Norfolk Health & Wellbeing Board

Date: **Tuesday 26 April 2016**

Time: **Part A in public 9:30am**
Part B in private (development workshop)

Venue: **South Norfolk District Council, Long Stratton**

Membership	Substitute	Representing
William Armstrong	Alex Stewart	Chair, Healthwatch Norfolk
Cllr Yvonne Bendle	Cllr Alison Thomas	South Norfolk Council
Stephen Bett	Jenny McKibben	Norfolk's Police and Crime Commissioner
Harold Bodmer	Catherine Underwood	Executive Director Adult Social Services
Dr Hilary Byrne	Antek Lejk	South Norfolk Clinical Commissioning Group
Cllr Penny Carpenter	Cllr Marlene Fairhead	Great Yarmouth Borough Council
Cllr Trevor Carter		Breckland District Council
Cllr Annie Claussen-Reynolds		North Norfolk District Council
Pip Coker		Voluntary Sector Representative
T/ACC Nick Dean	T/ACC Nick Davison	Norfolk Constabulary
Ruth Derrett		NHS England, East Sub Region Team
Dr Anoop Dhesi	Mark Taylor	North Norfolk Clinical Commissioning Group
Andy Evans	John Stammers	Great Yarmouth & Waveney Clinical Commissioning Group
Cllr Gail Harris	Phil Shreeve	Norwich City Council
Joyce Hopwood		Voluntary Sector Representative
Cllr James Joyce		Chairman, Children's Services Committee, Norfolk County Council
Dr Ian Mack	Dr Sue Crossman	West Norfolk Clinical Commissioning Group
Cllr Elizabeth Nockolds		Borough Council of King's Lynn and West Norfolk
Cllr Andrew Proctor	Cllr Roger Foulger	Broadland District Council
Michael Rosen	Don Evans	Executive Director Children's Services
Dr Louise Smith		Director of Public Health
Dr Wendy Thomson		Managing Director, Norfolk County Council
Dan Mobbs		Voluntary Sector Representative
Cllr Brian Watkins		Norfolk County Council
Cllr Sue Whitaker	Cllr Elizabeth Morgan	Chair, Adult Social Care Committee, Norfolk County Council
Tracy Williams	Jo Smithson	Norwich Clinical Commissioning Group

Persons attending the meeting are requested to turn off mobile phones.

For further details and general enquiries about this Agenda please contact the Committee Administrator:
Nicola LeDain on 01603 223053
or email committees@norfolk.gov.uk

Part A

1	**Apologies**	Clerk	
2	**Minutes**	Chair	(Page **3**)
3	**Members to Declare any Interests**	Chair	
4	**Any urgent business**	Chair	

Items for discussion/action

6	**Integration and transformation**		
	a) Norfolk & Waveney Sustainability and Transformation Plan	Wendy Thomson	(Page **6**)
	b) Norfolk Better Care Fund Plan	Harold Bodmer/ CCGs x 5	(Page **12**)

Close of public meeting – short break
Part B

	H&WB Review – development workshop	Daniel Goodwin

Information updates

- **Healthwatch Norfolk Board** – you can access the most recent HWN Board papers at the following link
- **Norfolk Health Overview & Scrutiny Committee** – you can access the most recent NHOSC papers at the following link

Norfolk County Council

Health and Wellbeing Board
Minutes of the meeting held on Wednesday 3 February 2016 at 9.30am
in Colin Chapman Room, Hethel Engineering Centre, Hethel

Present:

Cllr Yvonne Bendle	South Norfolk Council
Harold Bodmer	Executive Director, Adult Social Services
Dr Hilary Byrne	South Norfolk Clinical Commissioning Group
Cllr Trevor Carter	Breckland District Council
T/ACC Nick Davison	Norfolk Constabulary
Cllr Gail Harris	Norwich City Council
Joyce Hopwood	Voluntary Sector Representative
Antek Lejk	South Norfolk Clinical Commissioning Group
Dr Ian Mack	West Norfolk Clinical Commissioning Group
Jenny McKibben	Deputy Police and Crime Commissioner
Dan Mobbs	Voluntary Sector Representative
Cllr Elizabeth Nockolds	Borough Council of King's Lynn and West Norfolk
Cllr Andrew Proctor	Broadland District Council
Michael Rosen	Executive Director Children's Services
Dr John Stammers	Great Yarmouth & Waveney Clinical Commissioning Group
Alex Stewart	Healthwatch Norfolk
Dr Louise Smith	Director of Public Health
Jo Smithson	Norwich Clinical Commissioning Group
Dr Wendy Thomson	Managing Director, Norfolk County Council
Catherine Underwood	Director of Integrated Commissioning
Cllr Brian Watkins	Norfolk County Council
Cllr Sue Whitaker	Chair, Adult Social Care Committee, NCC

Also present:

- Anne Gibson, Executive Director of Resources, Norfolk County Council

1 Apologies

1.1 Apologies were received from Cllr Penny Carpenter, Cllr Annie Claussen-Reynolds, Dr Anoop Dhesi, William Armstrong (substituted by Alex Stewart) and ACC Nick Dean (substituted by T/ACC Nick Davison).

2. Minutes

2.1 The minutes of the Health and Wellbeing Board (HWB) held on the 4 November 2015 were agreed as a correct record and signed by the Chair.

3. Declaration of Interests

3.1 There were no interests declared.

4. Urgent Business

4.1 There was no urgent business received.

5. Integration in Norfolk and the Better Care Fund Plan

5.1 The Board received a report which explained that Norfolk's 2015-16 BCF programme was a key mechanism for the delivery of integration in Norfolk. It was an ambitious programme addressing the suite of national indicators including targeting a reduction in non-elective admissions of 3.5%. This report provided a structured review of progress with Norfolk's BCF plan 2015/16 so far using the national Better Care Fund Self-Assessment Tool. The report also outlined the planning parameters for next year and made proposals for developing the Norfolk BCF programme for 2016/17, building on the BCF 2015/16 programme.

5.2 The Board recognised that there was unprecedented financial pressure for the whole system and that the challenges across health and care nationally were reflected in Norfolk including increasing demand, difficulties in recruitment and financial challenge. It was recognised that whilst each of the organisations has plans to address their own financial and operational challenges, the scale of change needed required collaborative transformation across services and across traditional boundaries

5.3 The outcome of the structured review of the BCF programme 2015/16 highlighted interventions which had the most positive impact and where they had not achieved desired impact, including where plans may have been too ambitious in terms of the number of schemes that required developing and implementing. It was noted that focused work was being carried out in order to achieve the national target for non-elective hospital admissions. Joint teams were providing support to reduce unnecessary admissions and, for example, parts of the County were focusing on those with special conditions where, with coordinated support, interventions were making a real difference.

5.4 It was recognised that the health and social care system in Norfolk was complex and it would be important for partners to work together to carefully readjust the system in order to bring about improvements, for example, in relation to delayed transfers of care.

5.5 Members noted that in addition to the Better Care Fund plan work there were workstreams being carried out by the whole systems resilience group, and the need to ensure that these were appropriately linked.

5.6 The Board **RESOLVED** to;

- Note the BCF 2015/16 progress submission to NHS England for the period 1 July to 30 September 2015 and commission a 'deep-dive' style review of the position around provision of 7-day services across Norfolk.
- Provide any final considerations and agree in principle to the overarching proposals for Norfolk's 2016/17 BCF Programme in time for the initial submission on 8 February 2016.
- Agree what actions the Board / individual members would take to help address key issues in relation to BCF 2015/16 and/or planning for 2016/17.

6. Joint Health and Wellbeing Board Strategy Implementation Update

6.1 Members received a report which explained that it had been 18 months since the Board had signed off the current Joint Health and Wellbeing Strategy. A mid-way review of the Strategy Implementation Group (SIG) had been carried out and proposals were agreed including giving the Group more of a co-ordinating role, rather than a representative role, and streamlining membership accordingly. Progress continued to be made and the

quarterly strategy update was contained within the report.

6.2 Members discussed the importance of prevention and early intervention having been identified as priority areas, but concerns were also raised around the urgency of some critical issues that are impacting now that needed to be addressed. There was overall agreement for the Board to keep focused on the impact based outcomes.

6.3 Dr Louise Smith, DPH, updated the Board on the plans underway for making mental health and a priority for Norfolk and asked the Board to consider a wider concept of 'mental wellbeing and happiness'. The DPH outlined the outcome of the recent mental health seminar which was designed to help identify the focus and ambition and confirmed that there was an appetite for change and an opportunity for the H&WB to create that common purpose and to look at equity of esteem. The Board agreed that it had a major role to play in addressing this and it was an important and urgent issue.

6.4 The Board **RESOLVED** to;

- Confirm agreement of the new Terms of Reference of the board sub-committee – Strategy Implementation Group (SIG) in Appendix 1.
- Note the summary update on how other board strategy priorities are progressing as shown in Appendix 2 of the report.
- Note progress being made towards making Mental Health a board priority in Appendix 3.

The next meeting would take place on **Tuesday 26 April 2016** at 9.30am. The venue would be confirmed.

The meeting closed at 1pm

Chairman

Norfolk Health and Wellbeing Board

26 April 2016
Item 6a)

Report title:	**Norfolk & Waveney Sustainability & Transformation Plan**
Date of meeting:	**26 April 2016**
Sponsor:	**Dr Wendy Thomson, MD, Norfolk County Council**

Reason for the report

Sustainability and Transformation Plans (STPs) are being introduced across the Country as part of the delivery of the **NHS Five Year Forward View** - the new shared vision for the future of the NHS.

STPs are place-based, system-wide plans for health and social care, and the guidance states that, amongst other things, **success depends on "having an open, engaging, and iterative process** that harnesses the energies of clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government **through health and wellbeing boards**".

Report summary

This report outlines the new national policy initiative of STPs. The NHS shared planning guidance Delivering the Forward View asks "every health and care system to come together to create their own ambitious local blueprint for accelerating implementation of the Five Year Forward View" through a new Sustainability and Transformation Plan which will cover the period from October 2016 to March 2021.

These are place-based, system-wide plans for health and social care across the country and should cover integration with local authority services "including, but not limited to, prevention and social care, reflecting locally agreed health and wellbeing strategies". NHS England expects STPs to be submitted at the end of June 2016 and they will be subject to formal assessment in July. This is an important milestone in implementing the NHS new models of care outlined in the Five Year Forward View (5YFV).

The **Norfolk and Waveney** geographic 'footprint' will be covered by a **single STP** and a system-wide executive group has been established to oversee the development of the Norfolk and Waveney STP. An **initial submission**, in the form of a set of slides, was required by NHS England on 15 April 2016. We are not permitted to publish this interim submission but the set of slides has been sent to Board members to see in advance of the meeting and hard copies will be available on the day.

Key questions for discussion

- How do the emerging priorities of the Norfolk & Waveney STP support the Board's drive to deliver its overarching goals - integration, prevention, reducing inequalities?
- As a forum for shared leadership and collaboration, the H&WB has the opportunity to both influence the STP and be kept informed of its development and implementation – how can this best be achieved?
- What are the implications for other partners in the H&WB in relation to the STP, and its influence and 'reach' into wider communities?

Action/decisions needed:

The Health & Wellbeing Board is asked to:

- Comment on the initial submission to NHS England
- Consider and form a view about the H&WB's advice for future submissions noting that the final submission is due in June
- Agree that the STP should be brought to the H&WB on a regular basis as part of the STP work programme's engagement strategy and appropriate reporting arrangements

1. Sustainability and Transformation Plans (STPs)

What are they?

1.1 The recent NHS Shared Planning Guidance introduces new local health and care system Sustainability and Transformation Plans (STPs) - place-based, system wide, multi-year plans. Set within the context of the Five Year Forward View (FYFV), which was published in 2014, and the significant challenges facing the NHS, this recognises the need to move from short term organisationally focused changes to transformational, system wide initiatives with a population focus.

Must do's

1.2 STPs must cover all areas of CCG and NHS England commissioned activity including:

- **Specialised services**, where the planning will be led from the 10 collaborative commissioning hubs
- **Primary medical care**, and do so from a local CCG perspective, irrespective of delegation arrangements

1.3 The STP must also cover **better integration with** local authority services, including, but not limited to, **prevention and social care, reflecting locally agreed health and wellbeing strategies.**

National challenges or 'gaps'

1.4 As well as outlining how they will deliver the Government's Mandate to NHS England (Annex 2, Page 22 of the Guidance), STPs will need to address a series of 'national challenges' or 'gaps', which fall into three themes (Annex 1, Page 17):

- **Improving health and wellbeing** – including plans for a "radical upgrade in prevention, patient activation, choice and control, and community engagement".

- **Improving quality and developing new models of care** – including plans for a "new care model development, improving against clinical priorities, and rollout of digital healthcare"

- **Improving efficiency to achieve financial balance** – including plans for how areas will achieve financial balance across their local health system and improve the efficiency of NHS services".

1.5 Local health and care economies are required to set out their transformation programme to close their 'gaps' and build the sustainable health system for their local population for 2020 based within the framework of the Five Year Forward View.

1.6 From 2017/18 onwards, **STPs are expected to "become the single application and approval process** for being accepted onto programmes with **transformational funding".**

New Care models and STPs

1.7 This is an important milestone in implementing the NHS new models of care outlined in the Five Year Forward View (FYFV). Published in October 2014, the FYFV sets the future of the NHS in the context of communities and partners including local authorities. It recognises that for the future, there needs to be a much stronger emphasis on population health and prevention. Breaking down barriers in the provision of care is fundamental; between GPs and hospitals, physical and mental health and between health and social care.

1.8 Solutions are for local determination but the FYFV sets out a series of models:

- **Multispecialty community providers** – where groups of GPs combine with other services such as community health services, hospital specialists and perhaps mental health and social care to provide integrated community services
- **Primary and acute care systems –** combining for the first time general practice and hospital services to create integrated hospital and primary care providers
- **Urgent and emergency care networks** – redesigning services to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services
- **Viable smaller hospitals** – including the option to partner with larger hospitals
- **Specialised Care** – specialist services could be consolidated where there is a strong relationship between the number of patients and the quality of care
- **Modern maternity services** – giving midwives options to take charge of the maternity services they offer
- **Enhanced health in care homes** – with the NHS providing more support for frail older people living in care homes

1.9 These models are being tested with Vanguard schemes recognised across the country to inform planning. There are no Vanguards in Norfolk. The spending review provided additional dedicated funding streams for transformational change, building up over the next five years. This protected funding is for a range of initiatives, including the spread of the FYFV new care models through and beyond the vanguards.

1.10 NHS England expects that the **development of new care models will feature prominently within STPs** and areas will need to determine how they will respond to this in planning how they will drive transformation to close the care and quality and financial gap. Further information about the new care models and progress with trialling of models at vanguard sites is available at the following link: https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/.

Health and Wellbeing Boards

1.11 The guidance has clear expectations about health and wellbeing boards and states that, amongst other things, **success also depends on "having an open, engaging, and iterative process** that harnesses the energies of clinicians, patients, carers,

citizens, and local community partners including the independent and voluntary sectors, and local government **through health and wellbeing boards**.

Timescales

1.12 Initial submissions were due to NHS England on 15 April 2016. Final STPs are due to be submitted at the end of June, and will be subject to formal assessment in July.

1.13 CCGs and NHS providers one year operational plans for 2016/17 continue to be organisation-based but consistent with the emerging STP.

2. Developing the Norfolk and Waveney STP

Local 'footprint' or planning area

2.1 National planning requirements are set out in the guidance together with the timescales. The **first step** was for local areas to come together to agree the geographical footprint covered by their sustainability and transformation plan, noting that the plan was intended as an "umbrella plan, holding underneath it a number of different specific delivery plans, some of which will necessarily be on different geographical footprints".

2.2 It has been proposed by local leaders that this **geographical footprint is Norfolk and Waveney** and this has been approved by NHS England. This means that the STP will incorporate the Waveney area, which sits under the Suffolk Health & Wellbeing Board, and the rationale for this is that it is important that the footprint reflects the geography of the James Paget hospital.

System-wide Executive Group

2.3 A system-wide executive group has been established to oversee the development of the Norfolk and Waveney STP. This arrangement is based on the existing group of chief executives across the health and care economy who have been leading the development of a programme of work to address the current challenges across the system. The group includes the chief executives of the 5 CCGs in Norfolk and Waveney, the 3 NHS foundation hospital Trusts, the Norfolk and Suffolk mental health trust, the community health and care providers, independent care providers, the Ambulance Trust, the Local Medical Committee and the County Council.

Initial submission

2.4 The key focus so far for the executive group has been the preparation of an initial Norfolk and Waveney planning submission - a template of slides - which was required by 15th April 2016. We are not permitted to publish this interim submission but the set of slides has been sent to Board members to see in advance of the meeting and hard copies will be available on the day.

2.5 The Norfolk and Waveney initial submission outlines **high level governance** arrangements including the footprint area for planning purposes, the nominated lead – in this case Dr Wendy Thomson, MD, Norfolk County Council – and the organisations represented. The submission also gives and initial outline of the process for **involvement and engagement.**

2.6 The submission goes on to outline how the STP will address the **three national challenges or 'gaps'**:

- Improving the health of the people in your area

- Improving care and quality of services
- Improving productivity and closing the financial gap

2.8 It also outlines the **emerging priorities** which are as follows:

Key areas for focus	Emerging system priorities
Prevention at scale	• Ensure every child has the best start in life through the healthy child programme • Tackle the preventable causes of ill health in older people and those with mental health conditions • Deliver targeted early intervention programmes that support people to remain independent and well in their own homes and communities
New/sustainable models of care at scale	• Determine at pace which models of care are a best fit for our footprint to achieve our aspiration of returning to aggregate balance and supporting more people in a community setting • Adopt learning from the Vanguards and local initiatives to integrate primary, community and social health and care provision and work jointly across the acutes • Determine an approach to sustainability of all sectors including Domiciliary Care and Primary Care
Workforce change	• Achieve a healthy and productive workforce by stepping up existing workplace initiatives • Focus on attracting and retaining high quality staff across the health & care sector, including independent providers
Enabling culture & behaviours	• Address cultural and behavioural issues among the public and staff, with the ambition of creating greater credibility for community provision and reducing confusion about the use of emergency care
Structural enablers and infrastructure	• Establish an approach to achieving one estate and ICT infrastructure • Developing and delivering the digital roadmap so that all heath and care records are digital by 2020, Information is shared between organisations in a way which is core to them and resources are optimised through standardisation
Commissioning & contracting	• Simplify commissioning and contracting arrangements to adopt a greater one system perspective for commissioning and reduce the number and complexity of contracts • Achieve greater consistency in provision and core standards across the footprint through standardisation

2.9 The initial submission also outlines emerging thinking about the areas where we would like support, including areas for national or regional support, support in relation to national barriers, around sharing good practice and in relation to identified key risks.

Action

3.1 The guidance is clear that health and wellbeing boards have a key role to play in relation to STPs, in particular in relation to engagement. It is envisaged that areas will have an "**open, engaging, and iterative process that harness the energies** of clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government **through health and wellbeing boards**". The Board will want to consider how it can best use its 'reach' into wider communities in terms of engagement around the national challenges or 'gaps' (1.4 above) and the emerging priorities (2.8 above).

3.2 **Key questions for discussion are**:

- How do the emerging priorities of the Norfolk & Waveney STP support the Board's drive to deliver its overarching goals - integration, prevention, reducing inequalities?
- As a forum for shared leadership and collaboration, the H&WB has the opportunity to both influence the STP and be kept informed of its development and implementation – how can this best be achieved?
- What are the implications for other partners in the H&WB in relation to the STP, and its influence and 'reach' into wider communities?

3.3 **The Health & Wellbeing Board is asked to**:

- Comment on the initial submission to NHS England
- Consider and form a view about the H&WB's advice for future submissions noting that the final submission is due in June
- Agree that the STP should be brought to the H&WB on a regular basis as part of the STP work programme's engagement strategy and appropriate reporting arrangements

Officer Contact

If you have any questions about matters contained in this paper please get in touch with:

Name	Org	Email
Wendy Thomson, MD	Norfolk County Council	wendy.thomson@norfolk.gov.uk

Norfolk Health and Wellbeing Board

Item 6b)

Report title:	**Integration and the Better Care Fund plans 2015/16 and 2016/17**
Date of meeting:	**26 April 2016**
Sponsor: (H&WB member)	**Executive Director of Adult Social Services Chief Officer of each of the five Norfolk CCGs**

Reason for the Report

The Health & Wellbeing Board has a duty to promote integration and Board members have agreed that driving integration is one of its three strategic goals in its Joint Health & Wellbeing Strategy. It is the body responsible for developing and implementing the strategic plan for the Norfolk Better Care Fund Plan and is accountable, overall, for the Norfolk Better Care Fund.

Report summary

Norfolk's BCF programme is a key mechanism for the delivery of integration in Norfolk - it provides a vehicle not only for furthering integration between health and social care, but to support transformation which is required to address the sustainability of the system. The 2015/16 Plan was an ambitious programme addressing the suite of national indicators including targeting a reduction in non-elective admissions of 3.5%. This report provides an update of progress with Norfolk's 2015/16 BCF plan along with the most recent BCF quarterly submission to NHS England.

The report also updates on the development of the Norfolk 16/17 programme, which builds on the learning from the 2015/16 programme and notes the need to resolve funding allocations. The 16/17 is therefore not available for approval and the report notes how this will be progressed. Lastly an update is provided on successful bids for support from NHS England and details how these will be used to build an impactful programme in 16/17.

Key questions for discussion

- What are the key learning points from programme in 15/16?
- What are the key issues for the Board in relation to the challenges going forward?
- How can the Board/Individual members support and influence agreement of the 16/17 programme?

Action/decisions needed:

The Health & Wellbeing Board is asked to:

- Consider and comment on the information outlined in this paper **(key questions for discussion are above and the draft narrative submission is attached as Appendix B)**
- Note that agreement on the 2016/17 BCF programme has yet to be reached and the work that is underway to achieve this agreement
- Agree what actions the Board/individual members will take to help address key issues in relation to 2016/17
- Note the BCF 2015/16 progress submission to NHS England for the period 1 October to 31 December 2015

1. Background

1.1 The H&WB approved the Norfolk Better Care Fund (BCF) 2015/16 for submission to NHS England in time for implementation from 1 April 2015. At its meeting in April 2015, the Board agreed to set up a BCF Sub-Group with responsibility for signing off the quarterly submissions to NHS England and agreed that those quarterly submissions would be reported to the next formal meeting of the H&WB. Members also agreed that the focus at Board meetings should be on:

- Looking at what is being delivered
- Identifying barriers to progress or blockages in the system and agreeing how to tackle them
- Looking at performance trends
- Evaluating overall what is being achieved
- Agreeing what further action is needed by partners and/or the Board as a whole to meet our strategic aims for Norfolk.

1.2 At its last meeting in February 2016, the H&WB considered the wider context in which partners were working - the challenges across health and care nationally which were reflected in Norfolk including increasing demand, difficulties in recruitment and financial challenge. It was recognised that whilst each of the organisations has plans to address their own financial and operational challenges, the scale of change needed required collaborative transformation across services and across traditional boundaries.

1.3 The Board considered the outcome of a structured review of the BCF programme 2015/16, based on a national self-assessment tool, which had been used in each CCG area in Norfolk. It highlighted interventions which had the most positive impact and where they had not achieved desired impact, including where plans may have been too ambitious in terms of the number of schemes that required developing and implementing.

1.4 The full BCF technical guidance and templates for the BCF 2016-17 were released, albeit much later than planned, and the Board have considered key aspects of the new policy framework for the BCF 2016-17 and noted some key changes from last year, including the fact that the Pay for Performance (PfP) framework has been removed, and in its place additional requirements relating to delayed transfers of care and NHS commissioned out of hospital services.

1.5 Members considered the early, draft BCF schemes for 2016-17 which were based on the self-assessments carried out in CCG localities, engagement with key stakeholders, organisational priorities, CCG operational planning and adult social care's Promoting Independence strategy. These had been developed from each CCG area and together formed the foundations of draft proposals. The Board gave overall approval to the proposed direction of travel for developing those plans.

2. BCF in the Wider Context

2.1 The challenges across health and care have a high profile nationally. A clear policy focus on integration of health and social care remains and is described and emphasised in the development of Sustainability and Transformation Plans. The programmes and services formulated through the BCF will support the achievement of these ambitions and are a key mechanism for delivering integration.

2.2 The County Council and Norfolk CCGs have well developed collaborative arrangements to seek to maximise resources and the impact on the health and social care system. Current approaches have evolved to respond to changes in national policy, population health and wellbeing.

2.3 The local health and care system in Norfolk is facing significant financial challenge. Integrated structures between CCGs, the County Council and community health providers provide a sound basis on which to deliver the objectives of the Better Care Fund (BCF) and improvements in performance and outcomes combined with more efficient delivery will continue to be sought through this programme.

3. Norfolk's Better Care Fund 2015/16

3.1 The impact of implementing the BCF 2015/16 schemes in Norfolk has seen some positive results against the mandated national metrics including reducing delayed transfers of care, reducing admissions to residential and nursing care and increasing the effectiveness of reablement.

3.2 The stretch target of reducing non elective admissions by 3.5% continues to be a challenge which the programme will not meet in 2015/16, although, there is some local variation to non elective admission rates.

3.3 Previous assessments of performance in 15/16 indicated that most positive impact was noted in:

- Community based care interventions
- Use of risk profiling in conjunction with locality based integrated care teams
- Development of rapid response services for who fall.

3.4 The review of the 2015/16 BCF indicated that while schemes were designed and implemented in individual CCG localities they did seek to deliver similar outcomes and impact. It is proposed that a stronger collaborative approach is taken for 2016/17 to ensure we build on shared learning, reduce duplication of effort and deliver consistency of high quality interventions across Norfolk.

Norfolk's Quarterly Progress report to NHS England

3.5 Reporting on progress in Norfolk is required on a quarterly basis and the most recent report, signed off by the BCF subgroup of the H&WB, was submitted on 25/2/16. The submission is provided in **Appendix A.**

4. Planning for the 2016/17 BCF and proposals

BCF 2016-17 guidance

4.1 Detailed BCF guidance was issued on 23 February 2016 and has provided clarity on the requirements for the 16/17 plan. Overall plan requirements include:

- BCF funding will be transferred into one or more pooled funds once a joint spending plan is approved by NHS England
- Health and Wellbeing Boards will agree how the fund will be spent with plans signed off by the County Council, CCGs and local authorities

- Plans will be approved by NHS England in consultation with the Department of Health (DH) and the Department for Communities and Local Government (DCLG).

4.2 Local partners will need to develop and the H&WB approve:

- A jointly agreed narrative including details of how national conditions will be addressed
- Confirmed funding contributions from each partner organisation
- A spending plan which sets out funding of each of the BCF schemes
- Quarterly plan figures to meet the national metrics
- Engagement with stakeholders in formation of the plan will need to be demonstrated.

4.3 Final submission of plans from Health and Wellbeing Boards was originally due on 25 April 2016 but has now been extended to 3 May 2016.

4.4 As noted in the February paper to the H&WB a key change in the 16/17 BCF programme has been the removal of the Pay for Performance framework which tied an element of funding to a reduction in unplanned admissions to acute hospital. Two additional requirements have been added:

a) Each local area will develop an action plans for managing delayed transfers of care (DTOC) which will include targets and consider risk share agreement

b) To continue investment in commissioned out of hospital services including social care.

4.5 In addition (and similar to 15/16) Disabled Facilities Grant (DFG) has been included in the Fund so that the provision of adaptations and associated funding can be incorporated in the strategic consideration and planning of investment. While DFG will be paid to upper tier authorities in 16/17 the statutory duty on local housing authorities to provide aids and adaptations under the DFG, to those who qualify, will remain and funding will be transferred accordingly. All funding pooled through the Better Care Fund, including DFG funding, will need to be allocated on the basis of plans that are jointly developed and agreed with relevant local authorities.

4.6 Social Care capital grant to local authorities with responsibility for adult social services will be discontinued from 2016/17 and all capital grant funding is now in the DFG element, increasing the value of the DFG fund in Norfolk by £2.3m. As part of the BCF planning a workshop was held to focus on DFGs and how to derive the greatest benefit through housing authorities' engagement in the BCF. Alongside optimising the use of the DFG funding there is a clear recognition of the opportunities for engaging district and borough council expertise and resources alongside health and care services, particularly with regards to housing and community support. To facilitate this engagement, it has been agreed that district council's will be members of the BCF partnership boards which oversee the pooled budgets between Norfolk County Council and each CCG.

Development of the Norfolk BCF 2016/17

4.7 The BCF plan for 16/17 has been in development, following the direction agreed at the last Health and Wellbeing Board. However, the financial apportionment has yet to be resolved. The CCGs have indicated that they will not support the protection for social care which was provided in 15/16 continuing in 16/17, due to the pressures on their budgets. The Council has indicated that it will not support the removal of £7.1m BCF funding from social care due to the impact this would have on services and social care provision. Partners have met to identify ways to work together to achieve savings to reduce this pressure, but have not yet reached agreement.

4.8 Two draft submissions of the BCF and associated scheme level plans have been submitted to NHS England but did not include financial allocations or risk sharing agreements. Plans have been submitted with the caveat that the eventual financial agreements may change the narrative BCF plan. Feedback from the BCF Assurance process is yet to be received however that without financial resolution, the plan will not be approved.

4.9 To resolve the financial issues, the partners have requested external support and this support is to be provided through the BCF team at NHS England. A meeting is planned with a view to reaching agreement. A verbal update will be provided on progress.

4.10 The full plan, including financial commitments and risk share agreements, will need to be approved by the Health and Wellbeing Board and a draft is contained in **Appendix B**.

Proposed BCF Schemes 16/17

4.11 Norfolk's BCF Schemes for 2016/17 have been developed with stakeholders at local integrated care boards and bought together at the Norfolk wide BCF Programme Group. The following highlights the main themes that are being developed for 2016/17:

1. **Integrated care teams**: Further development and embedding of locality based integrated care teams and care coordination
2. **Community based care and support including crisis response:** Targeted community care and support closer to home (either in the community or in people's homes) and further introduction of self-care and management to keep people independent for longer.
3. **Care home admissions to hospital:** Targeted interventions in care homes to reduce hospital admissions, which have shown to be particularly high in Norfolk.
4. **Effective discharge/DTOC Plans.** Interventions to reduce delayed transfers of care (DToC) in line with the expected national focus on DToC for 2016/17 and ensure people have a timely return to home from hospital.
5. **Disabled Facilities Grant and housing adaptations:** Discussions with local authority colleagues confirms the potential for more fundamental and ambitious partnerships on the use of DFGs and the previous social care capital grant. Age and condition appropriate housing and adaptations are key to supporting independence and the wider goals of the BCF. Closer partnerships have been agreed through locality partnership boards and will support delivery of a wide range of initiatives, both within and parallel to the BCF.

6. **Learning disability**: development of cost effective and community focused services for adults with learning disabilities

4.12 In addition to these six core areas each CCG area is developing bespoke local schemes which support these priorities or concentrate on a particular local priority that requires targeted approaches to meet the national conditions or metrics of the BCF.

4.13 These six key areas provide opportunities for the sharing of good practice where they are already delivering well in localities, opportunities to work jointly across systems to reduce duplication of effort and ensure consistency of high quality services for all residents in Norfolk.

4.14 This approach also provides the opportunity for local flexibility as they are shaped and implemented around CCG boundaries so will therefore also reflect the different requirements of that population, the distribution of services and organisational and stakeholder priorities.

4.15 Draft proposed schemes, building on the evaluation of 15/16 schemes and detailing ambition for 16/17 schemes, are contained within Appendix B**,**

BCF Support Funds – update on outcome of the bids for support

4.16 Norfolk submitted two bids to the BCF support programme and were successful in both:

Bid 1 – awarded £20k to support a strategic review, using external facilitators, to detail and document the impact of integration and design of health and social care services. Scoping of this work is now completed. Outcomes from this work will support the BCF programme for 16/17 and focus on achieving required impact.

Bid 2 – awarded £45k to enable and support the development and delivery of a Norfolk and Suffolk health and social care sector workforce and skills action plan. The plan has been developed by stakeholders including Norfolk and Suffolk County Councils, CCGs, health Education East and Community Health Providers. The priorities of the plan will focus on employment within the health and social care sector. Priority areas will be presented to the New Anglia Local Enterprise Partnership (LEP) which works with businesses and public sector partners to help grow jobs in Norfolk and Suffolk.

4.17 Both proposals are being progressed and will support the priorities of the 16/17 BCF.

5. Proposals/Action

5.1 The Health & Wellbeing Board is asked to:

- Consider and comment on the information outlined in this paper **(key questions for discussion are on page 1 and the draft narrative submission is attached as Appendix B)**

- Note that agreement on the 2016/17 BCF programme has yet to be reached and the work that is underway to achieve this agreement

- Agree what actions the Board/individual members will take to help address key issues in relation to 2016/17

- Note the BCF 2015/16 progress submission to NHS England for the period 1 October to 31 December 2015

Officer Contact

If you have any questions about matters contained in this paper please get in touch with:

Name	Tel	Email
Catherine Underwood	01603 224378	catherine.underwood@norfolk.gov.uk
Sera Hall	01603 223062	sera.hall@norfolk.gov.uk

IN TRAN communication for all

If you need this Report in large print, audio, Braille, alternative format or in a different language please contact 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.

Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 26th February 2016.

The BCF Q3 Data Collection

This Excel data collection template for Q3 2015-16 focuses on budget arrangements, the national conditions, payment for performance, income and expenditure to and from the fund, and performance on BCF metrics.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an overview of progress with your BCF plan, the wider integration of health and social care services, and a consideration of any variances against planned performance trajectories or milestones.

Cell Colour Key

Data needs inputting in the cell
Pre-populated cells
Question not relevant to you

Throughout this template cells requiring a numerical input are restricted to values between 0 and 100,000,000.

Content

The data collection template consists of 9 sheets:

Checklist - This contains a matrix of responses to questions within the data collection template.
1) Cover Sheet - this includes basic details and tracks question completion.
2) Budget arrangements - this tracks whether Section 75 agreements are in place for pooling funds.
3) National Conditions - checklist against the national conditions as set out in the Spending Review.
4) Non-Elective and Payment for Performance - this tracks performance against NEL ambitions and associated P4P payments.
5) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.
metric in BCF plans.
7) Understanding support needs - this asks what the key barrier to integration is locally and what support might be required.
8) New Integration metrics - additional questions on new metrics that are being developed to measure progress in developing integrated, cooridnated, and person centred care
indicators.

Checklist

This sheet contains all the validations for each question in the relevant sections.
All validations have been coloured so that if a value does not pass the validation criteria the cell will be Red and contain the word "No" and if they pass validation they will be coloured Green and contain the word "Yes".

1) Cover Sheet

On the cover sheet please enter the following information:
The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board.

template have been completed the cell will turn green. Only when all 9 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This plays back to you your response to the question regarding Section 75 agreements from the Q1 and Q2 2015-16 submissions and requires 2 questions to be answered. Please answer as at the time of completion. If you answered 'Yes' previously the 2 further questions are not applicable and are not required to be answered.

they have?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the six national conditions detailed in the Better Care Fund Planning Guidance are still on track to be met through the delivery of your plan (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/). Please answer as at the time of completion.

It sets out the six conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' and 'No - In Progress' that these are on track. If 'No' or 'No - In Progress' is selected please provide a target date when you expect the condition to be met. Please detail in the comments box what the issues are and the actions that are being taken to meet the condition.
'No - In Progress' should be used when a condition has not been fully met but work is underway to achieve it by 31st March
Full details of the conditions are detailed at the bottom of the page.

4) Non-Elective and Payment for Performance

This section tracks performance against NEL ambitions and associated P4P payments. The latest figures for planned activity and costs are provided along with a calculation of the payment for performance payment that should have been made for Q4 - Q2. Two figures are required and one question needs to be answered:

Input actual Q3 2015-16 Non-Elective Admissions performance (i.e. number of NEAs for that period) - Cell O8
Input actual value of P4P payment agreed locally - Cell F19
If the actual payment locally agreed is different from the quarterly payment suggested by the automatic calculation in cell AR8 (which is based on your input to cell O8 as above) please explain in the comments box
Please confirm what any unreleased funds were used for in Q3 (if any) - Cell F34

5) Income and Expenditure

following information:

Forecasted income into the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual income into the pooled fund in Q1 to Q3
Forecasted expenditure from the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual expenditure from the pooled fund in Q1 to Q3

Figures should reflect the position by the end of each quarter. It is expected that planned income and planned expenditure figures for Q4 2015-16 should equal the total pooled budget for the Health and Wellbeing Board.

There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan or amendments to forecasts made since the previous quarter.

6) Metrics

This tab tracks performance against the two national supporting metrics, the locally set metric, and the locally defined patient experience metric submitted in approved BCF plans. In all cases the metrics are set out as defined in the approved plan for the HWB and the following information is required for each metric:
An update on indicative progress against the four metrics for Q3 2015-16
Commentary on progress against the metric

If the information is not available to provide an indication of performance on a measure at this point in time then there is a drop-down option to indicate this. Should a patient experience metric not have been provided in the original BCF plan or previous data returns there is an opportunity to state the metric that you are now using.

7) Understanding support needs

This tab re-asks the questions on support needs that were first set out in the BCF Readiness Survey in March 2015. These questions were then asked again during the Q1 2015-16 data collection in August. We are keen to collect this data every six months to chart changes in support needs. This is why the questions are included again in this Q3 2015-16 collection. The information collected will be used to inform plans for ongoign national and regional support in 2016-17.

The tab asks what the key barrier to integration is locally and what support might be required in putting in meeting the six key areas of integration set out previously. . HWBs are asked to:

Confirm which aspect of integration they consider the biggest barrier or challenge to delivering their BCF plar
support to take

There is also an opportunity to provide comments and detail any other support needs you may have which the Better Care Support Team may be able to help with.

8) New Integration Metrics

This tab includes a handful of new metrics designed with the intention of gathering some detailed intelligence on local progress against some key elements of person-centred, co-ordinated care. Following feedback from colleagues across the system these questions have been modified from those that appeared in the last BCF Quarterly Data Collection Template (Q2 2015-16). Nonetheless, they are still in draft form, and the Department of Health are keen to receive feedback on how they could be improved / any complications caused by the way that they have been posed.

For the question on progress towards instillation of Open APIs, if an Open API is installed and live in a given setting, please state 'Live' in the 'Projected 'go-live' date field.
For the question on use and prevalence of Multi-Disciplinary/Integrated Care Teams please choose your answers based on the proportion of your localities within which Multi-Disciplinary/Integrated Care Teams are in use.

9) Narrative

In this tab HWBs are asked to provide a brief narrative on overall progress in delivering their Better Care Fund plans at the current point in time with reference to the information provided within this return.

Better Care Fund Template Q3 2015/16

Data collection Question Completion Checklist

1. Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

2. Budget Arrangements

S.75 pooled budget in the Q4 data collection? and all dates needed
Yes

3. National Conditions

	1) Are the plans still jointly agreed?	2) Are Social Care Services (not spending) being protected?	3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	i) Is the NHS Number being used as the primary identifier for health and care services?	ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	6) Is an agreement on the consequential impact of changes in the acute sector in place?
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" estimated date if not already in place (DD/MM/YYYY)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Comment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

4. Non-Elective and P4P

Actual Q3 15/16	Actual payment locally agreed	Cumulative quarterly Actual Payments >= Cumulative suggested quarterly payments	If the actual payment locally agreed is <> suggested quarterly payment	Any unreleased funds were used for: Q3 15/16
Yes	Yes	Yes	Yes	Yes

5. I&E (2 parts)

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Please comment if there is a difference between the annual totals and the pooled fund
Income to	Forecast	Yes	Yes	Yes	Yes	Yes
	Actual	Yes	Yes	Yes		
Expenditure From	Forecast	Yes	Yes	Yes	Yes	Yes
	Actual	Yes	Yes	Yes		
	Commentary	Yes				

6. Metrics

	Please provide an update on indicative progress against the metric?	Commentary on progress
Admissions to residential Care	Yes	Yes
	Please provide an update on indicative progress against the metric?	Commentary on progress

	Reablement	Yes	Yes
		Please provide an update on indicative progress against the metric?	Commentary on progress
	Local performance metric	Yes	Yes
	If no metric, please specify	Please provide an update on indicative progress against the metric?	Commentary on progress
Patient experience metric	Yes	Yes	Yes

7. Understanding support needs

Which area of integration do you see as the greatest challenge or barrier to the successful implementation of your Better Care plan	Yes

	Interested in support?	Preferred support medium
1. Leading and Managing successful better care implementation	Yes	Yes
2. Delivering excellent on the ground care centred around the individual	Yes	Yes
3. Developing underpinning integrated datasets and information systems	Yes	Yes
4. Aligning systems and sharing benefits and risks	Yes	Yes
5. Measuring success	Yes	Yes
6. Developing organisations to enable effective collaborative health and social care working relationships	Yes	Yes

8. New Integration Metrics

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Yes	Yes	Yes	Yes	Yes	Yes
From Hospital	Yes	Yes	Yes	Yes	Yes	Yes
From Social Care	Yes	Yes	Yes	Yes	Yes	Yes
From Community	Yes	Yes	Yes	Yes	Yes	Yes
From Mental Health	Yes	Yes	Yes	Yes	Yes	Yes
From Specialised Palliative	Yes	Yes	Yes	Yes	Yes	Yes

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	Yes	Yes	Yes	Yes	Yes	Yes
Projected 'go-live' date (mm/yy)	Yes	Yes	Yes	Yes	Yes	Yes

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Yes

Total number of PHBs in place at the beginning of the quarter	Yes
Number of new PHBs put in place during the quarter	Yes
Number of existing PHBs stopped during the quarter	Yes
Of all residents using PHBs at the end of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	Yes

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	Yes
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes

9. Narrative

Brief Narrative	Yes

Cover

Q3 2015/16	
Health and Well Being Board	**Norfolk**
completed by:	Sera Hall
E-Mail:	Sera.Hall@norfolk.gov.uk
Contact Number:	01603 223062
Who has signed off the report on behalf of the Health and Well Being Board:	Cllr Brian Watkins - Chair of the HWB

Question Completion - when all questions have been answered and the validation

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	24
4. Non-Elective and P4P	5
5. I&E	17
6. Metrics	9
7. Understanding support needs	13
8. New Integration Metrics	67
9. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:	Norfolk

Have the funds been pooled via a s.75 pooled budget?	Yes
If it has not been previously stated that the funds had been pooled can you now confirm that they have?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question which is pre-populated, the data is from the Q1/Q2 data collection previously filled in by the HWB.

National Conditions

Selected Health and Well Being Board: Norfolk

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these are on track as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include a date **and** a comment in the box to the right

Condition	Q4 Submission Response	Q1 Submission Response	Q2 Submission Response	Please Select (Yes, No or No - In Progress)	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	Commentary on progress
1) Are the plans still jointly agreed?	Yes	Yes	Yes	Yes		
2) Are Social Care Services (not spending) being protected?	No - In Progress	Yes	Yes	Yes		
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	No - In Progress	No - In Progress	No - In Progress	No - In Progress	30/04/2017	All plans are in place and are developing on track to deliver an approach and implement key 7 day services in Norfolk. This is building and sharing on the learning from Great Yarmouth's earlier adopter plan for 7 day services which cover all 10 clinical standards. The completion date is in line with that required by the 10 Clinical Standards for 7 Day
4) In respect of data sharing - confirm that:						
i) Is the NHS Number being used as the primary identifier for health and care services?	Yes	Yes	Yes	Yes		
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes	Yes	Yes	Yes		
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes	Yes	Yes	Yes		
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	No - In Progress	No - In Progress	No - In Progress	No - In Progress	31/03/2016	The infrastructure and integrated teams are in place to enable this. Next step actions are on course to embed this approach.
6) Is an agreement on the consequential impact of changes in the acute sector in place?	No - In Progress	Yes	Yes	Yes		

National conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engag with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

2) Protection for social care services (not spending)
Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number
The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

6) Agreement on the consequential impact of changes in the acute sector
Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Footnotes:
Source: For each of the condition questions which are pre-populated, the data is from the quarterly data collections previously filled in by the HWB.

Better Care Fund Revised Non-Elective and Payment for Performance Calculations

Selected Health and Well Being Board: Norfolk

	Baseline				Plan					Actual					
	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	% change [negative values indicate the plan is larger than the baseline]	Absolute reduction in non elective performance
D. REVALIDATED: HWB version of plans to be used for future monitoring.	22,905	23,320	23,029	23,835	22,667	22,702	21,812	22,642	23,331	23,331	23,335	24,104	23,268	3.5%	3,266

Which data source are you using in section D? (MAR, SUS, Other)	MAR	If other please specify	
Cost per non-elective activity	£1,490		

	Total Payment Made			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Suggested quarterly payment (taken from above)*	£0	£0	£0	£0
Actual payment locally agreed	£0	£0	£0	£0

If the actual payment locally agreed is different from the suggested quarterly payment (taken from above) please explain in the comments box (max 750 characters)	n/a

	Total Unreleased Funds			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Suggested amount of unreleased funds**	£354,620	£920,820	£1,813,330	£1,777,570
Actual amount of locally agreed unreleased funds	£354,620	£920,820	£1,813,330	£1,777,570

	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Confirmation of what if any unreleased funds were used for (please use drop down to select):	acute care	acute care	acute care	acute care

Footnotes:

Source: For the Baselines, Plans, data sources, locally agreed payment and cost per non-elective activity which are pre-populated, the data is from the Better Care Fund Revised Non-Elective Targets - Q4 Playback and Final Re-Validation of Baseline and Plans Collection previously filled in by the HWB. This includes all data received from HWBs as of 11th December 2015.

*Suggested quarterly payment (taken from above) has been calculated using the technical guidance provided here http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/. The key steps to calculating the quarterly payment are:

a. take the cumulative activity reduction against the baseline at quarter end and divide it by the cumulative Q3 2015/16 target reduction;

b. multiply that by the size of the performance pot available; and

c. subtract any performance payments made for the year to date.

The minimum payment in a quarter is £0 (there will not be a negative payment or 'claw back' mechanism) and the maximum paid out by the end of each quarter cannot exceed the planned cumulative performance pot available for release each quarter.

**Unreleased funds refers to funds that are withheld by the CCG and not released into the pooled budget, due to not achieving a reduction in non-elective admissions as set out in your BCF plan. As payments are based on a cumulative quarter end value a negative (-) quarter actual value indicates the use of surplus funds from previous quarters.

HWBs should consider whether there is a need to make adjustments to Q3 payments where over or under payments may have occurred in Q4 2014/15, Q1 2015/16 or Q2 2015/16 due to changes made to NEA baselines and targets.

	Planned Absolute Reduction (cumulative) [negative values indicate the plan is larger than the baseline]				Maximum Quarterly Payment				Performance against baseline				Suggested Quarterly Payment								
Total Performance Fund Available	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Total Performance fund	Total Performance and ringfenced funds	Q4 Payment locally agreed	Q1 Payment locally agreed	Q2 Payment locally agreed
£4,866,340	238	856	2,073	3,266	£354,620	£920,820	£1,813,330	£1,777,570	-426	-15	-1075	567	£0	£0	£0	£0	£4,866,340	£16,295,000	£0	£0	£0

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Norfolk

Income

Previously returned data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£19,293,380	£13,801,260	£14,683,080	£14,683,080	£62,460,800	£62,461,000
	Forecast	£19,599,950	£13,519,950	£13,519,950	£13,519,950	£60,159,800	
	Actual*	£17,272,933	£15,846,950				

Q3 2015/16 Amended Data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£19,293,380	£13,801,260	£14,683,080	£14,683,080	£62,460,800	£62,461,000
	Forecast	£19,599,950	£13,519,950	£13,519,950	£13,519,950	£60,159,800	
	Actual*	£17,272,933	£15,846,950	£13,519,950			

Please comment if there is a difference between either annual total and the pooled fund	N/A

Expenditure

Previously returned data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£19,293,380	£13,801,260	£14,683,080	£14,683,080	£62,460,800	£62,461,780
	Forecast	£17,272,950	£13,519,950	£13,519,950	£15,846,950	£60,159,800	
	Actual*	£16,738,383	£14,054,502				

Q3 2015/16 Amended Data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£19,293,380	£13,801,260	£14,683,080	£14,683,080	£62,460,800	£62,461,780
	Forecast	£17,272,950	£13,519,950	£13,519,950	£15,846,950	£60,159,800	
	Actual*	£16,738,383	£14,054,502	£13,519,950			

Please comment if there is a difference between either annual total and the pooled fund	N/A

Commentary on progress against financial plan:	Difference between Plan and Forecast for each pool is the inclusion of the NCC ICES to enhance the pool beyond minimum CCG amount. P4P not achieved and therefore not released into the pool. All revenue monies spent to Plan and on a straight line basis (including ICES). DFG monies reported as actually paid from pool. Social Care Capital Grant has been re-profiled in the Forecast expenditure to be spent in final qtr.

Footnotes:

*Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB.

National and locally defined metrics

Selected Health and Well Being Board:	Norfolk

Admissions to residential Care	% Change in rate of permanent admissions to residential care per 100,000
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	No further comment

Reablement	Change in annual percentage of people still at home after 91 days following discharge, baseline to 2015/16
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	No further comment

Local performance metric as described in your approved BCF plan / Q1 / Q2 return	Estimate diagnosis rate for people with dementia
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	No further comment

	Q32 from GP Survey: in the last 6 months, have you had enough support from local services or organisations to help

Local defined patient experience metric as described in your approved BCF plan / Q1 /Q2 return	manage your long term health condition(s)? Please think about all services and organisations not just health services.
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	

Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	No further comment

Footnotes:

Source: For the local performance metric which is pre-populated, the data is from a local performance metric collection previously filled in by the HWB.
For the local defined patient experience metric which is pre-populated, the data is from a local patient experience previously filled in by the HWB.

Support requests

Selected Health and Well Being Board:	Norfolk

Which area of integration do you see as the greatest challenge or barrier to the successful implementation of your Better Care plan (please select from dropdown)?	4.Aligning systems and sharing benefits and risks

Please use the below form to indicate whether you would welcome support with any particular area of integration, and what format that support might take.

Theme	Interested in support?	Preferred support medium	Comments - Please detail any other support needs you feel you have that you feel the Better Care Support Team may be able to help with.
1. Leading and Managing successful better care implementation	Yes	Central guidance or tools	n/a
2. Delivering excellent on the ground care centred around the individual	Yes	Case studies or examples of good practice	n/a
3. Developing underpinning integrated datasets and information systems	Yes	Case studies or examples of good practice	n/a
4. Aligning systems and sharing benefits and risks	Yes	Central guidance or tools	n/a
5. Measuring success	Yes	Case studies or examples of good practice	n/a
6. Developing organisations to enable effective collaborative health and social care working relationships	Yes	Case studies or examples of good practice	n/a

New Integration Metrics

Selected Health and Well Being Board: Norfolk

1. Proposed Metric: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	No	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Metric: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Shared via interim solution
From Hospital	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Social Care	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Shared via interim solution
From Mental Health	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Specialised Palliative	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Shared via interim solution

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	In development	Unavailable	In development	In development	In development	In development
Projected 'go-live' date (dd/mm/yy)	n/a	n/a	n/a	n/a	n/a	n/a

3. Proposed Metric: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	No pilot underway

4. Proposed Metric: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the beginning of the quarter	108
Rate per 100,000 population	12

Number of new PHBs put in place during the quarter	11
Number of existing PHBs stopped during the quarter	6
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	98%

Population (Mid 2015)	882,569

5. Proposed Metric: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **non-acute** setting?	Yes - in most of the Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **acute** setting?	Yes - in most of the Health and Wellbeing Board area

Footnotes:

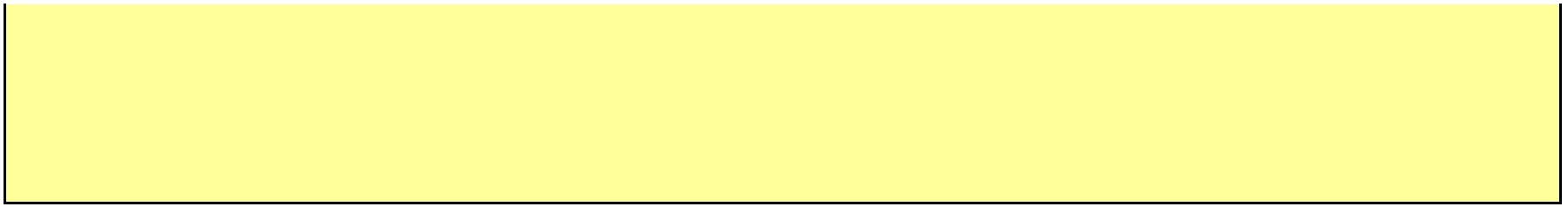
Population projections are based on Subnational Population Projections, Interim 2012-based (published May 2014).
http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/2012-based-projections/stb-2012-based-snpp.html

Narrative

Selected Health and Well Being Board:	Norfolk

Remaining Characters	31,332

Please provide a brief narrative on overall progress in delivering your Better Care Fund plan at the current point in time, please also make reference to performance on any metrics not directly reported on within this template (i.e. DTOCs).
Norfolk's Better Care Fund schemes continue to progress well against plans and where evidence indicates that the schemes are having a positive impact the learning is being shared and developed. Where evidence of impact is not being demonstrated the schemes are being reviewed and refocused to ensure a proactive and responsive approach. Schemes have been reviewed and planning for 16/17 is now well advanced. The local partnership boards provide the local focus and grip for current and future planning and the County BCF Board provides the opportunity to manage the significant requirements of the programme, share good practice and build on what works. Local networks and governance continue to develop expertise and exercise leadership. There is positive progress against targets for delayed transfers of care, reductions in residential and nursing care admissions and people remaining at home 91 days after hospital discharge, however there still remain significant challenges, due to the demographic pressures, in delivering against the ambitious and stretching BCF target for non elective admissions. 16/17 schemes will build on evidenced success to challenge and transform system outcomes. It is anticipated as schemes continue to develop that the impact in this area will improve, however Norfolk's health and care system is mindful that despite robust planning, winter pressures continue to present a significant risk.



Appendix B

Norfolk Health and Wellbeing Board
BCF Narrative Submission
2016 – 2017

A. Confirmation of funding contributions

1. Authorisation and sign off

Signed on behalf of NHS Great Yarmouth and Waveney Clinical Commissioning Group	
By	
Position	
Date	
Signature	
Signed on behalf of NHS North Norfolk Clinical Commissioning Group	
By	
Position	
Date	
Signature	
Signed on behalf of NHS Norwich Clinical Commissioning Group	
By	
Position	
Date	
Signature	
Signed on behalf of NHS South Norfolk Clinical Commissioning Group	
By	
Position	
Date	
Signature	
Signed on behalf of NHS West Norfolk Clinical Commissioning Group	
By	
Position	
Date	
Signature	
Signed on behalf of Norfolk County Council	
By	
Position	
Date	
Signature	
Signed on behalf of Norfolk Health and Wellbeing Board	
By	
Position	
Date	
Signature	

2. Overview of funding contributions for 2016/17

Contributions	Gross Contribution 2016/17	Gross Contribution 2015/16
Norfolk County Council	£6,367,664	£6,080,000
NHS Great Yarmouth and Waveney CCG	£7,169,276	£7,120,000
NHS North Norfolk CCG	£11,472,003	£11,553,000
NHS Norwich CCG	£12,442,039	£12,245,000
NHS South Norfolk CCG	£14,311,134	£14,020,000
NHS West Norfolk CCG	£11,811,353	£11,443,000
Total Contribution	**£63,573,469**	**£62,461,000**

3. Planned expenditure and changes from 2015/16

Discussions are ongoing on the CCG contributions into the pooled fund. Norfolk County Council will contribute the DFG monies, enhanced by the inclusion of social care capital grant.

The relative contributions to the pooled fund for 2016/17 are still subject to planning discussions and negotiation between Norfolk County Council and the CCGs. One of the key elements in this discussion will be reaching agreement over the approach to the protection of social care.

Planned expenditure	2015/16	2016/17
Acute	-	
Mental Health	£1,938,000	
Community Health	£12,049,000	
Continuing Care	£545,000	
Primary Care	£2,142,000	
Social Care	£37,099,000	
Other	£8,689,000	
Total	**£62,462,000**	

i. 2015/16 Qualitative Scheme Review

To support the preparation for developing the Better Care Fund plans for 2016/17, each of the five CCG areas in Norfolk carried out a self-assessment of the impact and progress of their schemes to date using the tool provided by the national BCF team provided.

The assessments highlighted some key areas where interventions had the most positive impact. These included:

- Community based care interventions where care and support is delivered closer to or in people's homes to prevent avoidable hospital admissions or residential care placements.

- The use of risk profiling, formation of locality based integrated care teams, with dedicated care coordination, and direction to community based support had a positive impact on maintaining individuals independence and maintaining this following a hospital admission through strong reablement services,
- Development of rapid response services for people who fall, also had a positive impact on avoidable hospital admissions.

Assessments also revealed that although the schemes were designed, developed and implemented in the individual CCG localities, with different names and focus, they did seek to deliver similar outcomes and impact. Given the limited resources in each locality, where appropriate, a stronger collaborative approach is proposed for 2016/17 to ensure we build on shared learning, maximise efficiency of resources, and deliver consistent high quality interventions across Norfolk.

There is recognition that some areas may have been too ambitious in terms of the number of schemes that required developing and implementing and this may have created a delay in mobilisation and impact. The emphasis in 2016/17 will be to focus on the evidence of what works both within Norfolk, and nationally, build on the strong foundations developed over the last 12 months and to target a fewer number of bigger impact schemes.

Many of the service lines being developed by the CCGs have similar themes and it has been agreed to work collaboratively on a number of these in order to progress as a whole.

4. Consultation and engagement of local providers in planning

Consultation with NHS providers and other key stakeholders is taking place as part of the process of developing, submitting and refining the Norfolk BCF plan; all CCGs have individual governance arrangements for engaging with key partners including leading on liaison and engagement with the three acute hospitals

Provider consultation and engagement also takes place on a locality level with integrated health and social care locality provider forums held on a quarterly basis. These forums are a key method of sharing and shaping BCF plans with providers of services across the piste.

Norfolk benefits from shared teams between the main community health provider and NCC social care staff forming a fully integrated operational service across four CCG areas. This collaboration ensures that effective communication and engagement is achieved across health and social care operational teams. Similar mechanisms in the east also achieve this goal.

B. Narrative Plan

1. Our Shared Vision for Health and Social Care Services

Integration of services is a priority for Norfolk where it is recognised that current health and social care services will become unsustainable given demand for services and financial imperatives. The BCF programme is a key mechanism for the delivery of integration in Norfolk. It provides a vehicle not only for furthering integration between health and social care, but to support transformation which is required to address the sustainability of the system.

The development of the Better Care Fund plan for Norfolk is a complex process because of the number of stakeholders involved. The work to develop and agree the plan with all of the key conditions and assumptions that sit behind it is still being undertaken. This version reflects the current position and work to date. The further work on the plan will be undertaken and concluded by the next plan submission date. This will include reaching the necessary agreements over respective financial contributions, any risk arrangements, the detail about the delivery of countywide schemes outlined in Section D and the relationship with locality level schemes, and agreement with local NHS providers about the implications of these plans.

Development of overarching plans for integration of health and social care are fundamental to the continued evolution of Norfolk's BCF plans and significant progress is being made in forming a culture of shared planning and delivery. This first submission of the draft BCF reflects that drive and ethos but remains a draft with progress to be made before a final submission in April. Plans are ambitious and will need to be delivered at pace in 16/17 to deliver the shared objectives and vision of an integrated system.

The opportunity provided by the Better Care Fund and the drive to ensure robust plans are in place by 2017 for integrating health and social care by 2020 supports the ambition of Norfolk's integration vision and reflects the future direction of the NHS outlined in the Five Year Forward view. This vision is reflected in Norfolk's Promoting Independence Strategy which promotes improving the health and wellbeing of the people in Norfolk by moving away from problem management towards preventative activities and embracing integration across health, social care and housing.

Norfolk's vision for health and social care integration has been developed and continues to be tested through local partnerships led by the CCGs and NCC where a transformed and integrated health and care system will be reflected by the following core principles:

- **People will be able to access effective and co-ordinated care which is delivered at home or in their local community:** This will see services delivered closer to home and where they need to be provided in a specialist acute setting, time spent there will be minimised through the support of a co-ordinated network of community based health and social care services.
- **Services will be shaped around the individual:** Health and social care services will be built around what individuals need and what works for them. Services will continue to build on a well-established personalised approach which will be better at delivering the outcomes people seek because they are tailored to individual need.
- **People will be supported to manage their own care and wellbeing:** People will be empowered and supported to manage their social care needs and health conditions so that they maintain their own wellbeing as far as possible to enhance quality of life and to reduce the need for formal services.
- **Primary care will be at the heart of care co-ordination:** Primary care will be the core of our services. People will be able to connect with health and care services in their community and can be confident that their primary care services are well connected with a much wider range of help and support.

Planning should start at a local level: In Norfolk, we think that it makes sense for most planning and development of services to take place within the natural health and care systems at a local level. For this our basis is the geography of Clinical Commissioning Groups. However, it is also accepted that some issues

are countywide concerns and, where appropriate, we plan and operate on a county wide level for consistency and efficiency. Acute services effectively form three sub systems in Norfolk and engagement with these is led by individual CCGs. This vision is underpinned by the Joint Strategic Needs Assessment (JSNA), which describes the current and future health and wellbeing needs in Norfolk, and is available on http://www.norfolkinsight.org.uk/jsna.

i. 1.2 Health and Wellbeing Board Strategy

The findings from this have in turn helped identify the health priorities in the Joint Health and Wellbeing Strategy for Norfolk (http://www.norfolk.gov.uk/view/NCC122775). The strategy recognises that the best way of addressing these priorities is through Integration – partners working together to provide effective, joined up services. Therefore Norfolk's BCF ambitions are informed and supported by our Joint Health & Wellbeing Strategy priorities which are focused on:

1. Reducing inequalities in health and wellbeing
2. Prevention – providing help and support at an earlier stage before crisis
3. Making Norfolk a better place for people with dementia and their Carers

ii. 1.3 Clinical Commissioning Group Planning

Norfolk's BCF vision has been shaped in line with CCG 2016/17 Operational plan priorities as well as the development of a Norfolk and Waveney Sustainability and Transformation Plan (STP) which will improve care delivery for Norfolk people over the next five years.

iii. 1.4 STPs

Delivering a sustainable plan that meets the numerous and significant challenges facing the NHS will take several years of co-ordinated activity. The focus needs to move from short term isolated changes to transformational, system wide initiatives. To that end, all CCGs in Norfolk and Waveney have joined together in committing to deliver a STP which outlines the following:

- Help create and maintain a safe and high quality health and care service
- Balance the NHS budget and improve efficiency and productivity
- Lead a step change in the NHS in preventing ill health and supporting people to live healthier lives
- To improve out of hospital care
- Support research, innovation and growth

iv. 1.5 Norfolk County Council – Reimagining Norfolk and Promoting Independence

This decade is witnessing huge changes in the scope and scale of public services. After several decades of growth, the new normal facing local government is continuing resource reductions at a time of growing demand for services.

In Norfolk, as in other parts of the country, there are challenges serving an ageing population, a more mobile population, rapid technological advances and social changes which, among other things, see people living further away from family support networks. There are high expectations from citizens who in other fields of society value 'one-touch' services which are efficient and individual to them.

In Norfolk, the numbers of births and deaths have stayed constant over the last five years, as has the number of people aged under 65. But within this there has been a substantial increase (12%) in the population aged over 65, imposing increasing strains on health and social care systems.

The Council agreed four priorities in February 2015. These core commitments go beyond our statutory responsibilities and avoid retreating to minimum levels of service. We aim for:

- A well-**educated** and skilled population
- With '**real' jobs** which pay well and have prospects
- **Improved infrastructure** - air, sea, road, rail, broadband and mobile network
- coverage
- Vulnerable people **supported** – more living independently and safely in their communities

The integration of health and social care is a critical element of our move towards a seamless Norfolk public service, and the government's agenda for public service reform. Hence alongside the development of the local public service summit, the County Council has initiated a process that brings together the leadership across Norfolk's five CCGs, three hospital trusts, two community health trusts, one mental health trust, the ambulance service, independent service providers, NHS England (eastern region), and the newly established NHS Improvement.

After a series of productive planning sessions, enabled by Sir John Oldham, this group of agencies has defined the 'Norfolk Principles of Care' to be embedded in all of our services, and proposed a 'transformation executive' composed of Chief Executives across the local authority and NHS . Its overarching purpose is to improve health outcomes for the population of Norfolk through the delivery of successful programmes at scale.
It has established a series of workstreams to tackle the most important issues facing the health and social care system in Norfolk, and agreed to work at practical solution at pace, recognising the burning platform driving the system. The workstreams are:

• **Keeping me at home – particularly care for frail elderly and** those with multiple long term conditions, including mental ill health. The aim is to have a comprehensive approach to helping people avoid admissions to hospital.
• **Future care and sustainability -** Improving the care within and sustainability of acute and secondary care including mental health services across Norfolk. The workstream will also look at new designs for primary and community health care services.
• **Prevention and wellbeing -** Engaging and motivating citizens and their communities in preventing ill health, recognizing that many more people are able and willing to contribute to their own care.
• **Developing the right workforce for the future -** Recruitment of a new workforce to fit the future needs of health and social care in Norfolk, and training the existing workforce for future demands including health coaching and remote interventions.

In addition, further work will be done to communicate with the public and with staff within the NHS and the Care sector about these important developments.

2. The case for change
The Better Care Fund and the associated schemes are required to deliver results at a time of high public profile system challenges, particularly unprecedented financial pressure nationally on the NHS and Local Authorities.

In 2016/17 Norfolk's CCGs and Adult Social Services are no different in facing significant and various challenges. Many of these reflect national challenges, but they are given a distinctive flavour by local demographic, workforce and geographical characteristics in Norfolk.

These challenges are reflected and met in the formation of the plans for the 16/17 BCF. It is important to note, that in line with overarching plans for integration, that increasingly the BCF plans are incorporated in and reflected by individual organisational plans such as Reimagining Norfolk, CCG Operational Plans and QIPP programmes.

i. Increasing patient need and demand

The demographic profile of Norfolk overall features a high proportion of older people with a prevalence of long term conditions, which if not managed effectively, can result in the need for higher cost complex health and care services.

As in many other parts of the UK, Norfolk is anticipating population growth over the coming years. However, in Norfolk this growth is forecast to be concentrated among over 65s and 85s. The most significant increase in the population of over 85s will be seen in the area covered by North Norfolk, where more than one in twenty people will be aged 85 or older by 2021. This increase in the number of older people is likely to drive increased demand for health and care services if targeted interventions, delivered at the right time, in the right place by the right person (including self-management) are not provided.

The rising demand for services and the impact that this is having on the health and social care system can be illustrated by a number of factors such as a rise in non-elective admissions to hospital and increases in demand for homebased care.

Health and social care plans all reflect the need to actively use preventative interventions in order to manage demand for services. This principle is reflected strongly within the BCF.

ii. Geography & Recruitment/Retention

Norfolk is a predominantly rural county which poses a significant challenge to the delivery and accessibility of support and services. Ambulance response times are the most evident example of the challenge posed by rural geography but the impact is felt system wide and necessitates innovative solutions. In addition ensuring that the right community services can be accessed closer to peoples' homes (to reduce avoidable ambulance conveyance, hospital and residential care admissions) is also problematic but essential in a rural county such as Norfolk.

Another impact felt throughout the local system is the difficulty experienced in recruiting and retaining personnel. National challenges in specialties such as Accident & Emergency (A&E) are amplified in the rural environment of Norfolk. For example, the age profile of General Practitioners (GPs) combined with current recruitment levels means primary care is facing a significant challenge in workforce sustainability at a time when it is being asked to play an ever greater role in the system. In addition the ability to recruit and retain care staff compounds the difficulties in ensuring that the right community care is available to keep people independent or support them after a time of crisis (e.g. hospital admission)

The impact of these issues will in part reflect the national increase in Delayed Transfers of Care from hospital (an area of risk in Norfolk) and quality and performance concerns and failure of some providers due to shortage of staff, linked to staffing issues.

Plans formulated reflect joint work with health, social care and other local authorities to increase recruitment and retention across health and social care sectors.

iii. System financial sustainability

The health and social care system faces a period of significant financial challenge. Forecast demand, both in terms of absolute numbers and the complexity of need, is likely to outstrip future financial allocation, requiring substantial savings to be made through Norfolk CCG QIPP (Quality, Innovation, Productivity and Prevention) programmes and Adult Social Care's Promoting Independence Strategy. These initiatives to reduce demand and ensure efficient public spending must be underpinned and supported by the schemes within the Better Care Fund.

All public commissioners and providers are under continuous pressure to remain in budget and to achieve savings and efficiencies and this is an important driver for change. The Council's Promoting Independence Strategy embodies this approach and aims to improve the health and wellbeing of the people in Norfolk by creating a culture which encourages mutual aid, with communities taking control and responsibility. It focuses on reducing some of the current level of demand and spending for formal care packages and through focussing on preventative activities.

CCGs are expected to develop and achieve effective QIPP plans for the next year which will contribute towards bringing them and local health systems back into financial balance. The NHS Five Year Forward View outlines that health will need to define new priorities including a new relationship with patients and communities, engaging effectively in prevention and building stronger partnerships. The CCGs are required

take a systems view and develop this locally through Sustainability and Transformation Plans (STPs). Health is charged with leading local systems planning using the STP which must encompass effective integration plans which include prevention and social care.

As part of this, due to the scale of the financial challenge faced by both commissioners and providers, we must continue to work, through the BCF and elsewhere, in close collaboration to develop, implement and review the transformational changes required by to the local health and care system.

The combination of all the system challenges outlined here and others (including fragmented health and social care IT systems, the need for seven day services and implementation of the national living wage) threaten the long term sustainability of the health and care system but should and can be mitigated by the transformational changes that the BCF can deliver.

2. Plan of action for delivering change

Proposals detailing specific service and project lines that will deliver the BCF ambitions are contained within Section F. Key milestones will be developed from individual project lines and monitored through existing governance arrangements.

i. Governance arrangements to support integrated care

Norfolk Health and Wellbeing Board will provide the whole system governance of the delivery of this plan. The Health and Wellbeing Board is a democratic committee of the Council. The Chief Officers Group (CCG chief officers and Norfolk County Council's Director of Community Services) will provide the executive level governance and oversight of performance outcomes and will secure accountability to the Norfolk Health and Wellbeing Board. There is a system leadership group established for each health system which has been drawn around the acute services (i.e. West Norfolk Alliance, Great Yarmouth and Waveney System Leadership Partnership and Central Norfolk System Leadership Group). The system leadership groups are comprised of chief executive level membership from commissioners and NHS providers, with wider membership variously from independent and community sectors. The Community Services Performance Board will monitor performance at a local and countywide level, with a specific remit of ensuring that the Council's duties in relation to social care are met. The BCF Programme Group provides a similar remit for all BCF indicators (health and social care). A diagram showing these arrangements can be found in Appendix A.

The governance arrangement for each of our five CCGs can be found in last year's BCF submission.

ii. Management and oversight in place to support the delivery of the BCF plan

A programme management approach is in place to support and monitor the delivery of the BCF for Norfolk, chaired by the Director of Integrated Commissioning and with locality and workstream leads represented from the commissioning partners. Programme management has been established within each CCG locality to secure clear local delivery plans, ensure resourcing and to provide a local management and oversight of delivery of the BCF workstreams.

The Better Care Programme Group provides the countywide management of implementation and impact of BCF schemes. The Programme Group meets each month and provides the point of escalation, challenge and management of interdependencies. These are also reported at the local integration boards. The Programme Group has recently reviewed the monitoring and oversight of the Norfolk programme and has developed a common dashboard to secure an oversight of the system wide impact of change.

The first line of accountability and challenge for the delivery of the locally based schemes will be to the local integration boards, comprising members of local authorities, integrated teams and CCGs, and this is where initial remedial action will be determined. The Countywide Programme Group secures oversight of the programme overall to address a) delivery of whole system change, b) identifying and managing dependencies and c) providing a route for the wider programme and remedial actions. The summary

report of the Norfolk programme is provided to the Chief Officers network where escalation can be addressed.

iii. Segmented Risk Stratification

We understand the importance of risk stratification in enabling us to improve the quality of our services and reduce costs. Our 2015/16 plans and review show that it was used successfully to positively impact on maintaining individuals independence and maintaining this following a hospital admission through strong reablement services. Risk stratification forms key part of many of our 2016/17 schemes, embedding it further in the BCF process.

3. Our approach to financial risk sharing and contingency

Agreement about financial risk sharing and contingency is subject to the planning discussion and negotiation between Norfolk County Council and the CCGs about the pooled fund arrangements and contribution levels

C. National Conditions

1. Plans are jointly agreed

The Better Care Fund (BCF) is seen by key partners and stakeholders, as a key enabler towards greater health and social care integration. This submission reflects that the plans proposed for 16/17 have been jointly agreed across key stakeholders. The BCF Partnership Boards are a key element for ensuring that this join up between key organisations continues to develop to support this agenda.

All plans are agreed by individual CCGs, locality boards, countywide groups and receive final approval and sign off from the countywide Health and Wellbeing Board.

Discussions are ongoing about the Disabled Facilities Grant (DFG) with the expected outcome of agreeing use of this on a county wide and locality basis. Further integration of DFGs in to the BCF programme and understanding of the contribution they make to achievement of key metrics will build on the development of the Integrated Housing Adaptation Teams which operate across Norfolk.

2. Maintain provision of social care services

Agreement on this element is being progressed and will be confirmed when Norfolk wide agreement is reached.

Care Act

Implementation of the Care Act: The Care Act 2014 was implemented in April 2015 and introduced a range of new duties and guidance that impacted on all adult social care policy and practice. In Norfolk a programme of implementation included:

- A review and update of all policies and procedures to reflect changes in eligibility criteria and new guidance on how we deliver care and support
- A new assessment process that focuses on giving our service users choice and control, putting more emphasis on local community services and person's existing support network, interests and wishes
- The development of a Market Position Statement with partners
- The initiation and development of a comprehensive workforce development programme
- Provide strengths based training to all social care teams to ensure assessments are compliant with CA responsibilities

Over the next year we will be focussing on embedding the changes and focusing on achieving excellence in our delivery of social care.

Support for Carers

Norfolk County Council provides a free universal carers' support service that is delivered by a partnership of local Carers Agencies. The service is available free of charge to anyone in Norfolk in an unpaid caring role and comprises:

- A Carers Handbook
- Carers website
- A free Carers Helpline available Monday to Saturday
- 1-1 support service for Carers with more complex needs
- Learning Grants
- Carers Group Grants
- Carers Funding service (for accessing trust and other funding sources)

- Free of charge short breaks (respite care) for one off or short term needs (maximum 30 hrs per year)

Breaks for Carers

Carers who care for someone who has a FACS eligible need for respite or a short break are supported with an Adult Social Services purchased short break. Or a given a Direct Payment to purchase a break directly. These breaks are purchased through an accredited list of Short Break and specialist Home Care providers.

3. Delivery of 7 Day Services

Progress in achieving 7 day service delivery, and the removal of variation in access and outcome across the week, will be expected from all providers. This has required cooperative working and innovation in delivering services within the current payment framework.

The recent 5 year forward view for mental health report stipulates that people facing crisis should have access to mental health care 7 days a week. In response to this requirement the following services are delivered; Crisis Resolution and Home Treatment (CRHT), acute in-patient beds, Section 136 suite. This will form part of the response to 7 day services for each CCG.

Countywide, Norfolk County Council has made an investment into weekend social work teams to support the implementation of the Better Care Fund 7 day services. There is currently a weekend social work presence at the NNUH and JPH and work is ongoing to introduce this service at the QEH. This is supported by further funding for a weekend Care Arranging Service to support the hospital teams when Packages of Care are needed.

Weekend social work teams have the following benefits;

- Help to improve service user experiences as workers can talk through choices and options for discharge
- The weekend service also speeds up the period of time (i.e. bed days) needed to complete some of the more complex assessments vital to safe and timely discharge thus improving the patient experience by ensuring their care is delivered in the most appropriate environment as quickly as possible
- The weekend workers are able to provide a customer service/CareFirst checking service to the hospital staff at weekends helping NHS staff to make more meaningful decisions re referral to social care thus enabling us to target services and resources where they were most needed.

Norfolk County Council has also invested in, a county wide, Norfolk First Response service – comprising Swift Response, a 24 hour, 7 day service, to rapidly respond to unplanned care needs, and Norfolk First Support, a 7 day Reablement Service, which supports hospital admission avoidance and expedites discharge.

There have been significant advances made in social care provision including 7 day operation of the majority of residential care homes and home care provision across the county. Emergency arrangements are place to ensure cover where arrangements are still being robustly established.

Each locality is developing plans to ensure that 7 day working becomes a reality and individual delivery mechanisms reflect the differing arrangements in place. A summary of these is provided below:

Great Yarmouth and Waveney CCG together with key partners is an early adopter of seven day services. An Integrated Steering Committee to lead a whole system approach to the delivery of 7 day services has been established since June 2014 with representatives from all the NHS and Social Care providers across Great Yarmouth and Waveney.

In response to the requirement for mental health care to be provided 7 days a week, the following services are delivered; Crisis Resolution and Home Treatment (CRHT), acute in-patient beds and Section 136 suite.

In **North Norfolk CCG** there are plans to extend ICC support to early evenings and weekends via the presence in integrated care duty teams.

One of the objectives of the "NN1 Development of Community Care Teams around GP clusters" scheme is "to establish options for working towards 7 day service delivery model across the community care teams and supporting services".

The **Norwich CCG** HomeWard initiative includes a virtual ward providing health care in patients' homes, and an intravenous therapy service. These services operate between 08:00 and 20:00 seven days per week. A procured bed pilot initiated in 2015-16 provides step-up and step-down care 7 days per week supported with in-reach therapy from HomeWard.

The **South Norfolk CCG** plans will cover the extension of some aspects of community provision to prevent some of the admissions that take place because of a current lack of speed and flexibility in accessing community health and social care resources. Analysis of unplanned admissions to acute from care homes for example show these happen most in the evening and at weekends. Additional support needs to be available at these times to maximise the impact on preventable admissions.

In **West Norfolk CCG**, there are plans to build on progress made in 2015/16. For example, through optimising utilisation of the ICC service, Swift First Response, Norfolk First Support, block purchased home care and care home support, all of which are available on a 7 day basis. The existing Virtual Ward is a 7 day care model which has had a huge impact on facilitating hospital discharge and Intermediate Care beds with therapy support are available 7 days a week. Community Matrons operate an on-call rota over Saturdays and Sundays and in addition to those services, extending the capacity of the Rapid Assessment Team, providing support at the front door of the hospital to link patients to community services, is a key scheme for 2016/17. Utilisation of telehealth technology will also enable 7 day monitoring and intervention where appropriate.

The totality of these plans should ensure effective 7 day services across the county.

4. Better data sharing

There are ambitions to meet this target largely through the digital road mapping project across Norfolk which includes all CCGs and Norfolk County Council. This work includes the commitment to have fully interoperable electronic health records so that patient's records are paperless

Over 95% of individual patient records on the **Norfolk County Council** Care First record system have the NHS number recorded. Norfolk County Council is planning the procurement of a replacement system to Care First, which is linked in to the Digital Road map planning to ensure that new systems will have the functionality to dovetail with health systems and allow use of open APIs which would enable the development of the integrated digital care record.

All providers in **Great Yarmouth and Waveney** have signed up to using the NHS number as the primary identifier. The NHS number is used for direct care purposes with controls operated to secure the Caldicott Principles are adhered to in delivering direct care directly to service users.

For invoice validation CeFf controls are in place (controlled environment for finance,) ensuring that where NHS numbers are used to validate invoiced care, this information is not retained beyond the time required to carry out the purpose for which it was collated. For secondary care purposes data is pseudonymised and anonymised to ensure information risk is managed effectively.

In **North Norfolk CCG** and **Norwich CCG,** ICCs have access to both Health and Social Care records. The NHS number can be used on both systems (SystmOne and CareFirst) to search for records. Patient consent to share health records is always obtained and explanation is given in the new ICC patient/service user leaflet.

The development of a team of Integrated Care Co-ordinators linked to each of the 4 primary care localities within **South Norfolk CCG** is a practical recognition of the work still to be undertaken within and by Norfolk systems to allow for robust and regular sharing of data through the NHS number. The ICCs are able to access the key IT systems used in Norfolk by social care, community health and primary care. An Enhanced data Sharing Module on SystmOne is used to record consent from patients for their information to be shared with health and social care. This supports the work of the ICCs.

In line with other CCGs in Norfolk, **West Norfolk CCG** is promoting the facilitation of better data sharing between local partners and organisations and this approach will be further developed through projects focusing on:

- The progression of the implementation of a standardised proactive, effective and efficient frailty risk stratification and MDT system that identifies patients who would benefit most from MDT care planning;
- Improving Preventative and Crisis Support for Community Alarm Service Users;
- Crisis support in the community and at the 'front door' of the Acute hospital, to maintain the independence of patients (health and social care) and help them to remain in their own homes.

5. Joint approach to assessments and care planning

This is being addressed Norfolk-wide within the Integrated Care programme being led through the integration of community health services and Adult Social Care.

There are joint approaches to assessments and care planning across the authority and BCF plans for 2016/ 17 evidence that Dementia and Mental Health remain a priority for commissioners across all CCGs. Detail on CCG specific initiatives that ensure a joint approach are detailed below:

The Out of Hospital teams are fully functional across **Great Yarmouth and Lowestoft** with further plans to extend the service to South Waveney. Out of Hospital services provide a rapid response function in the system supporting 'at risk' individuals by coordinating timely assessment and joint care planning between health and social care. All individuals have access to Consultants in acute settings or Named GP's and/or Community Matrons once Care Packages are in place. This model has had a significant impact on reducing non-elective emergency admissions. The recently launched 'Shape of the System' public consultation has been used to inform development of a Waveney Out of Hospital model.

In **North Norfolk CCG** there is a joint approach to assessment and care via the Multi-disciplinary Team meetings held in GP practices and facilitated by the Integrated Care Coordinators. ICCs record the accountable professional on their monthly spreadsheet returns.

Norwich CCG has invested in Integrated Case Management and Integrated Care Co-ordinator roles. The benefits of this investment are under review with Norfolk County Council's Adult Social Services and Norfolk Community Health & Care. We are jointly exploring wider support to primary care for all patients with complex conditions.

In **South Norfolk CCG** the integrated community health and social care provider (NCHC) has been working with GP practices to establish and record baselines for the level of MDT and joint planning activity. NCHC has been supporting practices with MDT planning arrangements.

As in other localities, In **West Norfolk CCG** there is a joint approach to assessment and care via the Multi-disciplinary Team meetings held in GP practices and facilitated by the Integrated Care Coordinators. ICCs record the accountable professional on their monthly spreadsheet returns.

6. Agreement on consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

All activity contained with the Better Care Fund plan for 16/17 will involve consultation with providers so they understand any impact. This is in addition to the wider consultation with providers done by the Local Authorities and the CCG to inform strategic aims which then inform local activity.

The Locality Provider Forums in place in each locality are a key mechanism to communicate key messages to support and co-produce with providers' future service offerings. As per best practice, any impact on individual providers will always be held to take advantage of any opportunities for co-production.

Three CCGs (west, east and north) hold the responsibility for liaison and communication with the three Norfolk acutes and activity and plans are co-ordinated through these channels.

7. Agreement to invest in NHS commissioned Out-of-hospital services

In addition to locality specific schemes all partners are committed to explore how community health and social care services such as home care, continuing health care, services for those with a learning difficulty and nursing/residential care homes can work more efficiently, with a person centred focus. There is real ambition to develop plans that, while reflecting locality detail, can operate effectively across the county producing real system change and benefit. These plans continue to be developed and will feature in plans going forward.

Work as part of the 'one public service' in Norfolk which includes all seven district/city/borough councils, also reflects the impact and importance of housing for individual wellbeing. Ambitious plans are being formulated that reflect the strategic nature of disabled facilities grants and how use of these funds and the housing expertise of partners can be combined to support achievement of shared objectives.

Agreement to collaborate on plans across all Norfolk CCGs and NCC include:

- Services with those with a learning difficulty
- Care homes
- Disabled facility grants
- Homecare and integrated approach to healthcare services

Individual CCG plans for out of hospital services include:

Great Yarmouth and Waveney CCG Shape of the System Public Consultation set out an ambitious vision to extend the out of hospital model using integrated teams and beds with care across Great Yarmouth and Waveney. This model was supported by the local public and by May 2016 all areas will have access to an out of hospital team. This will enable the closure of inpatient beds in both the acute and community hospitals and the enhancement of both the environment and staffing at Beccles Hospital to provide enhanced Intermediate Care and specialist palliative care.

Out of hospital services have two key elements:

- The out of hospital team is a multi-disciplinary team of health and social care professionals who provide care at home whenever they can. They offer intensive, short-term care, reducing as the patient regains their health and independence. Care is holistic, coordinated, responsive and goal-focused, and delivered using a case management approach. The team is supported by generic workers who carry out basic nursing, therapeutic and personal care tasks. Shared values and aims underpin the care delivered by the team, while joint triage and assessment processes are also in place.
- Beds with care are available for patients who do not need an acute admission but require more care than can be safely delivered at home. When a bed with care is needed, it will be provided in a setting which will fully meet the patient's clinical and care needs. It will also be as close to the patient's home as possible. All admissions to beds with care are managed by out of hospital teams

following assessment of the patient. The teams provide in-reach to beds with care and supports the patient to prepare for discharge back home.

Out of hospital services are available 24/7. The teams have 24/7 senior nurse and rehabilitation support worker rotas and senior therapists and social workers covering seven days. Admission to a bed with care is possible seven days a week.

An analysis of the financial and social value of the Out of Hospital team was completed during 2015/ 16 and will inform future development and planning of community based services. Further analysis of this system is being shared by all CCGs to ensure that good practice

North Norfolk CCG promote 'out-of hospital' support via the crisis support service which will provide a multi-disciplinary team offer with the appropriate skill mix to reduce the short term admissions (0-3 LOS) for avoidable conditions (UTis, Falls etc).This will service will be able to repatriate a patient to a home setting on discharge from hospital and reduce the system need and reliance on some of the North Norfolk in-patient beds at the community hospitals.

Norwich CCG's main Out-of-Hospital focus has been establishing the HomeWard which provides health and social care (including step-up and step-down care) in patients' homes. HomeWard includes a rapid response service, intravenous therapy, and is being expanded to include end-of-life care, mental health services and a community gateway to integrate the services provided and focus them on the patient.

In addition to HomeWard, the CCG has:

- Commissioned Age UK (via paid staff and volunteers) to provide up to 12 weeks of intensive community support for patients in a pilot scheme. The scope has recently been widened to all GP practices in the Norwich area.
- Worked with Age UK to develop the Marion Road dementia centre to provide a key role in post-diagnosis dementia support.
- Employed an Admiral nurse to support GP practices in their diagnosis and support of people with dementia.
- Piloted complex multi-disciplinary team meetings at the Old Palace Medical Practice. Outcomes have included avoiding referrals to secondary Mental Health services; unmet social care needs identified; and support of patients from acute care with multi-agency packages of care.

The main plan for **South Norfolk CCG** is to transform community health services including learning from the approach taken by Great Yarmouth and Waveney CCG. For the CCG this would follow on from an overriding priority to focus on QIPP plans to reduce demand and make savings which contribute to bringing the CCG back into financial balance.

West Norfolk CCG recognises that community based services play a crucial part in managing system pressures and supporting patients effectively, ultimately improving their outcomes and experience. There are a wide range of community services in place, however, key areas for development include support at an early stage through the Living Independently in Later Years (LILY) scheme, which provides information and support to help older people to access services. There is also investment in Care Navigation services and a key priority over 2016/17 will be to optimise utilisation of ICCs to support moderate and high risk patients to access relevant services in a coordinated way. Work is also underway to optimise the interface between Virtual Ward and Reablement Services to both avoid hospital admission where possible, and to appropriately expedite discharge back into the community with support to recover and regain independence. This approach therefore seeks to address needs from relatively low needs through to those with significant vulnerability.

8. Agreement on a local action plan to reduce Delayed transfers of care and improve patient flow

Focus on delayed transfers of care provides a real opportunity to join up system initiatives. Each of the three Norfolk systems has a systems resilience group which closely monitor flow through the systems and increasingly this work is combined with the management of social care services needed to ensure safe transfers back to the community. These groups also monitor progress in achieving the 10 national clinical standards.

Countywide plans being developed by the Integrated teams include the development of a resilience network of care providers to ensure that homecare can be provided at short notice for those being discharged and investigation (in conjunction with the Local Government Association) into the cost benefits of integrated domiciliary care. Both initiatives will be developed within the framework of the BCF integrated plan.

Plans for the formulation of a robust and evidenced plan that covers all three subsystems within Norfolk are in place and there is confidence that this will agreed and implemented later in April. These plans will build on the rapid response services that Norfolk County Council already provides through Swifts and Nightowls.

Individual locality plan preparation includes the following:

In **Great Yarmouth and Waveney CCG** the CCG CHC team have been working closely with the Acute and have agreed the best way to record activity so that it is in line with the updated NHS England guidance. The CHC team have also agreed to a five day turnaround for assessments once the checklist has been completed, and to also ensure the full and appropriate use of the twelve discharge to assess beds commissioned by the CCG. Given all of these actions we expect to meet the stretch target of 2.5% by the end of the financial year.

This work is further supported by the Urgent Care Board and membership includes; Clinical Commissioning Group, Acute and Community Providers, Local Authorities, Mental Health Trust, District Councils and the Ambulatory and Out of Hours providers. The purpose of the forum for senior representatives from key organisations within the Great Yarmouth and Waveney health and social care system to work together to deliver safe, high quality integrated urgent care.

This includes;

- The development of an integrated resilience plan which encompasses seasonal pressure points such as winter.
- Providing senior decision making to remove obstacles which may affect smooth and timely discharge.
- Promoting sustainable change and shared learning, ensuring the integrated use of resources and capacity.
- The development of a monthly dashboard including predictive analysis to provide a system wide overview of performance in relation to capacity, constraints and actions.
- Continuing the multiagency work for high dependency individuals, especially vulnerable adults (homeless, drug and alcohol related problems, mental health problems), working closely with district councils and voluntary agencies.
- Reviewing the effectiveness of community and mental health services, including the role of walk-in centres and minor injury units within Great Yarmouth and Waveney and how they integrate with the James Paget University Hospital NHS Foundation Trust.
- Continuing to work with the local ambulance trust and the Great Yarmouth and Waveney NHS 111 and out of hour's provider to ensure effective service delivery to agreed performance standards.
- Seeking opportunities to reduce attendance or admission to the James Paget University Hospital NHS Foundation Trust for children, the frail elderly and those patients with long term conditions.
- Understanding how the local health and social care economy can support carers.

The Urgent Care Board reports quarterly to a Systems Resilience Group and other partner Boards.

The CCG has also commissioned twelve discharge to assess beds to enable both rapid transfer from an acute bed, and also the provision of a more appropriate environment to assess patients and reach a better decision regarding their long term care needs.

The DTOC plan for the Central Block CCG's (**North Norfolk CCG**, **Norwich CCG** and **South Norfolk CCG)** main acute provider, the NNUH, is embedded within the Urgent Care Recovery Plan section 5: Exit block & sustainable discharge. The recent launch of the Multi-disciplinary discharge hub at the NNUH plans to reduce delayed discharges; progress is being monitored weekly with escalation routes to senior managers to address any blockages.

South Norfolk CCG continues to develop a focus on understanding and overcoming DTOCs. It will collaborate with the other central CCGs, NHS providers and social care to implement plans to reduce DTOCs. In addition the CCG will use available powers and levels to ensure that each respective provider within the discharge system is taking full control of its responsibilities in respect of patient flow and reducing DTOCs.

As in other Norfolk localities, **West Norfolk CCG** has a strong track record of effective integration to reduce delayed transfers of care, as demonstrated in above target performance during 2015/16. West Norfolk has a lower than national average DTOC and has also seen an improvement in the reduction of Excess Bed days. However, it is recognised that further changes are needed to maintain and improve performance further to cope with rising pressures. One of the schemes that is helping to achieve this is the new Continuing Health Care (CHC) pathway which has removed the process of CHC check-listing from the Acute Trust, thereby speeding up the discharge process. Data analysis is being conducted to assess where else greatest impact can be made to ensure that future plans are targeted most effectively. This will involve full engagement and ownership by the West Systems Resilience Group, taking into account the need to address cross border provision with Cambridgeshire and Lincolnshire. The SRG already has DTOC plans which can be used as a framework for development and a key element of this will be to differentiate between support needed for typical and complex discharges. Intermediate care provision, reablement, home care and care home support will be critical elements of plans to further improve integrated working.

D. Schemes for 2016/17

Norfolk's BCF Schemes for 2016/17 have been developed with stakeholders at local integrated care boards and bought together at the Norfolk wide BCF Programme Group. The following highlights the main BCF theme areas that are being developed for 2016/17:

1. **Integrated Care Teams**: Further development and embedding of Locality Based Integrated Care Teams and care coordination
2. **Community Based Support & Self Care:** Targeted community care and support closer to home (either in the Community or in People's homes) and further introduction of self-care and management to keep people independent for longer. The opportunity to work with district councils to align and remodel support and services for the provision of DFGs will also be included here.
3. **Crisis Response**. Further development of responsive and reactive integrated care interventions responding to with Health, Family Carer or Care package breakdown, dementia, palliative care and falls.
4. **Care Home Admissions to Hospital:** Targeted interventions in care homes to reduce hospital admissions, which have shown to be particularly high in Norfolk.
5. **Integrated Acute Discharge Hubs.** Interventions to reduce delayed transfers of care (DToC) in line with the expected national focus on DToC for 2016/17.
6. **Falls Prevention**: Continuation of integrated falls prevention programme
7. **Disabled Facilities Grant:** Discussions with local authority colleagues confirms the potential for more fundamental and ambitious partnerships on the use of DFGs and (previously) social care capital grant.

Age and condition appropriate housing and adaptations are key to supporting independence and the wider goals of the BCF. Closer partnerships have been agreed through locality partnership boards and will support delivery of a wide range of initiatives, both within and parallel to the BCF.

In addition to these six core areas each CCG area is developing bespoke local schemes which support these priorities or concentrate on a particular local priority that requires targeted approaches to meet the national conditions or metrics of the BCF.

These six key areas provide opportunities for the sharing of good practice where they are already delivering well in localities, opportunities to work jointly across systems to reduce duplication of effort and ensure consistency of high quality services for all residents in Norfolk.

This approach also provides the opportunity for local flexibility as they are shaped and implemented around CCG boundaries so will therefore also reflect the different requirements of that population, the distribution of services and organisational and stakeholder priorities.

i. Countywide Ambitions and Plans

Commissioners are agreed that specific areas of the BCF plan would strongly benefit from either taking a whole systems countywide approach, or an acute system pan-CCG approach. These six key areas provide opportunities for the sharing of good practice where they are already delivering well in localities, opportunities to work jointly across systems to reduce duplication of effort and ensure consistency of high quality services for all residents in Norfolk. Commissioning leads have discussed other areas (for example arrangements for supporting the health and social care needs of people**.** learning difficulties) which are not sufficiently scoped to include in the BCF plan but which may be introduced because they would strongly benefit through taking a more integrated approach.

Areas where a combined approached show most promise are:

- Work with residential homes to reduce admissions
- Learning difficulty provision
- Disabled facilities grant
- Homecare and integration with locality health services

The final detailed approach to these common priority areas must provide the opportunity for flexibility which reflects the different requirements of that population, the distribution of services organisational stakeholder priorities. It need to acknowledge that within Norfolk the localities are at different places in respect of integration.

One of the tasks in agreeing the final Norfolk BCF plan will be to show more clearly where the arrangement for a particular scheme will be dependent of collaborative work across localities because this would be the most efficient approach.

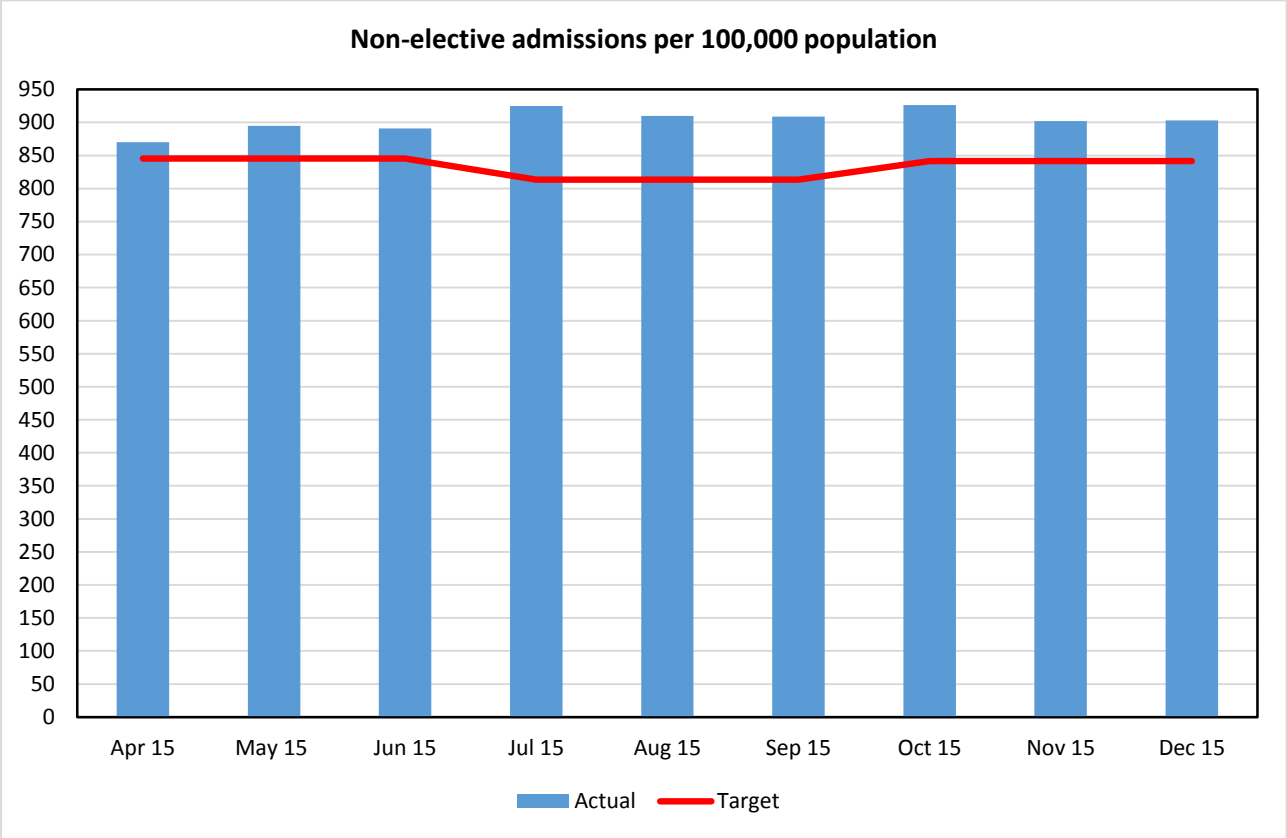
E. National Metrics

1. Non-Elective Admissions

In 2015/16 the target for Non-Elective Admissions was a 3.5% reduction on the 2014 baseline.

We have measured our performance against this target so far based upon MAR data. From 2016/17 we will be using the SUS data.

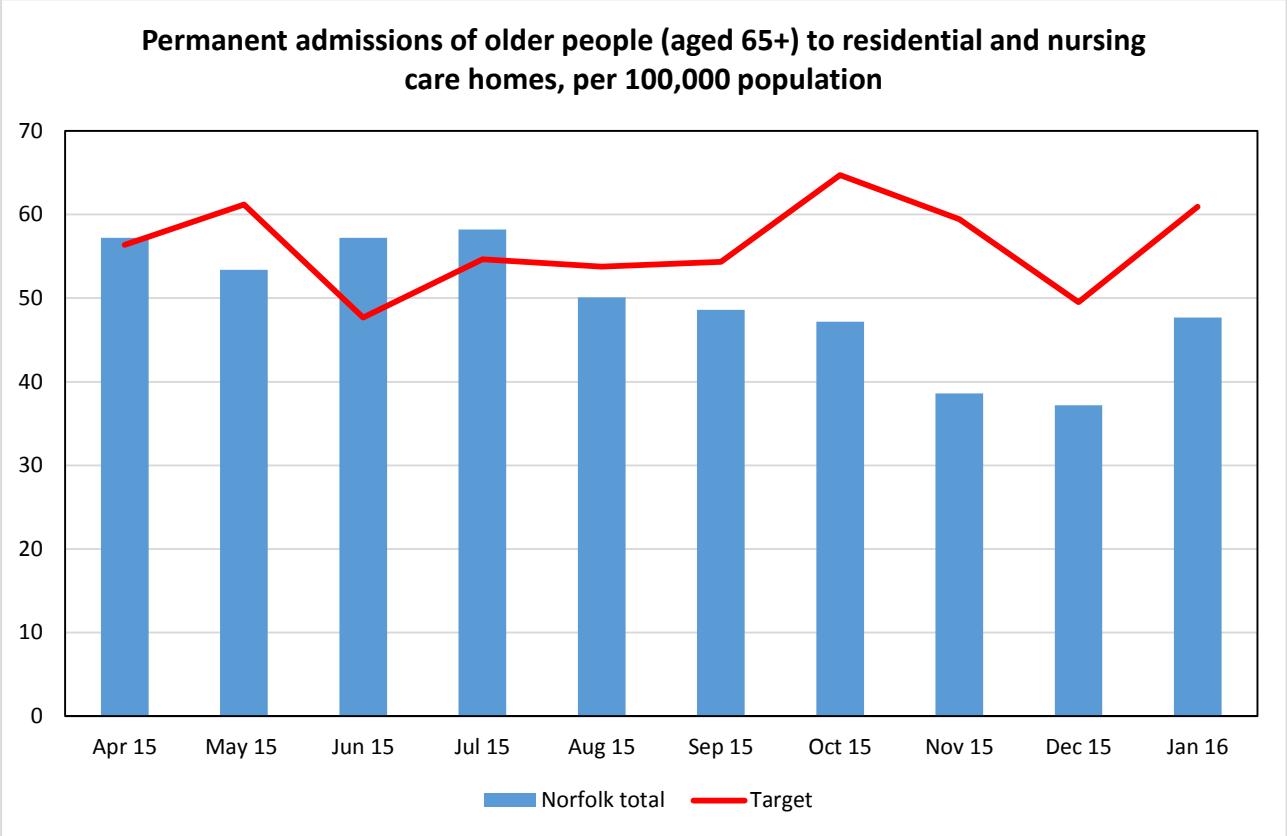
As the chart below shows, we are unlikely to meet our target for non-elective admissions in 2015/16, these have in fact increased compared to the 2014 baseline figure. It should also be noted that there is variation in performance at a CCG level and also where particular admission groups have been targeted – including avoidable admissions (and as a subset those with Long Term Condition) and falls.



2. Admissions to residential and care homes

In 2015/16 the target for permanent admissions of older people to residential and nursing care was a 5.7% reduction on the 2014/15 baseline. Note, the monthly target for permanent admissions is profiled according to the number of working days per month. As such, it is not a flat line target.

As the chart shows we are likely to meet this target for 2015/16, with particularly low admissions in Q3 2015/16. There is variation in performance at CCG level, with not all CCGs on track to meet their target, but all are showing improved performance.

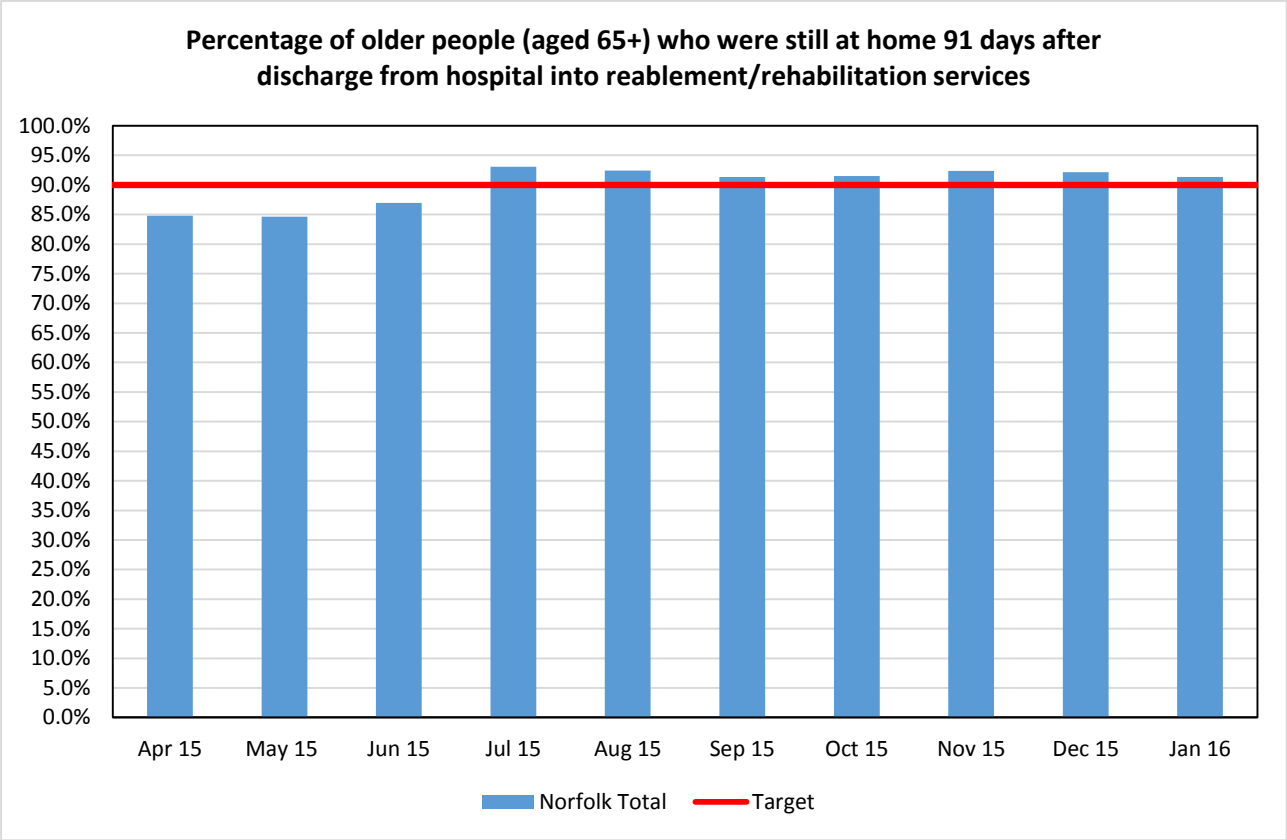


For 2016/17 our target will be a maximum of 1308 permanent admissions. This represents a 5% reduction in the number of admission compared to the 2015/16 forecast of 1377. This target is likely to place Norfolk better than the median for the family group.

3. Effectiveness of reablement

In 2015/16 the target for the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services was 90%.

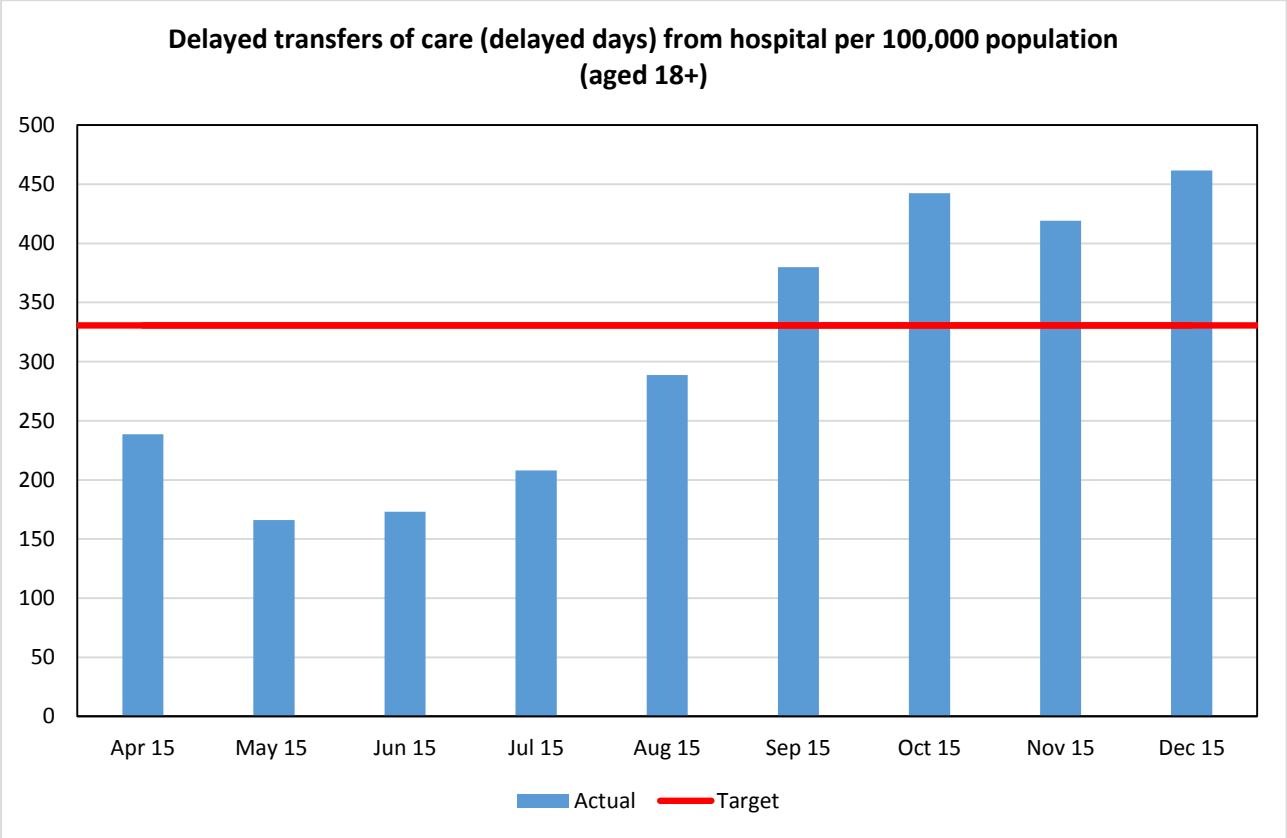
As the chart below shows, this target had been consistently met since Q2 2015/16 and as at January 2016 our performance is 91.4%. There is variation in performance at CCG level, with not all CCGs on track to meet the target.



For 2016/17 our target will remain at 90%. The family group average is 83%. 90% represents significantly better than average performance whilst being realistic given the growing scope of reablement services in Norfolk.

4. Delayed transfers of care

In 2015/16 the target for Delayed Transfers of Care was a 4% reduction on the 2014 baseline of 28,388 delayed days. Whilst performance was below target between April and August 2015, the target has been missed between September and December 2015. The earlier good performance means that we are still currently on track to meet this target.



F. BCF Schemes in detail

1. GYW1 – Supporting independence by provision of community based support interventions

Scheme ref no.
Scheme 1 - GYW
Scheme name
Supporting independence by provision of community based support interventions
What is the strategic objective of this scheme?
To deliver community based support interventions, in partnership with the Voluntary and Community Sector to deliver holistic packages of support to individuals to help support and manage their wellbeing. Effective community based support interventions, should enable and support people to maintain or regain their independence. The aim is to help prevent people's needs from escalating and requiring further health and social care interventions.
Overview of the scheme
There is a number of activity that has been identified to support the objective of this scheme. This activity covers three key areas, which include; Accessing and use of community resources – This can be developed through interventions such as Social Prescribing (see below), or community based services which effectively sign post to community resources. Supporting the development of voluntary and community resources – Ensuring that the voluntary and community sector are supported effectively to develop the necessary community resources. A key element is working with the community to enable them to resilience and solutions to respond to identified need. Commissioning community based interventions – Where need has been identified, and where appropriate, for services/ interventions to be directly commissioned by health and social care.
The evidence base
Community based support interventions, Self-care & self-management - Patient self-management seems to be beneficial for patients with COPD and asthma.[1] [2] [3] The Cochrane reviews concluded that education with self-management reduced unplanned hospital admissions in adults with asthma, and in chronic obstructive pulmonary disease COPD patients but not in children with asthma. There is evidence for the role of education in reducing unplanned hospital admissions in heart failure patients.[4]

[1] Purdy; Avoiding Hospital Admissions – What does the research evidence say? Kings Fund Dec 2010 http://www.kingsfund.org.uk/sites/files/kf/Avoiding-Hospital-Admissions-Sarah-Purdy-December2010.pdf

[2] Effing T, Self-management education for patients with chronic obstructive pulmonary disease. Cochrane Database Syst Rev. 2007 Oct 17;(4):CD002990.

[3] Tapp S, Lasserson T, Rowe B (2007). 'Education interventions for adults who attend the emergency room for acute asthma (Cochrane Review)'. Cochrane Database of Systematic

Reviews, issue 3, article CD003000. DOI: 10.1002/14651858.CD003000.pub2.

[4] Kirsty J. Boyd; Living with advanced heart failure: a prospective, community based study of patients and their carers The European Journal of Heart Failure 6 (2004) 585– 591.

There is some evidence that demonstrates that investment in learning for older people can reduce the costs of medical and social care and improve the quality of life for older people, their families and communities, NIACE, 2010.[5]

Respite Care - A report for the Princess Royal Trust for Carers and Crossroads Care (2011)[6] states that investing in respite care results in savings resulting from reduced costs to health and social care: spending more on breaks, training, information, advice and emotional support for carers reduces overall spending on care by more than £1bn per annum, as a result of reductions in unwanted (re)admissions, delayed discharges and residential care stays.

A focused review of the UK literature by the Audit commission looked at the effectiveness and cost effectiveness of respite care of older adults (60+ or 65+) and included cost effectiveness studies from the US literature.[7] Day care, home help/care, institutional respite care and social work/counselling were found to be effective and/or cost-effective for carers in terms of one or more of the outcomes in improving carer welfare and delaying admission to institutional care.
The following evidence base is focused on the research done into Social Prescribing.

Systematic research into SP initiatives is limited and the strongest support for it is qualitative in nature. Due to the variety of initiatives it is also difficult to make comparisons between them (Kimberlee 2013) Branding and House (2009) also note that due to the complexity of the interventions it is very difficult to evaluate the impact of Social Prescribing through research on measuring hard outcomes.

Grant et al (2000) carried out a randomised controlled trial and economic evaluation of such an initiative which took place across 26 GP practices in Avon, comparing patients with psychosocial problems who were referred to the Amalthea project (a liaison organisation between primary care and a voluntary organisation) and patients receiving routine GP care. They concluded that referral to SP initiative resulted in clinically important benefits such as significantly greater improvements in anxiety, other emotional feelings, ability to carry out everyday activities, feelings about general health and quality of life. Dayson et al (2013) suggests that 18-24 months should be allowed for real changes to be identified including associated costs to commissioning. (6)

The Rotherham Social Prescribing pilot and Age UK Kensington and Chelsea Primary Care Navigator Service have reported outcomes on health services in their evaluations. Their conclusions include the following observations:
1. The CCG, GP practices and the wider NHS benefit from the opportunity to refer patients with LTCs to community based services that complement traditional medical interventions. The pilot provides GPs with a gateway to these services and wider VCS provision. There are a number of signs that these interventions could help reduce demand on costly hospital episodes in the longer term.
2. Other public sector bodies, particularly local authority public health and social care, benefit from additional services that can be accessed by people with complex needs. Wider preventative benefits are likely to emerge over a longer period. There are strong links between the pilot's achievements and the borough's Health and Well-being Strategy.
3. People with LTCs and their carers benefit from an alternative approach to support. There is evidence that social prescribing clients are becoming more independent, have experienced a range

[5] NIACE: Lifelong Learning: Contributing to wellbeing and prosperity http://www.niace.org.uk/sites/default/files/2010-Spending-Review.pdf
[6] The Princess Royal Trust for Carersand Crossroads Care. (2011). Supporting Carers: The case for change.
[7] Pickard, L. (2004). The effectiveness and cost-effectiveness of support and services to informal carers of older people. A review of the literature prepared for the audit commission. Audit Commission.

of positive outcomes associated with their health and well-being, and are becoming less socially isolated.
4. Funded VCS providers have benefited from the opportunity to broaden and diversify their provision for people with complex needs. It has enabled a number of smaller community level providers to engage with health commissioning for the first time, whilst enabling more established providers to test the effectiveness of new and innovative types of provision. (7)

This potential is increasingly being recognised across the country and there are numerous examples of SP initiatives being set up recently including Luton and Derby.

2. GYW2 – Integrated Community Health and Social Care Teams including Out of Hospital Team

Scheme ref no.
GYW2
Scheme name
Integrated Community Health and Social Care Teams including Out of Hospital Team
What is the strategic objective of this scheme?
To continue to develop integrated community health services and the Out of Hospital team to contribute towards the delivery of joined up and quality care. This scheme is very much focused on the delivery of commissioned out of hospital services, in line with the new national condition detailed in the Better Care Fund 2016/17 policy framework. This is focused on enabling GYW CCG to achieve its strategic objectives of: Care closer to home Integrated service provision Reduction in emergency admissions to acute beds This will be focused on two main arears for delivery; Most Capable Provider We are confident that by 2016/17 the citizens of Great Yarmouth and Waveney will receive their health and social care, and some district/borough services, from a cohesive integrated care system (ICS). The above excerpt from the Shape of the System Business Case is reflected in one way or another throughout NHSGYWCCG strategic documents which describe moving ever closer to an integrated care system (commissioner and provider). Integral to this is the further implementation of Out of Hospital Teams and associated services, and the optimisation of the acute and community hospital bed base so that care at home becomes increasingly the norm, with care in hospital only used when other means are impossible. Out of Hospital Team (OHT) Great Yarmouth and Waveney Continued development of the OHT building on the success of this service in 2015/16. This will continue to contribute towards the aim to provide care at home whenever it is safe, sensible and affordable to do so. The care will be organised around the patient, focusing on individual need and empowering independence.
Overview of the scheme
Most Capable Provider

These aspirations are well known to our local providers having been discussed at length through the System Leadership Partnership and featuring in the CCG's commissioning intentions over the past two years.
To this end we will be, in conjunction with NEL CSU, embarking on a process to establish the Most Capable Provider to deliver care and support which is more integrated, better coordinated and sustainable across the locality, with an emphasis on support in the community.
The output from the process will be a new contract with a prime supplier. There will be a 5 + 2 commitment for the provision of the required service bundles under an agreed commercial model. There will be a requirement to evidence the cost and service delivery efficiencies gained by the provision of an integrated service model.
The services have been chosen as they are considered to have most impact on the ability to deliver the outcomes and will be greatly improved if the management of the services is streamlined. They are all services which impact on admission prevention and facilitating early discharge and when linked to better patient flow and bed management, will prevent unnecessary admissions to the acute unit and ensure patients are cared for in the most appropriate place. The ability to manage beds across the patch – acute, community, intermediate, beds with care – will improve more appropriate utilisation of available beds.
We also wish to see innovative ideas to utilise our scarce senior professional resource (health and social care) flexibly and for that to include support to primary care.

Out of Hospital Team
The Out of Hospital Team (OHT) is an inter disciplinary team of health and social care professionals for whom the objective of its service is to provide care at home whenever it is safe, sensible and affordable to do so. The care the team provides is organised around the patient, focusing on individual need and empowering independence. The team offers intensive, short term care, reducing as the patient regains health and independence. Care is holistic, co-ordinated, and responsive and goal focused, using a case management approach.
The OHT is made up of key health and social care professionals supported by workers able to perform many types of basic nursing, therapeutic and personal care tasks.
Referrals to the OHT will be accepted for patients registered with a GP. Referrals can be made by any health or social care worker. Patients referred to the service must be 18 years of age and over.

Referrals are only accepted for housebound patients or those who are only able to leave their place of usual residence with substantial support; irrespective of whether the patient, when medically fit, is normally ambulant. Referrals for ambulant, self-caring patients with capacity will not be accepted by the OHT.
Referrals are made to the OHT through East Coast Community Health's Single Point of Access. Some referrals are expected to come through Suffolk County Council's Single Point of Access. These referrals are immediately and automatically directed to the Out of Hospital integrated Triage Team.
Referrals must be for patients for whom it is considered input from the OHT will be of benefit.
Referrals could, for example, include:
Patients experiencing an acute exacerbation of their Long Term Condition
Patients experiencing acute symptoms due to chest infection or urinary tract infection
Patients whose mobilisation has suddenly reduced or is rapidly deteriorating
Patients for whom the current care package is no longer robust enough and urgent review and amendment is required to prevent a breakdown of carer support
Patients requiring a supported hospital discharge to their usual place of residence
Patients presenting at Accident and Emergency who do not require an emergency admission but do require additional short term support to enable them to return home
Patients who require a short term placement in a bed with care

Palliative and End of Life patients requiring short term input for example following a fall or an infection
The evidence base
Integrated community health and social care teams - Evaluating integrated and community-based care – the Nuffield Trust review of national integrated care pilots and virtual wards[8] showed reductions in planned admissions and in outpatient attendances for some interventions that involved case management using multidisciplinary teams and those using virtual wards, but no evidence of a general reduction in emergency admissions. King's Fund analysis of the evidence[9] suggests that joint commissioning between health and social care that results in a multi-component approach is likely to achieve better results than those that rely on a single or limited set of strategies. The Torbay integrated care model has reduced the use of hospital beds by a third from 750 in 1998/1999 to 502 in 2009/2010. Emergency bed day use for people aged 75 and over fell by 24% between 2003 and 2008 and by 32% for people aged 85 and over.[10] [11] The Institute of Public Care at Oxford Brookes University reports that joint health and social care investment in dental care, podiatry services, incontinence, dehydration monitoring (liquid intake), falls prevention and stroke recovery services has a positive impact on admissions to residential care.[12]

3. GYW3 – Care at Home

Scheme ref no.
Scheme 3 - GYW
Scheme name
Care at Home
What is the strategic objective of this scheme?
This scheme focuses on the delivery of services and models of support that keep people independent and well for longer, and where possible, regain skills that will prevent, reduce, and delay additional care and support. This is a key element of the Local Authority strategic aims which are; Norfolk County Council – Promoting Independence Suffolk County Council – Supporting Lives Connecting Communities

[8] Evaluating integrated and community-based care – a review of national integrated care pilots and virtual wards http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/evaluation_summary_final.pdf
[9] Goodwin et al, 2012, Integrated care for patients and populations: Improving outcomes by working together – The King's Fund: http://www.kingsfund.org.uk/publications/integrated-care-patients-and-populations-improving-outcomes-working-together
[10] http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/south-devon-and-torbay-coordinated-care-case-study-kingsfund13.pdf
[11] Thistlethwaite, P. (2011) "Integrating health and social care in Torbay: improving care for Mr Smith" The King's Fund, London: http://www.kingsfund.org.uk/sites/files/kf/field/field_document/PARR-combined-predictive-model-final-report-dec06.pdf
[12] CARE SERVICES IMPROVEMENT PARTNERSHIP. Care Services Efficiency Delivery Programme; Configuring joint preventive services: a structured approach to service transformation and delivering better outcomes for older people

Overview of the scheme

There is a number of activity that has been identified to support the objective of this scheme, which includes;

Delivery of new models of Home Support

Norfolk and Suffolk County Council and Great Yarmouth and Waveney Clinical Commissioning Group, have or are working towards a jointly commissioned Home Support Service that is focussed on increasing/maintaining independence and on delivering better outcomes in health and social care for our Clients.

Home Support is the delivery of an agreed package of care for adults in their own homes, who have been assessed as having a social care or primary health need, which has arisen as a result of a physical or mental impairment or illness.

This new model addresses the Council's statutory duties as outlined in the Care Act 2014, and the CCGs statutory duties under the National Framework for Continuing Healthcare Services and NHS Funded Nursing Care (2012) through adopting an outcomes-based approach and characterised by the ability to empower local Clients/Carers through activities that promote wellbeing through preventing, reducing or delaying the need for care and support. The Service will promote and encourage Clients to maintain and/or maximise their independence.

Integrated EOL / Palliative Care

Activity will also focus on developing an integrated palliative and end of life care service to provide high quality and consistent palliative care in the patient's preferred place of care. It is crucial that there is co-ordination of a range of flexible health and or social care packages to support further patients to die in the home care setting, offer a timely and co-ordinated response to crises and ensure effective information sharing with partner organisations, patients and carers.

Equipment in the home

When people's independence is at risk, it is crucial that they have the right support to restore their wellbeing or at least to minimise their dependency. For example, when someone's mobility is deteriorating, ensuring that their home is adapted, or getting advice about coping with the early stages of dementia to allow someone to keep living safely at home. Equipment, adaptations and assistive technology can play a crucial part in helping people to manage at home and live independently.

Reablement services

Develop targeted reablement approaches and services that aid the discharge of adults from hospital into the community. This reduces demand for further formal packages of care and supports the implementation of strengths based assessments to identify people's potential for independence.

Rapid/ Crisis response

Develop a clear rapid/ crisis response offer across Great Yarmouth and Waveney, which successfully reduces avoidable admissions and supports people appropriately at home. Identify gaps and opportunities to co-ordinate or commission services needed.

The evidence base

Care Act 2014

A key driver of change are the legal duties under the Care Act 2014. It requires councils to promote individual wellbeing, to prevent the need for care and support, and where care and support is required to reduce or delay the need for it.

Reablement Services - The evidence base for reablement services is limited by a lack of robust studies. However, there is evidence that reablement can reduce on-going homecare costs to social care.[13] The results showed a reduced use of home care services over time associated with median cost savings per person of approximately AU $12,500 over nearly 5 years when compared with individuals who had received a conventional home care service.

Glendinning et al (2010) showed that there is a 60% reduction in social care costs for those receiving reablement.[14]

Physical Rehabilitation - A Cochrane review of 67 trials, involving 6300 participants showed that physical rehabilitation for long-term care residents may be effective, reducing disability with few adverse events, but effects appear quite small and may not be applicable to all residents. There is insufficient evidence to reach conclusions about improvement sustainability, cost-effectiveness, or which interventions are most appropriate.[15]

Assistive Technology – Tele Health - Tele health is effective in reducing hospital admissions in people with chronic heart failure (meta-analysis of 11 randomised controlled trials showed a significant 21% reduction in hospital admissions in this group of patients.[16]

In addition, the results of a meta-analysis study support the use of telephone-delivered CBT as a tool for improving health in people with chronic illness.[17]

Assistive Technology – Tele Care - Tele care and Falls prevention: There is some evidence from a longitudinal prospective cohort study that a light path plus tele-assistance reduced falls and significantly reduced post-fall hospitalisation.[18]

Tele care and Dementia Care: The British psychological Society (2007) recommends that dementia care plans should include environmental modifications to aid independent functioning.[19]

Two case studies are highlighted below that show the effectiveness of tele care. This is low quality evidence and must be interpreted with caution. Evidence from evaluation of tele care provision in Essex and impact for social care found that for every £1 spent on tele care, £3.82 was saved in

[13] Lewin GF et al 2013 - Evidence for the long term cost effectiveness of home care reablement programs. Clin Interv Aging. 2013;8:1273-81.
[14] Glendinning et al (2010) Home Care Re-ablement Services: Investigating the longer-term impacts (prospective longitudinal study) SPRU/PSSRU report http://socialwelfare.bl.uk/subject-areas/services-activity/social-work-care-services/spru/135160Reablement10.pdf

[15] Crocker T Physical rehabilitation for older people in long-term care. Cochrane Database Syst Rev. 2013 Feb 28;2:CD004294.
[16] Inglis SC, Clark RA, McAlister FA, Ball J, Lewinter C, Cullington D, Stewart S, Cleland JGF (2010). 'Structured telephone support or telemonitoring programmes for patients with chronic heart failure (Cochrane Review)'. Cochrane Database of Systematic Reviews, issue 8, article CD007228
[17] Muller I, Telephone-delivered cognitive behavioural therapy: a systematic review and meta-analysis. J Telemed Telecare. 2011;17(4):177-84.
[18] E.A. Tchalla, et al The effect of fall prevention and management technologies Gerontechnology 2012; 11(2):347

[19]The British Psychological Society (2007) Dementia. http://www.nice.org.uk/nicemedia/pdf/CG42Dementiafinal.pdf

traditional care.[20] Tele care in North Yorkshire project evaluation estimates one year savings in care packages of £1 million.[21]

Home Improvement Interventions - There is a range of evidence demonstrating the resultant cost benefits of home repairs, adaptations and hospital discharge housing related help in the Fit for Living Network. This showed that for every £1 spent on handyperson services (which provide fast, low cost help with adaptations and repairs), £1.70 was saved, the majority to social services, health and the police; hospital discharge schemes offering housing help to speed up patient release save local government social care budgets at least £120 a day.

An analysis by Care and Repair Cymru of the outcomes of their Rapid Response Adaptations programmes identified that every £1 spent generated £7.50 cost savings to the NHS. These savings were associated with speeded up hospital discharge, prevention of people going into hospital and prevention of accidents and falls in the home providing an adaptation in a timely fashion can reduce social care costs by up to £4,000 a year.

The cost effectiveness of Home adaptations – a report by The University of Bristol based on a review of case studies revealed: [22]
Adaptations to the home can reduce the need for Homecare daily visits. In the cases reviewed – between £1,200 and £29,000 saved per year
Savings in home care costs by home adaptations mainly found in younger disabled people. In older people adaptations are found through prevention of accidents or deferring admission to residential care and improved quality of life
Home adaptations can reduce the need for residential care in disabled people
Findings on the impact of adaptations include 70% increased feelings of safety and an increase of 6.2 points on the SF 36 scores for mental health
Home adaptations that improve the environment for visually impaired people leads to savings through prevention of falls.
The provision of adaptations and equipment can save money by speeding hospital discharge and preventing hospital admission
Audit commission stresses effectiveness and value of investment in equipment and adaptation to prevent unnecessary and wasteful health costs
Adaptations give support to carers and avoid health care costs for strain and injury

Palliative care – local evidence
Public health mapping: In July 2013 Public Health Norfolk published the following findings re the palliative care needs of the population of Great Yarmouth and Waveney:
The number of expected deaths per annum in Great Yarmouth and Waveney is approximately 2,000 patients per annum (Marie Curie EOL Atlas 2010/11), so over 2 years the commissioners (the CCG, and Norfolk and Suffolk County councils) would expect that approximately 80% of these 4,000 patients and their carers would need support from health and social care services.

Some of the wards in Great Yarmouth and Waveney are amongst the most deprived in England with 27% of the population of Great Yarmouth living in the most deprived postcode areas in the country.

[20] Evaluating telecare and telehealth interventionsWSDAN briefing paper: http://www.kingsfund.org.uk/sites/files/kf/Evaluating-telecare-telehealth-interventions-Feb2011.pdf
[21] Department of Health (2009) 'Use of resources in adult social care A guide for local authorities' http://www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/Personalisation_advice/298683_Uses_of_Resources.pdf
[22] The cost effectiveness of Home adaptations: Report - Better Outcomes, lower costs – University of Bristol Office for Disability Issues (Heywood and Turner, 2007) http://odi.dwp.gov.uk/docs/res/il/better-outcomes-report.pdf

This leads to a significant incidence of life limiting illnesses associated with lifestyle issues e.g. cancer, chronic respiratory disease and heart disease. Dementia as a co-morbidity is also an issue in relation to an increasing need for palliative and end of life care services to 2025. This work also shows that 54% of local patients die in hospital, despite their preference being for receiving care in their home care setting (62% EOE wide).

The development of services in or closer to home will in particular support the needs of the elderly population who are more likely to experience rural isolation and difficulty in accessing services.
Palliative Care Skills Audit (Norfolk & Suffolk Palliative Care Academy and UEA 2013): The Academy carried out a skills audit with the UEA in 2013 which showed that 63% of staff asked were providing palliative care but had not received any training in the last 3 years to do so.

Marie Curie Delivering Choice Programme: The Marie Curie Delivering Choice Programme showed a significant variation in the quality of end of life care and also showed a need to improve the education and training for generalist staff providing palliative and end of life care (Marie Curie Delivering Choice Phase 3 report 2011).

How We Manage Death and Dying in Norfolk (Norfolk County Council and Norfolk and Waveney Cancer Network 2005): Showed a significant variation in the quality of local palliative care services.

4. GYW4 – Support for people with dementia and mental health problems

Scheme ref no.
Scheme 4 - GYW
Scheme name
Support for people with dementia and mental health problems
What is the strategic objective of this scheme?
To deliver specialist support to people with dementia and their cares to avoid / delay admissions to hospital / care and provide assessment of on-going care needs.
Overview of the scheme
Activity within this scheme will cover the following key areas; Information advice and advocacy services (including Dementia Advisors) Effective, timely and accessible information, advice and advocacy is critical in enabling people to make well informed decisions. It is a core element of the provision of support which helps people manage long term conditions and prevents or delays the need for higher costs, more formal care interventions. Dementia Advisors based within community mental health teams can take referrals of people with a new diagnosis of dementia. The support is about helping people to understand the dementia diagnosis including providing information about the impacts and course of the illness.

Targeted dementia service
This includes the following services;

Flexible Dementia Service - that enables people with dementia, who are in crisis or potential crisis situations, to remain in, or return to, their homes, which will help prevent inappropriate admissions to acute services, unnecessary admissions to residential/nursing care and avoid Delayed Transfers of Care. This will include giving Family Carers support, advice, and guidance in continuing their caring role.
Dementia Intensive Support Team - Dementia Intensive Support Teams (DIST) will provide services in the community and in-reach into to acute hospitals to aid safe and early discharge. Service provided daily (7 days per week) 08:00 to 21:00.

The evidence base

Dementia Care - In a systematic review of RCTs, four out of six good quality studies found that case management of dementia patients was associated with delayed or reduced institutionalisation, although in one study this was only significant in one of three countries studied. However, none of the good quality studies found evidence for savings in healthcare expenditure or reduced hospitalisation rate/emergency visits. NHS investment in early assessment services for people with dementia can produce significant savings for social care, particularly in relation to residential care (National Dementia Strategy – Impact Assessment – economic case for early assessment and memory services).[23]

Intensive Case Management for Mental Health patients - A Kings Fund Paper in 2010[24] on the research evidence around avoiding hospital admissions recommended that commissioners and providers should consider implementing intensive and/or assertive case management for people with mental health illnesses. This is most effective when focused on patients with frequent hospital use and assertive case management by multidisciplinary teams may reduce mental health admissions.

A Cochrane review of 'Intensive case management for severe mental illness' (2011)[25] found that ICM is of value at least to people with severe mental illnesses who are in the sub-group of those with high level hospitalisation (about 4 days a month in past 2 years) and the intervention should be performed close to the original model.

Integrating Mental Health into Chronic Disease Management - There is a growing evidence base that suggests that more integrated ways of working with collaboration between mental health and other professionals offers the best chance of improving outcomes for both mental health and physical conditions. There is also evidence that the costs of including psychological or mental health initiatives within disease management or rehabilitation programmes can be more than outweighed by the savings arising from improved physical health and decreased service use.[26]

Integrated Care Pathways for Mental Health - An Evidence briefing (2011)[27] produced by the Centre for Reviews and Disseminations found that there is some evidence suggesting that ICPs can reduce mental health hospital costs, most studies were not conducted in the UK NHS.

[23] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/168220/dh_094051.pdf
[24] Avoiding hospital Admissions: What does the research evidence say? The Kings Fund. Sarah Purdy. December 2010.
[25] Intensive case management for severe mental illness (Review). Dieterich M, Irving CB, Park B, Marshall M. Wiley 2010.
[26] The Kings Fund and Centre for Mental Health : Long-term conditions and mental health, Naylor et al 2012
[27] Evidence briefing on integrated care pathways in mental health settings. National Institute for health research. Sept 2011.

Mental health promotion through early intervention in psychosis is thought to be cost-saving for the NHS.[28] This involves a multidisciplinary team with emphasis on an assertive approach to maintaining contact with the patient and encouraging a return to normal vocational pursuits. UK evidence shows it can reduce relapse and readmission to hospital and improve quality of life.

Early intervention in psychosis (modelled on a target group of people aged 15-35 years) is thought to save the NHS over £5 for every £1 spent within one year.

Crisis Resolution and Home Treatment for Mental Health patients (CRHT) - Crisis Resolution and Home Treatment (CRHT) services for mental health patients have been shown to decrease unplanned hospital admissions and length of stay. [29] [30]

The National Audit Office suggests that the NHS could save £12-50 million annually by increasing the number of patients taking part in CRHT programmes.[31] Integration of CRHT or other community teams with inpatient staff can lead to reductions in bed use, and this approach in Norfolk has led to annual savings of approximately £1 million.[32]

The clinical interventions are based upon NICE Guidelines.

The National Dementia Strategy (NDS) was supported by a full economic impact assessment and it contains 17 objectives. Those objectives that are relevant to mental health services have formed the basis of the service proposal's objectives.

In the area covered by NHS Norfolk and Waveney there are over 15,000 people with dementia but less than half of them are in receipt of a diagnosis. In other words more than half of the people with dementia locally have no diagnosis and therefore no access to treatment that can prolong their quality of life and independence, delay expensive institutionalisation, and help prevent expensive episodes of unplanned care.

5. NN1 – Development of Community Care Teams around GP clusters

1.	**Scheme Title**	Development of Community Care Teams around GP clusters
	Scheme Ref Number	NN1

2. What is the strategic objectives of this scheme

To implement the formation of community care teams around the North Norfolk 4 GP clusters so that cohorts of 'at risk' people are collectively reviewed and managed via MDT meetings and there is easy access via Integrated Care Co-ordinators (ICCs) to support services in the community.
The community care teams will work closely their primary care colleagues to:

[28] Knapp M, McDaid D, Parsonage M (eds) (2011). Mental Health Promotion and Mental Illness Prevention: The economic case. London: Department of Health.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215626/dh_126386.pdf
[29] National Audit Offi ce (2007a). Helping People Through Mental Health Crisis: The role of Crisis Resolution and Home Treatment services. London: The Stationery Office. Available at: www.nao.org.uk/publications/0708/helping_people_through_mental.aspx

[30] Chiles JA, Lambert MJ, Hatch AL (1999). 'The impact of psychological interventions on medical cost offset: A meta-analytic review'. Clinical Psychology: Science and Practice, vol 6, no 2, pp 204–20
[31] Howard C, Dupont S, Haselden B, Lynch J, Wills P (2010). 'The effectiveness of a group cognitive-behavioural breathlessness intervention on health status, mood and hospital admissions in elderly patients with chronic obstructive pulmonary disease'. Psychology, Health and Medicine, vol 15, no 4, pp 371–85.
[32] Department of Health (2009) partnerships for Older people projects final report. London. Department of Health.

- Use risk profiling tools to identify the following categories 'at risk' people :
  - End of life
  - Complex case management
  - Prevention
- This will include strong links to the Multi-Disciplinary Discharge hub at the NNUH to support people discharged from hospital
- Work towards the delivery of 7 day working
- Facilitate shared access to health and social care records (via ICCs) so that there is a joint assessment to care planning at the regularly occurring MDT meetings
- Reduce the number of avoidable emergency hospital admissions

3. What is the intended impact of the scheme (Outcomes)

Objective	Impact
To implement a community care team framework around the 4 GP clusters that includes MH and LD roles	Clear framework based on the service quality standards that can then be used to performance manage the community care teams
To implement the Edmonton frailty toolkit across all 4 GP clusters	Create a standardised mechanism to manage complex cases at a GP cluster level
To audit the ICC referral pathway	Ensure that all ICCs are working is the same way following identified referral routes
To implement the ECLIPSE data analysis tool across all GP practices	Provide a more sophisticated mechanism to identify and manage patients with complex heath conditions
To establish a standard MDT format across all GP practices. This will include mental health and LD professionals as part of the MDT meetings. GSF reviews for people on End of Life pathway will be included as part of the MDT meetings	A joint approach to assessment and care planning will ensure that all 'at risk patients' are regularly reviewed and proactively directed to appropriate care for their individual needs
To establish options for working towards 7 day service delivery model across the community care teams and supporting services.	Availability of 7 day services in the local community that keep people living in their desired home location.
To deliver meaningful staff stakeholder, patient/ service user consultation and engagement and communications throughout the lifecycle of the project	Communication and engagement will be a key driver in a shared vision across all stakeholders for the project

4. What are the key success factors for implementing this scheme

Key Milestone or Activity	Timescale
Updated North Norfolk NCH&C Community, Nursing and Therapy Specification signed off	March 2016
Implementation (including links to primary care) of Edmonton Frailty Tool across all 4 GP clusters	May 2016
Clinical audit of enhanced ICC team to review quality and impact of ICC referrals completed	June 2016
Implementation of ECLIPSE data analysis across all 19 GP practices	August 2016
Operations manager role such that resources are effectively managed across the 4 GP clusters	September 2016

Community Care team structure and cost envelope agreed	September 2016
Go live date for Community Care teams	December 2016

5. The Evidence Base

Please see 2015/16 NN1 and NN2 Integrated Care Evidence base.
The North Norfolk Integrated Care programme has been established since 2012 and is based on the national John Oldham QIPP LTC programme. The following infrastructure is in place which is starting to show achievement of 2015/16 BCF targets :

- All 19 GP practices are aligned to 4 GP clusters
- Risk profiling tools are used to identify patient 'at risk or who would benefit from early preventative support
- Integrated care co-ordinators (ICCs) support the holistic review of a person's needs and identify opportunities for accessing
- MDT meeting co-ordinated by the ICCs are held at least 8 times per year where health and social care professionals jointly review and discuss people needing help
- Voluntary sector services (Red Cross Outreach and Voluntary Norfolk befriending service)

An external review of the Integrated Care Co-ordinators role and their link to the voluntary sector was conducted by Warwick University which concluded that:
'ICCs *improve the critical review capacity of the CCG in multiple ways. In particular, their ability to engage closely with the voluntary sector is an important element of their role. By integrating voluntary organisations with health and social care services, ICCs work as a coordination capability to prevent avoidable admissions into urgent care*. '
Dr Charlotte Croft, Research Fellow, Warwick Business School, February 2015
Over 30% of ICC referrals are to voluntary sector agencies and since the teams has been in place referrals in particular to the Red Cross Outreach service and Voluntary Norfolk Befriending service.
An evaluation of the impact of the Integrated Care model was conducted with over 100 MDT members, from each of the 4 GP clusters, in April 2014. The findings informed the 20/15/16 Integrated Care Programme and were as follows :

- Increase the capacity of Integrated Care Co-ordinators (ICCs)
- Improve continuity of care for patients by having the same members of staff working with GP practices
- Improve the way we identify and manage cohorts of at risk patients
- Have a single point of contact for professionals to access health and social care services
- Review the community matron role

The 2015/16 BCF Dashboard is showing progress towards targets and in particular:

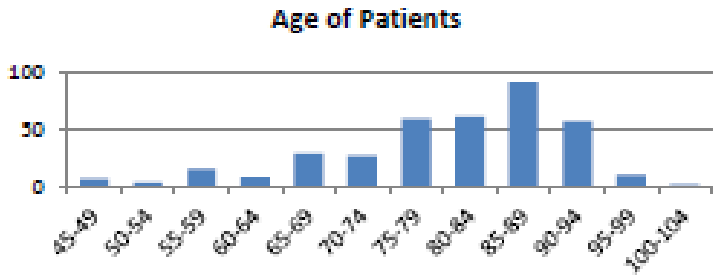
- Emergency hospital admission figures are 1% down when compared to data from 2014/15. This reduction compares very favourably with our CCG neighbours who are collectively showing and average increase of 3.2 % when compared to the same period in 2014/15 (Table 1). It is also a significant improvement on the 13/14 v 14/15 emergency admission figures which for the same period showed an increase of 3.0%.

Table 1 : CCG Comparison of Admission avoidance results

	Emergency Admissions Activity			
CCG Name	2014/15	2015/16	Diff	% Diff
NHS North Norfolk CCG	**12,848**	**12,719**	**-129**	**-1%**
NHS Norwich CCG	14,897	15,687	790	5.30%

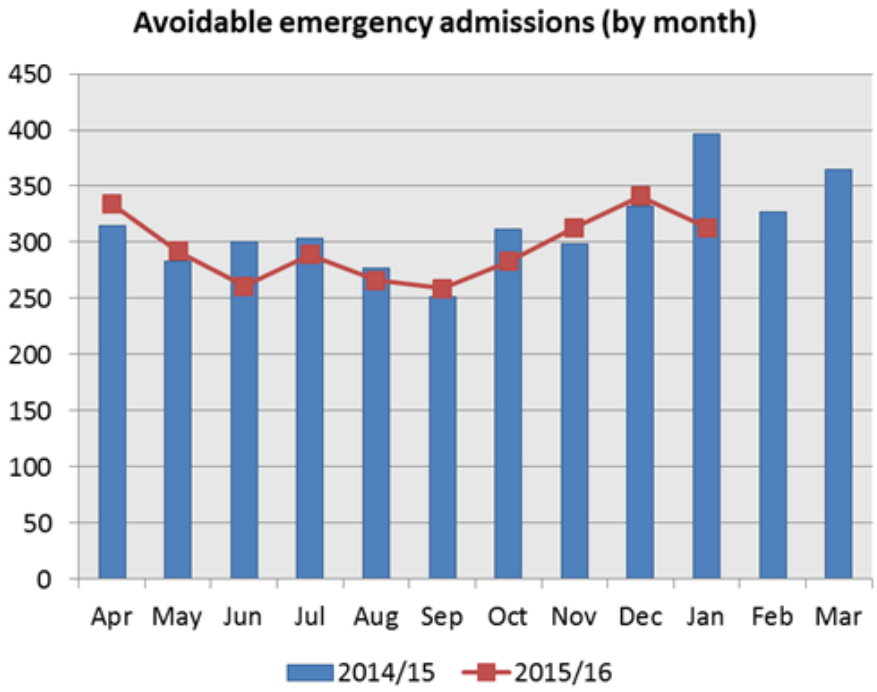
NHS South Norfolk CCG	15,841	16,151	310	2.00%
NHS West Norfolk CCG	16,559	17,521	962	5.80%
Total	**60,145**	**62,078**	**1,933**	**3.20%**

- The greatest emergency admission reductions are for people aged between 60 < 95 years (368 less people an associated cost saving of over £1 million). These are the age range that the Integrated Care Co-ordinators (ICCs) are targeting (Graph 1).



Graph 1 : Age range with ICC support (ICC February 2016 dataset)

- Avoidable emergency hospital admissions (see graph 2 below) have decreased by 3.8% when compared to data from 2014/15 which equates to 118 fewer avoidable admissions than during 2014/15.



Graph 2 : Comparison of Avoidable Emergency Admission by month

6. The Delivery Chain

Commissioner or Provider	Role
Commissioning Manager – Integrated Team	Project management, engagement and communications. Chair the operations groups and provide feedback at board level.

Primary Care Clinical Commissioner	To support alignment of primary care staff to community care teams and implementation of ECLIPSE data analysis tool
NCH&C ops teams	To implement frailty tool across all community nursing team and alignment of the community nursing team resources to GP clusters
NCC ops teams	Alignment of social care resources to community care teams – including LD
NSFT ops teams	Alignment of MH resources to community care teams
Integrated Care Board	To sign off recommendations, inform and support the delivery of the programme
QIPP Programme & BCF Boards	To review and monitor impact

7. Value for Money

Investment Requirements	Potential Efficiencies
The community care teams will be made up by re-arranging the current resources available. The cost of ECLIPSE (annual fee £25K) will be financed through savings made. The new role of Operations Manager may require additional investment as specialist administrative skills will be required	Cost savings made by reducing emergency admissions to hospital and increased efficiency through joint assessment of need and co-ordinated delivery of care

8. How will this build long term capacity for integrating health and social care

The co-location of community care teams closely aligned and working alongside GP practices will drive efficiencies across health and social care such that duplication is removed and greater numbers of 'at risk' and frail elderly patients are supported at home and in their community.

9. How will this scheme support people effectively and improve patient or service user satisfaction.

The formation of integrated care teams, that have strong relationships with their primary care and community care colleagues will create more continuity of care for the patient and foster a mentality of collaborative teamwork such that care is shaped around and responsive to individual people and their personal needs.

10. Stakeholder Engagement

A clear integrated care vision and strategy will be created which outlines all the key projects and how they link together. Regular monthly updates will be shared across health and social care to keep everyone up to dates with progress. Stakeholders and operations staff will be involved in the review and design of efficient patient pathways to deliver care in the community.

11. How does this scheme represent a whole system approach

The development of care teams will create 'mini health economies' that will link services seamlessly to ensure patients will have access to the services they require and will reduce the avoidable hospital admissions and short term stays.

12. How will this scheme support the shift towards early help and prevention, community support and self-care

Earlier identification of people through the regular review of 'at risk' cohorts of patients will shift support towards early help and prevention. The ICCs will be supported working as part of an integrated care team accessing health and social care records to create a holistic review of patients and promoting referrals to voluntary sector organisations and self-help groups. More training will be delivered to health and social care professionals so they are able to promote self care options available.

13. Risks & Mitigations

Identified Risks	Likelihood	Severity	Score	Mitigation
Increased support of people in the community has the capacity to increase social care support needs	3	4	12	Monitoring of social care needs and options in place to adapt resources if required
Reduction in community care beds will mean that increased support and resources will be required in the community	4	3	12	Gap analysis of community assets to feed into future commissioning plans

14. Feedback Loop – how will you measure the outcomes form this scheme

Outcomes (from 3 above)	How will this be measured
More people supported at home and in the community	• Reduction in emergency admissions to hospital • More people die in their preferred place of care • Reduction in mental health admissions to hospital • Reduction in the number of patients aged 65+ conveyed to hospital by ambulance
Improved patient outcomes	GP Patient satisfaction surveys
Increased involvement of staff to update / redesign care pathways that drive efficiencies across health and social care	• Staff satisfaction surveys • Staff turnover and retention • Increased use of data metrics to measure impact of improvement initiatives
Increased referrals and engagement with voluntary sector employees	Referrals to voluntary sector providers and self-help groups

6. NN2 – Crisis Response Service

1. Scheme Title Crisis Response Service

Scheme Ref Number NN2

2. What is the strategic objectives of this scheme

The project objective is to provide a rapid integrated crisis response to adult patients in North Norfolk. The crisis response service will build on current duty teams to deliver responsive care is in a home setting thus preventing unnecessary hospital and residential care home admissions. Following crisis intervention, where necessary, people will referred back to mainstream health and social care including voluntary services.

3. What is the intended impact of the scheme (Outcomes)

Objective	Impact

To provide a clear and defined pathway for people where deterioration within their health and social circumstances are now in crisis.	Providers will work collaboratively to create a seamless patient journey that will result in improved outcomes
To provide short term care which will enable the person to remain in their residence whilst professionals work to provide a care package and necessary referrals to mainstream services.	Delivering a reduction in: - 0-3 day acute admissions - Ambulance call outs - Residential care respite services - Permanent Residential/Nursing Care Placements
Referral onwards to appropriate agencies e.g., social, health and voluntary agencies.	Promote Independence and reduce demand and expenditure on more formal complex services.

4. What are the key success factors for implementing this scheme

Key Milestone or Activity	Timescale
Develop the project plan to include engagement and financial envelope	31 March 2016
Agreement and sign off of pathway	15 April 2016
Detailed Resource planning	30 April 2016
Implement pilot	1 May 2016 – 31 May 2016
Review of pilot and update plan	1 June 2016 – 29 June 2016
Go live with Crisis Response Service	30 June 2016

5. The Evidence Base

Rationale – why is this intervention being proposed and what evidence supports this?

Proposal:

Based on developments as part of North Norfolk's 2015/16 CCG QIPP and Integrated Care Program the following intervention is proposed:

Develop, align and integrate community health and social care services to provide:

1. A single point of access to non-emergency services
2. A multi- disciplinary Crisis Response to address an immediate need when a crisis occurs
3. Rapid access to appropriate community services across health and social care to address the needs that have given rise to a "crisis"

The crisis interventions will include those that arise from:

- Home based Falls
- Carer Breakdown/Illness
- Preventable Health Related Issue e.g. Dehydration
- Dementia Support
- Occupational Therapy Intervention

Evidence:

This is an expansion of North Norfolk's Rapid Access Service for Falls. This contributed to a reduction in falls (as a subset of emergency admissions) of 11% as compared to the same period in 2014/15. The

hypothesis is that a similar impact can be achieved for other 'crisis' situations described above for other avoidable admissions and residential care placements.

April 2015 – Dec 2015

Measure	2014-15	2015-16	Variance	%
Falls emergency admissions	1239	1103	-136	-11.0%

NHS & LGA Consultant -John Bolton highlighted that the 3 main reasons for a residential care intervention are due to a fall, dementia related or continence issues

6. The Delivery Chain

Commissioner or Provider	Role
CCG	Planning, implementation, service promotion and progress monitoring
NCH&C / Mental health/	Providing nursing and therapy care
NCC / LD/ NFS	Social Care, Therapy and reablement support
Integrated Care Co-ordinator	Co-ordination and signposting
Domiciliary Care Agencies	Sitting Service and personal care packages
Voluntary / Housing agencies	Wrap around care support
GP	Clinical responsibility and follow up
EEAST / 999/ Out of Hours	Transport and emergency diagnosis

7. Value for Money

Investment	Potential Efficiencies
Investment in additional specialist resource e.g. sitting services, Physio and equipment	Cost saving due to reduced hospital admissions

Description of what savings this will deliver (cost of number of reductions in avoidable admissions for example) and any costs associated with delivering the scheme.

8. How will this build long term capacity for integrating health and social care

The development of an integrated crisis response service will keep at home people who are in a crisis situation. This service will specifically target falls, health crisis associated for carers, chronic health issues and supporting mental health crisis.

9. How will this scheme support people effectively and improve patient or service user satisfaction.

Patient user satisfaction will be increased as the crisis support service will enable more people in short term medical crisis situation to remain in their residence without the need for a short term stay in hospital or residential care.

10. Stakeholder Engagement

A clear crisis response pathway will be created which outlines the scope of the service, access point and benefits. Stakeholders will be involved in the design and review of efficient patient pathways to deliver care in the community.

11. How does this scheme represent a whole system approach

It is proposed that the crisis response service will be co-ordinated from the SPOC at Rebecca House. There will be a seamless transition to ensure that unplanned care needs are resolved and passed to local community care teams.

The approach will align, integrate and coordinate crisis response interventions across health, mental health and social care. These include:

- Norfolk First Support – Reablement Service
- Norfolk First Support – Swift / NFR Service
- Independence Matters – Flexible Dementia Respite Service
- NCC Operational Team – Social Care Support
- Integrated Care Co-ordinators – co-ordination and sign posting
- NCHC – Nursing and therapy support
- NFST - Rapid Response Service

12. How will this scheme support the shift towards early help and prevention, community support and self-care

The crisis response service will stop people being unnecessarily transported to hospital for short term stays and ensure that the appropriate care package and support options are in place.

13. Risks & Mitigations

Identified Risks	Likelihood	Severity	Score	Mitigation
Resistance to change	3	3	9	Due to relentless change initiatives, some NHS colleagues are prone to change fatigue. Refocus to Crisis Response and the achievable benefits will reinvigorate teams to realise quick wins
Failure to understand project roles & responsibilities	4	4	16	The project team will identify clear definable roles and responsibilities. Obliterate the risk of working in silos.
Impact of County Wide projects may inhibit progress and limit traction on Crisis Response	4	5	20	Steering Group established to combat deviation from project plan.
Failure to secure the necessary budget will result in project failure	4	5	20	Discussions in place with executive lead to identify project budget
Pace of the project does not remain in line with national and regional initiatives	2	5	10	Constant horizon scanning and flexing the plan to meet national imperatives
Lack of availability of care packages may mitigate ability to keep people supported in their own home	3	5	15	Work with domiciliary care providers to find creative ways to have care packages available to meet crisis needs

14. Feedback Loop – how will you measure the outcomes from this scheme

Outcomes (from 3 above)	How will this be measured
More people supported at home and in the community	Reduction in :

	• Avoidable hospital admissions, particularly reducing the amount of 0-3 day hospital stays • Avoidable short term/respite care residential/nursing care admissions • Avoidable Permanent Residential or Nursing Care home Admissions.
More efficient use of ambulance services	National EEAST dataset
Improved patient outcomes and experience	Patient satisfaction surveys

7. NN3 - Targeted Support to Promote Independence

1. Scheme Title Targeted Support to Promote Independence

Scheme Ref Number NN3

2. What is the strategic objectives of this scheme

This programme will further develop the self-care menu of options available to patients living with or at risk of developing long term medical conditions, support better alignment and joint working within the voluntary sector, deliver targeted housing support to older people and improve integration of homecare within the locality.

3. What is the intended impact of the scheme (Outcomes)

Objective	Impact
People identified through the MDT process are offered a tailored menu of options to allow them to manage aspects of their conditions and lifestyles.	People are able to manage their conditions without input from health or social care practitioners resulting in a better experience of the health system and reduced avoidable admissions to acute or residential settings
The menu of options is in place and readily available to people, practitioners and carers and includes : 1. Condition specific information tailored to the person 2. Peer support and self-help groups in the local community 3. Information about services and alternative therapies 4. Access to targeted wellbeing programmes including supported activity.	People, professionals and carers know what services are available, how to access and pay for them and what they can hope to achieve by using them. Peer support exists in localities where needed. Partnership working with PH and District's supports all statutory bodies to meet their objectives without duplication and reduces the likelihood of gaps emerging in the locality.
The causes of unplanned avoidable admissions are reviewed on a monthly basis by cluster to target interventions swiftly.	Targeted interventions can be rolled out quickly and in the right areas to have the biggest impact on reducing avoidable admissions.
Practitioners adopt social prescribing as a mechanism for supporting people to improve their wellbeing.	People are able to volunteer, access community activities and engage with other groups resulting in improved wellbeing.
Voluntary sector and housing services are remodelled to deliver care and support aligned to	Every funded voluntary sector service can demonstrate how they are supporting people to

promoting independence, and understands integrated working.	achieve outcomes in line with promoting independence.
The offer of Disabled Facilities Grants (DFG) is clear and accessible so adaptations can be delivered in a timely way.	People are supported to stay in their own homes which are made safe and accessible for longer.

4. What are the key success factors for implementing this scheme

Key Milestone or Activity	Timescale
Process developed and embedded that builds on the practice dashboards to identify top reasons for avoidable admission by GP cluster	Dashboard development agreed Feb 2016 Routine reporting to integrated system including vol sector and PPG's from April 2016 Clinical support made available to PPG to put in place targeted interventions from May 2016
A self-care pathway is in place that aligns cohorts of patients with the self-care continuum. The self-care menu of options is in place to support each stage of the pathway. Referral routes in to services are established	Pathway drafted by Self-care Advisory Panel by March 2016 Signed off by ICP Board April 2016
Health and social care practitioners are supported to understand the pathway and access elements of the (menu of options) in an appropriate and timely way.	Training to locality teams undertaken May 2016
A proforma is produced by the SAG (Self-care Advisory Group) that allows clinicians to develop patient specific information about their condition easily. Peer Support best practice is researched and a programme for implementation developed.	SAG convened to develop proforma May 2016 Clinical sign-off of proforma via ICB June 2016 Roll-out across GP Practices July 2016 Self-help to develop self-care guidance delivered to PPG's and Voluntary Sector June 2016
Social prescribing programme developed and training delivered to a pilot cluster to include all members of the MDT. Programme rolled out over locality	Social prescribing best practice identified and programme developed June 2016 Pilot cluster engaged and SP trialled for 3 month period Sept 2016
Homesupport block re-commissioned for remaining areas of North Norfolk to deliver an outcome focused service.	Block design aligned to GP Clusters April 2016 Market engagement June 2016 Procurement undertaken Nov 2016 New service April 2017
Housing support for older people is reviewed and remodelled to deliver a time limited strengths based service increasing capacity and aligning with integrated care.	Initial proposals to NCC SMT March 2016 Development work June 2016 Procurement undertaken Sept 2016 Mobilisation from Jan 2017
The funding and specification for delivering DFG's is reviewed and considered with HIA funding to propose a new approach for the locality.	Initial scoping April 2016 Initial proposals July 2016

5. The Evidence Base

This scheme builds upon work undertaken through the BCF for 2015/16 which sets out the health and wellbeing benefits for people together with the financial benefits for the health and social care system.

6. The Delivery Chain

Commissioner or Provider	Role

Commissioning Manager – Integrated Team	Project management, engagement and communications. Chair the self care group and provide feedback at board level.
Voluntary sector providers including housing and homecare	To work with commissioners to realign their services with the GP Clusters
Integrated Care Board	To sign off recommendations, inform and support the delivery of the programme
NCHC & NCC Operational teams	Active participation in MDT process and utilise the self-care menu of options when working with people
QIPP Programme & BCF Boards	To review and monitor impact

7. Value for Money (see attached calculation)

Investment Requirements	Potential Efficiencies
Self-care Information - £1,500 Cost of publication and design	Calculated as 1% of the 42,000 patients identified through Kaiser hierarchy of need in North Norfolk as having a long term condition[33] (110 patients @ £1700 per avoidable admission) **£187,000**
Self-care menu of options (including self-care pathway, social prescribing, voluntary sector support and access to health and wellbeing activity) – no cost implications	
Remodelling of homecare to include strengths based outcome focused support and inclusion of up to 10 days of placing packages on hold. – no cost implications	Calculated as a reduction in delayed discharges of care (excess bed days) of 60 days per GP Cluster per month (<1%) @ average of £211 per day) **£151,000**
Improvement in the delivery of DFG's to people who are living in unsuitable housing – no cost implication	Avoidance of 1 residential care placement per month plus a reduction in delayed discharges of 20 days per month **£151,755**

These savings will be calculated by taking an average cost of avoidable admissions against the 2015/16 NHS Tariff considering Market Rate Credit and using existing numbers of avoidable admissions. The delivery of these savings will be dependent on the continued integration of health and social care and the specification design for the Integrated teams. In terms of financial reporting, the QIPP and BCF boards will consider both numbers of reduced avoidable admissions *and* actual cost of activity on a month-by month basis.

8. How will this build long term capacity for integrating health and social care

Reducing the reliance on acute health and targeting home and community based support for people will effectively deliver integrated approaches to care shifting people from the health sector and in to the social care sector. Improving the delivery of self-care and voluntary sector driven services to people managed by integrated teams will keep frail and elderly people at home for longer creating capacity in both the health and social care system.

9. How will this scheme support people effectively and improve patient or service user satisfaction.

This scheme will enable people to access better information and support in order to take control and manage their health conditions better. People who are active in the management of their symptoms and conditions tend to report more positively on their experiences of health and social care as demonstrated by NHS Health Education East's evidence base for the delivery of self-care.

10. Stakeholder Engagement

[33] See Appendix 1 – Kaiser Hierarchy of Need

Key stakeholders are as follows:

- Voluntary sector providers delivering community based support – engagement through the NCC Locality Provider Forum and the NNCCG Community Engagement Panel. Further work will be undertaken with Community Action Norfolk to identify and engage with other voluntary sector organisations currently not working with the CCG
- Patients and Carers – through the established self-care advisory board set up in 2015/16.
- GP and other Health Care Professionals – links have already been developed with the Primary Care Development group within the CCG and these will be extended to the Council of members in 2017/

11. How does this scheme represent a whole system approach

Work undertaken under the guise of the Integrated Care Programme in 2015/16 has established 4 GP Clusters in North Norfolk and this created mini health economies. These will be further extended in 2016/17 to bring in voluntary sector providers working in day and community services, befriending and outreach services and domiciliary care to reflect the whole system centred around the person.

12. How will this scheme support the shift towards early help and prevention, community support and self-care

This whole scheme underpins a shift towards early help and prevention. The use of risk stratification will identify people earlier on in their health or social care journey and the creation of broader health economies centred around the GP clusters will enable people to access appropriate information and services in their vicinity to take enable self-care.

13. Risks & Mitigations

Identified Risks	Likelihood	Severity	Score	Mitigation
Lack of engagement from non-clinical MDT members resulting in gaps in identifying the right cohort	2	3	6	Clear process for risk stratification to include non-clinical partners such as District Councils and housing providers
Increased flow of referrals in to social care from health	4	3	12	Clear monitoring of referrals to SC supported by flexible referral processes in to the voluntary sector to stem demand for SC input
Pace of change becomes difficult to manage and partners disengage	2	2	4	Defined programme of work to be widely shared to support partners to anticipate the pace of change
Self-care group loses focus and changes the direction of the programme	2	3	6	Co-production of self-care programme to ensure focus and engagement continues. Refresh terms of reference and membership
Housing providers disagree with the proposals to remodel support to older people	3	4	12	Early engagement and a clear rationale for refocusing support to be shared at the earliest opportunity

14. Feedback Loop – how will you measure the outcomes form this scheme

Outcomes (from 3 above)	How will this be measured
Please see attached BCF Metrics paper which covers all BCF schemes delivered in North Norfolk	

Condition specific avoidable admissions	Emergency admissions for **acute** conditions that should not usually require hospital admission (1c)
Performance reports from voluntary sector providers	Referral rates and destination of referrals (from ICC staff submissions) Performance data from Volunteer Service Performance data from housing support services

8. NN4 – Reductions in Acute Admissions from Residential & Nursing Care

1. Scheme Title — **Reductions in Acute Admissions from Residential & Nursing Care**

Scheme Ref Number

2. What is the strategic objectives of this scheme

The scheme draws together numerous activities delivered across health and social care to reduce the number of people admitted to an acute setting from a residential or nursing care setting. This scheme will build upon work undertaken in 2015/16 linked to the delivery of the Green Envelope Scheme, falls reductions, anticipatory prescribing and falls management linked to Harm Free Care. In 2016/17 acute admission reductions will focus on improvements in education and training delivered in conjunction with the CCG lead for Clinical Quality and Patient Safety and seek to change the way in which medications are managed for people living in a care home setting.

3. What is the intended impact of the scheme (Outcomes)

Objective	Impact
Review Hertfordshire model to reduce acute admissions from residential care and propose an approach for North Norfolk	Established best practice from elsewhere will deliver an evidence base to encourage North Norfolk providers to adapt new practices in managing patients.
Improve the health care delivered to patients through the development and delivery of education and training programmes looking at the safe management of specific acute conditions (UTI's, management of pressure ulcers, wound care).	Staff will have improved knowledge of managing acute symptoms and be supported to develop the right skills to prevent the development of these conditions
Develop and deliver an education programme to residential and nursing care homes to reduce the occurrence and provide safe management of UTI's, falls, COPD, Dementia, Diabetes, palliative care and other long term conditions.	Staff will have an improved skill set to support patients to manage their long term conditions better with a direct reduction in avoidable hospital admissions.
Implementation of the Green Envelope Scheme to provide an emergency care record for people at risk of requiring emergency medical treatment.	The scheme will improve the delivery of emergency care through GP and community health services and support the avoidance of hospital admission.
Develop a gain share approach to maintaining people in a residential care setting and embed this within NCC and NHS CHC contractual terms and conditions	Incentivised service providers will seek to maintain their residents in their care homes rather than rely on early admission to acute to manage conditions.
GP's and clinicians provide a comprehensive and flexible out-of-hours service to support care home providers in managing exacerbations of long term conditions.	The availability of an OOH service will reduce the need for hospital admissions at weekends and evenings. Patients will experience greater continuity of care.

Increase the uptake of people receiving a pneumonia vaccine to reduce the occurrence of the disease in residential and nursing care and the scheme extended to include front-line staff.	People will be vaccinated against the condition and admissions to the acute will reduce as a result.
The Community Nursing and Therapy service delivered by NCHC will consider the role of delivering clinical advice and support to residential care settings through the use of Community Matron Champions in order to better manage people with long term conditions.	Patients will be able to stay within their care setting and access the right treatment at the right time to manage their illness or LTC without the need for admission to an acute service.
Extend and implement the falls pathway in to residential and nursing care homes so that homes consider the behavioural, clinical and environmental aspects of falls reduction	People will be better supported to reduce the risks that lead to falls and the number of admissions will reduce.
Workforce development issues are resolved to ensure that care home providers can recruit and retain high quality, skilled carers and nurses.	The workforce will stabilise supporting the delivery of continuity in care. Patients will receive better care and support to enable them to remain in their care setting.

4. What are the key success factors for implementing this scheme

Key Milestone or Activity	Timescale
Analysis of specific conditions that result in admissions from care homes by GP hub undertaken and a routine process put in place	Initial analysis – March 2016 Monthly monitoring thereafter
Establish a network of care home providers linked to the CCG quality network to engage with residential care providers	May 2016 (in line with next Quality Network)
Workshop undertaken to identify the barriers to keeping people in a care setting when LTC's exacerbate and identify practical solutions to shape a 'Managing LTCs in Residential Care' pathway	July 2016
Best practice models researched in terms of contractual terms and condition, management of LTC's in residential care	June 2016
Review current practice within GP surgeries to identify challenges with managing LTC's in care homes and make recommendations to CCG Governing Body	July 2016
Workshop to discuss practice within care homes and input from GP's carried out to determine how locality GP's can support better maintenance of people in care homes	July Council of Members 2016
Development and sign-off of Managing LTCs in Residential Care' pathway including clinical input and links crisis response project.	August 2016
Link with revised service specification for Community Nurse and Therapy services delivered by NCHC	March 2016

Development and extension of 'Green Envelope' care plans in line with the management of medication and emergency care records.	August 2016
*Note workforce development issues will feed in to each aspect of the programme rather than as a stand alone activity.	

5. The Evidence Base

Analysis of avoidable admission data for 2014/15 and 2015/16 from the acute system has identified an increasing number of people admitted to an acute setting as a direct result of:

- The development and poor management of UTI (including catheter acquired UTIs)
- Development and poor management of pneumonia
- Increased delirium and exacerbations of mental health conditions
- Increased falls

In order to reduce the number of admissions from care settings, individual work streams will be delivered to target these specific conditions and build upon work already undertaken to improve the quality of patient-care

6. The Delivery Chain

Commissioner or Provider	Role
Commissioning Manager – Integrated Team & Individual project managers within the CCG	Project management, engagement and communications.
North Norfolk Quality Network	Provide guidance and risk management to the project.
Integrated Care Board	To sign off recommendations, inform and support the delivery of the programme
Individual GP Practices	Delivery of key interventions to support the implementation of an LTC in Care pathway
NCHC & NCC Operational teams	Active participation in managing people in residential care
QIPP Programme & BCF Boards	To review and monitor impact

7. Value for Money

Investment Requirements	Potential Efficiencies
The delivery of these work schemes will be managed through the existing clinical and commissioning teams with investment required to support the publication of materials such as the Green Envelop Scheme and the delivery of workshops to develop and implement to LTC pathway.	**£220,000**

The BCF dashboard does not currently include a report to look at the number of people admitted to an acute setting from residential or nursing care. This is currently a sub-set of the 40% avoidable admissions - Long-Term Conditions.

The source data includes a flag to state whether a person comes from their own home in the community or from within a residential or nursing home setting. Immediate work is being undertaken to construct a report to enable a clear measure of the number of admissions coming from specific types of settings.

The target for the overall reduction of 2.9% for emergency avoidable admissions equated to 505 patients kept out of an acute setting. With an assumption that 25% of these came from residential or

nursing care, it is proposed this scheme could reduce avoidable admissions by 127 per year with efficiencies of £220,000 over the financial year. This will be made up of a reduction of LTC admissions and a reduction in falls admissions.

8. How will this build long term capacity for integrating health and social care

Residential care is predominantly delivers social care with nursing care delivering additional nursing care. Residential care homes work regularly with social care operational teams whereas nursing care work predominantly with health teams. By developing and delivering a single long term conditions management in care pathway, extending the training offer to include residential care and delivering green envelope schemes across the board with equal access to health, the integration of health and social care within nursing and residential settings will be improved.

9. How will this scheme support people effectively and improve patient or service user satisfaction.

This scheme will enable residential and nursing care settings to deliver improved patient-care and reduce the impact of managing long-term conditions on the person. By closer working with clinical and quality teams, front-line staff will be better trained to prevent and manage exacerbations of specific long term conditions, reduce the likelihood of developing infections such as pneumonia and UTI's and improve the quality of care received by people.

10. Stakeholder Engagement

The key stakeholders are as follows:

- Residential and Nursing Care providers delivering front-line health and social care services to people living in their settings – engagement through the locality quality network and the North Norfolk Provider Forum. One to one engagement during the roll-out of various schemes under this programme.
- GP Practices – through specific workshops delivered within the Council of members and Primary Care Development Group to develop a 'Management of LTC's in Residential settings' pathway
- Community Nursing Teams – through the weekly operational group and specific activities.
- Carers – engagement through the locality carers network to influence and support the delivery of the LTC pathway.

11. How does this scheme represent a whole system approach

Integrating the approaches taken by health and social care to nursing and residential care will support whole-system working with equitable access to clinical and quality support. This will lead to an improvement in the way in which people residing in these settings receive care and support.

12. How will this scheme support the shift towards early help and prevention, community support and self-care

Improving the skills of knowledge of front line staff to recognise and respond to the in the early warning signs of specific infections and providing training on treatment and avoidance will contribute to the prevention agenda and reduce the numbers of people requiring treatment in an acute setting.

13. Risks & Mitigations

Identified Risks	Likelihood	Severity	Score	Mitigation
Lack of engagement from practices and care homes resulting in an inconsistent approach across the locality	**2**	**3**	**6**	Clear communication strategy developed and implemented. Regular reporting of progress to GP Practices and care homes
Pace of change becomes difficult to manage and partners disengage	**2**	**2**	**4**	Defined programme of work to be widely shared to support partners to anticipate the pace of change

Residential and nursing care homes disagree with clinical processes	**3**	**4**	**12**	Early engagement and the development of a clear rationale for implementing changes. Consider a gain share approach
Lack of capacity within care homes to undertake training and development	**3**	**4**	**12**	Consider financial incentives for participation

14. Feedback Loop – how will you measure the outcomes form this scheme

Outcomes (from 3 above)	How will this be measured
Reduction in LTC emergency admissions to hospital	The specific metrics for this scheme will need to be derived from the following existing BCF metrics as sub-set showing admissions from residential and nursing care using the care home flag within the SUS data.
Reduction in falls emergency admissions	

9. NN5 – Development of a Multi-Disciplinary Discharge Hub at NNUH

1. Scheme Title Development of a Multi-Disciplinary Discharge Hub at NNUH

Scheme Ref Number NN5

2. What is the strategic objectives of this scheme

To launch and develop an integrated complex discharge hub involving Norfolk & Norwich University Hospital (NNUH), Norfolk Community and Health Care (NCH&C), Norfolk County Council (NCC) and Continuing Health Care (CHC) teams.
The discharge hub:

- Will support the wards and facilitate discharge.
- Has commitment from all organisations with escalation to senior managers whenever necessary.
- The aim of discharging people earlier from hospital needs to be backed up by ensuring suitable support is available for them in the Community and/or their own homes.
- Reduce the length of stay, particularly for patients with complex needs.
- People with Mental Health problems may need extra support on discharge from both general acute and Mental Health in-patient beds, therefore this new hub will have strong links to the Mental Health discharge co-ordination teams.

3. What is the intended impact of the scheme (Outcomes)

Objective	Impact
People are discharged more quickly from hospital with appropriate support.	Reduced DTOCs; shorter Length of stay; reduction in excess bed days; improved patient experience.
Improved links to community care following discharge from NNUH, especially links into Integrated Care Teams.	People are supported in the community and/or their own homes such that further crises and re-admissions are avoided.
People with Mental Health and Learning Disabilities are well supported in hospital and enable to be discharged earlier.	Reduced stress for patients and their carers; shortened hospital stays; re-admissions avoided.

4. What are the key success factors for implementing this scheme

Key Milestone or Activity	Timescale
Launch of Integrated Complex Discharge hub – NNUH	January 2016
Enhanced discharge "Hit Squad" in place since early Feb - reduction of delayed complex discharges by 50% achieved.	February 2016
Re-introduction of Social care discharge notices.	In progress
Appointment of Trust Discharge Manager to drive discharge processes.	Appointment made. Start date May 2016

5. The Evidence Base

Multi-disciplinary hubs or lounges are not new; they are being successfully used in many other actue hospitals across the UK. In particular, the scheme in South Warwickshire was used as a model and the link below gives details.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/458983/South_Warwickshire.pdf

The 5 main causes for Delayed Transfers Of Care (DTOCs) as reported by Mark Burgis, Chief Operating Officer, North Norfolk CCG:

- CHC processes, complexity of assessments and, in particular brokerage - difficulty finding placements.
- Social care delays – awaiting assessment completion.
- Social care delays - difficulty with big packages of care and placements.
- Awaiting simple community hospital based rehabilitation beds – delayed discharges in the community beds.
- Awaiting complex rehabilitation bed, i.e. Acquired Brain Injury beds.

Norfolk System Urgent Care Dashboard - Part 2
04th March 2016

NHS North Norfolk Clinical Commissioning Group

7) Delayed Transfers of Care

Local Metrics

Indicator (patients)	15/12/2015	22/12/2015	29/12/2015	05/01/2016	12/01/2016	19/01/2016	26/01/2016	02/02/2016	09/02/2016	16/02/2016	23/02/2016	01/03/2016
NNUH work in progress	149	146	164	149	170	138	174	144	165	168	124	108
NNUH Medically fit for discharge	57	53	48	33	50	37	62	53	73	75	57	63
Delay reason when patient choice	5	9	10	5	4	4	7	5	11	13	7	10
NNUH MFD target	20	20	20	20	20	20	20	20	20	20	20	20
NNUH longest no. of days waited	78	85	92	99	106	74	82	89	96	103	110	117
NNUH avg no. of days waited	10.0	11.8	14.3	18.1	11.7	11.6	9.3	11.1	7.9	9.5	12.4	11.8
*1 NCH&C total DTOCs	26	27	22	16	22	22	16	22	22	11	15	11

*1 Where data is not available on a particular day, the figure from the nearest available day has been used

NNUH DTOC Snapshots ***(data in table based on last Thursday of the month)***

Reason for Delay (grouped)	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	YTD
Health	22	12	11	30	27	10	20	28	12	36	15	223
Other	9	2	8	10	9	9	7	6	6	8	10	84
CHC	6	5	5	14	12	2	9	10	13	17	19	112
SS	6	5	6	14	8	11	10	15	12	3	11	101
Total	43	24	30	68	56	32	46	59	43	64	55	465

7) Delayed Transfers of Care (continued)

National Metrics *(source : Unify2 - Monthly DTOC SITREP + KH03 & QNCBed quarterly beds occupied* via Steve Fern, NHS England)

Indicator	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
*2 DTOC rate	5.0%	2.6%	2.4%	2.4%	2.4%	2.5%	1.7%	1.8%	2.4%	3.3%	5.8%	4.9%	5.5%	6.6%
DTOC rate (target)	3.5%	3.5%	3.5%	3.5%	3.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
DTOC split NHS	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
DTOC split Social Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
No. of NHS bed days	1,437	784	723	638	725	713	484	510	701	974	1,643	1,443	1,545	1,941

*2 *DTOC rate* - the % of delayed bed days against the total number of available bed days

Updated recovery dates and monthly trajectory for DTOC rate [Mark Burgis]:
March - 4%, April - 3.5%, May - 3%, June 2.5% and sustained beyond.

6. The Delivery Chain

Commissioner or Provider	Role
CCG	To monitor discharge hub activity and patient outcomes
Provider	To provide necessary integrated team of staff to enable earlier supported discharge.
CCG/Community care teams: NCC/NCH&C/GP practices/NSFT	Development of fully integrated Community Care teams based on 4 GP clusters in North Norfolk to ensure adequate health/social care support available post-discharge and to avoid re-admissions wherever possible.

7. Value for Money

Investment	Potential efficiencies
Development of Integrated Complex Discharge hub – NNUH Possibly cost of one co-ordinator post but mostly no additional cost as this new hub is about re-designing the ways the organisations work together.	Cost savings on DTOCs and excess bed days for social care and Health

8. How will this build long-term capacity for integrating health and social care

Shorter stays in hospital are beneficial for both health and social care. Earlier discharge is good as long as support networks are present to ensure re-admissions to hospital do not occur or that people admissions to long-term residential/nursing care is avoided whenever possible. Health and social care staff will need to work together to create a seamless service for people.

9. How will this scheme support people effectively and improve patient or service user satisfaction.

Most people do not really want to be in hospital, they want to be at home so good for patients/service users too.

10. Stakeholder Engagement

NNUH, NCHC, NCC, GPs, patients, carers, NSFT, IC24, Ambulance Trust, Voluntary sector (especially Royal Voluntary Service out of hospital service).

11. How does this scheme represent a whole system approach

Involves social care, health community and acute services, and mental health trust.

12. How will this scheme support the shift towards early help and prevention, community support and self-care?

This scheme is supporting people who already have health issues which could potentially involve a hospital admission and looking at ways of supporting them in the community instead.

13. Risks & Mitigations

Impact ↓	Likelihood →			
	1 - Unlikely	2 - Possible	3 - Likely	4 - Certain

4 – Major	4	8	12	16
3 – Moderate	3	6	9	12
2 – Minor	2	4	6	8
1 - Negligible	1	2	3	4

Identified Risks	Likelihood	Impact	Score	Mitigation
Discharge hub and other interventions to enable faster discharge fail	2	3	6	Weekly monitoring of KPIs. The new hub has senior manager sign up from all organisations involved with escalations routes to unblock any obstacles.
Brokerage for CHC likely to be problematic because of difficulties sourcing placements and packages of care.	3	3	9	KPIs and recovery plans for all parts of the CHC processes in place & on target to deliver Enhanced support to CSU team to address brokerage issues.

14. Feedback Loop – how will you measure the outcomes form this scheme

Outcomes (from 3 above)	How will this be measured
Reduced DTOCs	Number of bed days lost to DTOCs (target = <650 in aggregate) Number of patients medically fit for 24+ hours in acute beds (max 25% by Mar 16) Number of daily discharges facilitated by Discharge Hub (target = 20 per day)
Reduced length of stay	Weekly LOS review of all patients >7 days.
Reduced excess bed days	SUS data
Reduction in discharge delays and re-admissions for people with learning disabilities and/or mental health problems	SUS data for both plus specific LD ICD codes, e.g. Down's syndrome, GP LD registers, NNUH acute liaison nurse data.
Improved patient experience	Patient Surveys

10. NCH1 – Primary Care – new models of care

Scheme ref no.
NCH1
Scheme name
Primary Care – new models of care
1. Strategic objective:
To work with GP member Practices to develop new models of care in line with the requirements set out in the Five year Forward View. We have identified the two models from the Five Year Forward View that best fit with the footprint and demographic of Norwich CCG: • A new model of care for Norwich - based on the Multispecialty Community Provider (MCP) model.

- Enhanced Care in care homes - to pilot a new model to provide enhanced at the Bowthorpe Care Village together with best practice in dementia care, falls prevention and management, end of life/palliative care, and community engagement.

2. Overview of scheme:

Development of a New Model of Care for Norwich

GP Practice members and CCG staff are working together on scoping the vision for a Norwich Model for the health system (MCP) to support the national ambition for delivering primary care at scale.

GP Practice locality clusters within the Norwich CCG boundary will be supported to move to a new delivery model with local hubs offering extended and specialist services (spanning locally commissioned health and social care) in a community setting. The shared model will include 7 day access and co-ordinated domiciliary visits. The first stage will be for cluster practices to co-operate in developing shared primary care services for older patients and those with long term conditions. A particular focus will be on keeping patients independent, well, and at home.

Enhanced Care in Care homes

In Norwich we have multiple care homes with an increasing trend towards specialist dementia and palliative care units, and a new model of care to deliver enhanced care in care homes is a priority for the CCG. The focus on this model has been accelerated by the opening of Bowthorpe Care Village in April 2015. This scheme is the first Housing with Care project to be delivered under the Building a Better Future strategy. The aim of the development is to promote active ageing, with a central Village Hub providing living, dining and café facilities, meeting rooms, well-being and activity suites, hair salon, shop and treatment room. The village will provide an 80-bed specialist care home and 92-apartment 'Housing with Care' units.

Norwich CCG in partnership with social care and the care home provider have designed and are piloting a new model of care for the village using a multispecialty team (including a community pharmacist) to provide on-site Primary Care service seven days a week.

Service Objectives are:-

- Improving this vulnerable group's overall health by providing a more holistic service
- Ensuring that patients' individual preferences are captured
- Reducing inappropriate admissions
- Improving medicines concordance and management
- Promotion of effective end of life care planning
- Building effective communication links between primary health care teams and nursing and residential care staff
- Promotion of best practice in the identification, treatment and management of dementia

Additionally this service will aim to enhance the level and continuity of integrated Health & Social care available to residents in Bowthorpe Care Village (BCV), achieving the best clinical outcomes for residents.

3. Impact of scheme:

Bowthorpe Care Village:

- Reduction in unplanned admissions into acute care (N&NUH)
- Early identification and management of health conditions (through closer GP:care home relationships)
- Increased focus on prevention (falls prevention in particular)
- Increased primary care service provision covering 7 days
- Improved co-ordination and patient flow between the different levels of service provision (via multi-disciplinary team meetings, integrated care-co-ordination and shared patient records)
- Improved (timely and targeted) patient care through the development of a single care plan shared by all providers
- Improved quality experience for patients and families
- Improved quality and consistency of provision and enhanced working relationships between General Practice and care/nursing homes
- Improved medicines concordance and management in care/nursing homes
- Reduced A&E attendances and emergency admissions
- Reduced ambulance conveyances to the acute hospital
- Best practice for dementia care, falls prevention and palliative/end of life care
- National target for dementia identification (67%) exceeded
- Improved care for people with dementia in care and nursing homes
- Reduction in number of people attending A&E due to a fall (and consequently fewer ambulance conveyances)
- Reduced acute hospital admissions due to falls

New Model of Care for Norwich:

- Integrated out of hospital care
- Extended group/expanded GP practices working together
- Wider range of out of hospital care
- Including shifting the majority of outpatient consultations and ambulatory care to out of hospital settings

4. Measuring outcomes:

The key measures in the impact statement (above) are incorporated into a monthly performance dashboard produced by the CCG's Business Intelligence team The dashboard enables trends to be tracked and specific changes identified for detailed analysis.

Feedback will be sought from professionals, patients and their families/ carers to ensure initiatives are delivering planned outcomes.

Specific targets are being defined.

Outcome	How this will be measured
Reduction in unplanned hospital admissions	SUS data (NHS monthly activity return) and YourNorwich & BCF Dashboards
Increased primary care provision	GP Survey

Single care plan shared by all providers	To be determined. Project will make shared care plan available to all providers.
Reduced A&E attendances	SUS data (NHS monthly activity return) and YourNorwich & BCF Dashboards
Reduced ambulance conveyances	SUS data (NHS monthly activity return) and YourNorwich & BCF Dashboards
Reduced hospital admissions due to falls	SUS data (NHS monthly activity return) and YourNorwich & BCF Dashboards

5. Key success factors:

- A new model of care for Norwich is developed and piloted in line with the timeframe set out below.
- Exemplar services for dementia, falls and palliative/end of life care piloted at Bowthorpe Care Village with reduced ambulance conveyance, A&E attendance and emergency admissions.

6. Key milestones / activities:

Milestone / activity	Timescale
Programme Plan for vision developed: • Project board and team in place • Project plans created for workstreams • Initial engagement with stakeholders	April 2016
Hub and Spoke implemented for general practice • WIC as enhanced urgent care service • Extended hours offered • Norwich estates plan implemented • Norwich IT plan implemented • Full engagement with providers	April 2017
Norwich Model for the health system piloted	April 2018
Norwich model fully implemented	April 2019

7. Evidence base:

- NHS England Five Year Forward View
- NHS Outcomes Framework 2014/15
- Unplanned admissions data at N&NUH for 2012/13, 2013/14, 2014/15
- Care Home for Older People. Intermediate Care. Standard 6

- Falls prevalence and costs modelled by the DoH Fracture Prevention Service (2009)
- High number and cost of hospital unplanned admissions from falls in care homes
- Cochrane reviews
- Care co-ordinators' feedback

8. Delivery chain

The Senior responsible officers for the New Models of Care work are Amanda Carver (Assistant Director of Primary Care Development) and James Elliott Director of Clinical Transformation.

9. Investment requirements and VFM:

Investment	£s	Potential efficiencies
Development of primary care Includes CQIN of £372,000	£610,676	Shared primary care services. Extended service availability. Focus on keeping patients out of hospital.
Attain resource to specify model and contracts	£30,000	
Establishing the Bowthorpe care village primary care model	£200,000	Pilot multi-specialty team. Best practice for dementia, falls and end of life care. "Active aging" of vulnerable patient cohort avoiding hospital admissions.
Integrated Care Co-ordinators	£74,000	Joined up care across all health and social care professionals.
Medicines management	£53,000	Improved targeting of medicines and waste reduction.
Risk stratification annual fee	£15,000	Ability to target specific patient cohorts.
Total	**£982,676**	

10. **Contribution to health and social care integration:**

Scheme will implement a primary care model of multi-disciplinary community providers with local hubs offering extended and specialty care. This can include: palliative care, falls prevention, dementia management, IV therapy, medicines management and access to HomeWard services. Each hub will have access to local, community resources.

11. **Patient/user satisfaction:**

The new model is patient focused with a range of healthcare services, including specialties, available locally and conveniently.

12. **Stakeholder engagement:**

Norwich Practices Ltd (NPL), NCH&C, Norwich area GPs and Practice staff, NCC (particularly Norfolk First Support, the Emergency Duty Team, Swifts and Night Owls), IC24, Ambulance Trust, NorseCare.

13. **Whole system approach:**

The new model is for primary care services, but will engage with social, community and acute healthcare providers depending on patient need. One aim of the scheme is to enable a holistic view of each patient so that the most appropriate package of health and social care can be arranged.

14. **Early help and prevention, community support and self care:**

The new models of care will target health and social care resources at each patient via the primary care hub model. Multi-disciplinary teams will promote rapid assessment and referral to engage the right support for each individual. This will include community and voluntary support services.

The falls initiative is targeting early awareness, self-help and prevention to reduce the number of falls. Best practice is being defined which will be trialled at the new Bowthorpe Care Village then rolled out more widely across care and nursing homes.

Building on the 2015-16 focus on dementia diagnosis, improved, integrated support will be offered to people using a new dementia pathway supported by an Admiral nurse working with GP practices. Dementia best practice in a care home setting will be tested at the Bowthorpe Care Village and subsequently rolled out across Norwich.

15. **Risks and mitigations:**

Risk	Likelihood	Impact	Score	Mitigation
The new models take longer to implement than the BCF project timescale.	3	3	9	Phased rollout of the new model and exemplary practice.

11. NCH2 – Integrated Community Health and Social Care Services

Scheme ref no:
NCH2
Scheme name
Integrated Community Health and Social Care Services
1. Strategic objectives of the scheme:
To create and deliver an integrated health and social care system that supports Norwich's population to remain living independently with a good quality of life for as long as possible, and to deliver high quality person-centred services effectively through working together. The focus in 2016-17 will be on specific areas where improvements will have the greatest impact on national indicators, notably reduced acute hospital admissions.
2. Overview of the scheme:
The scheme comprises a number of initiatives all focusing on preventative services enabling people to remain independent for as long as possible reducing the need for acute, particularly emergency, care:

Integrated dementia care

- In 2015/16 this project delivered information, advice and support for people with dementia, their families and their carers. A new dementia pathway was developed together with more accurate coding. An Admiral Nurse was recruited to work with local practices to increase the rate of diagnosis.
- In 2016/17 we will work with GP practices to refine the dementia pathway and assist them in implementing best practice (particularly in the diagnosis of people with dementia). A major focus will be post-diagnostic support. The Admiral Nurse will be retained for a further year to provide clinical leadership.
- A new 80 bed dementia care home (part of the Bowthorpe Care Village) will become the dementia exemplar for other care and nursing homes.
- Norfolk County Council currently commissions a flexible dementia response service offering short-term respite care to families and carers of people with dementia. The service capacity will be extended in 2016/17 and day care opportunities also offered.

Falls prevention

A multi-agency falls reference group has been established to review the way falls are managed, monitored and prevented. Falls prevention is already considered by all other CCG projects to ensure opportunities for improvement are identified and acted upon. The falls pathway will be redeveloped and rolled out alongside identified best practice at the new Bowthorpe Care Village.

Protecting Social Care

Continuing support by Social Workers and Occupational Therapists for people with social care needs in community and acute settings. This includes:

- Protecting access to social care services and care packages which enable people to manage long term health conditions and disabilities.
- Social work assessment and care planning with integrated health and social care arrangements in community settings.
- Provision of equipment and specialist sensory support services.
- Maintaining services to improve mental health outcomes, including helping people with dementia to live at home for longer.
- Provision of effective early interventions and support to prevent increase in need; reduce the likelihood of hospital admission; reduce health crises; and defer moves to higher care settings. Prevention services include the 24/7 Emergency Duty Team, Swifts unplanned care service, and Night Owls (out of hours unplanned care and rapid response).
- Contributing to timely hospital discharge and recovery from ill health and injury. Reablement provided through Norfolk First Support.
- Ensuring support and care provided safely, and that the market for social care provision responds to changing needs.

Mental Health Rehabilitation & Recovery (potential scheme subject to business case)

Provision of a new, integrated rehabilitation and recovery service offering long-term support to people with complex mental health problems. Support will address a broad range of need: housing, debt, education and training, life skills, co-morbid mental health issues and self-confidence.

3. **Impact of scheme:**

- Patients receive a co-ordinated approach to their care, improving their experience and outcomes
- Patients at high risk of hospital admission are identified and a co-ordinated approach taken to reduce admissions and readmissions
- Reduction in falls and improved falls pathways

- Reduction in number of short stay emergency admissions due to falls
- Reduction in emergency ambulance callouts due to falls in care homes
- Falls best practice implemented at Bowthorpe Care Village
- Integrated approach to dementia support – voluntary sector staff and volunteers are part of the dementia management process
- Maintaining independence for dementia patients as long as possible
- Dementia best practice implemented at Bowthorpe Care Village
- Carer health and wellbeing maintained through access to dementia respite care
- Improved quality of life for people with long term conditions
- People with mental health conditions supported in the community

4. Measuring outcomes:

Specific targets are being defined.

Measures for dementia and falls are tracked in a monthly performance dashboard produced by the CCG's Business Intelligence Team. This will enable us to detect trends and evaluate the impact of the scheme.

Regular feedback will be sought from care professionals, patients and their families/carers.

Outcome	How this will be measured
Reduced acute hospital admission and readmission	SUS data (NHS monthly activity return) and YourNorwich & BCF Dashboards
Reduction in number of falls	Norwich BCF dashboard
Reduction in number of short stay emergency admissions due to falls	SUS data (NHS monthly activity return) and YourNorwich & BCF Dashboards
Reduction in emergency ambulance callouts due to falls in care homes	Norwich BCF dashboard
Reduction in care and nursing home long term admissions due to falls	SUS data (NHS monthly activity return) and YourNorwich & BCF Dashboards
Reduction in people with mental health conditions needing hospitalisation	To be determined
Improved post-diagnostic care for people with dementia	To be determined
Increase in number of people supported to manage their LTCs	Patient/service user data from GP Patient Survey results

5. **Key success factors:**

- Acute admissions are reduced
- Number of falls is reduced
- Number of people dying in their own homes is increased
- More people with dementia are living independently
- More people with long term conditions are able to live independently and manage their health

6. Key milestones / activities:

Milestone / activity	Timescale
Dementia respite service extended	July 2016
Mental health rehabilitation and reablement model designed	September 2016
Dementia best practice defined and implemented at Bowthorpe rolled out to other care homes	December 2016 (for first tranche)
Falls best practice defined and implemented at Bowthorpe rolled out to other care homes	December 2016 (for first tranche)

7. **Evidence base:**

- Analysis of unplanned admissions and identification of the 2% most vulnerable people through use of the local risk stratification tool
- Skills for Health (DoH and Health Education England) – Dementia Core Skills Education & Training Framework (Oct 2015)
- High number and cost of hospital unplanned admissions from falls in care homes.
- Falls prevalence and costs modelled by DoH Fracture Prevention Service (2009)
- Cochrane reviews

8. Delivery chain:

Initiatives are led by Programme Managers from both the CCG (Bruce Rumsby and Joe Farrow) and the Integrated Commissioning Team (Ann Clancy) to ensure each is fully considered from health and social care perspectives. Programme groups are meeting monthly.

The potential Mental Health project is being led by Euan Williamson of NSFT, sponsored by Clive Rennie.

Strategic support, sponsorship and overall direction for the scheme is provided by James Elliott. Director of Clinical Transformation at Norwich CCG, and Karin Bryant, Assistant Director of Clinical Commissioning, and by Mick Sanders, Head of Integrated Commissioning.

9. Investment requirements and VFM

Investment	£s	Potential efficiencies
Integrated dementia care (renewal of Admiral nurse's contract)	£63,424	Improved dementia pathways and rollout of best practice enabling people with dementia to be better supported at home and consequently reducing need for acute care and premature admission to care homes.

ICES equipment service	£805,000	People supported to remain at home reducing need for acute care and premature admission to care homes.
Protection of social care	£4,557,000	Early intervention and support to prevent health crises. Enabling people with LTCs to manage their conditions at home. Timely hospital discharge through Norfolk First Support.
Mental health rehabilitation and recovery (new, potential initiative)	?	Mental health integrated into assessment and support of people with health and social care needs. Increased management of mental health problems within the community.
Total	**£5,425,424**	(excludes Mental Health project costs)

10. **Contribution to health and social care integration:**

This scheme is specifically aimed at increasing system capacity for integration across health and social care through a number of preventative initiatives. These will ensure that patients and service users receive a co-ordinated approach to their care and ongoing support needs.

The particular focus in 2016-17 is on:

- Falls prevention
- Dementia care
- Protection of social care services (including integrated care assessment and planning, prevention services and reablement)
- Integration of Mental Health into assessment, care planning and reablement.

Through close liaison and integration of providers (e.g. multi-agency pathways), targeted care and early intervention will enable more support and treatment, including prevention, to be undertaken in patients' homes. This will reduce the need for acute hospital care and also reduce unplanned admissions, ambulance conveyances and A&E attendances.

11. **Patient/user satisfaction:**

Further integration of health and social care providers allows a more holistic view to be taken of each patient and improved targeting of treatment.

Prevention services and improved community care will enable more people to receive the support they need at home or in the local community. This is consistent with patient surveys which show that people want to be treated at home and not in hospital.

12. **Stakeholder engagement:**

NCH&C, NCC (particularly Norfolk First Support, the Emergency Duty Team, Swifts and Night Owls), GPs, NSFT, IC24, Ambulance Trust, care home providers.

13. **Whole system approach:**

The scheme's initiatives involve a wide range of health and social care providers spanning public and private sectors, NHS organisations and NCC.

14. **Early help and prevention, community support and self care:**

The falls initiative is targeting early awareness, self-help and prevention to reduce the number of falls. Best practice is being defined which will be trialled at the new Bowthorpe Care Village then rolled out more widely across care and nursing homes.

Building on the 2015-16 focus on dementia diagnosis, improved, integrated support will be offered to people using a new dementia pathway supported by an Admiral nurse working with GP practices. Dementia best practice in a care home setting will be tested at the Bowthorpe Care Village and subsequently rolled out across Norwich.

15. **Risks and mitigations:**

Risk	Likelihood	Impact	Score	Mitigation
The business case for integrated Mental Health rehabilitation and reablement will not be agreed by central Norfolk CCGs delaying or stopping the project.	3	3	9	Business case being tabled at each CCG. Alternative funding arrangements may need to be investigated.

12. NCH3 – Out of Hospital - HomeWard

Scheme ref no: NCH3

NCH3

Scheme name:

Out of Hospital – HomeWard

1. Strategic objectives of the scheme:

To implement an integrated model of multi-disciplinary health and social care professionals providing care in the usual place of residence whenever it is safe, sensible and affordable to do so. The care provided will be accessed through a community gateway and be organised round the patient, focusing on individual need and supporting independence.

HomeWard will address the following strategic measures:

- Reduce avoidable hospital admissions and re-admissions
- Reduce A&E attendances
- Reduce excess hospital bed days
- Reduce delayed transfers of care
- Reduce ambulance conveyances
- Reduce premature admission to long term residential care

2. Overview of the scheme:

The original HomeWard model established in 2015/16 aimed to provide high quality, personalised, patient-centred care for people experiencing a healthcare crisis. The service maximised their functional ability and independence to remain in, or return to, their usual place of residence, receive dignified end of life care in their preferred place, or provide a suitable alternative to an acute hospital bed. The service delivered both step-up care (for patients who might otherwise have been admitted to an acute bed) and step-down care (for patients with rehabilitation or intermediate care needs when returning from hospital to their home or a procured/spot-purchased bed).

It put in place:

- A **virtual ward** providing short-term integrated health and social care from a team of professionals in patients' homes or in temporary placements in procured / spot-purchased beds. Supports step-up (admission avoidance) and step down from Alder Ward / N&NUH.
- The piloting of a community based **rapid response** service to support patients with short-term illness, exacerbation of a chronic condition, or palliative needs. The menu of services included point of care testing, access to telephone advice, and specialist tests at the N&NUH.
- **Community IV therapy** for patients on cellulitis, UTI and bone infection pathways and other conditions subject to risk assessment.
- A spot-purchased bed pilot voiding short-term assessment and rehabilitation focused on optimising an individual's stale level of independence with the lowest appropriate level of ongoing support.

In 2016/17, HomeWard will be extended to deliver an enhanced service specification which has been developed based on the findings of the intermediate care review. This includes:

- A community gateway for all unplanned health and social care interventions (including multi-provider triage).
- Clinical co-ordination, tracking and pathway management of all NCCG patients within the intermediate care system.
- Rapid clinical assessment of patients in the community through the realignment of existing Community Nursing & Therapy resources with HomeWard.
- Therapy and social care in-reach and pathway planning of NCCG patients in procured and spot-purchased bed provision.
- Additional Community IV pathways (subject to risk assessment).
- Enhanced palliative/end of life care pathways.
- Integrated community mental health services.

3. Impact of the scheme:

- A reduction in unplanned admissions into acute care calculated on an individual case basis using patient level data for "step up" admissions to HomeWard.

- Savings due to a reduction in excess bed days (over trim) at NNUH), linked to certain specialties, end of life care and community IV pathways.

- Anticipated savings due to the reduced requirement for community inpatient beds in 2016/17.

In addition, we expect to see the following outcomes (specific targets still to be decided):

- Reduction in length of stay within the acute hospital and community bed provision.
- Reduction in Delayed Transfers of Care (DTOCs) from acute and community inpatient beds.
- Reduction in ambulance conveyances to the acute hospital.
- Increase in the number of people supported to remain in or return to their usual place of residence (including patients at end of life).
- Reduction in unnecessary premature admissions into long term nursing and residential care.
- Reduction in the utilisation (and associated cost) of procured/spot-purchased beds.
- Reduction in admissions to community inpatient and procured/spot-purchased beds outside of the Norwich area.
- Increase in the number of people who die well in their preferred place of care.

4. Measuring outcomes:

The measures in the impact statement (above) are already incorporated into a monthly performance dashboard enabling trends to be tracked and specific changes identified for detailed analysis.

Regular, detailed performance data is required from the service provider in the Service Specification for HomeWard.

Feedback is also sought from professionals, patients and their families/ carers.

Outcome	How this will be measured
Reduction in length of stay within the acute hospital and community bed provision	YourNorwich & Norwich BCF Dashboards
Reduction in Delayed Transfers of Care (DTOCs) from acute and community inpatient beds	SUS data (NHS monthly activity return) and YourNorwich & Norwich BCF Dashboards
Reduction in ambulance conveyances to the acute hospital	YourNorwich & Norwich BCF Dashboards
Increase in the number of people supported to remain in or return to their usual place of residence (including patients at end of life)	NCH&C HomeWard KPI report
Reduction in unnecessary premature admissions into long term nursing and residential care	NCH&C HomeWard KPI report
Reduction in the utilisation (and associated cost) of procured/spot-purchased beds	NCH&C HomeWard KPI report
Reduction in admissions to community inpatient and procured/spot-purchased beds outside of the Norwich area	NCH&C HomeWard KPI report
Increase in the number of people who die well in their preferred place of care	YourNorwich & Norwich BCF Dashboards

5. **Key success factors:**

- Reduced community inpatient admissions and readmissions (including out of area).
- Reduced community inpatient bed days.
- Reduced A&E attendances (including out of area).
- Reduced admissions for patients receiving Community IV service.
- Reduced excess bed days for patients receiving Community IV service.
- Reduction in spot-purchased beds.
- Reduced delayed transfers of care (DTOCs).
- Reduced ambulance conveyances.
- Reduction in premature admissions to long term residential care.

6. Key milestones / activities:

Milestone / activity	Timescale
Alternative rapid assessment solution in place	September 2016
Single point of referral and multi-provider triage available via NCH&C hub	September 2016
Clinical co-ordination of all patients in intermediate care settings (including patient tracking)	September 2016
HomeWard pathways for falls and end of life care agreed and implemented	September 2016

7. Evidence base:

The HomeWard initiative has demonstrated significant improvements in 2015/16, which can be built on in 2016/17. At the end of November, these were:

- between April and December 2015, total number of admissions to community inpatient beds maintained at 2014-15 levels despite an increase in demand across the urgent care system (338 compared to 339 in 2014-15)
- Total number of bed days has reduced from 198 days (2.1%) for the same period
- 9% reduction in <u>out of area</u> community inpatient admissions

17% reduction in <u>out of area</u> community inpatient bed days (498 fewer days since April 2015)
no increase in total community inpatient admissions (there was a 3.5% reduction in October 2015)
a 4.3% reduction in total community inpatient bed days (346 fewer days since April 2015, although this was 489 in October)

In addition, the following evidence bases have been drawn on:

- NHS Outcomes Framework 2014/15
- The 2013 and 2014 National Audits of Intermediate Care
- Intermediate care – halfway home. DoH 2009
- National Service Framework for Older People. Standard Three: Intermediate Care.
- British Geriatrics Society. Intermediate Care Guidance for Commissioners and Providers of Health and Social Care
- "Care Homes for Older People, National Minimum Standards and the Care Homes Regulations 2001" Intermediate Care - Standard 6

- NICE Quality Standards – End of Life care (2011)
- Unplanned admissions data at N&NUH for 12/13, 13/14, 14/15
- Evaluation of Community IV CQUIN in 14/15
- One chance to get it right (2014)
- Evidence gathered from the Domino programme (acute care)
- Evidence from the virtual ward implementation in West Norfolk
- Analysis of community beds review which showed Norfolk as under-provided

8. **Delivery chain:**

Norwich CCG commissions the Norfolk Community Health & Care Trust (NCH&C) to provide HomeWard. In 2016/17 the aim is to integrate further health and social care services through the Community Gateway. This will include:

- Intensive home-based reablement (provided by Norfolk First Support within Adult Social Care at Norfolk County Council)
- Community mental health services (provided by Norfolk & Suffolk NHS Foundation Trust)
- Access to community assets through the Voluntary Sector co-ordinator (Voluntary Norfolk).

The project's sponsor is James Elliott, the CCG's Director of Clinical Transformation. The project is led and managed by Claire Leborgne, Programme Manager. Clinical guidance is provided by the CCG's Clinical Reference Group and an assigned lead.

The project reports into the HomeWard+ Steering Group and the YourNorwich Group.

9. **Investment and VFM:**

£2,507,800 comprising:

Investment	£s	Potential efficiencies
Virtual Ward	£1,175,000	More patients treated in the community reducing the need for acute hospital beds and associated A&E attendance and ambulance conveyances.
Rapid Response	£95,000	Rapid, multi-disciplinary assessment and intervention with emphasis on non-acute pathways.
Community IV Therapy	£112,800	IV treatment at home avoiding hospital treatment costs.
Additional funding to deliver enhanced service specification	£225,000	Multi-disciplinary community gateway integrating primary, acute and community health and social care (including voluntary and charitable sectors).

Community hospital beds for Norwich patients outside Norwich area	£900,000	Patients admitted to Norwich community hospital (Alder Ward) avoiding additional expense of out-of-area admissions.
Total	**£2,507,800**	

10. **Contribution to health and social care integration:**

HomeWard is integrating health and social care provision through a community gateway which will include all key NHS providers, Norfolk County Council, and specific voluntary sector partners.

Its focus is on assessing and treating patients within the community, enabling people to remain, appropriately supported, at home.

Patient hospital stays and admission into long term residential care are being reduced or avoided through home treatment and a rapid response service which looks at alternative patient pathways, the emphasis being on community care where this is appropriate.

Delayed transfers of care are also being addressed as HomeWard provides a step-down facility enabling earlier discharge from acute care.

11. **Patient/user satisfaction:**

HomeWard enables more people to receive the health and related social care they need in the community and either in or close to their home. This supports the findings of national and local surveys which consistently show that people want to be treated at home and not in hospital.

12. **Stakeholder engagement:**

NCH&C, NNUH, NCC, GPs, NSFT, IC24, Ambulance Trust, voluntary sector (particularly Age UK and Voluntary Norfolk).

13. **Whole system approach:**

HomeWard is actively involving all major health and social care providers (as above) to ensure full integration and a whole system approach.

14. **Early help and prevention, community support and self care:**

HomeWard offers local, community treatment and support for people with health needs obviating, where possible, the need for acute hospital care or care home admission.

15. **Risks and mitigations:**

Risk	Likelihood	Impact	Score	Mitigation
	3	3	9	

Additional investment for phase 2 not agreed				Implementation of phase 2 to be discussed as part of 2016-17 contract negotiations.

13. NCH4 – Community Assets

Scheme ref no:
NCH 4
Scheme name:
Community Assets
1. Strategic objective:
Community Assets is a programme of related community-based initiatives promoting self-care and independence plus a range of support services within the community. The overall objective is to prevent hospital admissions, reduce hospital length of stay, and reduce the need for long-term residential care. The scheme has the following objectives: • To mobilise community support and promote sustainable self-care, harnessing the knowledge and skills of the voluntary sector. • To develop and improve a wide range of support services to help people live independently at home. • To develop support for carers. • To create a strategic framework to address housing priorities for people with health and social care needs.
2. Overview of the scheme
Supporting Self-Care (education, tools and resources) Developing a partnership approach to patients, families, and communities in Norwich, investing to equip patients and carers with the knowledge and skills for sustainable self-care, and ensure health professionals work with patients to develop self-management plans, including lifestyle changes. Improved and more accessible information, advice and advocacy will be provided so that people are better placed to arrange their own care, including through use of personal budgets. **Support for Carers** Norwich CCG is working in partnership with the County Council, other Norfolk CCGs and the jointly funded Carers Agency Partnership to ensure that countywide arrangements are remodelled and delivered in the best way for Norwich. This includes implementation of the Care Act's responsibilities for carers. It will also deliver the cross-county carers' strategy action plans agreed with the Carers Council for Norfolk. **Promoting Independence** The second year of a community pilot scheme with Age UK commissioned to provide up to 12 weeks of reablement and preventative care through its volunteers for selected frail and elderly patients. Year 1 of the scheme saw referrals from selected GP practices to 2 Promoting Independence Co-ordinators who manage a volunteer pool. In 2016/17 an additional 2 Co-ordinators will be recruited, other community assets will be investigated, the scheme opened up to all GP practices in the Norwich area, and links to HomeWard explored. Targets for the service will be agreed in January 2016. **Housing Support**

Development of a more systematic, strategic approach to housing and accommodation priorities for people with health and social care needs. Creation of a strategic framework which will guide the development of a range of accommodation support options which could include: supported housing, disability adaptations, community equipment services, assistive technology, and the work of Home Improvement Agencies. The initiative will build on the existing partnership work between health (including public health), housing and social care aligned to our Healthy Norwich initiative to ensure that people are well supported to live independently at home.

3. Impact of the scheme:

- Enabling patients to remain well, independent and in their own homes for longer without recourse to primary or acute care
- Increase in number of people with long-term conditions able to manage their health without regular clinical intervention.
- Increase in patients offered reablement with consequent shorter stays in acute care and reduced readmissions
- Meeting policy requirements, achieving cost efficiencies and greater independence for patients
- Greater use of the voluntary and community services to support people in the community
- Voluntary sector staff and volunteers integrated into assessments and care management processes
- Viability of community support tested and a model established for its further rollout
- Improved support for carers
- Improved health and wellbeing of carers
- Reduction in unplanned admissions for people with supported carers
- Reduced long-term admissions to care and nursing homes for people with supported carers
- Increased effectiveness of reablement – increase the proportion of older people (over 65) still at home 91 days after discharge from hospital into reablement/rehabilitation services
- Information and guidance on self-care available and readily accessible to people who need to manage their health and wellbeing
- Targeted support for self-care available through variety of channels
- Reduction in projected levels of need for primary and acute care
- Reduced care and nursing home placements
- Appropriate, cost-effective accommodation provided for people with health and social care needs
- Improved co-ordination of housing support services

4. Measuring outcomes:

The key measures in the impact statement (above) are incorporated into a monthly performance dashboard produced by the CCG's Business Intelligence team. The dashboard enables trends to be tracked and specific changes identified for detailed analysis.

Feedback will be sought from professionals, the voluntary and community sector, patients and their families/ carers to ensure initiatives are delivering planned outcomes.

Age UK is commissioned to provide reablement support for "Promoting Independence". This includes performance reports to enable the success of the pinot to be assessed.

Specific targets are being defined.

Outcome	How this will be measured

Increase in people with LTCs enabled to live independently at home	GP Patient Survey question on adequacy of support from local services and organisations.
Increase in number of patients offered reablement	SUS data (NHS monthly activity return) and YourNorwich & BCF Dashboards
More carers report they feel adequately supported	To be determined.
Increased effectiveness of reablement (the number of older people still at home 91 days after hospital discharge into reablement)	SUS data (NHS monthly activity return) and YourNorwich & BCF Dashboards
Reduction in care and nursing home placements	SUS data (NHS monthly activity return) and YourNorwich & BCF Dashboards
Reduction in unplanned admissions to hospital	SUS data (NHS monthly activity return) and YourNorwich & BCF Dashboards

5. Key success factors:

- More patients remain well and independent in their own homes for longer
- Reduced care and nursing home placements for people:
    - managing their own care with advice and guidance
    - in receipt of reablement support
    - whose carers receive support
    - who benefit from a new accommodation option
- Unplanned admissions to acute hospital are reduced (as above)
- Voluntary sector and community services play a greater part in patients' health and wellbeing
- Voluntary sector staff and volunteers integrated into assessments and care management processes
- Accommodation priorities and principles developed and agreed with partner organisations
- Options to deliver accommodation priorities devised and specific schemes planned

6. Key milestones / activities:

Milestone / activity	Timescale
Report completed on accommodation needs across Norfolk	March 2016
Targets and measures set for year 2 of Promoting Independence pilot	April 2016
"Help at Home" model implemented for self-care	October 2106
New service model for supporting carers implemented	December 2016

7. Evidence base:

- The right advice and assistance needs to be in place to enable people to support themselves to live independently at home
- Budget and demographic pressures point to the need for further investment in local communities
- Self-management studies for COPD, asthma and heart failure (Purdy, Effing, Tapp, Lasserson, Rowe and Boyd)
- NIACE lifelong learning report (2010)
- Results from year 1 of the Promoting Independence pilot
- "My Health, My Way" (personalised support for people living with a health condition) pilots in Dorset and Cornwall

8. Delivery chain:

The Integrated Commissioning team led by Mick Sanders, Head of Integrated Commissioning for Norwich, is working closely with Norwich CCG, Norfolk County Council and other partners to co-ordinate this scheme reporting to the CCG "YourNorwich" Board as well as to Norfolk County Council's Executive Director of Adult Social Services. The scheme will also link to other initiatives throughout Norfolk through the Integrated Commissioning Team meetings.

9. Investment requirements and VFM:

£3,562,100 comprising:

Investment	£s	Potential efficiencies
Reablement	£351,000	Reductions in hospital and care home admissions and readmissions. Patients able to manage their conditions in the community.
Promoting Independence pilot (year 2)	£58,100	As above – targeted voluntary sector support for people with reablement and support needs in the community.
Support for Carers	£435,000	Improved health and wellbeing of carers and the people they look after. Reduced crisis care.
Care Act implementation	£468,000	
Early interventions	£1,495,000	Appropriate early support and care to avoid worsening of condition and need for acute care.
Voluntary sector contracts	£755,000	Voluntary sector support integrated into health and social care providing additional capacity and specific local community support.

Total	**£3,562,100**	

10. **Contribution to health and social care integration:**

The Community Assets scheme is a programme of community initiatives promoting independence and self-care. Norwich CCG and NCC are working in partnership with the Carers Agency Partnership, district councils, and Age UK to progress scheme initiatives and ensure a rich network of help and support is available to people with health and social care needs. The voluntary sector is being fully integrated into care planning and support led by health and social care.

11. **Patient/user satisfaction:**

The scheme focuses on self-help and local support mobilised through community-based organisations. The primary aim is to keep people out of hospital and help them maintain their independence in their own home.

12. **Stakeholder engagement:**

Carers Agency Partnership, Norwich City Council, Broadland District Council, Age UK, Voluntary Norfolk.

13. **Whole system approach:**

Voluntary sector resources are working in partnership with NCC and Norwich CCG and are being integrated into planning and support for reablement and for carers.

14. **Early help and prevention, community support and self care:**

The scheme targets:

- Sustainable self-care
- Support for carers
- Mobilisation of community support (including the voluntary sector)
- Development of accommodation options that will promote health, wellbeing and independence.

15. **Risks and mitigations:**

Risk	Likelihood	Impact	Score	Mitigation
No lottery funding has been secured to continue the Promoting Independence pilot making its future uncertain.	3	3	9	Alternative funding options being explored. Funding for year 2 of pilot has been protected.

14. SN1 – community services redesign - integrated discharge and care at home for frail older people, people with disabilities and long term conditions

5.1 Scheme 1 – community services redesign - integrated discharge and care at home for frail older people, people with disabilities and long term conditions

5.2 Overview and evidence base for the Scheme

There is an overriding expectation that commissioners and NHS providers will achieve efficiency savings and balance budgets in the short term. For South Norfolk CCG the achievement of QIPP savings to seek efficiencies while maintaining or improving quality will need to take first priority in the coming year.

The proposal is for a systems redesign project to make more efficient and effective use of community resources to reduce admissions and increase patient independence. The approach would seek to meet the expectations of the NHS Five Year Forward View by taking "decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care". The approach would include: review of beds commissioned in the SNCCG locality to establish a system of beds use through which rehabilitation, acute prevention and reablement are optimised and patient flow through bed based and other care pathways is managed. One aim would be to free investment through reducing acute care and some level of community bed based care to develop locality based multi-disciplinary discharge and care at home teams which would support people to go home and to remain at home where it was safe to do so.

People in South Norfolk already benefit from integrated community health and social care services, increasing coordination and third sector and volunteering services which focus on supporting the health, social care and wider needs of individuals. Community redesign would build on and enhance these services by delivering in the following areas consistent with the identified need to transform care (Kings Find 2014 'Community services: How they can transfer care):

- Reduce complexity of services including the interfaces between services
- Wrap services around primary care
- Build multidisciplinary teams for people with complex needs, including social care, mental health including dementia and other services
- Support these teams with specialist medical input and effective pathways particularly for older people
- Create flexible and responsive services that offer an alternative to hospital stay
- Build an infrastructure to support the model based which includes the pays in which services are measured and paid for

This would also require the reorganisation of current health and social care community delivery. The teams would be very accessible to GPs practices, acute discharge staff and to patients, families and carers once a patient referral has been accepted. The threshold for referrals would be set with hospital/ care home admissions avoidance and discharge as two key factors. The teams would offer time limited interventions before referral back to primary care and community health and social care support. The interventions would include nursing and therapies, reablement, social care assessment, rapid access to home care/ equipment and out of hours capability.

The scope of the redesign of community services needs to include meeting mental health needs in a holistic way. Building on the BCF work in 2015/16 the priorities are to ensure that community services promote recovery from mental health crisis, and there is adequate mental health expertise at the locality level in multi-disciplinary care teams to ensure that mental health needs are considered holistically and mental illness is effectively managed to reduce the likelihood of exacerbation.

Comprehensive community redesign also needs to include health care and support arrangements for people with learning difficulties. Norfolk County Council is looking at the costs paid for supported living arrangements, many of which are historic and were developed as part of plans for local hospital

closures in the 1990s. In addition the potential for expanding the use of supported housing for some people with learning difficulties has also been identified.

The outcome of The Winterbourne View enquiry requires a joint locally planned approach to meeting the needs of people with autism and learning difficulties where these are complex. The local Transforming Care Plan which has been drafted by CCG and NCC leads lays out how services local services will be reshaped to particularly deliver a reduction in out of area placements and in the use of medium and long term hospital inpatient care beds.

Additional specific considerations around arrangements for people with learning difficulties include:

- Understanding the package costs being met by the CCG through Continuing Health Care and NCC in residential homes, supported living and home care, and commissioning jointly or consistently to achieve the best value from these packages
- Planning for use of PHBs combined with Personal Budgets to meet expectations that people with learning difficulties will be amongst the next cohort of people to be offered PHBs and that localities should be considering PHBs in the context of reducing admissions
- Maximising independence through increasing use of reablement
- Ensuring a clear delivery model for case management
- Providing meaningful day opportunities close to home to reduce the regular travelling and the costs of that travelling

Evidence base

The 2015/16 Norfolk BCF evidence base (ref) summarises the evidence in respect of Integrated Care pilots, virtual wards, Multi-disciplinary team working, long term condition specialisms (including support for self-management.

There is growing evidence through the BCF vanguards about the impact of community integrated community based initiatives.

The Great Yarmouth and Waveney system undertook a major reorganisation of its bed and community based provision and is evidencing positive outcomes.

5.3 Objective

Objective	Outcome
Building the capacity across to support more people to maintain independence for longer and reduce use of higher care.	Individuals are able to remain living independently for longer. Avoidable admissions to acute are reduced. Admissions to residential and nursing care are reduced as more people are supported to maintain independent living.

5.4 Key Milestones & Activity

Key Milestone or Activity	Timescale
Establish a high level leadership group with commissioning and provider leads to outline delivery options for community services	To be confirmed
Understand what the data and information tells us about where the stress points are in respect of	To be confirmed

supporting more patients at home and avoiding admissions to acute and higher care	
Understand what needs are currently met through bed based provision, which could be met for people in their own homes and what service capacity and features would be required in the SNCCG locality to achieve this	To be confirmed
Lay out options and undertake public consultation	To be confirmed
Explore finance, commissioning, procurement options for whole system delivery - seek a pilot of some elements in one locality and evaluate	Late 2016 early 2017
Undertake any service remodelling/ procurement and/or contract negotiation	Late 2016/ early 2017
Model all community bed based provision (step up, down, end of life, intermediate care, virtual wards) as a directly commissioned single service or system with strong links to residential care provision	To be confirmed
Develop reablement as a health and social care service, linking with community hospitals and care homes to get people home more quickly and to keep the community bed stock as used as possible.	To be confirmed
Develop home care as a very responsive service with strong links to health provision	To be confirmed
Agree and introduce ways of managing budgets, commissioning and contracting for community services which commit health and social care commissioners, primary health care, secondary healthcare, community mental health, social care and other key providers to providing simple, seamless services with shared outcomes	To be confirmed
Fully introduce new community services model	April 2018

5.5 Value for Money

Potential Cost of Scheme/ value of existing services in the SNCCG BCF	Potential Efficiencies
£12,500,000	To be confirmed

Description of what savings this will deliver (cost of number of reductions in avoidable admissions for example) and any costs associated with delivering the scheme.

5.6 Components of delivery chain: Service elements that would contribute to the plan either in current form or following remodelling

Activity	Provider/s

Preventative services: Promoting advice, practical help and community support; Support to reduce pressures on statutory health and social care provision;	NCC front door services (offering appointments in community clinic settings); NCC and CCG funded third sector advice and support providers; District Council community signposting and community navigators; District Council DFGs, small grants and handypersons; Early help hubs; Housing support; Volunteering for health; Carers support; Community groups and assets;
Community help in a crisis: Rapid response; Acute medical care at home	NCH&C community nursing and therapies; Primary care; NCC social work assessment and care planning; NCC Swifts and Night Owls; Independent nursing and care homes; Community mental health teams; Dementia Intensive Support; Acute providers
Recovery and living with long term conditions: supported discharge when there is no longer a medical need to be in hospital; medical care; support with complex needs; support to self-care; befriending; practical help at home;	NCH&C nursing and rehabilitation; Integrated and coordinated care through GP; NCC commissioned home care; NCHC intermediate care; NCC reablement (Norfolk First Response); NCC contracted beds with Norse care; Independent Community Equipment; NSFT Mental Health services including primary care facing dementia support; District Council DFGs; Norfolk Learning Difficulties Service Medicines Management

5.7 Metrics

Outcomes (from 3 above)	How will this be measured
Individuals are able to remain living independently for longer.	To be agreed
Avoidable admissions to acute are reduced	To be agreed
Admissions to residential and nursing care are reduced as more people are supported to maintain independent living.	To be agreed
Reduction in delayed transfers of care	To be agreed

15. SN2 – Reducing delayed transfers of care

6.1 Scheme 2 – Reducing delayed transfers of care

6.2 Overview and evidence base for the Scheme

There is a clear expectation within the conditions for the 2016/17 Better Care Fund that local care systems will effectively address unacceptably high levels of Delayed Transfers of Care DTOC). Each local

area will produce and action plan and partially this will need to be driven through Systems Resilience planning arrangements around each acute hospital.

A DTOC occurs when a patient's care pathway is delayed from an acute or non-acute setting (including community and mental health) and the patient is ready to depart from such care and is still occupying the bed. A patient is ready for transfer when:
a. A clinical decision has been made that patient is ready for transfer AND
b. A multi-disciplinary team decision has been made that patient is ready for transfer AND
c. The patient is safe to discharge/transfer.

Currently the commissioner meets the costs of excess bed days and DTOC. In some instances the cost of excess bed days is appropriate to the care of the patient, however in the case of DTOC the lack of ownership from associate providers in health and partners in social care has led to a situation where a percentage of delays could be attributed to the boarding of patients. SNCCG will contract a risk share of excess bed days with partners in Health and is proposing to apportion total Social care costs under the better care fund allocation.

Evidence base

Excess bed days constitute around 10% of the total Acute bed cost to NHS SNCCG (c£1.81million in 2014/15). From this total an estimated cost of c£950k can be attributed to delayed transfers of care (DTOC).

6.3 Objective

Objective	Outcome
Reduce delayed Transfers of Care to close to zero or another agreed level, ensuring that patient pathways flow well throughout and that the independence of patients is maximised wherever it is safe to do so	Reduce DTOCs to agreed level; improve discharge experience for patients

6.4 Key Milestones & Activity

Key Milestone or Activity	Timescale
Establish processes for detailed and common understanding for DTOCs across the acute system	To be confirmed
Ensure daily validation and review of all for all DTOCs	To be confirmed
Establish and maintain a smooth process for escalation and actions to unblock DTOCs with each partner clear about their responsibility	To be confirmed
Ensure that pathways for patient with complex needs are effective including Continuing Health Care pathways and Discharge to Assess	To be confirmed
Open discussions with NCC regarding attribution of DTOC costs	
Agree aggregate acute CCG position on DTOC and excess bed days with associate commissioners for 2016 17 contract negotiations ensuring that SNCCG tolerances are met	
To launch and develop an integrated complex discharge hub involving Norfolk & Norwich	To be confirmed

University Hospital (NNUH), Norfolk Community and Health Care (NCH&C), Norfolk County Council (NCC) and Continuing Health Care (CHC) teams.	
Work with Age UK and NCCG to use underutilised respite service for discharge with reablement	

6.5 Value for Money

Potential Cost of Scheme/ value of existing services in the SNCCG BCF	Potential Efficiencies
£500,000	To be agreed

Description of what savings this will deliver (cost of number of reductions in avoidable admissions for example) and any costs associated with delivering the scheme.

Components of delivery chain: Service elements that would contribute to the plan either in current form or following remodelling

6.6

Activity	Provider/s
Establish effective systems for monitoring and removing all DTOCs throughout bed based care pathways	Norfolk & Norwich University Hospital; West Suffolk Community Hospital; Norfolk and Suffolk Community Health & Care; Norfolk and Suffolk Mental Health Foundation Trust Hospital; Norfolk County Council Adult Social Services (Social work; Care Arranging Service; commissioned home care)

6.7 Metrics

Outcomes (from 3 above)	How will this be measured
Reduce Delayed Transfers of Care	To be decided

16. SN3 – Reducing admissions to acute hospital from care homes

7.1 Scheme Title - Scheme 3 – reducing admissions to acute hospital from care homes

7.2 Overview and evidence base for the Scheme

Other local health and social care systems have piloted approaches to reducing admissions from care and nursing homes through training for care home staff and offering out of hours and other support. GP practices are under particular pressure where there is a concentration of care homes in their locality. CCG analysis of admissions indicates that there are a number of areas in which admissions can be reduced through focussing on early detection and management of symptoms by the care home. This will be combined with support to care homes about who to contact and in what circumstances when residents are showing signs of particular illness. The main focus for this work would is:

1. To support care home staff in areas of the locality where there are relatively high numbers of care homes through education and training in their ability to assess, recognise and help prevent deterioration in key conditions including increasing knowledge and confidence about which health staff to involve.

2. To build a longer-term solution across the whole CCG to reduce hospital admissions from care homes, but with access to a community geriatrician and /or enhanced GP support, end of life expertise (training and support) and wider out-of-hours support). This model will be informed by further work

taking from best practice and refining from the training initiative. The SNCCG work will dovetail with work being undertaken through the Pre Hospital Improvement Board to reduce use of ambulance services by care homes.

Evidence base

Admissions data showing the times that people are admitted from care homes and the reasons for admission.

We have considered directly and indirectly the training undertaken in care homes in South Lincolnshire, Peterborough and Suffolk.

There is evidence from Salford, Yorkshire and Salford about the impacts of primary care enhanced support to care homes.

The Airedale model highlights use of the role of technology in reducing care home admissions.

Hertfordshire and Vanguard sites provide sources for the efficacy of additional community support models to care homes.

7.3 Objective

Objective	Outcome
To develop a new, sustainable model of care for people living in residential and nursing homes.	Reducing emergency/unplanned acute admissions, a general reduction in costs and use of services such as 999, 111/OOH and mental health and a reduction in the level of support needed from primary care

7.4 Key Milestones & Activity

Key Milestone or Activity	Timescale
Develop framework and outline content for care homes training delivery	By end of March 2016
Evaluate and present options for training delivery in limited localities	By end of March 2016
Establish a detailed baseline with each care home prior to and after training for numbers of falls, numbers of urinary and catheter acquired infections, total numbers of grade 2,3 and 4 pressure ulcers, total unplanned hospital admissions, total ambulance call out, total GP visits	To be confirmed
Deliver training to care homes in agreed localities and measure impacts	To be confirmed
Consult with all key stakeholders on preferred care homes support delivery option and adapt proposal in the light of consultation	April 2016
Scope options for an out-of-hours point of contact to support care home providers in managing exacerbations of long term conditions.	April 2016
Scope options for providing additional support, clinical advice and guidance to care homes to	April 2016

support a reduction in admissions linked to conditions including UTI's and long term conditions and pneumonia's.	
Agree support delivery model, recruit to chosen model using existing resource where possible, augment with additional resource sourced as required through procurement, contract negotiation, enhanced services or other means as required to deliver	To be confirmed

7.5 Value for Money

Potential Cost of Scheme/ value of existing services in the SNCCG BCF	Potential Efficiencies
£300,000	To be confirmed

Description of what savings this will deliver (cost of number of reductions in avoidable admissions for example) and any costs associated with delivering the scheme.

Components of delivery chain: Service elements that would contribute to the plan either in current form or following remodelling

7.6

Activity	Provider/s
Training: delivering training to care home staff	Residential care and nursing care providers; Independent trainers; NCH&C; NCC; Third Sector Providers
Additional support:	GPs; NCH&C
Out of hours support:	111; GPs; NCH&C; central system CCGs (Out of Hospital Pre Improvement Board)

7.7 Metrics

Outcomes (from 3 above)	How will this be measured
Reducing emergency/unplanned acute admissions	To be decided
General reduction in costs and use of services such as 999, 111/OOH	To be decided
Reduction in development of particular conditions at the care home level including UTIs and falls related injuries	To be decided
Reduction in the level of support needed from primary care to care homes	To be decided

17. SN4 – Improved end of life care

8.1 Scheme Title - Scheme 4 – improved end of life care

8.2 Overview and evidence base for the Scheme

The improvement of care at end of life was a Better Care Fund scheme in the SNCCG locality during 2015/16 following the development of an end of life strategy. The main focus for the last year has been on the development of end of life patient records EPaCCS – Electronic Palliative Care Co-ordination Systems. These are advanced care plans for patients at end of life and the system is being rolled out to SNCCG practices with other CCGs looking to follow if results from use are positive. The aim for this

continuing plan will be to work on the other parts of the end of life strategy to support people to have a 'good death'. The task is around the delivery and co-ordination of the services which support people at end of life to ensure best continuity of carers. The plan will focus on developing an integrated and consistent end of life service. There is work to be undertaken to develop out of hours contact and escalation arrangements for families when things change. There is also a need to ensure adequate training for home care staff and other staff in care of people who are at end of life.

Evidence base

The 2015/16 Norfolk BCF evidence base (ref) summarises the evidence from The Kings Fund for structured end of life care pathways and evaluation of Marie Curie community based nursing care.

The South Norfolk CCG strategy lays out 'The Ambition for End of Life Care 2014-2019.

8.3 Objective

Objective	Outcome
To put each patient at the centre of planning and coordinate services around them to best support their preferences about choice over place of dying	Reduction of admissions to hospital and higher care settings; increase in numbers of people dying in their preferred place of care

8.4 Key Milestones & Activity

Key Milestone or Activity	Timescale
To be confirmed	

8.5 Value for Money

Potential Cost of Scheme/ value of existing services in the SNCCG BCF	Potential Efficiencies
£1,000,000	To be confirmed

Description of what savings this will deliver (cost of number of reductions in avoidable admissions for example) and any costs associated with delivering the scheme.

8.6 Components of delivery chain: Service elements that would contribute to the plan either in current form or following remodelling

Activity	Provider/s
Health provision: 24/7 End of life Advice line (for professionals); Regular community care, wound care, pressure care, catheter care, dressings; Pain Management; Urgent response; Inpatient treatment and care (oncology; specialist palliative care); Out of hours response Care co-ordination	NCH&C – Care at Home Team; community Nursing; Palliative bed based care – Pricilla Bacon Lodge; On call district nurse; Primary care; Palliative Care Consultants; On call GP 111; Integrated Care Co-ordinators; NNUH
Social care: Care arranging and planning; Safeguarding; Reablement and Response; Crisis response; Co-ordination	Norfolk County Council locality teams, front door, out of hours services, Homeshield; Swifts and Night Owls

Independent Sector: Domestic Home care – washing, dressing; Bed-based care; End of life preparation; Funeral preparation and planning; Bereavement support;	NCC contracted and independent home care; Residential Care Home; Care Homes with Nursing; Housing Associations /Housing Support; Funeral directors
Practical support: Equipment; Home Adaptations	Integrated Community Equipment Store (ICES); Breckland and South Norfolk District Council Integrated Housing Adaptations Teams
Third Sector: Bed based care at end of life; Community hospice outreach; 24/7 Advice line for professionals and carers Bereavement support Settling in service; Problem solving and support; Practical community support; Volunteers befriending and health support; Wheelchairs, commodes, (outside of ICES criteria)	Hospice provision; Red Cross Home from Hospital; Red Cross Older People's Outreach Service; Norfolk Voluntary Services; Red Cross Equipment provision; Macmillan Nurses

8.7 Metrics

Outcomes (from 3 above)	How will this be measured
Reduction of admissions to hospital and higher care settings;	To be confirmed
Increase in numbers of people dying in their preferred place of care	To be confirmed

18. WN BCF 1 – Optimisation of MDT process in primary care and community services

Scheme ref no.
WN BCF 1
Scheme name
Optimisation of MDT process in primary care and community services
What is the strategic objective of this scheme?
To provide more coordinated, multi-disciplinary, support to vulnerable frail patients to improve their experience and outcomes. To be achieved through implementation of a standardised proactive, effective and efficient frailty risk stratification and MDT system that identifies patients who would benefit most from MDT care planning. Facilitation of access to wider community support options including self-management to as many frail patients in West Norfolk. Based on the above this project aims to establish: 1. A substantial increase in the number of vulnerable frail patients identified and supported across practices 2. Effective use of a standardised MDT model across practices (to be piloted in the first instance) 3. An increase in number of patients supported in practice MDTs 4. Positive stakeholder feedback on Integrated Care Organisation (ICO) service and both the standard MDT and the Frailty Hub model

5. Patients with frailty and high support needs receive care which is consistently proactive, seamless and integrated (including utilisation of the Care Navigator Service)

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

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

Enhance the capacity and capability of staff to enable consistent, effective co-ordination and utilisation of care and access to integrated health and social care support at all practices. Design, pilot and roll out programme across 23 practices which establishes use of a standardised, multi-disciplinary risk profiling and care planning system, to identify vulnerable patients who would most benefit from MDT support (e.g. moderate and moderate/high frail patients). Implement and monitor the progress of the Frailty Hub project via a service performance dashboard and clear performance monitoring process. Ensure that available community support resources are utilised appropriately and effectively via MDTs as well as via advice and information at practice level outside of MDT.

The delivery chain

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

West Norfolk CCG including member practices
Norfolk County Council
Norfolk Community Health & Care NHS Trust (e.g. for ICO service)

The evidence base

Please reference the evidence base which you have drawn on

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

Building on the progress and service improvement of the ICO service in WN in providing targeted effective care and interventions across health and social care in West Norfolk by implementing a standardised MDT and risk stratification model across primary care in West Norfolk. There are also numerous examples of successful MDT developments across the country, with North Norfolk being a local example. This project is consistent with national guidance such as the NHS England 'MDT Development – Working Towards an Effective Multidisciplinary / Multiagency Team'.

Investment requirements

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

Potentially, £101,157 - Cost pa of employing 3x3 Band 4 ICCs including management, travel, phones, IT, enhanced pay for OOH. Subject to further review and potential pilot.

Impact of scheme

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

Units / £
TBC – Contingent upon scale of implementation across Practices.

Feedback loop

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

Stakeholder feed-back
MDT data

What are the key success factors for implementation of this scheme?
Reduction in non-elective admissions to acute services Reduction in admissions to residential care Delayed transfer of care (e.g. through arranging access to re-ablement service) Positive service user feedback (Experience metrics)

19. WN BCF 2 – Support to Patients with LTC and high risk of referral to funded/acute care

Scheme ref no.
WN BCF 2
Scheme name:
Support to Patients with LTC and at high risk of referral to funded/acute care
What is the strategic objective of this scheme?
Provision of effective, responsive care and efficient use of resources e.g. reduced community nursing and GP visits Improved quality of life for individual – more choice, control and proactive prevention and management Cost avoidance from reduced inappropriate hospital admissions Increased ability for patients to self-manage their symptoms
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Utilisation of telehealth and telecare to enable a target group of citizens with one or more long-term conditions and complex health and social care needs to manage their conditions with the support of accessible, co-ordinated and responsive services when they are needed. Using electronic equipment in the individual's home to measure vital signs such as weight, blood oxygen, pulse, blood glucose and respiration and capture this data for healthcare professionals, who will respond proactively when appropriate.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
West Norfolk CCG including member practices Norfolk County Council Norfolk Community Health & Care NHS Trust Borough Council of Kings Lynn and West Norfolk
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Project in Stoke-on-Trent: 19% decrease in A&E attendance and 31% in non-elective admissions in patient cohort. Project in Nottingham City: High patients and carers satisfaction (over 86% of cohort) Project in Leeds: 99% of CCG practice up-take

This project is consistent with best practice identified in the King's Fund 'Making our Health and Care Systems Fit for an Ageing Population' – including recognition that the efficacy of Telehealth schemes implemented in isolation is limited, and that success depends on an integrated approach.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
TBC – dependent on number of patients and aim of intervention (high cost would be dedicated staff, Tablets, rapid response team involvement Low cost could be telephone monitoring, use of an app, thermometer)
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Units / £ TBC
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
% of patients who report a positive experience of using assistive technology option (level of independence, experience of safety, improvement of quality of life) Positive stakeholder feed-back (Norfolk Swift Response, Norfolk First Support, GPs, primary care staff) Establish patient cohort's admission rate and A&E use of assistive technology. Compare with data during project University East Anglia evaluation if possible
What are the key success factors for implementation of this scheme?
Reduction in non elective admissions to acute services Reduction in admissions to residential care Delayed transfer of care (e.g. through arranging access to re-ablement service) Positive service user feedback (Experience metrics)

20. WN BCF 3 – Support to Care Homes

Scheme ref no.
WN BCF 3
Scheme name
Support to Care Homes
What is the strategic objective of this scheme?
Competencies and training opportunities across residential and nursing homes vary considerably. Lack of confidence of care/nursing home staff can lead to greater reliance on primary and community care services and higher admission rates to the acute sector. By putting in place targeted training, advice and information packages that aim to upskill to nursing home staff and build competence in the application of low level interventions which can prohibit escalation of care need, thus giving them more confidence in looking after residents in their homes, it is anticipated that this will result in less admissions to hospital, and unnecessary intervention from primary and secondary care teams.
Overview of the scheme Please provide a brief description of what you are proposing to do including:

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

Put in place a mechanism for shared training between nursing home staff and the acute trust and community nursing teams focusing on specific conditions/treatment areas which are synonymous with admission to the Queen Elizabeth Hospital in over 75s e.g.

- Urinary Tract Infections (UTIs);
- Risk assessment;
- Diabetes;
- Tissue viability;
- PEG feeding;
- Syringe drivers;
- Dementia
- Falls prevention

Providing the training and information locally will increase engagement from nursing homes and encourage their participation in the training. Upskilling nursing staff will enable them to feel more confidence in supporting residents' health and wellbeing and will benefit the patients/residents.

The delivery chain

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

WNCCG
Norfolk Community Health & Care
Queen Elizabeth Hospital King's Lynn Foundation NHS Trust
Norfolk Independent Care
Norfolk & Suffolk Dementia Alliance
Care Home Matrons
Care Navigators
Integrated Health and Social Care Community teams

The evidence base

Please reference the evidence base which you have drawn on

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

Feedback from staff forums suggests that a greater understanding of each other's roles and competencies would give more confidence when discharging patients from the acute sector back into the community, alleviating bed-blocking and facilitating early discharge.
UTI prevention programme in NNCCG
Falls Prevention training in WNCCG (previous) and NCCG

Using admissions data, it is possible to identify which nursing homes make the most admissions to the acute sector.

Significant benefits have been reported in the Nursing Times in relation to training packages delivered in Care Homes in Lincolnshire. This included (at the end of the first year): 60% reduction in visits to homes by District Nurses and GPs; 63% reduction in falls and a 75% reduction in recurrent falls; Care home-acquired grade 2 pressure ulcers were reduced by 63% and grade 3 and 4 by 88%, UTIs reduced by 66%, hospital admissions fell by 51%.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
£TBC
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Units / £ TBC
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Uptake of training programmes and evaluation by nursing home staff; Admission data
What are the key success factors for implementation of this scheme?
Reduction in emergency admissions to acute services from nursing homes; Improved discharge from hospital into the community;

21. WN BCF 4 - Improving Preventative and Crisis Support for Community Alarm Service Users

Scheme ref no.
WN BCF 4
Scheme name
Improving Preventative and Crisis Support for Community Alarm Service Users
What is the strategic objective of this scheme?
Community Alarms allow people who are vulnerable, isolated, or with significant medical conditions to live independently, secure in the knowledge that help is available 24 hours a day if the alarm is activated. Call Operators are always available to speak to the service user and arrange support, where required. The Community Careline Service (hosted by the Borough Council of King's Lynn and West Norfolk) is the largest provider of Community Alarms in West Norfolk. There are approximately 4800 service users across Norfolk (c. 2700 in West Norfolk and c. 1800 in North Norfolk), parts of Cambridgeshire and Lincolnshire. All of whom are within the catchment area of the Queen Elizabeth Hospital. The number of alarm calls received varies between a range of c. 5000 and 6700 per month. The strategic objective of this scheme is to ensure that Careline service users consistently receive a coordinated response from partners across the health and social care system. In particular, there will be a focus on: • **Prevention**: Identifying and responding to service users that demonstrate increasing needs and therefore need additional support to maintain their independence • **Crisis Response**: Ensuring that appropriate use is made of emergency and rapid response services
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?

Call handling for the Community Alarm Service is delivered by an external provider. Call handlers record details of the reason for each call and the actions taken. Frequent Caller reports are provided to the Careline Community Service Team (Borough Council) on a monthly basis and referrals are made to Integrated Care Coordinators (employed by Norfolk Community Health and Care NHS Trust), where deemed appropriate.

The first workstream of this scheme will focus on supporting the Call Handlers (located outside Norfolk) through provision of information and guidance regarding existing local community services that do not currently form part of existing call protocols.

Secondly, support for frequent callers will be optimised, in effect maximising the early warning role of the service. Although many of these callers will already be known to health and social care services, the existing integration with community services will be tested, and where appropriate, amended, to ensure that systematic responses are in place. This will include ensuring that service users are linked to Community Clinics, LILY, Care Navigators and other initiatives expected to develop during 2016/17.

Thirdly, the scheme will focus on the appropriate utilisation of emergency and rapid response services. It is known that in some cases Ambulance call outs could be avoided if other services are in place and utilised efficiently. Consideration will also be given to ensuring that Swift Response links with appropriate services following their intervention.

Fourthly, having ensured that service integration has been optimised, there will be a stronger platform to provide the service to those currently with less advanced needs, as part of a longer term prevention strategy.

The delivery chain

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

Commissioners: King's Lynn and West Norfolk Borough Council (Community Care line Service). West Norfolk CCG and Norfolk County Council.
Call Handler Provider: Currently Centra Pulse (contract runs until April 2016)
There are several other providers potentially involved in ensuring that there is an integrated approach to supporting Careline service users, across the statutory, community and voluntary sectors.

The evidence base

Please reference the evidence base which you have drawn on

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

- Between April 2014 and September 2015 the lowest alarm calls per month was 5061 and the highest was 6615
  Assumption – service users in the vast majority of cases are vulnerable and therefore relatively high risk of requiring health and social care support, particularly so if issues are not addressed quickly and via an integrated approach

- Anonymised call handling data showing individual entries by Call Handlers in response to Alarm Calls has been reviewed. This showed that there are often occasions where Ambulances are called due to the unavailability of other services
  Assumption – analysis of use of services is likely to demonstrate that resource redeployment (e.g. increasing Swift Response capacity) or clinical oversight could reduce unnecessary Ambulance attendance and conveyances

- Frequent Caller data for a typical month showed that 41 service users had called the alarm 10 times or more in that month.
  Assumption – high individual call volumes can indicate that the individual requires support and in some instance support they receive is insufficient and needs are therefore likely to escalate

- Public health data shows that, on average, 157 calls per month relate to falls that subsequently lead to utilisation of Ambulance (48%) and/or Swift Response services (26%)
  Assumption – In some instances falls could be avoided through earlier, more integrated support

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

£ TBC

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

Units / £ TBC

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

Outcomes can be measured through review of Call Handling data (e.g. regarding the actions that they record) and actions taken locally for (particularly for frequent callers, potentially recorded by Integrated Care Coordinators).

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

- Appropriate use of emergency and rapid response services
- Appropriate, timely and coordinated use of local services to support individuals to avoid crisis and maintain their independence
- Leading to less unnecessary permanent admissions to Acute Care and Care Homes

22. WN BCF 5 - Crisis Support: In the Community and at the 'Front Door' of the Acute Hospital

Scheme ref no.

WN BCF 5

Scheme name

Crisis Support: In the Community and at the 'Front Door' of the Acute Hospital

What is the strategic objective of this scheme?

There is a range of existing health and social care services in place to support individuals in crisis so that they are supported to maintain their independence at home rather than being admitted to hospital or a care home. However, the strategic objectives of this scheme will be to:

- **Support Crises in the Community**: Reconfigure existing service provision to enable the creation of a multi-disciplinary team that has the capability to respond rapidly to crises, to stabilise the situation

for a short period of time and to de-escalate and transfer support for individuals to either mainstream services or to enable them to self-manage.

- **Extend Crisis Support in the Acute Hospital**: Expand the operations of the multi-disciplinary Rapid Assessment Team so that they can ensure that greater numbers of patients presenting at Hospital are discharged immediately for community based support, where appropriate.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

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

The first workstream will introduce (through reconfiguration of existing resources) a multi-disciplinary team to coordinate and provide appropriate responses in crisis situations. The service will support people who are medically stable but require support (health or social care) to stay in their own home.

The team will offer comprehensive/ multidisciplinary assessment, short term therapy, treatment and personal care to support the individual's health and social care needs at the point of crisis, and is likely to include Occupational Therapy, Physiotherapy, Nursing, Social Work, Norfolk First Response.

The objectives of the service will be to:

- Initiate short term care in a crisis situation (e.g. within 2 hours of request) and co-ordinate the ongoing care of people experiencing a health or health related social care crisis in their own home (e.g. for up to 48 hours)
- Maximise independence and improve outcomes for service users
- Reduce inappropriate hospital and residential admissions through crisis intervention and support
- Link individuals back into their community and support networks thereby promoting their independence and reducing their need for ongoing health and social care support
- Ensure that external carers and families are reassured and supported to enable the service user to remain living in the community.

It is envisaged that referrals would be triaged via the NCHC Hub and supported by the existing Integrated Care Coordinator Team. Comprehensive multi-disciplinary support will be available during core hours (TBC) with a reduced clinical staffing model in operation out of hours.

The second workstream will comprise an expansion of the existing operation of the Rapid Assessment Team (a team including Nurses, Physiotherapy, Occupational Therapy and Social Services roles) at the Queen Elizabeth Hospital (QEH). This team supports medically stable individuals who present at QEH to receive community support where possible. During Monday – Friday, the team operates with c. 6 workers and 1 worker is available on reduced hours on Saturday and Sunday. This scheme will enable supply to more effectively match demand. The team will refer patients to the Community Crisis Response Team where appropriate.

The delivery chain

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

Commissioners: West Norfolk CCG and Norfolk County Council
Providers: Queen Elizabeth Hospital, Norfolk Community Health Care, Norfolk County Council

The evidence base

Please reference the evidence base which you have drawn on

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

Workstream 1

Research by CSED (Care Services Efficiency Delivery) demonstrates that properly resourced and joint crisis or rapid response services ensure fewer people are unnecessarily admitted to hospital or residential care resulting in better outcomes for the individual and greater efficiency in the system. An unnecessary assessment in A&E is traumatic for the person involved and increases the chance of admission to a medical assessment unit or an acute ward. Once away from home, a person can begin to lose independence increasing the chances of going into care.

An admission to hospital or care increases the likelihood that a frail older person will not return into the community. Studies show that the functioning of older people is reduced significantly within two days of being admitted to hospital, and in older people with any form of mental health need, there is evidence of increased mortality, increased length of stay, loss of independence and higher rates of admissions to care homes (National Audit Office, Improving Services for People with Dementia)
This proposal has been modelled on a similar service that has been commissioned by Nottingham City CCG (and its predecessors) for several years on the basis of consistently high performance in avoiding hospital admissions (particularly in relation to falls).

Workstream 2

Analysis of data provided by the RAT Service indicates that c. 66 admissions are avoided per month from the existing service. Extrapolating on the basis of this data for extended working at weekends (with some tolerance for reduced community capacity at weekends) indicates that an additional 14 admissions per month could be saved as a conservative estimate, at an estimate net annual gain of £175,000.

Investment requirements

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

£ TBC

Impact of scheme

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

Units / £ TBC

Feedback loop

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

Admissions avoidance data will be captured by the team and triangulated with data for Ambulance conveyances, actual Acute Hospital attendances and admissions, Care Home Permanent Admissions. Data about the causes of crises will also be captured in order to identify trends and provide performance information that will enable mainstream services to adapt accordingly.

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

- More appropriate use of emergency services / less pressure on mainstream health and social care services
- Reduction in unnecessary permanent admissions to Acute Care and Care Homes
- Improved discharges from Acute Hospital (by reducing rate of admissions)