statementpdfn)*

From a health and wellbeing perspective we know that:

- York has a higher rate of emergency hospital admissions for intentional self-harm than the national average. Additional psychiatric liaison resource in A & E has been put in place (funded through national monies) which will provide increased support for people. Other improvements in crisis care services and the introduction of a 'Safe Haven' initiative in 2017 are part of the wider system solutions to address this challenge.

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

transgender (LGBT) population.The Primary Care Home (west) initiative has identified childhood obesity as a priority and is taking forward a range of projects to try to improve these wider health determinants.
(***https://www.york.gov.uk/downloads/file/12806/joint_health_and_wellbeing_strategy_2017_to_2022***)

Evidence from a health perspective shows that there are a number of opportunities to ensure people are getting access to care at the optimum time.Service reviews across primary and secondary care are underway as part of a planned joint programme of work with York Teaching Hospital NHS Foundation Trust. Work is well underway on a revised musculo-skeletal pathway with respiratory and cancer pathways also in hand. To support these priorities, engagement work with partners and the public has been taking place during the last12 months.
https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2017/01/cfv-vale-of-york-jan17.pdf

Improving access to mental health services across all ages is a key priority for the next 12 months. This work is on-going and runs in parallel to the plans for a new mental health hospital by December 2019.

Sustainable, evidence-based, integrated solutions for care that supports our local vision are referenced throughout this plan. As a system we have recognised the financial pressure that faces individual organisations which, in turn, impacts us collectively. For 2017/19 we believe we have developed a set of investments that maintain existing services as well as looking to new opportunities that contribute to shared strategic plans.

Evaluation of 2016/17 schemes

The Better Care Fund Plan is critical to delivering the wider strategic vision for health and social care for York. Schemes within the plan are part of a larger pattern of service redesign and development. Our design principles provide a framework for deciding our priorities and planning for change.

The Joint Strategic Needs Assessment informs commissioning intentions and underpins the Joint Commissioning Strategy. Better Care Fund schemes also draw on evidence of effectiveness, learning and best practice from elsewhere, and translate these for local circumstances.

2016/17 schemes were evaluated using agreed metrics and key performance indicators against their individual aims that reflect the focus on reduction of non-elective admissions in accordance with the Better Care Fund requirements for the period.

A summary of the key elements of existing schemes that are continuing is given below:

Disabled Facilities Grant – This is a mandatory grant which helps disabled people to allow them to remain living in their own homes, safely and independently. Adaptations can include improving access to and around their home, bathing adaptations, adapting lighting and in some cases building extensions to meet very complex needs. Customers are means tested for grants. The maximum amount is £30k although the Council has discretion to add to this total. These customers would need on-going formal care if their home wasn't adapted which is much more expensive longer term than these one off grants. 160 grants were awarded in 2016/17 and a recent review of the DFG process resulted in the feedback that 100% of customers who responded felt safer remaining in their homes following the work. We are also running a pilot in the Clifton Ward called the Quick Fix Scheme. The service is targeting residents in that ward as a recent housing survey classed the houses in that area as being of a design and age where falls are more likely to occur. The intention is to reduce the admissions to hospital and subsequent treatment needed by making adjustments to prevent the falls occurring.

Community Support Packages (Protection of Adult Social Care) - We will deliver a 40% increase in community support packages to address demographic growth.

This funding is being used to support people to remain as independent as possible, preventing placement in residential and nursing care and allowing customers to be discharged from hospital and moved through reablement. The scheme allows for the purchase of approximately 3,400 hours of home care per week plus a contribution to social care staffing budgets to enable the assessment and review of customers. Key performance measures include numbers of people seen, outcomes, and reduction in the numbers of DTOCs and a reduction in numbers of residential and nursing care placements. In the past year there has been a reduction in York acute DTOCs from 2016 to 2017 alongside a reduction in the numbers of people entering Residential Care.

Carers support - This funding enables carers to lead their own lives whilst they look after a cared for person and maintain a caring role. Support includes respite for carers, direct payments and grants, improving what the Carer's Centre offer to support carers and other contracts to support Carers groups. The service will be re-commissioned during 2017 with an enhanced specification placing increased emphasis on identifying and supporting carers across the City. The scheme allows for significant investment in carers services to avoid preventable carer breakdown and associated unplanned admissions to hospital and residential/nursing care. It also reduces and delays the need for health and social care, improves outcomes and quality of life for carers and enables people to be supported at home following discharge from hospital. Key performance measures include numbers of carers supported, reduction in residential and nursing care placements, reduction in readmissions after 91 days, reduction in hospital admissions due to carer breakdown and improved outcomes identified through the Carers Satisfaction Survey. Outcomes this year include:

- A 10% growth in the number of new registrations with York Carers Centre
- Targets for the number of new referrals into the Hub have been exceeded by 12% since May 2016
- 1,119 customer contacts have been provided during extended opening hours (Friday / evening cover)
- The target for Carers Assessments of Need has been exceeded by 17% (88 completed assessments against a target of 75)
- Carers now have to wait for a maximum of 4 weeks for a carers assessment, compared to an average wait of over 8 weeks in May 2016
- Case studies evidence that a complete breakdown of the care giving role has been avoided for at least 207 households in the 11 month period May 2016 to March 2017

Care Act Implementation - Supports activities and services resulting from statutory duties imposed on local authorities by the Care Act 2014. Key services provided through this scheme include Care Act Advocacy Services, financial assessment/personal accounts and information/advice services, statutory safeguarding adults board, and increased support to Carers services. The outcomes we are expecting include services which intervene at an earlier stage, improvement in the wellbeing of the population, provision of information and advice, advocacy support, increased numbers of carers assessments and customers being reviewed in an appropriate and timely manner. Some of the outcomes achieved were a 10% growth in the number of new registrations with York Carers Centre, targets for the number of new referrals into the Hub have been exceeded by 12% since May 2016. (1,095 new referrals have been received against a target of 980) and the waiting list for Carers Assessments in the city has reduced from 90 to 21 since May 2016.

Reablement (Human Support Group contract) - **In 2017/19 we will deliver a 50% increase in reablement capacity.**

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

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

Community Facilitators - As the community hubs develop and extend across the whole HWB population these roles are seen as being fundamental to community development and resilience promoting self-care, self-management and proactive care.

Investment supports two members of staff within adult social care who connect customers with activities and support within their communities (for example dementia cafes) allowing them to remain independent and contribute to their communities. Their role includes supporting customers in feeling less isolated in their communities, increasing the wellbeing of customers, providing respite options for carers and supporting carers to maintain employment. Linked to this is a pilot social prescribing scheme which is a new initiative for 2017/108.

Step up/Step down Care Beds - Investment will support the provision of up to 12 residential beds with social care staff support to help prevent people from going into hospital, facilitate recovery when discharged from hospital and thus allow them to live in their own homes and communities. The key indicators are occupancy of SUSD beds (99.5% occupancy), people supported after hospital discharge (138 in previous year), length of stay in hospital, on-going packages of care following SUSD against likely cost of care if beds were not available and an analysis of SUSD. Key performance indicators include the length of stay of these people, their onward destination and their satisfaction with the service provided.

Telecare and Community Equipment - Investment supports the use of Telecare and equipment to assist people to remain independent and in their own homes; they can then continue to contribute to their communities and lead fulfilling lives. Provided by “Be Independent” and complimenting the warden call and response services the Council commissions, the service supports reductions in non-elective admissions to acute care, delays admission to long term residential/nursing care, reduces the number and size of domiciliary care packages and supports informal carers to carry the caring role for longer. The provision also improves people’s health and wellbeing and reduces the number of, and negative consequences of, falls**.** The key indicators include the number of items of equipment issued, the number of responses to alarms, hospital conveyances prevented, a reduction in A&E attendances, reduced home care packages and reductions in referrals due to carer breakdown. Approximately 19,000 equipment deliveries in 2016/17 with 98.5% delivered within 5 working days.

Home Adaptations - This scheme supports the prevention of early and/or unnecessary admissions of residents to hospital, nursing care and/or residential care by providing minor adaptations to their homes to prevent falls and allow continued access and use of their homes. Provided by Be Independent and complementing the Telecare, Warden Call and response service the Council commissions. The scheme helps towards reducing social care admissions, enhances the quality of life for people with care and support needs, improves carers reported quality of life, delays and reduces the need for care and support, reduces the need for readmission to hospital and supports people to recover from episodes of ill health. Key performance measures include numbers of adaptations issued, reduction in number of falls at home, number of people remaining at home 91 days after discharge from hospital, an increase in people’s satisfaction with the service and reduced A&E admissions.

York Integrated Care Team (YICT) - The YICT is 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. The 2016/17 plan established this model in each of the CCG’s HWB footprints and learning from each of the delivery models has informed the development of the teams for 2017/19.

The aim of the scheme is to support high risk and frequent/high usage patients, and those discharged from ED or wards via a daily MDT. Each MDT reviews the patients seen/discharged recently, updates their plan, assesses any support requirements and provides appropriate short or longer term support.

The decision to continue this scheme is based on analysis of the YICT which is positive and shows that NEAs are down by 2.1%, admissions are holding static and, when patients are admitted, their excess bed days have decreased by 25% when compared to 2015/16 figures.

Urgent Care Practitioners (UCP) - The UCP model implemented is a see and treat/hear and treat/see and refer onwards from the ambulance service to a variety of local health and social care teams. This in turn not only ensures the patient is given the right care in the right place but reduces A&E attendances and subsequent acute admissions. The decision to continue this scheme is based on 16/17 performance

data which shows that of 4,981 urgent care practitioner attendances an ambulance conveyance was avoided in 2,876 cases (57.7%).

Hospice at Home (Extended Hours) - The aim of this scheme is to reduce non elective admissions and A&E attendances for End of Life patients; increase the numbers of patients able to die in their preferred place of choice; improve the quality of patient and carer experience and increase the clinical and support time with patients and their carers.

During 2016/17 the service supported 495 people to be cared for in their own homes, of these, 150 (30%) were cared for during the extended hours of the service. For the duration of the extended service to date (Jan 15 – Mar 17), 281 crisis intervention cases were identified (over 56% of the 495 patients seen during that period). It is assumed that these crisis intervention referrals avoided a call out of other services such as ambulance and Out of Hours GPs.

Street Triage – this service is provided by TEWV to work alongside the North Yorkshire Police and support them in incidents involving people with Mental Health concerns. The aim of the service is to try and support officers in managing individuals with mental health with the least restrictive approach to their needs and this includes looking at alternatives to the police powers under S136 to detain an individual and offers up to 3 follow-up interventions to individuals not already linked into Secondary Care services to help prevent further crises and contact with the police. This scheme supports the local police and ensures an appropriate intervention for the individual. In 16/17 Street Triage team attended 81% of S136 detentions which have occurred in the York area and out of these 81% a further 71% have had an enhancement to their care package.

Out of hospital services (commissioned by CCG) – includes: specialist nursing, integrated community teams, community therapies, and community equipment and wheelchair services.

Specialist nursing services including: Specialist cardiac nursing and tissue viability play a crucial role in the primary health care team working alongside GPs and other health care professionals. They visit housebound people in their own homes or in residential care homes, assessing the health care needs of patients, providing high quality holistic nursing care to patients who have a nursing need. Community nurses have an important role in keeping hospital admissions and readmissions to a minimum and ensuring that patients can return to their own homes as soon as possible. As well as providing direct patient care, community nurses also have a teaching role, working with patients, their families and carers to promote self-management and independence. *Specialist Respiratory Practitioner* – practitioners give specialist advice and treatment options to improve the quality of life for patients and their families/cares living with chronic obstructive pulmonary disease (COPD) and other respiratory conditions to promote self-management and assist in preventing unnecessary admissions to hospital.

Integrated community teams/therapies including: *Specialist Continence Advisory Service* – is a multi-disciplinary team who are specialists in the treatment and management of bladder and bowel conditions. The service is provided for adults with

accessible clinics in local areas and home visits are provided when required. The aim is to treat and manage bladder and bowel dysfunction where possible maintaining individuals' comfort and dignity; *Community Response Teams* – this service was developed by bringing together the existing Fast Response and Intermediate Care Teams. These teams (made up of nurses, physiotherapists, occupational therapists and generic support workers) are able to support people to achieve short term goals to maximize their independence. This can be to help prevent an admission to hospital or to support an earlier return home following a hospital stay. The teams all work from 8am to 8pm, seven days a week – including bank holidays.

The 2017/19 Plan

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

Step 1 – Existing schemes maintained (following high level review)
Step 2 – Full year effect (FYE)/recurrent commitment costs applied
Step 3 – Risk share costs absorbed
Step 4 – Inflation/growth applied if applicable
Step 5 – Recurrent investment in non-recurrent pilot schemes/ Additional new schemes agreed and added

This methodology supports the following investment profile (note figures are rounded to the nearest £1K when compared to the BCF planning return template

Investment Profile	17/18 Proposed £m	18/19 Proposed £m
1. 2016/17 schemes maintained	12.203	15.196
2. FYE/Recurrent commitments	0.723	0.658
3. Risk share costs absorbed	1.227	0
4. Inflation/growth applied	0.104	0.126
5. Proposed commitments	1.091	0.571
Total pooled fund (£M)	**15.348**	**16.551**

Table 3: 2017/19 Investment Profile

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

The use of the iBCF is in line with both the Grant Conditions and the Intention of the Grant providing both stability to existing services and additional capacity.

- It is being used to "support existing adult social are services, as well as investment in new services" as required in Paragraph 46 of the Integration and BCF planning requirement for 2017-19
- It is being used "to enable the local authority to quickly provide stability and extra capacity in local care systems" as required in pages 17 and 18 of the 2017-19 Integration and Better Care Fund policy framework.

A summary of the services funded in 2016/17 and proposed for 2017/19 is given in Table 3. To provide further detail this full list of investments has been broken down into 'scheme types' to allow for classification of the investment going forward as described in Table 4. This analysis reflects the summary of BCF expenditure as set out in the Planning Return Template**.**

Summary of BCF Expenditure	2017/18 Expenditure	2018/19 Expenditure
Acute	732,243	732,769
Mental Health	150,150	150,150
Community Health	5,939,418	5,941,122
Primary Care	750,000	757,500
Social Care	7,624,259	8,397,523
Other	151,918	571,568
Total (£M)	**15,347,988**	**16,550,632**

Table 4: Summary of BCF expenditure by scheme type

Within each of these classifications, there is a mix of existing, system wide and additional new schemes as defined by the investment profile set out in Table 3.

- We can confirm the iBCF monies are not being used to fund carers' breaks and reablement services. These services are funded out of the core BCF in the amount identified for protection of social care.
- Furthermore, we can confirm that the iBCF does not replace and is not being used to offset against the NHS minimum contribution.
- We have developed iBCF and BCF as a two year investment plan, in 17/18 largely focusing on stabilizing the local system, and in 18/19 either enhancing or developing additional services to promote better flow through the system and reduced dependency on the acute sector and other statutory services.

Each scheme links to one or more of the BCF grant determination criteria of:

- Meeting adult social care needs
- Reducing pressures on the NHS, including supporting people to be discharged from hospital when they are ready
- Ensuring the local social care market is supported

Schemes that are new to the Better Care Fund for 17/19 are detailed below.

Arc Light (A Bed Ahead) - this scheme provides support for homeless clients who present at A & E in the form of a link worker, and also takes referrals from inpatient wards to assist with discharge arrangements. The scheme also prevents delayed discharge by offering a bed at the Arc Light Centre.

Age UK – Escorted Transport - the Age UK York Escorted Discharge Service provides personal transport home from hospital where indicated by clinical need and when patients are unable to make their own arrangements. The driver also completes a referral form that identifies other needs that the person may have such as such as needing assistance with washing and dressing. This information is subsequently shared with social services if their input is required. The scheme potentially reduces re-admissions to hospital by identifying potential crisis situations.

Rapid Assessment & Treatment Service (RATS) - this scheme provides additional support for the hospital Rapid Assessment Team to extend the service to cover

evenings and weekends. This requires additional occupational therapy, physiotherapy and social care support. The aim of this scheme is to increase the number hospital admissions avoided by assessing and treating patients that require short term support to return home 7 days a week (8.30am-8pm) including Bank Holidays. Funds pay for social care support required to provide the RATS extended hours scheme.

Priority Outreach - the aim of this scheme is to capture all referrals from the Rapid Assessment Therapy Service (RATS) providing a response within 2 hours to a RATS referral for patient support in the home avoiding admission and possible

readmission. Also includes additional ICT support enabling early supported discharge while awaiting packages of care to commence. This scheme also aims to avoid admissions and enable early discharge.

Step Up/Step Down Beds & Occupational Therapy (OT) - this scheme provides a flexible resource for patients who can be discharged with a requirement for intensive short term therapy. It also takes step-up referrals from GPs and UCPs so may prevent some admissions. This scheme also provides OT support for the therapy required in the nursing home, working as a link between RATS discharges and nursing home requirements. The intensive therapy supports prevents delayed transfers of care as well as preventing admission for those with minor rehabilitation/reablement needs.

Increased Reablement Capacity - building on the existing Reablement Service, this investment will enable the service to increase capacity and facilitate earlier discharges from hospital. Customers will be able to move on following their episode(s) of reablement so freeing up capacity to enable customers to be discharged from hospital and home with a reablement service and into a setting where they can be appropriately assessed.

Self-support Champions - will be based within the Council's assessment and care management teams and will provide dedicated staff resources to visit customers within 48 hours (where possible) of referral and enable staff to have a "different conversation" with customers and look to signpost people away from formal services to community resources. This will reduce delays for customers being seen that can result in deterioration and will further create capacity within reablement to focus on those most in need. A pilot has resulted in 38% of customers been signposted away to community resources.

'Ways to Wellbeing' - is York's social prescribing service, delivered by York Community Voluntary Service (CVS) in partnership with the local voluntary and community sector. It connects people to local community support to make them feel better. Nationally, 20-25% of patients consult their GPs for social problems, e.g. loneliness. The Service will reduce the use of GP appointments for social issues, helping people stay safe and well at home for longer.

Expanded handypersons service – investment in increasing the capacity and outcomes of the existing Handypersons Service, a new specification will include increased access for GP's, Out of Hospital support, low level prevention services and a Gardening service. Outcomes will include fewer deaths/injuries from falls, reduced social care admissions, delaying and reducing need for support, reducing need for readmission to hospital and reduction in A&E admissions and attendances.

Information & Advice – curate information and advice on community support and self-care across public health, adult social care, Health, Children's services and other local authority services. Linking to development of a cross system wellbeing portal, e-marketplace and re-design of Connect to Support web platform, the aim is to maximise an asset based approach across the voluntary and community sector. Provision of advice and guidance will support people to improve their health and wellbeing and demand on health and social care services will be reduced as people

are encouraged and supported to remain independent and as healthy as possible. The approach will see reduction in GP and A&E attendance, reduced hospital admissions and a reduction in health and social care contacts.

Alcohol Prevention – investment to drive a promotional campaign and the delivery of training programmes to support an early intervention and preventative approach. Low level drinking of alcohol has a wide body of evidence which demonstrates it is attributable to many different health conditions. These behaviours can result in a range of health conditions and social problems and the aim of the campaign will be to drive improvements in many areas including long term health conditions, social problems and alcohol dependence.

7 day working: multi-agency – to develop and facilitate discharge from hospital 7 days a week. This will improve customer experience ensuring that they do not spend unnecessary time in hospital with risks of deconditioning and hospital acquired infections. The system benefit will be reduced length of stays in hospital and the potential to reinvest resources from acute to community support. This project will connect into the work that is already in hand through the Complex Discharge Task and Finish Group.

Summary list of schemes	2016/17 Current £000	2017/18 Plan £000	2018/19 plan £000
Existing schemes continuing from 2016/17			
Disabled Facilities Grant	1,003	1,101	1,199
Community support packages	2,174	3,115	3,208
Contribution to social work post	137	138	139
Carers support	655	655	655
Care Act implementation	454	454	454
Community facilitators	40	40	40
Reablement services (Human Support Group contract)	1,099	1,099	1,099
Step up/step down beds	300	303	312
Telecare and Falls lifting	192	192	192
Community equipment	180	180	180
Home adaptations	75	75	75
York Integrated Care Hub	625	750	758
Urgent Care Practitioners	569	526	526
Hospice at Home	170	173	176
Street Triage	150	150	150
Out of hospital services (commissioned by CCG)	4,380	5,262	5,408
Additional new schemes			
Arc Light – A Bed Ahead	0	81	83
Age UK – Escorted Transport	0	91	93
Step up/step down beds & OT support (6 months funding pending review)	0	152	0
Rapid Assessment & Treatment Service (RATS) extended hours and social worker	0	207	208
Priory Outreach	0	180	182
Increased reablement capacity (7 months in 17/18)	0	97	168
Self-support champions (4 months in 17/18)	0	33	98
Social prescribing/ways to wellbeing (8 months in 17/18)	0	101	152
Expanded handypersons service (4 months in 17/18)	0	10	30
Information and advice (4 months in 17/18)	0	16	49
Alcohol prevention (5 months in 17/18)	0	15	47
7 day working: multi-agency project	0	0	300
Contingency funds	**0**	**152**	**571**
Total (£M)	**12,203**	**15,348**	**16,551**

Table 5: Summary of 2017/19 BCF schemes

Funding Contributions

An assessment of the investments in 2016/17 has been used to inform the funding plan and detailed list of schemes for 2017/19. The 2017/19 BCF plan has been jointly agreed by partners, including the level of maintenance for social care, funding for reablement and carers breaks as set out in summary in Table 5.

The full amount of the DFG allocation has been used within the BCF for 2017/19 as agreed by the City of York Council is the single local authority covering the York HWB population.

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

A summary of the services funded in 2016/17 and proposed for 2017/19 is given in Table 6.

Funding Contribution	15/16 Actual £m	16/17 Actual £m	17/18 Proposed £m	18/19 Proposed £m
LA Minimum (DFG)	0.951	1.003	1.101	1.199
LA Additional (iBCF and iBCF supplementary funding)	0.000	0.000	2.847	3.735
CCG Minimum	11.176	11.200	11.400	11.617
Total pooled fund	**12.127**	**12.203**	**15.348**	**16.551**

Table 6: 2017/19 Funding Plan

On completing the Planning Return Template, we note that this highlights the inflationary uplift impact on the fund for 20171/19 when compared to contributions in 2016/17. However, Table 7 demonstrates that we are spending more than the required inflationary uplift for social care protection expenditure within the pooled budget over the next two years. The table models three scenarios:

1. **Planning requirement** assumptions, applying the 1.79% and 1.90% uplift to the funding from CCG based on RNF, which has a total cumulative inflation of £0.188m

2. Our **Actual** spend on social care protection from within the template compared to the 2016/17 funding from CCG based on RNF, which has a total cumulative inflation of £0.315m

3. The **Planning template** requirement assumptions, applying the 1.79% and 1.90% uplift to the 2016/17 social care protection spend, which has a total cumulative inflation of £0.293m

Scenario		2016/17 £M	2017/18 £M	2018/19 £M	Total £M
1. Planning requirement	Funding from CCG based on RNF	3.412	3.473	3.539	**10.424**
	Inflationary uplift from 16/17		0.061	0.127	**0.188**
2. Actual	Funding from CCG based on RNF	3.412	3.676	3.463	**10.551**
	Inflationary uplift from 16/17		0.264	0.051	**0.315**
3. Planning template	Planned Social Care expenditure from the CCG minimum	5.306	5.401	5.504	**16.211**
	Inflationary uplift from 16/17		0.095	0.198	**0.293**

Table 7: Inflationary uplift for social care protection

Managing delayed transfers of care (DTOCs)

A partnership approach to managing DTOCs is in place through the Complex Discharge Programme.

This programme is overseen by a multi-agency Task and Finish Group on behalf of the A & E Delivery Board as set out in Graphic 4**.** The programme lead is a member of the BCF Performance and Delivery Group as this is a key element of the BCF plan. The Task and Finish Group is developing a performance report which includes length of stay for older patients, delayed transfers of care and stranded patients, weekend discharge rates and occupied bed days. The Task and Finish Group will also be tackling DTOCs from mental health settings.

There are five key work streams that fall within this programme:

1. Integrated Complex Discharge Planning Project

This project aims to improve the discharge planning process for patients with complex needs, based on best practice from NICE. It has four key workstreams; workforce (an integrated discharge liaison team), training and development, policies and procedures and communication (between acute and community teams and with patients and their carers).

2. Community Bed Review

Following an audit across all community inpatient beds and a range of stakeholder workshops, this project aims to take a home first approach to ensure that intermediate services (home and bed-based) meet the needs of patients. It will work with local people and clinicians to develop a co-produced model for the future.

3. Integrated Intermediate Care and Reablement

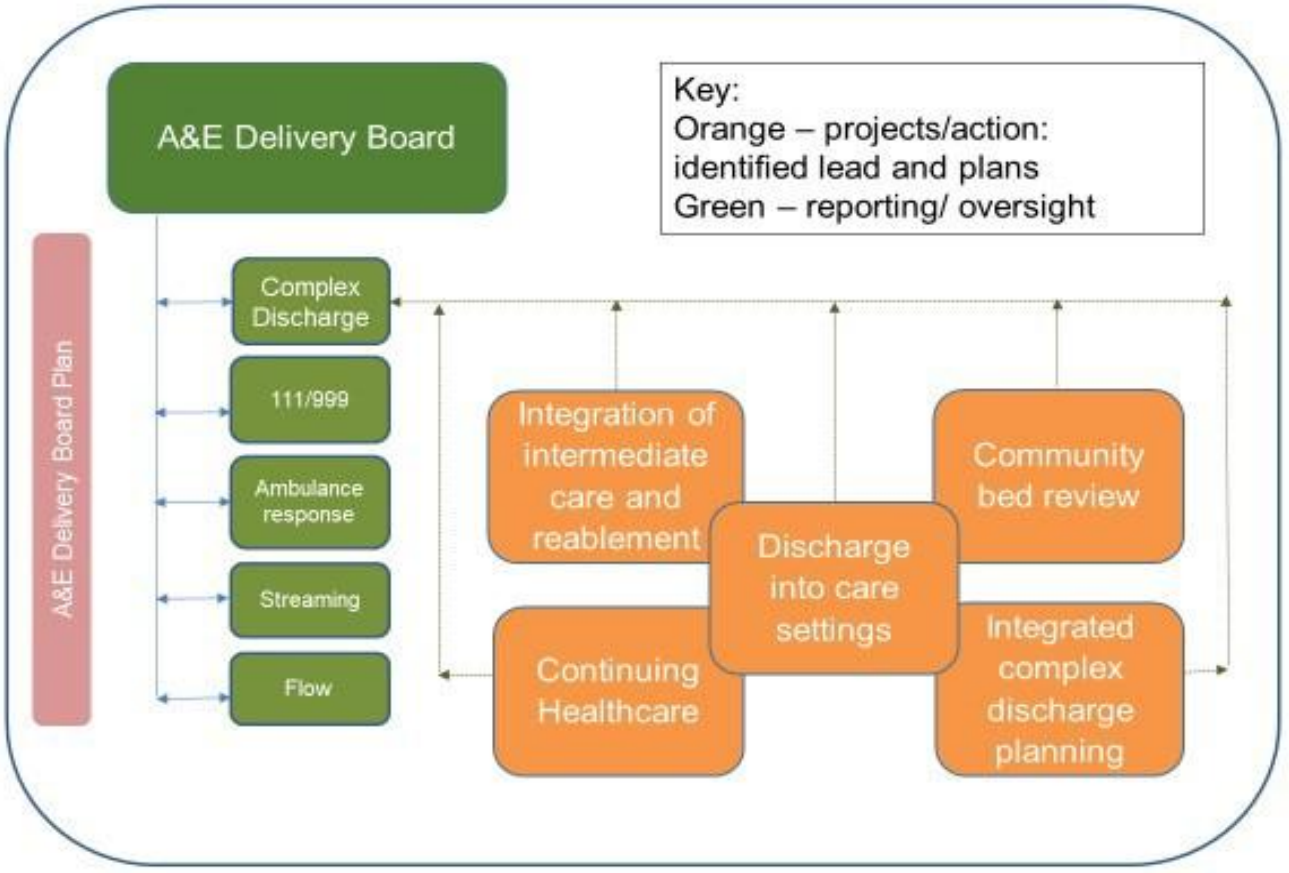
In each locality covered by the A & E Delivery Board, projects are underway (at different stages) to develop an integrated intermediate tier of services. These will bring together health intermediate care (Community Response Teams) with local authority reablement services and voluntary sector wellbeing support in order to simplify referral pathways (for both step up and step down referrals), ensure people receive the right service first time and maximise capacity within available resources.

4. Ensuring 85% of Continuing Health Care (CHC) Assessments take place outside Acute Settings

This project sits within a wider context of redesign of CHC (as set out in Gateway letter 07091) and aims to deliver the national requirement for assessments of continuing health care which needs to take place outside of acute settings, ensuring patients have reached their optimum independence before making decisions about long-term care needs. We recognise that, for those who are eligible for CHC, improved timelines for decision making are crucial.

5. Improving Discharge into Care Settings

This project sits within wider developments to improve the support provided to care home residents and staff. It aims to improve the communication between hospital teams and care home staff, minimising the time that residents need to spend in hospital.



Graphic 4: Complex Discharge Group arrangements

High Impact Change (HIC) Model

A system wide self-assessment has been undertaken by the Complex Discharge Programme Task and Finish Group (see Appendix 1). The results of the self-assessment are being used to review the projects underway within the programme. To support this, a multi-agency 'Stranded Patient Review' was conducted at York Hospital to understand the reasons why patients faced extended stays in hospital. The findings from the review and the self-assessment process are being triangulated to identify the priority areas for action.

There is a plan in place for implementing actions from the self-assessment as set out in Table 8 which shows how the High Impact Changes map across to the projects within the Complex Discharge Programme. The projects described are being delivered within a partnership approach with actions in place to support improvement against each HIC.

High Impact Change	Project Links
Early discharge planning	This is a key focus for the Integrated Complex Discharge Planning (ICDP) project and is also supported by the 'Flow' sub-group of the A&E Delivery Board which is implementing SAFER in acute settings. The Project Initiation Document for the ICDP project is included as Appendix 2.
Systems to monitor patient flow	The actions relating to this change predominantly sit with the Flow work stream, however the system has also approach the national Home from Hospital team to request support with system wide capacity and demand modeling.
Multi-disciplinary, multi-agency discharge teams	This is a key focus for the Integrated Complex Discharge Planning project shown in Appendix 2. The project to ensure that 85% of Continuing Health Care assessments take place away from acute settings is also key to delivering this change.
Home First / Discharge to assess	A 'Home First' approach runs throughout the Complex Programme and a project has already been completed to introduce the discharge to assess approach across all wards at York Hospital. The Integration of Intermediate Care and Reablement 'One Team' project (see Appendix 3 for more details) seeks to create additional capacity in intermediate tier services support the delivery of home based assessment of long terms needs.
Seven day services	This is covered for discharge planning teams as part of the Integrated Complex Discharge Planning project. The BCF plan includes a project to review seven day services in 2018/19.
Trusted assessors	This is included as part of the Integration of Intermediate Care and Reablement project and the Task and Finish Group are undertaking a self-assessment based on the recently released national guidance regarding opportunities to develop Trusted Assessment models. This could also be developed as part of the discharge into care settings project.
Focus on choice	A Joint Protocol is already in place but the review of this is included within the Integrated Complex Discharge Planning Project.
Enhancing health in care homes	The CCG are leading a project to improve support to care homes which includes admission and discharge processes (linking through the Complex Discharge Programme) and prevention of admission (through the Central Locality Delivery Group).

Table 8: Complex Discharge Group arrangements

NATIONAL CONDITIONS

7 day services
Developments early in 2017/18 include the extension of psychiatric liaison services across 7 days operating from within the local acute trust (YFT) as part of the A & E team which supports admission avoidance into an in-patient bed for those in crises. The service is not yet fully established in terms of staffing which is a priority going forward. Once a full complement of staff is in place it is expected that service pathways will be redefined to reduce hand-offs and unnecessary delays for people. An external evaluation will be undertaken to assess the impact of the scheme early in 2018. This information will be used to support financial modelling to ensure continuity of the scheme once the current national monies expire. A multi-agency project is in development as part of the BCF plan for 2018/19.

Joint approach to assessment and care planning
Continuing Health Care is one of the strategic programmes of work being addressed by the CCG. Current systems and processes are being reviewed following the appointment of a Director of Transformation and Delivery in July 2017. The CCG recognises that there are opportunities to manage this activity in a more integrated way with partners leading to improvement in pathways for people across health and social care systems.

Data Sharing
An overarching information sharing protocol is in place, and system partners are beginning to sign up to data sharing agreements that sit underneath this as needed. The CCG continues to promote the use of the NHS number as the common identifier across health and care services, and is confident that for health services, uptake is extremely good. More work is needed, however, to understand the current position, and any opportunities around social care use of the NHS Number.

In terms of service delivery, integrated working across services is developing well, with a number of multi-disciplinary team (MDT) based approaches to coordinating care for complex and frail patients. Explicit consent is obtained from patients to enable the sharing of information across agencies who are involved in their care. Currently, integrated access to clinical systems is limited (no EMIS/SystemOne interoperability) so MDTs are using multiple PCs to log into Provider systems to access and cross-reference information to help with care coordination.

Progress with Local Digital Roadmaps has been slow, with a view that the LDR footprint should ideally match the STP footprint, and conversations have taken place to understand whether governance arrangements could support this. Commissioning support (through Embed) is working with CCGs to develop Universal Capability Delivery Plans to support digital transformation.

Risk Management

In 2016/17 a set of risk management principles were developed and adopted within the Section 75 agreement as set out below:

Risk Share Principles

- Lead Partners should look to share gains as well as losses to incentivise good performance.

- All efficiencies/underspends generated from activities within the scope of the programme are attributed to the programme until the programme is in financial balance.

- When the programme is in balance, ideally any over achievement should be used to fund additional transformation activities and adding to the size of the BCF.

- As the Partnership Board reporting to the Health & Wellbeing Board, the Integration and Transformation Board should support recommendations on where to invest financial gains relating to the BCF plan.

- Lead Partners should spread risks and gains around the system to recognise the responsibilities/contributions of different partners.

- Providers should bear their share of risk and it is the responsibility of the commissioners, lead or joint, to agree a risk management plan with the provider.

- Where services are commissioned then the costs of failure should be recovered through the contract from the provider.

- Lead Partners should make a decision on financial risk share on a scheme by scheme basis.

- When services are jointly commissioned then losses and gains will be split 50/50 between commissioners.

- In a situation where there is a lead commissioner then losses and gains will be managed through discussion between CYC and CCG.

The key risks to delivery for this plan have been considered by the BCF Performance and Delivery Group and are regularly reviewed as at Appendix 4. The HWB updates include risk log reporting.

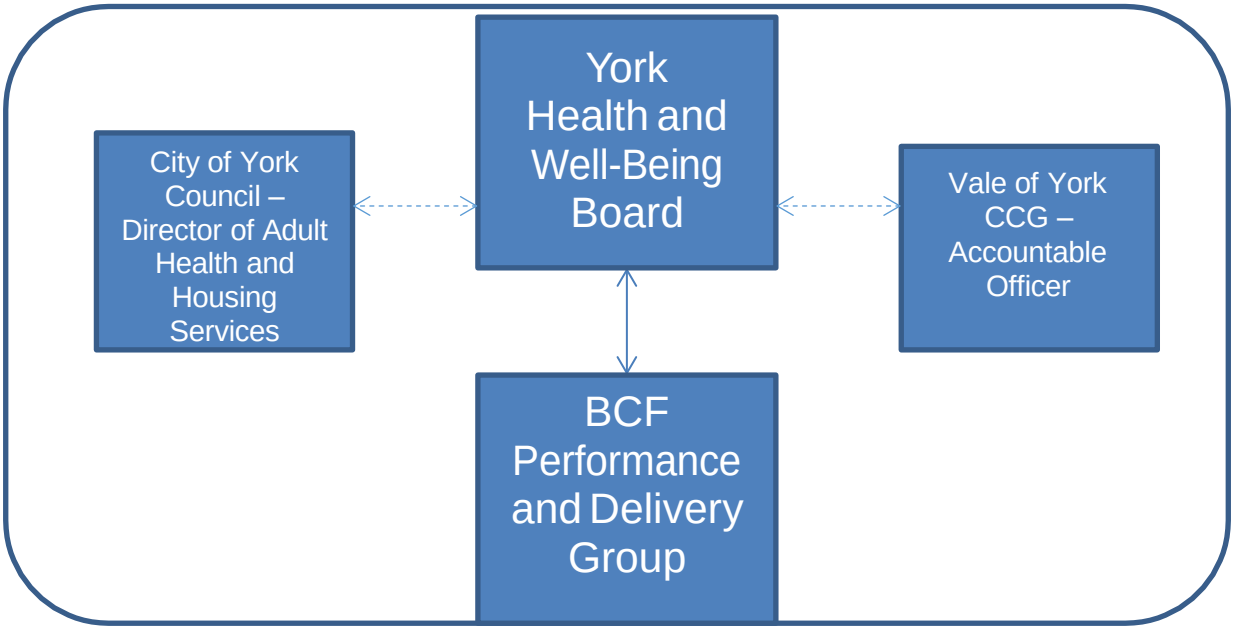
Programme Governance

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

The York HWB is a statutory committee of CYC and is chaired by the elected member with a responsibility for health and social care. The Board meets bi-monthly and, along with its wider health and wellbeing duties and exists to consider and make recommendations to the Council's Executive and the CCG on the use of BCF funding based upon jointly agreed plans. The Board covers the City of York Council population boundary and has a membership covering a broad range of partners as set out in Table 9.

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

Table 9: HWB Partners



Graphic 5 shows the programme governance in relation to the BCF arrangements

Approval and sign off

The York HWB has received regular updates on the BCF Plan throughout 2016/17 and, at the May meeting agreed to delegate authority to the Chair and Vice Chair of the Board to act as signatories to the plan should the submission timetable fall out with the Board meeting cycle.
(http://democracy.york.gov.uk/ieListDocuments.aspx?CId=763&MId=9352&Ver=4)

The 2017/19 BCF plan has been prepared with the involvement of partners represented in the BCF Performance and Delivery Group as well as through informal discussions held within other partnership forums.

A final draft version of the BCF narrative was considered and approved by the HWB on 6 September 2017 in advance of the final submission by 11 September 2017. The Board delegated authority for approval of the final plan to the Chair of the HWB, following consultation with the Chair of VOY CCG. Signatories to the plan include the Chair of the HWB, Chair of the CCG (who is also Vice-Chair of the HWB) and the Acountable Officers for the Council and CCG as set out in Table 10.

Members of the Board are aware of the extremely challenging financial difficulties facing health and social care commissioners and are cognisant of the financial constraint within the wider system.

The HWB recognize the efforts made over the last year in developing a shift towards greater collaboration across partners to achieve a balanced, agreed plan which is underpinned by the revised Joint Health and Wellbeing Strategy 2017/2022.

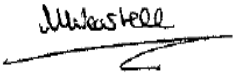
Role	Name	Signature	Date
Chair York Health & Wellbeing Board	Carol Runciman		11/09/17
Chair NHS Vale of York Clinical Commissioning Group	Keith Ramsay		11/09/17
Accountable Officer NHS Vale of York Clinical Commissioning Group	Phil Mettam		11/09/17
Chief Executive City of York Council	Mary Weastall		11/09/17

Table 10: BCF Plan Signatories

National Metrics

Delivery against the 2016/17 plan has been reviewed to inform the individual metric plans as set out in this section (Tables 11-14) reflect information in the planning return template (PRT).

- **Reduction in non-elective admissions**
  The NEA metric demonstrates a 3% reduction in 2017/18 over 2016/17, and a 13% reduction in 2018/19 over 2017/18. The CCG non-elective plan that was submitted includes reductions aligned to QIPP plans for 2017/18 and 2018/19. The ambitious trajectory for 2018/19 relies primarily on RightCare, the roll out of the integrated care teams, and the out of hospital care model, to account for the significant reductions planned.

  Local partners, including York Teaching Hospital NHS FT, are committed to working with the CCG to deliver this very ambitious improvement. Partners recognise the level of challenge in this trajectory and note that, based on national experience and previous local performance, there are significant risks to achieving this level of reduction in NEAs.

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

Table 11: Non-elective admission metric

- **Admissions to residential care homes**
  Reduced admissions to care homes as set out in Table 12 will be achieved through the protection of domiciliary care, alongside an enhanced and better integrated reablement offer. These schemes are closely linked to the development of more extra care housing as an alternative to residential care and the transformation of assessment and care management services to ensure people are able to access this.

		15/16 Actual	16/17 Actual	17/18 Plan	18/19 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	683.1	660.3	638.4	616.4
	Numerator	253	248	243	238
	Denominator	37,037	37,561	38,067	38,611

Table 12: Residential care homes metric

- **Reablement metric**
  A revised specification has been produced to support a reprocurement of this service - see on the 2017/19 Plan for further detail.

		15/16 Actual	16/17 Actual	17/18 Plan	18/19 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Annual %	75.7%	79.2%	86.0%	86.0%
	Numerator	106	42	41	43
	Denominator	140	53	50	50

Table 13: Reablement metric

Delayed transfers of care (DTOCs)

The BCF PRT Version v14 6b shows the trajectory for delayed days attributable to the NHS as zero. This is recognised locally to be incorrect and has been flagged to NHS England locally and the Better Care Fund Support Team nationally. We note the data given in the file: *BCF DTOC 15 August checkpoint supporting analysis received 8 September 2017* which sets out the level of NHS attributable daily delays as 'zero'. Following receipt of the initial pre-populated BCF planning return template on 13 July 2017, this issue was flagged, by email to the national Better Care Fund Support Team on 18 July 2017 requesting a telephone call to understand the rationale behind this data. A call was held on 19 July 2017 with input from CCG, CYC and the local Better Care Fund Support Team Manager. The advice given in this call was limited in terms of explanation as to where the 'zero' figure had originated from with a commitment to provide a follow-up to the call to provide further detail. An email was received by the CCG analyst on 20 July 2017 which stated the following:

It appears that the expectation for the NHS attribution is indeed '0'.

Note: "There is normal flexibility to propose a different distribution if more appropriate. It is recognized that some of the target reductions look very challenging, e.g.Sheffield, Nene, Oxfordshire. These may need to be discussed with respective regional teams."

Further discussion has taken place locally during August, including the reasons for the HWB not resubmitting the locally proposed trajectory. No further formal explanation has been provided until 11 September 2017 when discussion with the Lead Analyst, Data Science Hub confirmed that the pre-populated BCF template has pulled data through from an A&E Delivery Board submission in June 2017. Discussion with the Lead Analyst identified the following:

1. Potential under-reporting of all acute DTOC activity relating to the Vale of York CCG footprint that then informed the proportional NHS attributable delays for each of the CCG's HWB footprints. We understand this may be the case in other areas across the North.

2. Incorrect interpretation across the Vale of York system as to how the June A & E Delivery Board DTOC template showing the level of NHS planned reductions should be completed. On receipt of the submitted templates national analytical teams aligned the NHS data to LA data. On applying the reductions for LA DTOCs to the NHS trajectory, a negative number was created and then moved to 'zero' in recognition that a negative figure is not possible.

In the absence of a clear steer from NHS England about whether the "zero" can be corrected, and because we cannot replicate the derivation of the NHSE indicative plans, we have undertaken an exercise to estimate what the plan to reflect the York HWB footprint should be. We have included not just the NHS component, but also the adult social care component given the baseline date of February 2017. This month showed a particularly low count of delayed days – even after adjusting for days in the month. Also, from a CYC perspective, 99.9% of the DTOCs counted against CYC (NHS, ASC and Joint) are for Vale of York CCG patients.

The revised CYC plan is based on broadly two principles: firstly, that the number of delayed days for NHS:ASC:Joint are split 52:45:3. Secondly, the target level replicates the best performance seen over the past 9 months. The average monthly delayed days attributed to the NHS between November 2017 and March 2018 is 307; this is 29% lower than the 433 days per month for the CCG's patients in CYC measured over Q4 2016-17, but needs to be looked at in the context of time as DTOCs vary greatly from month to month and recognising seasonal pressures that need to be considered planning.

When agreeing proposed targets we have also needed to recognise the difficulties in setting the HWB footprint trajectory and plan in the context of the requirement to deliver the A&E delivery board footprint reductions of 3.5%. The ownership of these solutions by partners will be a critical factor in success. To this end we are in agreement that the proposed trajectory is realistic given the causes of delay and the work that needs to be done to move culture, systems and processes forward. Despite the challenges outlined above we are committed to work at pace and deliver sustained improvement.

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

Table 14: Delayed transfers of care metric

Following the escalation process the information below is now the agreed approach:

The revised DTOC Metric plan demonstrates our agreement and ambition to deliver the required 3.5% DTOC target.

	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Quarterly rate	1454.4	1682.7	1815.5	1173.6	1094.4	1062.7	873.8	835.8	845.0	854.1	854.1	831.2
Numerator (total)	2,497	2,889	3,117	2,032	1,895	1,840	1,513	1,457	1,473	1,489	1,489	1,457
Denominator	171,684	171,684	171,684	173,149	173,149	173,149	173,149	174,327	174,327	174,327	174,327	175,281

Appendix 1 – High Impact Change Model Self-Assessment

Impact Change	Where are you now	Comments
1) Early Discharge Planning	Elective: a) **Plans not established**: *Early discharge planning in the community for elective admissions is not yet in place*. Emergency/ unscheduled: b) ***Plans in place****: Plans in place to develop discharge planning in A&E for emergency admissions*	• Pre assessment focus is on the anaesthetic risk assessment of patients having surgery (POPs Model for elderly). There is no proactive management of potential complex discharge management, there is a strong drive at pre assessment to ensure no day case patients are admitted for social reasons and the onus is on the patients to identify support. Pre assessment can occur on the day of or day before surgery and not all patients are pre-assessed. Patients being referred in should have this discussion with the primary care. • SAFER , bundle includes EDD set within 48 hours - RATS identify/assess patients on admission to ED and aim to turn get them home from ED. York have a social worker attached and have links to York ICT team to support discharge. EDD not set in ED - AAU /AMU/B –EDD set for todays and tomorrows discharges
2) Systems to monitor patient flow	*a)* **Not yet established:** *No relationship between demand and capacity* *b)* **Not yet established:** *Capacity available not related to current demand* c) **Plans in place:** *Analysis of causes of bottlenecks underway and practice changes being designed* d) **Plans in place:** *Analysis of admissions variation on going with capacity increase plans being developed* e) **Plans in place**: Staff training in place to ensure understanding of the need to increase senior clinical capacity	• Discharge levelling and golden patient work implemented across both Acute sites • Capacity and demand work required for community teams • Support has been requested from NHSI for demand analysis across the system. • Stranded patient reviews planned 17 August to identify delays /escalation • SAFER/ Stranded patient escalation
3) Multi-disciplinary, multi-agency discharge teams including voluntary and community sector	a) **Plans in place:** *Discussion on going to create integrated health and ASC teams* *b)* **Plans in place**: *No daily multidisciplinary team meeting in place* c) **Not yet Established:** Continuing Healthcare assessments carried out in hospital and taking "too" long	• Integrated Complex Discharge planning project and the one team • Board rounds SAFER in acute and community units ASC team and community DLT attend the weekly Community MDTs. Integrated complex discharge planning model • Pathway 3 yet to be established for discharge to assess
4) Home First Discharge to Assess	*a)* **Plans in place:** *Nursing Capacity in community being created to do complex assessments in the community.*	• Expansion of Scarborough CRT has increased capacity in Scarborough for pathway 1, Pathway 1 has been supported by CRT however the One

	b) **Established :** People usually only enter a care/nursing home when their needs cannot be met through care at c) **Not yet Established:** People wait in hospital to be assessed by care homes	team in York through integration should develop pathway 1 to be supported by intermediate care and reablement. Complex discharge to identify pathway capacity. • CYC numbers show that there is a reduction in the number of people entering care/nursing homes • There is currently no evidence to support the current time to assess, local audit would need to be developed
5) Seven day services	*a)* **Not yet Established:** *Discharge and social care teams assess and organise care during office hours five days a week* *b)* **Not yet Established:** *OOH'S emergency teams provide non office hours and weekend support* c) **Not yet Established:** Care Services only assess and start new care Monday-Friday **Plans in place:** *Hospital Departments have plans in Place to open in the evening and weekends*	• CRT and RATS 7 day service 8-8pm. SW attached to RATS does not cover the full hours • Care Services will restart existing care but not new POC. Wards can request the restart of existing POC within 2 weeks of admission. • Pharmacy, diagnostic and transport available evenings and weekends Age UK home form hospital operate 7 days a week and into the evening. New patient transport contract due to commence April 2018
6) Trusted Assessors	a) **Not yet Established:** Assessments done separately by health and social care *b)* **Not yet Established:** Multiple assessments requested from different professionals c) **Not yet Established:** Care providers insist on assessing for the service or home	• One Team does have plans to develop trusted assessment but these are not yet in place. This forms the 2nd phase priority for the team who will be analysing and developing the internal referral processes between the teams and the training of the workforce. • Care home providers still come into assess although there some occasions when assessment is accepted for example fast track patients. CYC SW assessments accepted by care provider. Work to be developed through care home project.
7) Focus on choice	a) **Plans in place:** Draft pre-admission leaflet and information being prepared b) **Plans in place:** Choice protocol being written or updated to reduce seven days *c)* **Not yet Established:** *No Voluntary sector provision in place to support self funders*	• Admission and discharge leaflet "Planning your Discharge from Hospital" available, no reliable process to ensure every patient receives. Plans in place with DLO to build a sustainable process add to the complex discharge project Workstream 3 • Joint Protocol to be reviewed as part of the Complex discharge project Workstream 3 • No plans in place to involve voluntary sector we have an example where CYC social work team provide this support for self funders. •

8) Enhancing health in care homes	a) **Plans in place:** CCG and ASC commissioners working with care home providers to identify need. b) **Plans in place:** Specific high referring care homes identified and plans in place to address c) **Established:** Quality and safeguarding plans in place to support care homes	• Care Home project- Lead nurse for quality and safety appointed to work with care homes. • Care Home project: High referring homes known and plans in place with the care home project to work with these areas • The CQC inspections- the data shows that we do not currently have any inadequate homes in our area and we are actually above the national average for ratings. • Local authority homes have improvement plans in place.

Glossary

POPs – Proactive Care of Elderly People Undergoing Surgery

SAFER care bundle – Senior review, All patients to have an expected discharge date, Flow of patients to commence by 10am from assessment units, Early discharge, Review weekly for patients with extended length of stay

EDD – Expected discharge date

ED – Emergency Department

RATS – Rapid Assessment & Triage Service

AAU – Acute Admissions Unit

AMU – Acute Medical Unit

NHSI- NHS Improvement

ASC- Adult social care

DLT – Discharge Liaison Team

MDT – Multi-disciplinary Team

CRT – Community Response Team

CYC – City of York Council

OOH- Out of Hours

SW - Social worker

POC- Package of care

DLO – Discharge Liaison Officer

Appendix 2:

York Teaching Hospital NHS
NHS Foundation Trust

Integrated Complex Discharge Planning Project

Project Initiation Document

June 2017

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1. Introduction

1.1 Purpose of this document

The purpose of this document is to define and describe the Integrated Complex Discharge Planning Project. This project is one of a number of projects under the Complex Discharge Task and Finish programme and should be read in conjunction with the overarching programme.

1.2 Background and Context

This section outlines the context that has driven the need to develop this project.

National

The National Institute for Clinical Excellence (NICE) has issued a clinical guideline on the transition between inpatient and community (or care home) settings[2]. The guidance particularly emphasises two overarching principles; the importance of personalised care planning for this cohort of patients and communication and information sharing between teams (and with patients, their families and carers).

There are 6 key areas. These are:

1. Before admission;
2. Admission to hospital;
3. During hospital stay;
4. Discharge from hospital;
5. Supporting infrastructure;
6. Training and development.

The guidance highlights the role of a discharge co-ordinator, as part of a multi-disciplinary team, liaising with community teams to plan discharge and arrange follow-up support. It re-iterates that discharge planning must start from the point of admission to hospital and utilise existing care plans where these have been developed in the community. Redesign of discharge processes should be based on the recommendations in the NICE guideline.

[2] NICE (2015) Transition between inpatient hospital settings and community or care home settings for adults with social care needs (NG27)

An initial (partial) assessment coordinated by the Clinical Effectiveness Team in June 2016 demonstrated that the Trust was not fully compliant with the guideline. A more recent Quality Standard issued by NICE, 'Transition between inpatient hospital settings and community or care home settings for adults with social care needs (December 2016[3])', identifies five quality standards.

A recent scoping exercise against these standards demonstrated that the Trust does not comply fully against these standards. Appendix 1 provides a table summarising the findings. The five standards are:

1. Information sharing on admission;
2. Comprehensive geriatric assessment;
3. Co-ordinated discharge;
4. Discharge plans;
5. Involving carers in discharge planning.

Whilst these principles and key standards are the responsibility of all staff involved in the care of the individual whilst in hospital, it is essential that we adopt a system wide approach in the evaluation and design of the supporting processes to ensure better patient experience and improved compliance.

Local

In February 2017, the North West Utilisation Management Unit (at the Greater Manchester Academic Health Science Network) was commissioned by NHS Scarborough and Ryedale CCG on behalf of the NHS Vale of York CCG, NHS Scarborough and Ryedale CCG, NHS East Riding of Yorkshire CCG and NHS Hambleton, Richmondshire and Whitby CCG, to identify causes of the reduced Emergency Department performance at York Teaching Hospital NHS Foundation Trust. The report is based on national and local data analysis together with site based observations and it identifies key recommendations to improve whole system performance.

In February 2017, a paper was commissioned by the Deputy Director of Out of Hospital Care to explore the potential to develop an integrated discharge team approach. The report highlighted the current level of resource available across the teams and outlined four potential model options.

Option 1

[3] NICE (2016) Transition between inpatient hospital settings and community or care home settings for adults with social care needs – Quality Standard

No change to current organisational or line management arrangements but focus on service improvement strategies to improve communication and the development of pathways, with clearer processes for monitoring patients' progress and a review of roles and responsibilities along the pathway. Ensure not only focus for discharge from the acute bed base but also facilitating timely discharge from the community bed base.

Option 2

Merge the acute and community discharge liaison teams under the out of hospital care directorate management team and establish a co-located base. Re-structure the teams in order to establish a clear operational reporting structure. Develop and implement clear pathways for admission avoidance, discharge to assess, step down to community units and discharge from hospital wards/assessment units.

Option 3

Merge the acute and community discharge liaison teams as above with appropriate re-structure and accountability arrangements. Co-locate social care colleagues within same operational base in order to facilitate timely patient focussed pathways and inter professional problem solving. Have both social care and health colleagues line managed by one team leader working to joint goals.

Option 4

Fully integrate health and social care teams to come under single operational management reporting system which facilitates appropriate governance, accountability arrangements and budgets.

A decision has been taken recently to implement option 2 and integrate the acute and community discharge liaison teams and review the current structures and processes in place to manage complex discharge patients.

Currently the acute discharge liaison team have bases within York, Bridlington and Scarborough Hospital and the community discharge liaison team are based geographically at White Cross Court, St Helens and Malton. The City of York Council hospital social work team have a small office based within York Hospital and team base at Archways. The Operational Manager – Integrated Discharge Liaison Team and Community Discharge Team Leader are based at Archways.

The discharge liaison team, discharge liaison officers and social care team are central to the achievement of a large proportion of the NICE standards and are pivotal in coordinating complex discharges across the organisation.

2. Project Definition

2.1 Aims and Outcomes

This section describes the overall aims of the project and the measureable outcomes that will be achieved. The following section will then describe the changes that will be made to deliver these outcomes.

Aim:

1. To ensure patients have no unnecessary waits in hospital;
2. Patients receive a safe coordinated discharge;
3. Increasing the number of patients being discharged to their normal place of residency.

Outcomes

- Reduced number of Delayed Transfers of Care (DToC);
- Reduced number of stranded patients;
- Improved patient experience of the discharge process;
- Reduced length of stay;
- Reduce the number of occupied bed days.

2.2 Deliverables

This section outlines the key deliverable changes to be achieved these are:

- Ensure existing care plans are shared with admitting team;
- Review operational model of the discharge liaison team and develop standard operating procedures;
- Specify the role of the discharge co-ordinator;
- Use of technology to support identification of potential complex discharges and discharge planning;
- Review the Joint Protocol for Transfer of Care;

- Ensure discharge planning from point of admission;
- Development of training programme for discharge planning;
- Develop discharge care plans;
- Develop a post-discharge follow up calls process.

2.3 Authority for the Project

This project has been authorised by the Complex Discharge Task and Finish group reporting to the A & E Delivery Board. The Complex Discharge Task and Finish group is a multi-agency group that represents the key partners across health and social care (including commissioners).

2.4 Scope, Exclusions, Assumptions and Interfaces

This section attempts to define the scope of the project and the assumptions at the time of development.

Scope

The scope of the integrated complex discharge planning project is to address the discharge planning process for complex patients discharged from hospital and intermediate care (bed based and home based). Patients who are in hospital and intermediate care with complex needs will require referral for assessment by a range of members of the multi-disciplinary team, or the involvement of another agency or care provider.

Definition Complex Discharge:

Patients who have complex discharge needs are defined as:

- Patients that would be discharged home or to a carer's home or to intermediate care or to a residential or nursing care home (that is not their normal place of residency).

And

- Who have complex on-going health and social care needs which require detailed assessment, planning and delivery by the multi-disciplinary team and multi-agency working.

Exclusions

Simple discharges where patients do not require additional support from social services or health services at home to maintain independence.

Definition Simple Discharge Planning:

The action needed in the discharge planning for these cases does not usually require the involvement of a full multi-disciplinary team or require the involvement of another agency.

Patients with simple discharge needs are defined as those[4]:

- Being discharged to their own home or usual place of residency; and
- Having simple on-going care needs that do not require complex planning or delivery.

Assumptions

It has been assumed that, before the project undertakes the process change that has been described, we will know:
The work programme for the:

- Care homes project;
- Continuing health care review;
- Frailty comprehensive geriatric assessment project;

Interfaces

The other projects and pieces of work that interface with this project are:

- Interface with the ward based DLO and how they will work as part of this model; (led by Tracey Wright);
- Interface with the Safer Bundle, particularly clinical management plans and EDD; (led by Donald Richardson);
- Interface with stranded patient work (led by Donald Richardson)
- Interface with flow work (led by Mark Hindmarsh);
- Interface with frailty work (led by Jamie Todd);
- Interface with primary care coordinators (York Integrated Care Team and CAVA);
- Interface with Primary Care Home and York Care Collaborative;

[4] Department of Health (2010) Ready to go?
Planning the discharge and the transfer of patients from hospital and intermediate care

- Interface with Continuing Health Care review (VOYCCG Becky Case);
- Interface with Care Home project (VOY CCG Jenny Carter);
- Interface with Primary Care Frailty (S&R CCG);
- Interface with Future Focus - adult social care remodelling (CYC Mike Richardson).

2.5 Constraints

This section highlights the factors that will be critical to the success of the project and so, as a result, have the potential to significantly impact on delivery (and timescales). In deciding to proceed, consideration must be given to the potential risks arising from this and partners should be clear on the actions that will be collectively required to minimise these.

The following constraints have been identified:

- Staff time to attend meetings due to on-going operational commitments and existing commitments to other project work streams;
- The interdependencies of projects. There are a number of overlaps within this project and with other projects, consideration needs to be given to identify the priorities and interdependencies between each.

3. Project Approach

3.1 Governance

This section describes the structures and reporting mechanisms that will govern the project.

Executive Project Sponsor

The Executive Sponsor for this project is Wendy Scott

Project Board

The Project Board is the Complex Task and Finish Group

Project Lead/Owner

The Project Lead/Owner is Melanie Liley

Project Manager

The Project Manager is Gillian Younger

Project Team (Steering Group)

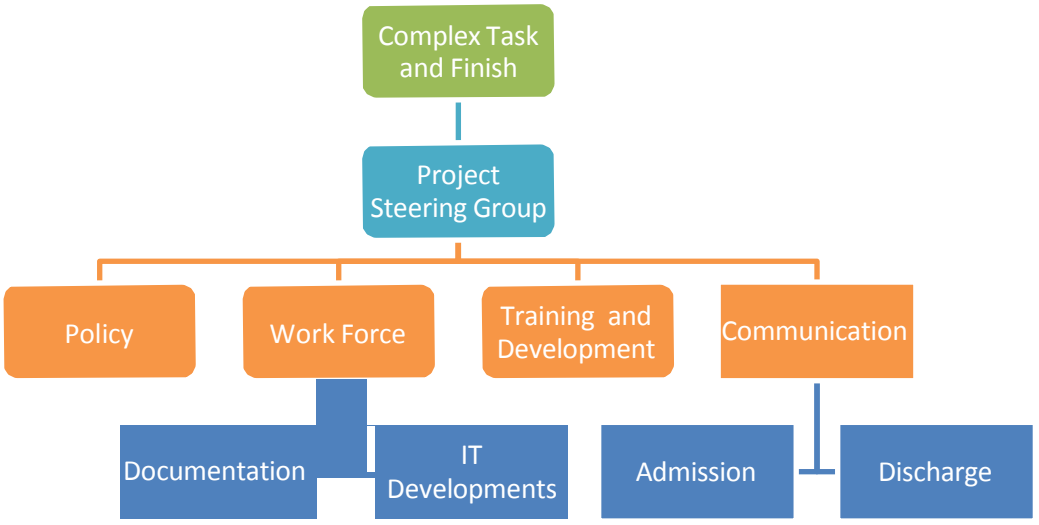
Name	Division/Organisation
Deputy Director Out of Hospital Care (Chair)	YHFT
Out of Hospital Community Service Manager *(Deputy Chair)*	YHFT
Senor Hospital Flow Manager	YHFT
Community Therapies Operational Manager	YHFT
Operational Manager Integrated Discharge Liaison	YHFT
Corporate Nursing Representative	YHFT
Discharge Liaison Team Lead/Manager	YHFT
Service Manager Hospital S/W Team	City of York
Service Manager Scarborough, Selby	North Yorkshire
Service Manager	East Riding
Project Manager	YHFT

Operational Leads

In order to achieve the aims and objectives of the project there will be a number of focused work streams, each work stream will have a nominated operational lead and work stream membership will consist of identified stakeholders. The work streams are as follows:

Work stream	Operational Lead
Workforce- Integrated Discharge Liaison Team	Bev Proctor
Training and Development	Sara Kelly
Policy	Tracey Wright
Communication Admission & Discharge Processes	Corporate Nursing

3.2 Project Organisation



Each work stream will report monthly into the project steering group. The steering group will report progress monthly to the Complex Discharge Task and Finish Group (Project Board).

Each work stream will be expected to complete a written update (plan on a page) on a monthly basis. The Steering Group will produce an executive summary for the Complex Discharge Task and Finish Group.

3.3 Stakeholders

Each work stream will undertake a stakeholder mapping and analysis exercise. Once stakeholders have been identified, they will be analysed to estimate their levels of interest and influence on the successful delivery of the aims and objectives of the work stream.

3.4 Communication

A communication plan will be developed by the steering group to identify the methods to be used to communicate the work and any changes made.

4. Project Plan

The three sections that follow describe the next steps for the project. It also sets out the approach that will be taken to identifying and managing risks associated with the programme.

4.1 Milestones and Timescales

A full project plan will be developed but the following table highlights the key milestones identified for the project and the timescales for these to be delivered. The draft project plan can be found in appendix 1.

Milestone	Timetable
Approve Project Scope	May 2017
Present draft Programme Initiation Document to multi-agency stakeholders	June 2017
Approve Programme Initiation Document	June 2017
Set up work streams and contract with work stream leads	June 2017
Undertake stakeholder mapping and analysis and develop communication plan	June 2017
Identify prioritisation and overlaps	July 2017
Write detailed project plan	July 2017

Implementation	August-December 2017

4.2 Deliverables

The full list of deliverables will emerge with the completion of the project plan, however the following table highlights some of the key early deliverables.

Deliverable	Timetable
Approve Project Scope document	May 2017
Draft Project Initiation Document	June 2017
Establish Integrated Complex Discharge Planning Project Group	June 2017
Communication Plan	June 2017
Risk Register	June 2017
Project Plan	July 2017

4.3 Risks

In order to support the management and mitigation of risk associated with the project; a comprehensive risk register will be established and held by the steering group.

5. APPENDICES

5.1 Appendix 1: NICE Quality Standards scoping exercise summary

The recent Quality Standard issued by NICE, 'Transition between inpatient hospital settings and community or care home settings for adults with social care needs (December 2016[5])', identifies five quality standards. A recent scoping exercise against these standards demonstrates that the Trust does not comply fully against these standards. Table 1 provides an overview of this scoping exercise and identifies some of the actions required to improve compliance.

Table 1: Quality Standards and Initial Assessment

Quality Standard	Assessment	Assessment Evidence
QS1: Information Sharing on Admission Adults with social care needs who are admitted to hospital have existing care plans shared with the admitting team.	Non-compliant	Discussions with the SNS team have started about identifying patients who have previously been discharged with a Section 5 (NOD) or who are known to be complex patients on the District Nursing/community teams' case load who have existing care plans. More understanding is required around the opportunities within primary care and social care processes for patients with existing care plans.
QS2: Comprehensive Geriatric Assessment Older people with complex needs have a comprehensive geriatric assessment started on admission to hospital.	Partial Compliance	Comprehensive Geriatric Assessment (CGA) is currently completed but is not in a single coordinated assessment. The information is collected during the admission process at various points by multiple professionals. Timeliness and comprehension needs to be improved. There are plans to pilot a single combined CGA document from the point of admission across both sites and the pilot will commence firstly in Scarborough.
QS3: Coordinated Discharge Adults with social care needs who are in hospital have a named discharge coordinator.	Non-compliant	Acute Discharge Liaison nurses and DLO have allocated ward responsibilities and manage complex discharge. DLO's (Managed by the patient flow team) are allocated to each ward manage all discharges. SW team act as the coordinator for social care. Need to define the role and agree the key responsibilities against the standard to provide greater assurance. Determine the role of the wider MDT in co-ordination.
QS4: Discharge Plans Adults with social care needs are given a copy of their agreed discharge plan before leaving hospital.	Partial Compliance	Electronic Discharge Notification gives very limited information; some chronic conditions have self- management plans? Need to better understand the documentation given to patients / family from social care Design a discharge care plan for consistency
QS5: Involving Carers in discharge planning Adults with social care needs have family or carers involved in discharge planning if they are providing support after discharge.	Partial Compliance	Family/Carers attend Acute MDT Meeting (case Conference) Family/Cares involved in initial assessments Discharge to assess family /carer involved and present at the point of discharge; model to be rolled out Complaints trends indicate that we do not communicate or involve patients Proactive evaluation of discharge experience of patients and family's

NICE (2016) Transition between inpatient hospital settings and community or care home settings for adults with social care needs – Quality Standard

Appendix 3:

York Teaching Hospital NHS
NHS Foundation Trust

Project Brief- Refresh Phase 2

Project Title: Integration of Intermediate & Reablement care 'One Team

1) Executive Sponsors	
Melanie Liley	Michael Melvin
YHFT	CYC

2) Operational Project Lead		
Rachael Smye	Dr Lesley Godfrey	Belinda Jones
YHFT/ CRT	Primary Care/ ICT	CYC/Adult Social care

3) Project Manager if applicable	
YHFT- Gillian Younger	CYC - Chris Weeks

Date of Project Brief Agreement	August 2016

Project Start Date	August 2016	**Project End Date**	1 April 2018

4) Background to the Project
In August 2016 through Provider Alliance project approval was given to commence an integration project for intermediate care and reablement within the City of York. **Aim:** The aim of the project is to design a patient centred intermediate rehabilitation and

reablement service across the City of York. The service aims to be responsive and well-coordinated to enable patients to be safely cared for/supported to remain in their own home and maximise independence

Project Scope:
Service included:

- Community Response Team
- Reablement Service (commissioned by CYC)
- York Integrated Care Team
- CYC Adult Social Care Teams
- Voluntary Sector

Requirements

1. Single Specification / Outcomes framework
2. Single point of access/triage
3. Co-location of teams
4. Shared Documentation/Assessments
5. Trusted Assessor model
6. Workforce Development
7. Co production model for design

The project has now been running for 1 year and entering phase two.

Phase 1: (August 2016 – August 2017) **Progress to date**

- Testing joint triage with core teams
- Space for co-location at Archways provided for up to 20 members of the 'One Team' to be co-located. Teams included are CRT, ISS, Hospital SW (own space), Reablement, Community Discharge Liaison Team.
- Co production model with service users and regular public reference forums in place. Public Reference Group, include customers and carers from the focus groups who expressed an interest, Healthwatch York, Older Citizens Advocacy York (OCAY), York Older People's Assembly (YOPA).
- Rehab social work team working with CRT directly has reduced the time from initial referral and reduced duplication and improved communication.
- The team have agreed a set of joint metrics/outcomes both quantitative and qualitative.

Phase 2: (September 2017– January 2018)

- **Embed the joint triage process** – This will start to see movement between teams and reduce the hand offs back to wards

- **Assess the feasibility of a single point of referral** for health and social care referrals into the one team (step down)- This will provide the wards with a simple referral pathway (joint referral documentation) and reduce the hand offs back to wards and further develop pathway 1 of supported discharge (Trusted Assessment) and more patients being assessed at home.

- **Standardisation of assessments between Hospital /community adult social care teams –** This will enable reablement to have a single assessment process, reduce time for Hospital social work teams

- **Workforce –** Begin to develop an in depth understanding of the role and competencies with each team and identify opportunities for share training and development. Explore the governance arrangement that would be required for joint care of patients

Phase 3: (January 2018– April 2018)

- Assessment of Progress

5) Key Objectives with Quality and Success Criteria

The outcomes and key functions of the service has remained unchanged these were:

Outcomes :

- People who use the service and their carers have a positive experience of care and support
- People and their carers are supported effectively to enable them to keep living in their own home or normal place of residence
- People are supported to recover from episodes of ill health or following injury

This project will include four of the key functions identified;

1. **Access and co-ordination** – the 'one team' will be expected to provide daily co-ordination of individuals in transition between care settings; regular meetings to support care planning for high risk individuals; an interface between the team and other services (including acute care) and co-ordination within the team.
2. **Rapid response** – the 'one team' will be expected to provide a timely response (within hours) to those with an urgent need, wrapping additional support around existing services to ensure an individual can remain at home in a crisis.
3. **Facilitated and supported discharge** – the 'one team' will be expected to actively pull individuals from acute settings, wrapping additional support around existing

services to ensure an individual can return home. This will include providing assessments of long term care and support needs where required.

4. **Maximising independence** – the 'one team' will work with individuals, taking a coaching approach, to promote prevention, self-care and the use of community support to maximise independence.

6) Key Stakeholders both Internal and External, including Finance and CET Leads (including contact details)

Project Team

Rachel Smye (YHFT)

Lesley Godfrey /Liz Allen (Primary Care)

Rachel Daniels (YHFT)

Sam Watts (previously Cathy Holman) (CYC)

Liz Conheeney (CYC)

Nicky Openshaw (Age Uk)

Emma Brough (YHFT)

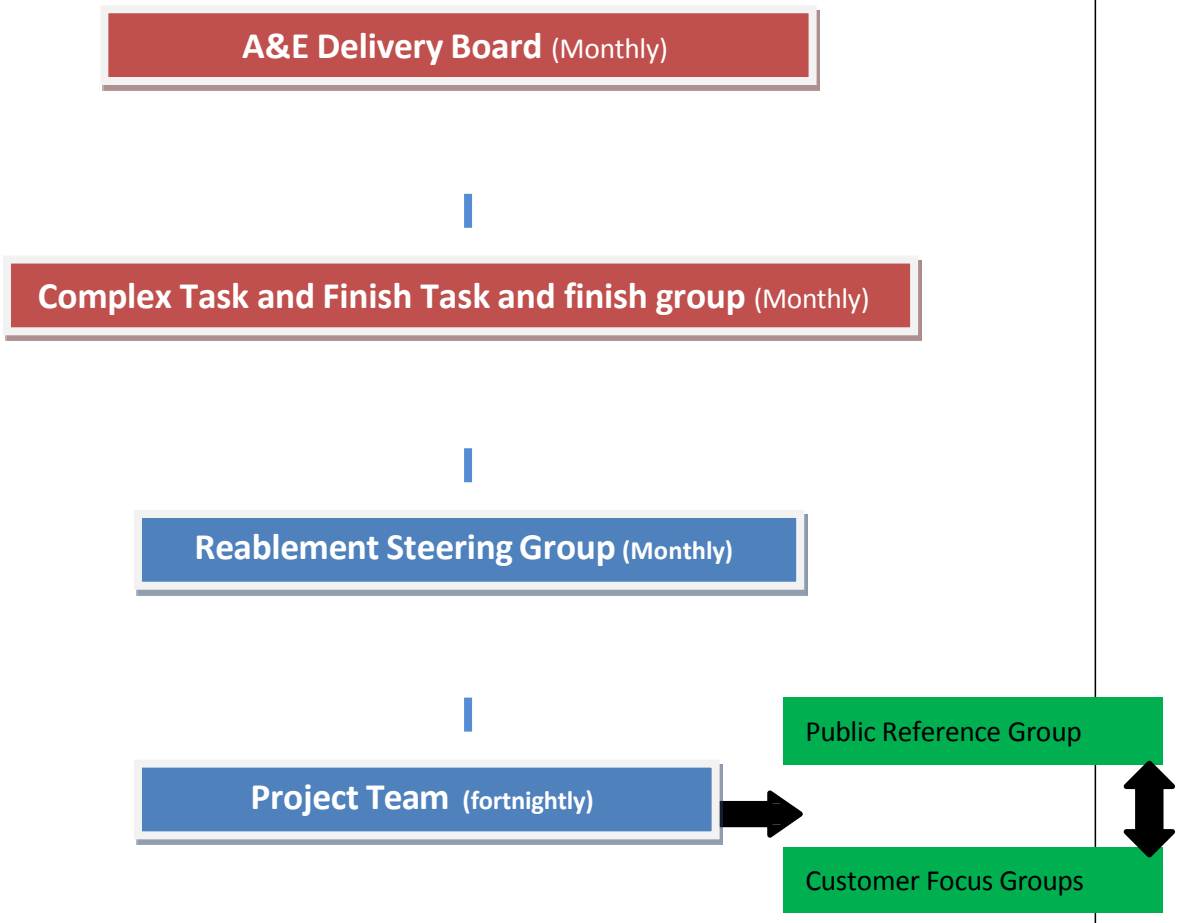
Community Discharge Liaison (YHFT)

Other stakeholders will be co-opted a plans and focus changes

7) Governance, Reporting and Monitoring including Communications Plan (including Frequency and Format)

Governance & Reporting and Monitoring

The Project Team will provide a monthly written update to the reablement steering group and the complex discharge task and finish group and report by exception an any other time.



8) Risk and Issues, and Constraints

There have been a number of constraints. In summary these include:

- The service scope for York CRT has changed significantly over the last 7 months team now cover north Ryedale and City North and has required the operational team to focus on the delivery of core business whilst balancing the demands of an integration agenda.
- CRT referral activity has increased by over 50 % and capacity is now at full

escalation.

- The reablement tender process ran from January – April and contract mobilisation commencing August 2017, have both delayed any direct engagement until the tender was awarded. However the specification was very clear about the one team model.

- IT delays in the installation of additional network capacity and equipment

9) Assumptions

- No further changes will be made to York CRT
- Mobilisation of the reablement contract continues as planned

10) Measures for Success

The team have agreed a set of joint metrics/outcomes both quantitative and qualitative. Outcomes include

- **Number of referrals** – The project aim is increase the number of referrals managed from the baseline of August 2016
- **Number of patients who remain in their own residency 91 days after discharge** – The project aim is to increase the number of patients remaining in their own residency.
- **The number of permanent admissions to residential care**. The project aim is reduce the number of patients admitted to residential care
- **Outcome from service -** The project aim is reduce the size of care package at start and service vs at end of service
- **Functional outcome from services** The project aim is increase the functional ability from the start of service vs end
- **Overall patient satisfaction with the service -** The project aim is increase patient satisfaction
- **Overall staff satisfaction with communication between services-** The project aim is increase staff satisfaction.

11) Resourcing Arrangements

Continued to be funded by existing resources

Approval Date: ……../……/……

Appendix 4: BCF Risk Log as of 26th July 2017

Risk Description	Consequences	Impact/Likelihood	Controls/mitigating actions
Inaccurate assumptions underpinning financial modelling and target setting within the plan.	• Financial consequences for whole system. • Knock on effect for future years. • Reduction in confidence in system leaders. • Reputational damage with national programme directors	High impact/low likelihood.	1. Monthly performance monitoring at BCF PD Task Group 2. Further work to develop a joint performance management framework. 3. Recovery plans whenever underperformance.
Failure to take up joint commissioning opportunities.	• Inefficient use of resources and duplication of activity. • Fragmented delivery, care and support. • Reduced opportunity to achieve a sustainable health and care system. • Difficulties in bringing about integration of health and social care by 2020.	High impact/low likelihood.	1. Joint commissioning strategy agreed 2. Risk management principles in place 3. Challenge at partnership boards. 4. Joint commissioning programme Manager appointed
Failure to achieve KPIs at individual scheme level.	• Performance impacted. • Assurance level of CCG impacted. • Potential financial impact (dependant on KPI measure)	High impact/moderate likelihood.	1. Monitoring of BCF delivery PD Group and HWB. 2. Organisational monitoring of individual schemes in line with lead commissioner.

Risk Description	Consequences	Impact/Likelihood	Controls/mitigating actions
Failure to achieve national targets (especially NEA)	• Performance impacted. • Assurance level of CCG impacted. • Potential financial impact (dependant on KPI measure)	High impact/moderate likelihood.	1. Monitoring of BCF delivery. 2. Organisational monitoring of individual schemes in line with lead commissioner. 3. Application of risk management principles. 4. Signed S75 agreed and in place. 5. Seeking reconciliation of ambulatory care reporting issues (NEA)
Workforce pressures affect delivery of schemes	• Reduced capacity and/or capability. • Negative impact on KPIs, financial and national metrics. • Wider system pressure.	High impact/moderate likelihood.	1. Joint workforce strategy in place. 2. Wider system focus via HWB partnership. 3. On-going discussions with strategic partners. 4. Monitoring of individual systems by lead commissioner to flag any issues at an early stage.
STP and Capped Expenditure Programme creates pressures on delivery of the BCF plan.	• Financial pressures. • Reputational damage. • Workforce disruption. • Negative impact on KPIs, performance.	High impact/high likelihood.	1. Involvement of senior leaders in STP planning arrangements. 2. Reporting via organisational systems. 3. Monitoring of BCF delivery via HWB. 4. Regular informal briefing sessions delivered by CCG to partners
External Inspection by CQC of BCF Programme	• Reputational damage • Limited power of CQC to take action	Low impact/High Likelihood	1. Capacity pressures with other reviews and inspections (CQC, SEND) 2. iBCF compliance with National Conditions