Better Care Fund

Norfolk Health and Wellbeing Board

Wednesday 15th July 2015

Norfolk BCF Aims - A Reminder

- **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 services.
- **Services will be shaped around the individual:** Healthcare and support will be built around what individuals need and what works for them. Services will be founded on a 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 to manage their needs and health conditions so that they maintain their own wellbeing as far as possible to enhance quality of life and to reduce the call on formal services.
- **Primary care we be 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 will develop at a local level:** In Norfolk, we think that it makes sense for detailed 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. This sits within the countywide planning framework under the Health and Wellbeing Board.

Norfolk County Council

NHS North Norfolk Clinical Commissioning Group

Integrated Working in North Norfolk: A Case Study

Referral to Integrated Care Co-ordinator (ICC)

Ali, one of the North Norfolk Integrated Care Co-ordinators, received a referral for Mrs B from her GP practice for an urgent assessment of falls/ admission avoidance.

Ali

Mrs. B's story on referral

Mrs B, who had lost her husband six months earlier, was finding it difficult , and very scary, living on her own. Mrs B had also fallen many times and needed another falls assessment to see why her balance was so bad. Part of the problem was that her house was very large with many steps and a vast living area; rather than using mobility aids, she was using the furniture to help steady herself.

Physiotherapy assessment

OT assessment

On same day

Ali contacted Mrs B for a chat on the phone and realised that she was still grieving for the loss of her husband . A few tears were shed but Mrs B agreed a falls referral to the physio would be a good place to start. Ali organised this for the same day as the occupational therapist's visit to check the equipment. The physio spent time talking with Mrs B as well as looking round her house. She concluded that Mrs B was feeling terribly upset and lonely after he husband's death and that this had caused her to become housebound and very withdrawn.

As a result of their assessments, the community team met to see how Mrs B could remain living at home while staying safe and well. Ali referred Mrs B to the local Red Cross Older People's team who carried out a thorough assessments in Mrs B's homes and reported back to the community team. The physio referred Mrs B to a group called Extend which runs a free 6 week class to encourage better mobility and socialising. Ali contacted Mrs B to check her progress. This led to a referral to Cruise for counselling to help with loneliness and isolation.

Red Cross OP Team assessment

Extend 6 week mobility course

Cruse counselling

Voluntary Norfolk

This is not the end of the story..... So inspired was Mrs B by the help and support she received, she decided to become a volunteer herself through Voluntary Norfolk.

Norfolk County Council

NHS
Great Yarmouth and Waveney Clinical Commissioning Group

HealthEast

The Out of Hospital Team, Gorleston: A Case Study

Initial Assessment in under 2 hours

↓

Appropriate care provision organised same day

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Full care package implemented within 12 hours

↓

Regular care reviews ensuring person centred care

Following a successful implementation in Lowestoft, Norfolk County Council are working with a community provider to deliver an Out of Hospital Service in Great Yarmouth.

By September 2015, an inter disciplinary team of health and social care professionals including community nurses, occupational therapists, physiotherapists, rehabilitation support workers and social workers that works 24 hours a day, 7 days a week will be in place

Supporting people going through a crisis, the team will take referrals from health and other professionals to:

- ✓ **Avoid a patient being admitted to a hospital bed in the first place**
- ✓ **Get the right support in place to enable the person to get home sooner if they are admitted**

This is the beginning of the story where the case studies are still being captured so the following case study evidences what an established and fully staffed team can deliver……

Interviews are currently taking place

Norfolk Social Care aims to be fully established in under 12 weeks

Norfolk County Council

NHS
Great Yarmouth and Waveney
Clinical Commissioning Group

HealthEast

The Out of Hospital Team, Gorleston: A Case Study

Before -
- Taken to her bed Malnourished
- Dehydrated
- Not taking medication
- Dog and human faeces

Joint Assessment within 2 hours of referral

After – 2 weeks later
- Medically stable
- Managing medication
- Self caring – x1 daily carer
- Attendance allowance
- Safe and clean home

HomeWard

Rapid Response, Virtual Ward, Community IV

Rapid Response: - a community based rapid response service responding to people with a short term illness, exacerbation of a chronic condition or palliative care symptoms or at end of life in their usual place of residence

Community IV Therapy: - expanding IV therapy service to enable more people to receive treatment in their usual place of residence

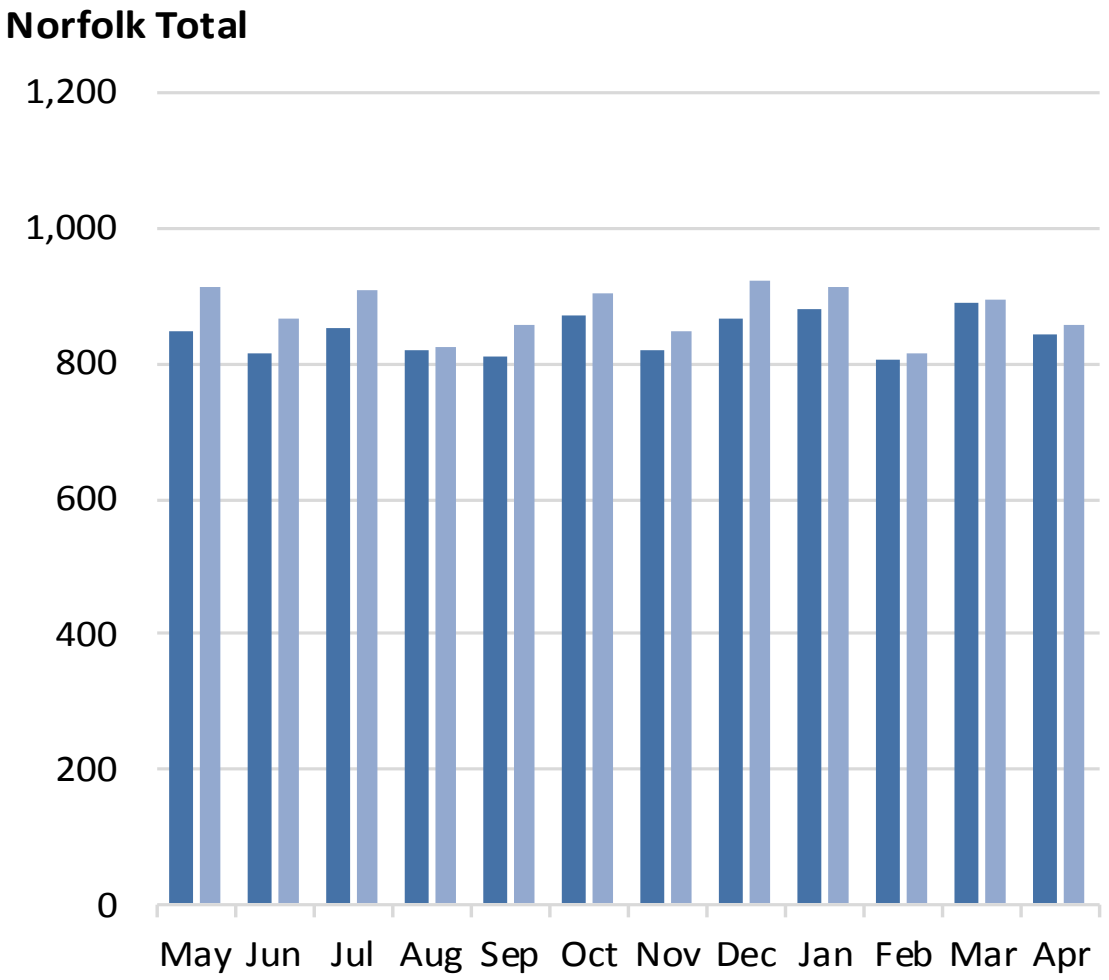
Virtual Ward: - providing step up and step down care to people in their usual place of residence

YourNorwich

NHS Norwich Clinical Commissioning Group

	Case Study 1 - Community IV	Case Study 2 - Virtual Ward
Initial assessment	• Person assessed and admitted to community IV service for 25 days	Before – Person admitted to NNUH whilst waiting for rehab at a specialist hospital
Care package discussed and agreed	• Treatment discussed and agreed with person and their family	Package of care at home discussed and agreed
Care package implemented	• Treatment closely monitored and avoided unnecessary trips to the hospital	After – Package of care implemented and reviewed
Regular Reviews	• Person extremely pleased to be at home and to participate in decisions	Person remains in their preferred place of care improving daily and gaining independence If progress continues need for specialist rehab will be reviewed Feedback from patient and her husband is very complimentary.

Non-elective admissions - where we are now



Non-elective admissions per 100,000 population for Norfolk – rolling 12 months

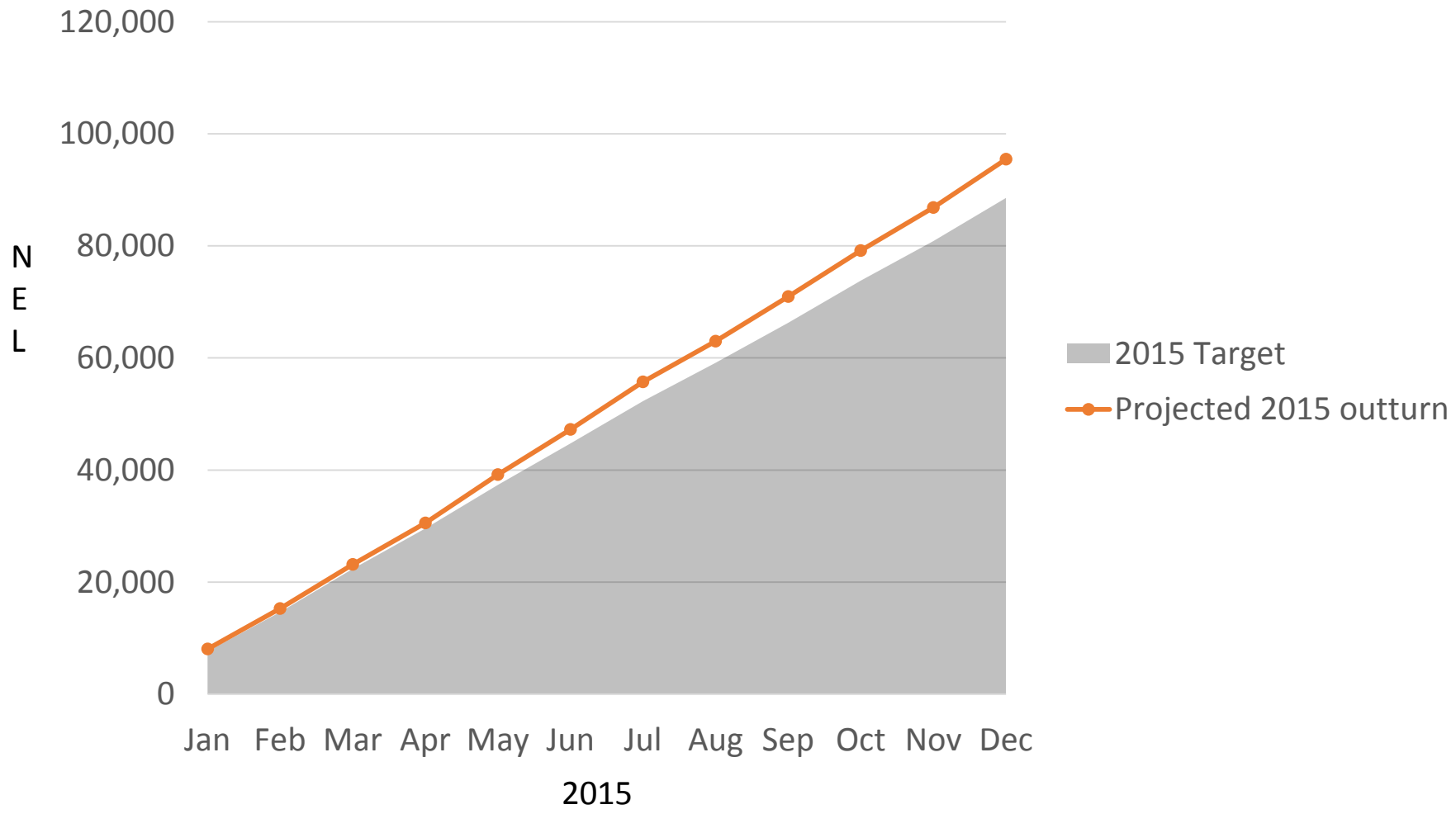
Non-elective admissions are going up across Norfolk (except GYW)

- May-13 to Apr-14
- May-14 to Apr-15

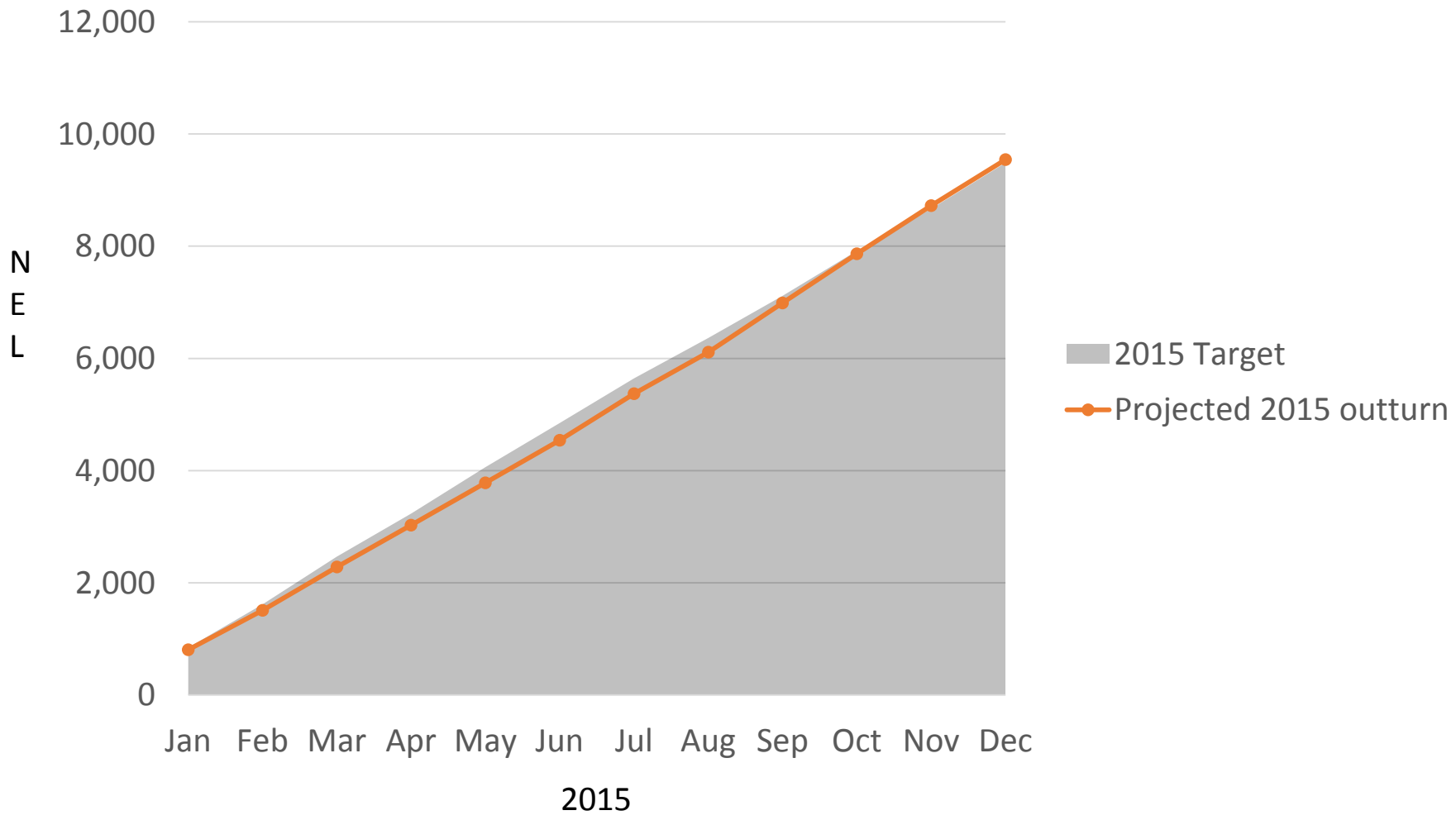
Non-Elective Admissions – where we will be at December 2015

- 3.5% reduction target - from 93,015 (2014) to 89,766 (2015) = 3,249
- Projection shows variance from target of 3,778 (increase of 529 on 2014 baseline)
- Intended to be a simple ‘all things being equal’ indicative projection of performance NOT technical modelling

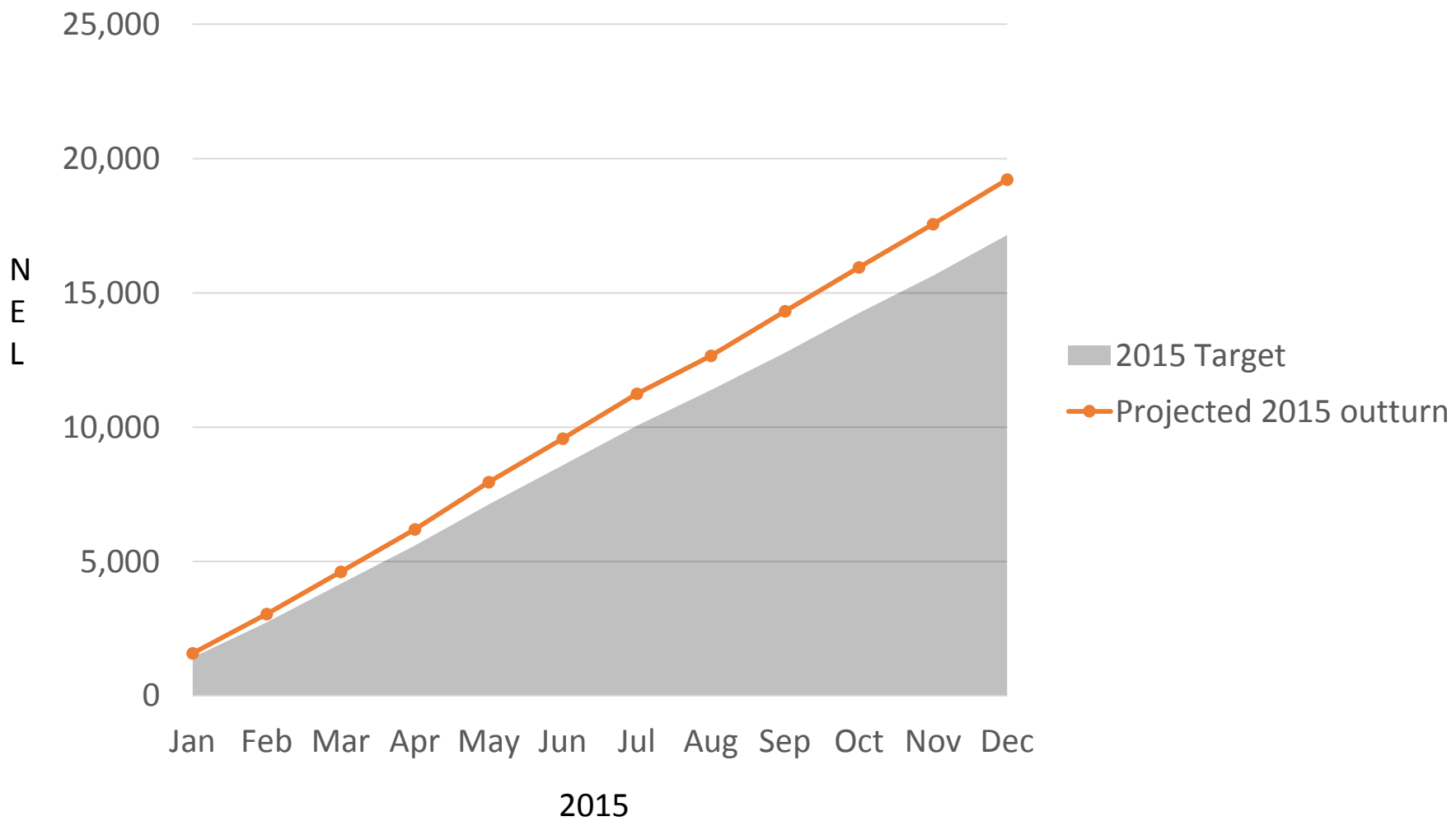
All Norfolk – cumulative projected NEL admissions for 2015 compared to target



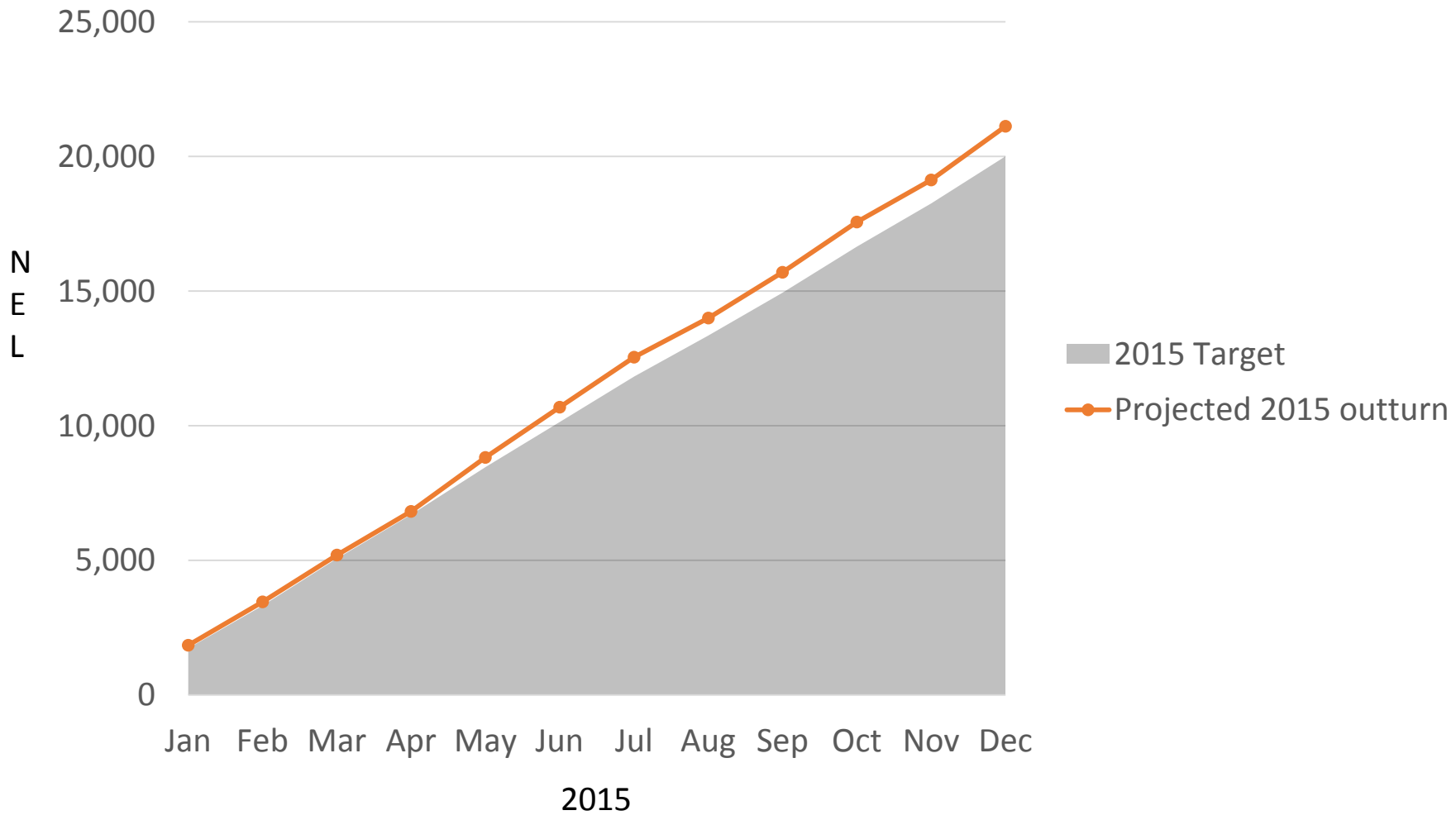
Great Yarmouth and Waveney – cumulative projected NEL admissions for 2015 compared to target



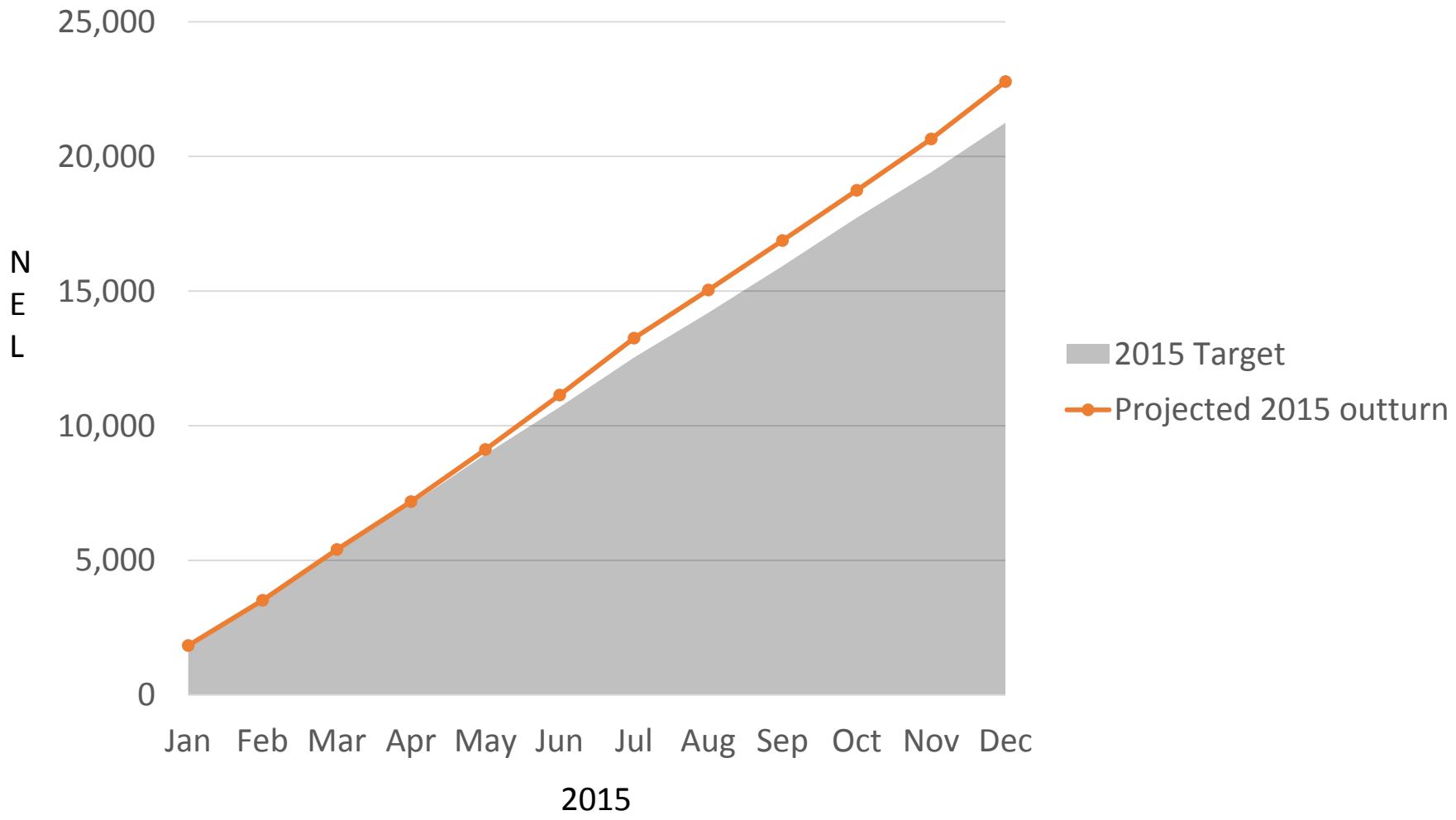
North Norfolk- cumulative projected NEL admissions for 2015 compared to target



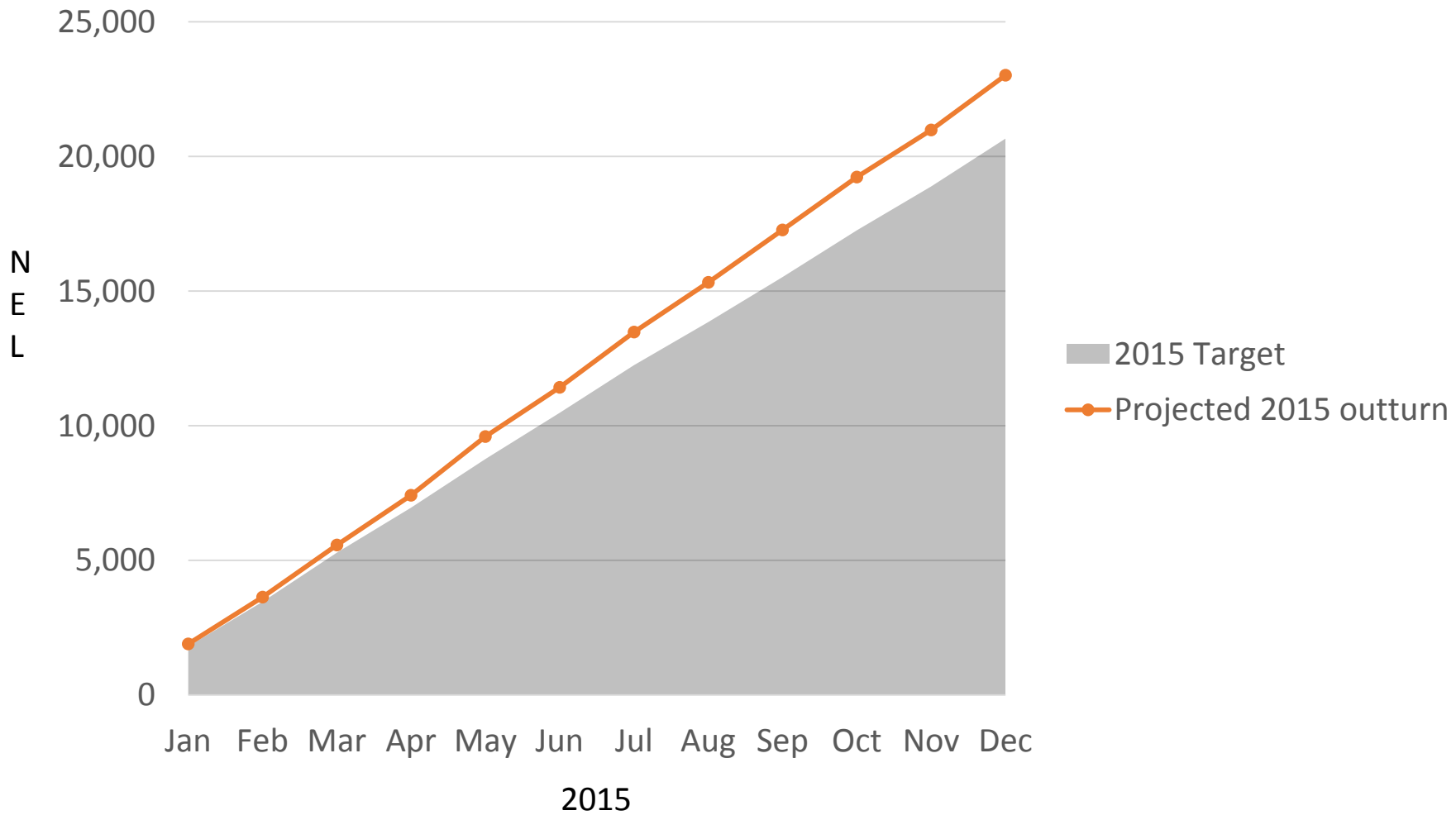
Norwich – cumulative projected NEL admissions for 2015 compared to target



South Norfolk – cumulative projected NEL admissions for 2015 compared to target



West Norfolk – cumulative projected NEL admissions for 2015 compared to target



Challenges

- Capacity – additional project support in place
- BCF has struggled for priority amidst other requirements
- Further work to do to clarify anticipated impact and actual benefit delivered from schemes
- Struggling to achieve envisaged benefits from some schemes originally devised early in 2014 – developing new initiatives

Reporting and Assurance

- NHSE quarterly reporting regime submitted in May – this didn't require metrics / income and expenditure
- NHSE have queried disparity between non elective admissions BCF plan and CCG Plans
- Next return due 29 Aug
- Local Partnership Boards established to govern S75 agreements (See next slide)

Governance at local level and who is round the table (1 of 2)

Each CCG operates a Partnership Board to Govern the scope of their Section 75 agreement including the pooled fund

- **NN CCG** - CCG Chief Executive (Mark Taylor), CCG Chief Finance Officer (Helen Stratton), Director of Integrated Commissioning (Catherine Underwood), NCC Finance Business Partner (Neil Sinclair), Pooled Fund Manager (John Everson) – First meeting to be held in July when the S75 is signed
- **GY&W CCG** - Director of Operations (Kate Gill), Chief Finance Officer (Zoe Pietrzak), Director of Integrated Commissioning (Catherine Underwood), Finance Business Partner (Neil Sinclair), Pooled Fund manager (Geoff Empson) – Meeting monthly at present
- **SN CCG** - CCG Chief Executive (Ann Donkin), CCG Chief Finance Officer (Jim Hayburn), Chief Operating Officer (Jocelyn Pike), Asst Director Out of Hospital Commissioning (Chris Coath), Director of Integrated Commissioning (Catherine Underwood), NCC Finance Business Partner (Neil Sinclair), Pooled Fund Manager (Rob Cooper) - Meets every 4-6 weeks.

Governance at local level and who is round the table (2 of 2)

Each CCG operates a Partnership Board to Govern the scope of their Section 75 agreement

- **WN CCG-** CCG Chief Executive (Sue Crossman), CCG Chief Finance Officer (John Ingham), Director of Operations (Kathryn Ellis), Director of Integrated Commissioning (Catherine Underwood), NCC Finance Business Partner (Neil Sinclair), Pooled Fund Manager (Roger Hadingham) – Meeting Monthly
- **Norwich CCG** - Director of Integrated Commissioning (Catherine Underwood), Director of Clinical Transformation NCCG (James Elliott), Acting Finance Director NCCG (Robert Kirton), Head of Integrated Commissioning & Pooled Fund Manager (Mick Sanders), Finance Business Partner NCC (Neil Sinclair), Acting Chief Executive NCCG (Jo Smithson), Integrated Commissioning Programme Manager NCCG (Jane Walsh) - Inaugural meeting 18th May subsequent meetings arranged at 6 weekly intervals.

West Norfolk Scheme Update

Scheme Name	Key Change Deliverables / New Services from the Scheme	Money (Investment in Services)	Progress
WN1 Integrated Care Organisation	Standardisation of best practice across West Norfolk's MDTs, including risk profiling, so that patients with high needs receive care which is consistently proactive, seamless and integrated Care Navigator service provided to support high needs patients to self-manage through use of existing community based services (1 year pilot)	£2,481,000	Proposal for standardised process developed following consultation with providers (Completed) New approach to be trialled in Practice areas Care Navigator service delivered by different providers (to trial different approaches). Referral pathways from GPs, Community Matrons, Social Workers and other MDT workers being utilised I year pilot commenced Feb 2015
WN2 Reablement	Closer working achieved between the two main reablement services in West Norfolk – NCC Norfolk First Support (six week reablement package for individuals) and Borough Council Home Improvement Agency (housing-related reablement)	£1,784,000	Objective met with joint awareness of each service and pathways for cross referrals. Complete
WN3 Acute Admission Avoidance/Discharge incl 7 day working	Enhancement to Rapid Assessment Team (RAT); extending weekend hours at hospital 'front door' Creation of 'Home from Hospital Partnership' to expedite discharge by resolving practical / housing / social issues	£3,523,000	Recruitment underway for 2 additional RAT staff Commences Sept 2015 Specification being drafted for Home from Hospital Partnership, in consultation with key stakeholders Commences October 2015
WN4 Promoting Independence	Provision of high quality information on the availability of community-based low-level support services A linked brokerage service to connect individuals to community-based services, identify resource shortfalls and stimulate the growth of additional local low-level "by the community, for the community" support services.	£981,000	Living Independently in Later Years (LILY) service up and running Complete Further development of service (LILY Plus) being taken forward by King's Lynn and West Norfolk Borough Council (including community volunteer navigators and community access points)
WN5 Dementia	To establish a dementia diagnosis and support model based around primary care that encourages referrals for diagnosis, provides a diagnosis in a setting local and familiar to the patient, and wraps around this process a knowledgeable and empowering support network.	£1,646,000	Dementia diagnosis rates have improved from 33% (2013/14) to 53% (May 2015) Support to GPs to increase diagnosis rates through utilisation of algorithm to diagnose dementia in persons with obvious cognitive and functional impairment Primary Care diagnosis and medication initiation and Post Diagnostic service improvements have commenced. End of Life work commencement expected December 2015

Norwich Scheme Update

Scheme Name	Key Change Deliverables / New Services from the Scheme	Money (Investment in Services)	Progress
NCH1 – Primary Care	Risk stratification system (April 2015.) New electronic prescribing system (all 22 GP practices by end March 2016). GP practices aligned to specific care/nursing (April 2015.) Locally commissioned services.	£1,143	System live at 17 GP practices. 3 pilot GP practices using electronic prescribing system. 34 of 35 care/nursing homes aligned to a GP practice. LCS – discussions in progress with GP practices to identify opportunities.
NCH2 – Integrated Community Health & Social Care	Enhanced roles and co-ordination between, multi-disciplinary teams and integrated care co-ordinators (November 2015). New signposting for patients and service users. Improved dementia diagnosis rates. Improved palliative and end of life care (March 2016).	£6,353	Recruitment of 2 further ICCs underway. Case management pathways updated for HomeWard. Admiral nurse recruited. Integrated end of life care options developed. Falls pathway being redeveloped.
NCH3 – Intermediate Care	Initial review of intermediate care and proposals for redesign (June 2015). Final review of intermediate care system and report. Virtual "HomeWard" operational taking step-up and step-down patients (March 2015). HomeWard evaluation (December 2015). Community IV therapy service live (April 2015).	£3,676	Draft evaluation report including redesign options for intermediate care produced. Rapid response, Virtual Ward and Community IV Therapy initiatives combined under HomeWard to ensure full integration. Rapid Response live. Community IV Therapy service live.
NCH4 – Community Assets	12 week intensive volunteer support initiative. Personal Health Budgets pilot (November 2015). Integrated carer support (August 2015). Improved information and advocacy for patients (October 2015).	£1,073	Age UK pilot live October 2014. Lottery funding for older people withdrawn. Personal budgets pilot launched. Carers Agency Partnership delivering carers action plan for Norwich. Review August 2015. Supporting self-care project initiated.

Great Yarmouth and Waveney Scheme Update

Scheme Name	Key Change Deliverables / New Services from the Scheme	Money (Investment in Services)	Progress
GYW1 Supporting Independence by the provision of community based interventions	The key deliverables for the total scheme are to enable people to live at home for as long as possible thereby reducing admissions to care homes and acute hospitals - the key change relates to development of integrated home support and hospice at home services	£3.1m	A significant proportion of this overall scheme relates to "protecting social care" and sustaining existing services / packages of care and these elements are on target.
GYW2 Integrated Community Teams and Out of Hospital Teams	The key deliverables for the total scheme is reduction in emergency admissions to acute hospital	£1.5m	Some health and social care teams now co-located. Out of Hospital Team in implementation with some staff in post and remainder being recruited, service will be fully functioning by Sept.
GYW3 Urgent Care Programme	Builds on resilience schemes developed as part of winter planning - key deliverables are reduction in demand on acute services both in terms of emergency admissions and delayed transfers of care.	£2m	Work is in hand to take forward individual projects within the overall scheme. Bids for funding to maintain some of these services have yet to be approved.
GYW4 Support for people with dementia and mental health problems	Flexible Dementia Service - urgent homecare for people with dementia in crisis - key deliverables are prevention of admission to care homes or acute hospital.	£530k	Pilot run and closed down as not financially viable, however achieved the key deliverables so alternative model being investigated

North Norfolk Scheme Update

Scheme Name	Key Change / Deliverables / New Services from the Scheme	Money (Investment in Services)	Progress
NN1: Risk Stratification	New risk profiling tool roll-out in progress: Project Board approval for Integrated Care Pack by 30/11/15. Risk profiling and Shared Access project to be completed 31/03/16.Benefit target: Reduction of 505 avoidable admissions (42 per month) for 2015/16 when compared to the 2015/16 baseline (2014/15 actual + 2.9% growth). Reduction in residential placements to 326 in 2015/16.	£0.000m	Original Predictive risk stratification tool established in all practices. April 2015 avoidable admissions higher than target. Exploring ways of reducing these with Integrated Care Programme Board including targeting avoidable admissions for UTIs and palliative care patients.
NN2: Integrated Care Teams	Four extra ICCs to be employed, total 8 by 31/08/15. Virtual hubs to be physical integrated teams from Health/ NCC adult care. New Service start date 14/12/15. Benefits as in NN1 above.	£1.516m	Integrated Care Teams set up in 4 virtual GP hubs. 4 Integrated Care Co-ordinators recruited. MDTs being used for high risk/need patients (target 2%).
NN3: Voluntary Sector and Self-Care Programme	Voluntary sector services targeted to maintain independence & wellbeing: Projects include: Self-Care & Self-Management strategy for patients & carers; review of assistive technology; locality homecare model and new spec for housing support. All to be achieved by 31/03/16.Benefit: To increase proportion of older people who are still at home 91 days after discharge from hospital into reablement / rehabilitation services to 90%.	£4.346m	New volunteer service commissioned to support integrated care patients. Mobilisation and review of new volunteering service referrals and outcomes. Not achieving reablement targets at present. To meet with Rapid Response service at NCC to discuss ways of improving this.
NN4: Fall Prevention Programme	Increased effectiveness of RACs service: Review of NCH&C Falls pathways by 31/07/15. Enhanced Falls Communications Plan by 31/08/15. Close management of RACs outcomes by 30/09/15.	£1.088m	Establishment of local NN Falls reference group linking to countywide group. Remodelling of acute falls pathway. Falls targets on track for April – monitoring required.
NN5: Dementia Support Programme	The development and strengthening of community hubs and dementia friendly communities. Focus on improved support for carers, including building business case for dementia advisors and admiral nurses. Benefit: Increased dementia referral rate to 66.7% by 31/03/16. Dementia rates below target. Working with NSFT to ensure memory clinic diagnoses are counted.	£1.100m	1st dementia friendly community hub achieved by 31/08/14 (total 6). Information pack developed following 6 months engagement with stakeholders, carers and service users launched 11/05/15. Signposting event for NN and rural Broadland held 01/06/15.
NN6: Urgent Care Programme	Timely / 7 day social care acute discharge planning and post discharge support by 31/03/17. Remodelled local community beds provision (End of Life care, CHC, acute rehabilitation & dementia).Linking with Domino project to achieve by 31/03/16. Benefit: Reduced Delayed Transfer of Care.	£2.382m	Clinical network group established to identify local needs & priorities. Mental health frequently attending / admitted patient scheme in place at NNUH but no future funding for the enhanced service which has had to be discontinued. Delayed transfers of care well within target.
NN7: Improving Mental Health Outcomes Programme	Provision of Alternative to Admission schemes. New Primary MH service goes live Sept 15.Will form part of integrated care teams. Service will be accessible directly to patients via self-referral. Pilot accelerated ambulance transportation system for mental Health patients. Benefit: Reduced avoidable admissions as in NN1 above.	£1.121m	Accelerated ambulance transportation in place and early results show waiting times for most severe patients decreased to an average of 24 mins for the ambulance to arrive on scene and begin conveyancing of the patient.

South Norfolk Scheme Update

Scheme Name	Key Change Deliverables / New Services from the Scheme	Money (Invested) in Services)*	Progress
SN1 – Integrated locality based teams	Supporting GPs and Primary Care to offer effective care close to home through investing in pathways, teams and services in localities	£3,757,000	An integrated hub for health and social care has been introduced with a single access point being developed. MDT arrangements are being audited and a number of practices will work on a best practice MDT model from July 2015. A team of Integrated Care Coordinators has been set up. A new service is being set up from July 2015 to pilot low level support to reduce falls
SN2 – Supporting independence, wellbeing and self-care	Closer working between primary care, secondary care and prevention services including information, advice and support for people with long term conditions, support for carers, help to manage medication	£1,287,000	A pilot service has been established in half of the GP practices offering advice and access to other supports for older people. Social care at home is being remodelled with new services from March 2016
SN3 – Integrated care for people with dementia	Ensuring effective services and help that can be accessed by people with dementia and their carers including specialist nursing, respite at home, dementia beds and information and advice	£1,630,000	A number of dementia services and initiatives have been established on an interim basis, are being piloted and/ or are being reviewed to inform commissioning intentions for 2016. These include an Admiral dementia nursing service covering all SN localities. The approach supports patient care and increases the confidence of GPs to diagnose
SN4 – Urgent care	Establishing effective interventions which reduce unplanned hospital admissions and facilitate discharge	£2,692,000	Leads are promoting the provider initiatives and pathways which have been established as part of joint planning dialogue with localities around admissions reduction
SN5 – Mental health	Ensuring good and timely mental health services which promote recovery and self-management	£1,380,000	A coproduction scheme is underway to identify the assets and community resources which contribute to recovery and mental well- being. This will report in February 2016
SN6 – End of Life care	Patients and carers are able to plan and ahead and supported to be in control of their end of life care	£939,000	The lead project is to roll out use of EPaCCS patient held care plans to all GP Practices by March 2016 across South Norfolk CCG to enable sharing of information necessary to ensure co-ordination of palliative and end of life care. Expected outcomes include improved care co-ordination and reduction in unplanned admissions to acute hospital at end of life.