Norfolk Health and Wellbeing Board

BCF Narrative Submission

2016 – 2017

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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	£12,867,664	£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. Summary Position

Norfolk County Council and its CCG partners are committed to a vision for the integration of health and social care for the benefit of patients and citizens as set out in this plan. The financial pressure in the health and social care system means that the spending commitments from 15/16 are not sustainable. All partners recognise that maintaining social care service provision is essential to the system, but the additional funding of £7.9m which was made available in 2015/16 by CCGs cannot be maintained in 2016/17. Removal of this funding for social care would destabilise the system and create major risk and cost for the health service.

Further detailed work has been undertaken to mitigate this risk and to release the funding in order to maintain social care services at a level which protects the system. This has been achieved through:

1. Reviewing existing BCF expenditure plans to consider redirecting commitments
2. Seeking further savings, additional to existing QIPP/savings plans, which can be delivered through integrated approaches
3. Testing the ambition and acceleration of existing savings plans
4. Considering reducing or stopping spend on lower priority services

We have also challenged the transformation ambition in our BCF plan in order to drive out the scale of change required to achieve sustainability which aligns to our emerging STP. This has led to an agreement on a more robust and challenging system redesign which will drive our BCF and underpin delivery.

As a result the partners now have an agreed BCF agreement covering 2016/17-2018/19. The plan, through a combination of further joint efficiencies and some decommissioning of services delivers a balanced plan from 2017/18 onwards. A non-recurrent gap of £5m in 2016/17 will be met by Norfolk County Council with one-off funding.

As part of the agreement and to ensure the delivery of savings and a more focussed BCF, Norfolk County Council and the CCGs have agreed to prioritise the shared pieces of work outlined in Section C.7 below.

i. Principles for financial settlement BCF Norfolk

1. A three year agreement covering 2016/17-2018/19 protects high priority social care spend to a value of £7.9m p.a.

2. This is being funded by a combination of:
    a. Further efficiency savings of £6.3m
    b. Disinvestment in services £2.1m

c. The resultant surplus of £0.5m being held as a joint risk reserve by the partners

3. The majority of the savings will be delivered in 2017/18 and hence there is a significant non recurrent gap in 2016/17, the majority of which will be met by NCC.

4. NCC will fund a one-off payment of £5m in 16/17 sourced from its non- recurrent provision

5. A single BCF programme and single BCF programme board for the whole Norfolk BCF programme and this will link to STP for governance

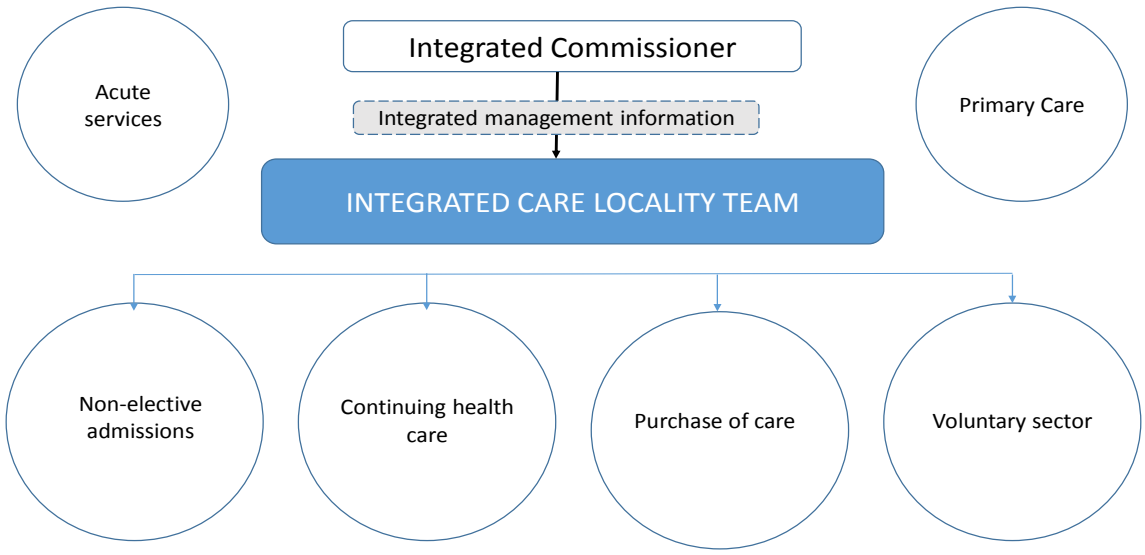
6. Open book reporting on both financial and service performance activity across all the services

7. Any additional non recurrent funding allocated to the CCGs by NHSE which is hypothecated for urgent care/system pressures during 2016/17 will be passed to NCC where possible, subject to any specific NHSE instructions regarding its specific use of operational and service pressure prevailing at the time which, with agreement, require additional expenditure of such non recurrent resources.

8. This will be secured in a Single Section 75 agreement

ii. Strategic Fit

During 2016/17 – 2017/18 our ambition will be to explore the future shape of community services as part of the development of our STP. We will consider how community health contracts, social care teams, mental health services, emergency hospital admissions including mental health, continuing healthcare budget and purchase of care budgets may be aligned in an integrated place-based arrangement in support of the Norfolk and Waveney STP. Locality teams will be incentivised to manage their locality budget to deliver savings and outcomes for the local population. Alongside this a detailed risk share will be clearly specified where required.



iii. Next Steps

The Norfolk system has made significant progress over recent weeks in reaching this agreement. However further work is needed to implement the plans including the firming up of the agreed savings plans

Experience from elsewhere also identifies that detailed risk sharing agreements between partners for 2017/18 are essential. Norfolk intends to draw upon the emergent lessons from vanguard and other sites who are more advanced in multi organisational contracts and risk shares.

4. Planned expenditure and changes from 2015/16

Following the approach in 2015/16 allocations for the Disabled Facilities Grant (DFG) to each District Council will again be made through the Better Care Fund. This will enable Housing Authorities to continue to meet their statutory duties to provide adaptations to the homes of people with disabilities while exploring how the increase in DFG funding can add value and support the wider BCF metrics

It has been agreed to pay the full DFG sum (including the social Care Capital Grant previously paid to the Council) to district councils along with the DFG. A high level plan has been agreed between authorities to ensure that the increase in funding is reflected in increased scope and impact of the fund.

Norfolk County Council (NCC) and the five CCGs in Norfolk and Waveney are committed to fully integrated working to achieve best outcomes and value for money for local people.

NCC and the CCGs have a range of initiatives in place to pursue objectives which are congruent with those set out in the national BCF guidance. Forming and agreeing revised financial and governance arrangements for the 16/17 BCF has been a fruitful process with the opportunity to reflect further on achievements and future challenges. An approach designed to ramp up impact and activity through the BCF has been agreed which will see the development of five key workstreams across the county. These workstreams will ensure that activity is focused to really maximise impact across the system.

The revised BCF plan will be presented to the Health and Wellbeing Board on 20 July 2016.

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 being taken 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 schemes being developed by the CCGs for 2016/17 have similar themes and it has been agreed to work collaboratively on a number of these in order to progress as a whole.

5. 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. CCGs hold regular Board meetings to discuss the integration of health and social care, at which are number of partners are represented, this may include: Primary Care, Acute Care, District Councils, Community Health Care, Norfolk County Council, East Ambulance Service Trust (EEAST), IC24, and voluntary and privates providers.

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 piece.

Norfolk benefits from shared teams between the main community health providers and NCC social care staff forming a fully integrated operational service across the five CCG areas. This collaboration ensures that effective communication and engagement is achieved across health and social care operational teams.

Our key stakeholders are:

- Service Users and Carers
- Norfolk County Council
- Five Clinical Commissioning Groups – Great Yarmouth and Waveney CCG, North Norfolk CCG, Norwich CCG, South Norfolk CCG and West Norfolk CCG
- Three acute hospitals – James Paget, Norfolk and Norwich University Hospital, Queen Elizabeth
- Seven District Councils – Breckland District Council, Broadland District Council, Great Yarmouth Borough Council, Kings Lynn and West Norfolk Borough Council, North Norfolk District Council, South Norfolk District Council
- Mental health providers - Norfolk and Suffolk Foundation Trust

- Voluntary sector providers – engagement through the NCC Locality Provider Forum and CCG Community Engagement Panels
- GPs and other Health Care Professionals
- Independent health and social care providers

Consultation and Engagement happens both across the county and at a CCG level, for more detailed information on how each CCG has specifically engaged and collaborated locally, please see Appendix A.

B. Narrative Plan

1. Our Shared Vision for Health and Social Care Services

Integration is a priority for Norfolk where it is recognised that current health and social care services will become unsustainable given increasing demand 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. Undoubtedly the plan will evolve over the year but reflects ambition and intent. Agreement going forward will include reaching the necessary consensus over respective financial contributions and any risk arrangements.

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. The plan reflects that drive and ethos. 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. The Promoting Independence Strategic Statement can be found in Appendix B.

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. 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. 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. 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. 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.[1]

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:

[1] Dr Wendy Thompson, (2016). *Re-imagining Norfolk – the County Council Plan*. [online] Available at: http://norfolkcc.cmis.uk.com/norfolkcc/Decisions/tabid/67/ctl/ViewCMIS_DecisionDetails/mid/391/Id/f4a3c641-695f-4bf6-8478-b20f36e68d14/Default.aspx [Accessed 28 April 2016].

- 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 where people live (to reduce avoidable ambulance conveyance, and 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. This 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.

3. 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.

While individual governance arrangements will continue to monitor implementation locally, revised arrangements, designed to strengthen and support the BCF, have been put in place and are reflected in the S75 (all parties) and a Memorandum of Understanding (between all CCGs). A countywide Programme Board, jointly chaired by CCG/NCC, will provide leadership and governance for the programme in addition to receiving performance and monitoring information about impact and pace of delivery. A diagram showing these arrangements can be found in Appendix C.

The governance arrangements for Great Yarmouth and Waveney CCG have changed from our 2015/16 BCF submission, details about this can be found in Appendix C.

The governance arrangement for the remaining four CCGs (North Norfolk, Norwich, South Norfolk and West Norfolk) 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 Fund Programme Board will provide the countywide management of implementation and impact of BCF schemes. The Programme Board will meet each month and provide 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 establishment of a robust countywide governance will be supported by the development of a suite of standardised performance reporting tools which will provide consistency and assurance of impact. A copy of the reporting dashboard can be found in Appendix D.

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 the Local Authority, District Councils, integrated teams and CCGs, and this is where initial remedial action will be determined. The Countywide Programme Board will secure oversight of the programme overall to address a) delivery of whole system change, b) identify and manage dependencies and c) provide 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.

4. Our approach to financial risk sharing and contingency

Agreement about financial risk sharing and contingency has been agreed through the recent negotiation process and is set out within the S75 which provides a clear framework for the 16/17 BCF. A copy of the draft S75 agreements can be found in Appendix E.

C. National Conditions

1. Plans are jointly agreed

The Better Care Fund (BCF) is seen by 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.

In recognition of the role that District/ Borough Councils and the need and vision for system wide integration, there is greater involvement with the development of BCF plans. This is supported by the Capital Grant Allocation through the BCF with a clear condition that there is a joined up approach to improving outcomes across health, social care and housing.

Within Norfolk, several workshops have been held with representatives from Norfolk County Council, CCGs and all of the seven District/ Borough Councils. Strategic principles have been agreed for delivery and this has informed the planning and delivery principles detailed in the paper included as Appendix F. Co-ordinating and focusing activity across the county is challenging, with varying historical arrangements for use of DFG. All partners are committed to exploring how processes for the distribution of DFGs can be simplified and impact increased. It is anticipated that understanding and plans will be developed as part of the overall partnership.

Further activity in early 16/17 is planned, to support the local planning process, which will be supported through the attendance of District/ Borough Councils at the local BCF Partnership Boards, where there will also be the opportunity to discuss and identify broader integration opportunities.

2. Maintain provision of social care services

Agreement on the protection of social care has been achieved and will be enacted through a three year S75 agreement. This agreement reflects the recognition of the importance of social care provision and its role in supporting the overall system.

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.

i. 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)
- Carers' assessors form part of social work teams and contribute to providing a comprehensive service for carers

ii. 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 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.

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 recruitment to this service at the QEH is in progress. 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 seven day operation of the majority of residential care homes and home care provision across the county. Emergency arrangements are in place to ensure cover where arrangements are still being robustly established.

Recently commissioned Home Support provision is contracted to provide an out of hours service ensuring that there is access to services over 7 days of the week. The enablers and barriers to ensuring this works

have been discussed with the providers via contract review meetings, which are attended by the Council's Care Arranging Service, Operational colleagues, the Contracts team and Commissioners.

The recent five year forward view for mental health report stipulates that people facing crisis should have access to mental health care 7 days a week. In respect of **mental health** the main provision is through Norfolk and Suffolk Foundation Trust with the following services already provided on a seven day basis:

- Older people acute inpatient services
- Dementia Intensive Support Unit
- Crisis Resolution Home Treatment teams
- Dementia Intensive Support Teams
- Psychiatric Liaison at the Norfolk and Norwich University Hospital Foundation Trust (NNUHFT) and the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEH)
- Police control room mental health team

As part of successful bid into the CAMHS Transformation Fund the following services are also being extended to cover seven day working in 16/17:

- Crisis Support services to under 18s
- A weekend liaison service for under 18s (at NNUHFT and QEH)

As part of 16/17 contract negotiations discussions are ongoing to extend community services to provide full seven day cover.

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 7 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. This action plan is now led by the Acute trust.

In response to the requirement for mental health care to be provided seven 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 seven 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 line with national ambition, the CCG is committed to working with its acute trusts so that 25% of the population will have access to acute services that comply with the four priority clinical standards every day of the week:

- Standard 2: Time to Consultant Review
- Standard 5: Access to Diagnostics
- Standard 6: Access to Consultant-directed Interventions
- Standard 8: On-going Review

The CCG will work with partners to ensure that half of the population will be offered the four standards by 2018 and that there will be complete coverage by 2020.

Central Norfolk CCGs (North Norfolk CCG, Norwich CCG, South Norfolk CCG) have agreed a timescale with the community provider through a contractual SDIP (Service Development and Improvement Plan) for scoping the need for 7 day community services:

- The CCGs and Norfolk Community Health and Care (NCHC) will map current services and understand where the pressure points are by 30th April 2016.
- CCGs and NCHC will jointly work up a business case which identifies the opportunities for and benefits of extending community provision to 7 days by 31st July 2016
- NCHC will explore opportunities to support achievement of priority clinical standard 5: access to diagnostics – by end September 2016
- Depending on the outcomes of this work (which will be monitored on a monthly and quarterly basis), output will be reflected in CCG and provider commissioning intentions for 2016/17

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 seven day basis. The existing Virtual Ward is a seven day care model which has had a huge impact on facilitating hospital discharge and Intermediate Care beds with therapy support are available seven 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 seven day monitoring and intervention where appropriate.

The totality of these plans should ensure effective 7 day services across the county. An overall milestone plan and risk log have been attached as Appendix H.

4. Better data sharing

There are ambitions to meet this target largely through the digital road mapping project across Norfolk and Waveney 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. Appendix I shows the capability deployment schedule for interoperable systems and processes across Norfolk (and Waveney).

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 four 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**. 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.

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.

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.

Colleagues within the community services, social care and mental health services will be co-located by the end of March 2016, allowing teams to work closer together and share key information to improve patient care. Discussions are underway between key stakeholders to extend a staff rotation programme for therapists and nurses, currently undertaken between acute and community, to further include mental health services.

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 CCGs 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.

Agreement has been reached that in addition to the locality schemes detailed in the Section F there will be five county wide workstreams, led jointly by CCGs and NCC which will really drive impact on BCF metrics. These are:

- Continuing Healthcare
- Frequent flyers (hospital admissions)
- Care homes
- Equipment
- Integrated Reablement

The previous version of the Norfolk BCF plan 2016/17 will not be substantially adjusted in the light of the agreement because we are already substantially into the year and work has commenced on many aspects of local schemes. The five agreed county workstreams already reflect areas common to the locality proposals. The county schemes will need to take precedence over locality specific schemes. Performance and impact of these workstreams will be monitored through the BCF Programme Board and will be supported by CCG/NCC business intelligence colleagues.

CCGs currently invest significantly in out of hospital services, most often through co-commissioning arrangements. Key community health services include:

- Out of hours care
- NHS 111
- NHS and independent intermediate care
- Community nursing and therapies
- Health support and care for long term conditions
- Voluntary sector support and care
- Independent Community Equipment Service (jointly commissioned with Norfolk County Council)
- IAPT services
- Community mental health support
- Funded nursing care and continuing health care packages
- Non-emergency patient transport

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 can be replicated in all CCG areas.

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.

A key facet of the BCF in **South Norfolk** in 2015/16 was to begin to increase the level of community support available in localities to support the planning and delivery of care coordinated through GP practices. 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 monitors flow through the systems. 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. A draft version of the plan can be found in Appendix G.

Individual locality plan preparation includes the following:

Great Yarmouth and Waveney CCG works in partnership with health and social care providers to both monitor and reduce delayed transfers of care. There is a DToC plan in place which is included in this return.

The current plan requires:

- Daily conference call between providers
- Mon- Fri attendance at the acute trust by CHC lead nurse
- 5 day turnaround for CHC assessments
- Regular senior monitoring meetings
- The CCG has also funded 12 discharge to assess beds and both county councils have supported the use of additional planning beds where necessary.

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 is 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.

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.

www.ecip.nhs.uk/About-Us/Participants

https://www.england.nhs.uk/wp-content/uploads/2015/04/resilience-planning-assurance-letter.pdf

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 including County Wide Ambitions

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. Revision of the BCF arrangements as part of the 16/17 negotiations require that a greater collective focus and action is taken on key areas that will impact across the system, these are fully integrated and informed by work on the STP. The key workstreams are:

1. **Continuing Healthcare:** Integration of the brokerage function for CHC – led by CCG
2. **Frequent flyers (hospital admissions):** a programme devised based on evidence on reasons for admissions and clear interventions – led by CCG
3. **Care homes:** a coherent countywide programme that will focus on enhancing services and training in care homes. Again the programme will be evidenced based and will engage registered managers and GPs in supporting people better in the community – jointly led by social care and CCGs
4. **Equipment:** Norfolk already has an integrated equipment service and this workstream will focus on driving the further development of this service and increasing the reach and scope of its remit – NCC led
5. **Integrated Reablement Services:** Reablement is a key factor in managing, reducing and delaying demand for front line services. Both health and social care have excellent re-ablement services; combining these will facilitate greater impact and effectiveness while maximising efficiencies of operation – jointly led by CCGs and NCC but with leadership from the East

Detailed programmes for these themes will be developed, implemented and monitored as part of the revised governance arrangements.

In addition to the main themes above work will continue on the areas identified below. Achieving real impact on the BCF metrics requires understanding and recognition of a number of interdependences. As all acknowledge the factors that contribute to ill health and use of public services are complex and multiple. Focus on these areas will support the five key themes and the development of a more integrated system overall.

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. **Integrated Acute Discharge Hubs:** Interventions to reduce delayed transfers of care (DToC) in line with the expected national focus on DToC for 2016/17.
5. **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.

These areas, in addition to the key themes, 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.

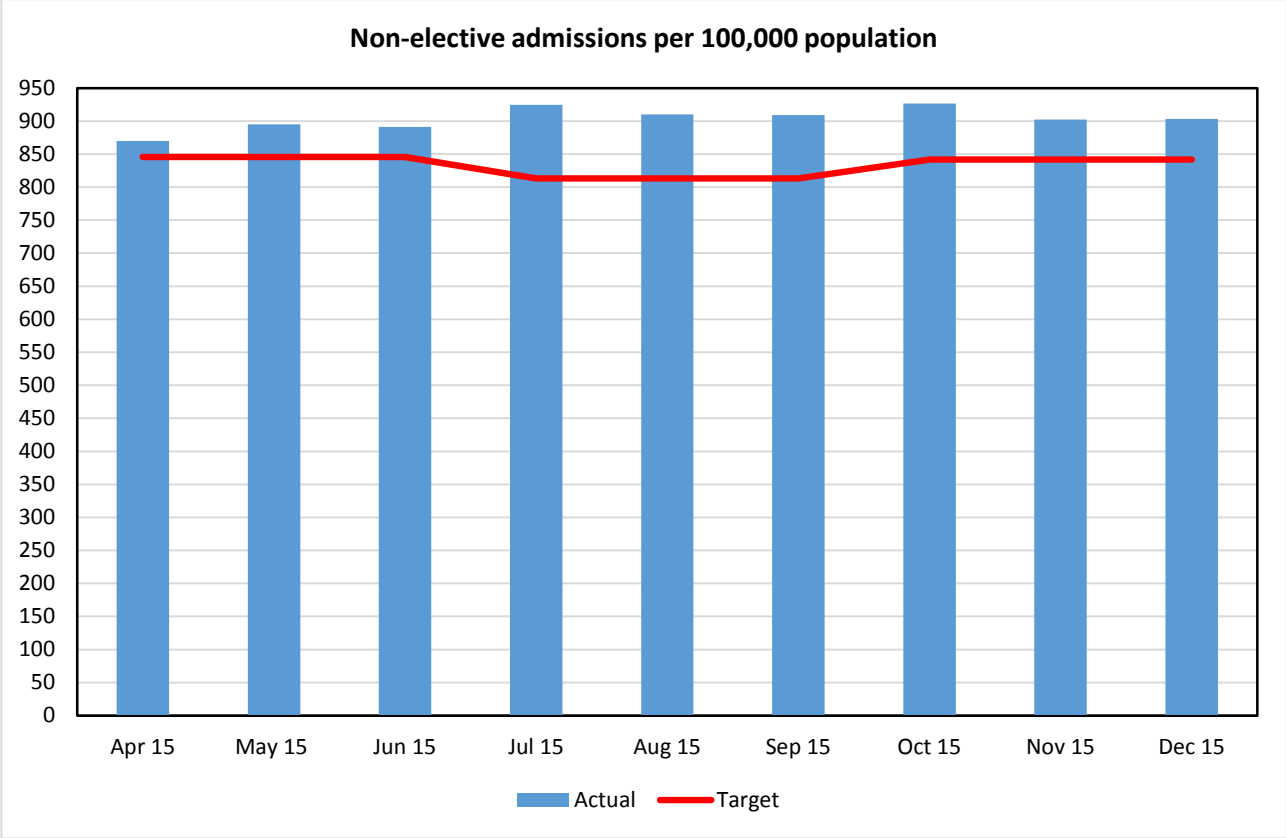
E. National Metrics

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.

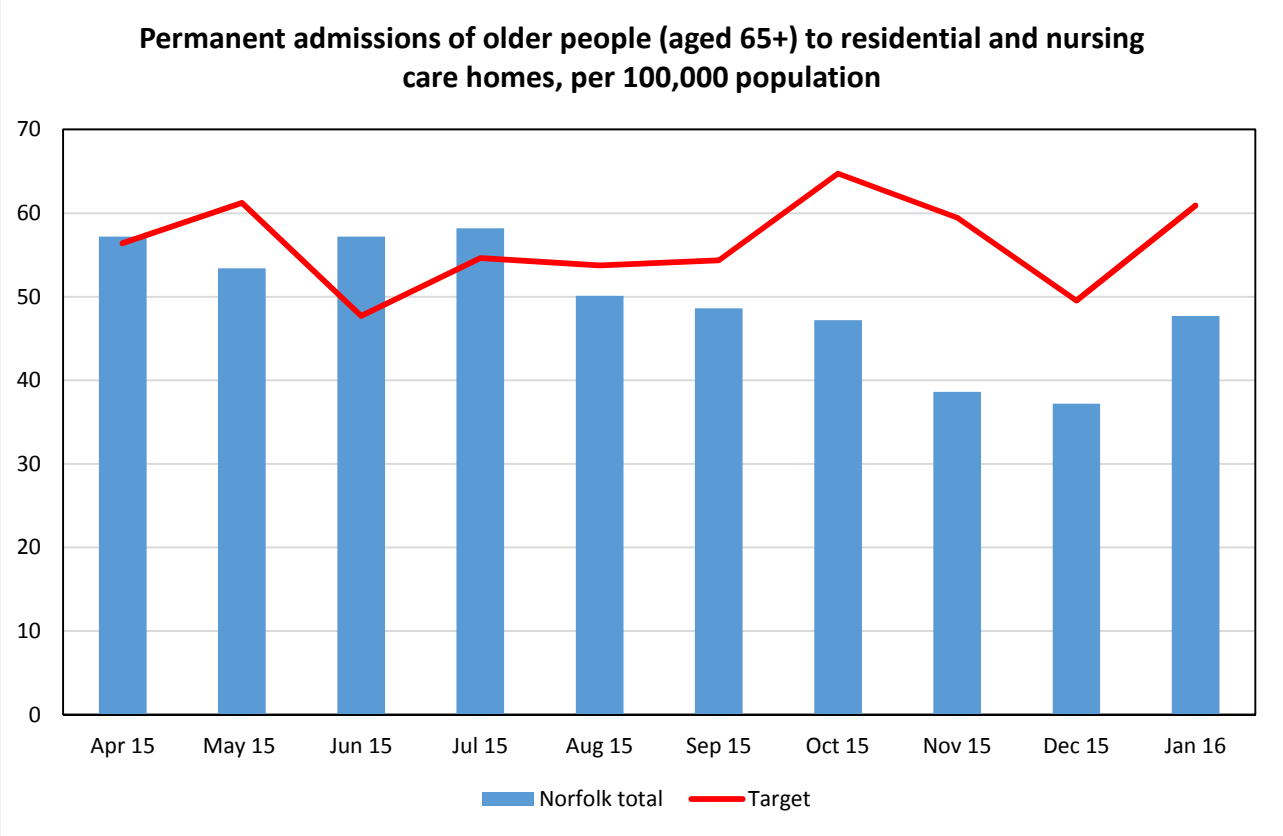
As the chart below shows, we are unlikely to meet our target for non-elective admissions in 2015/16, these have in fact increased compared to the 2014 baseline figure. It should also be noted that there is variation in performance at a CCG level and also where particular admission groups have been targeted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

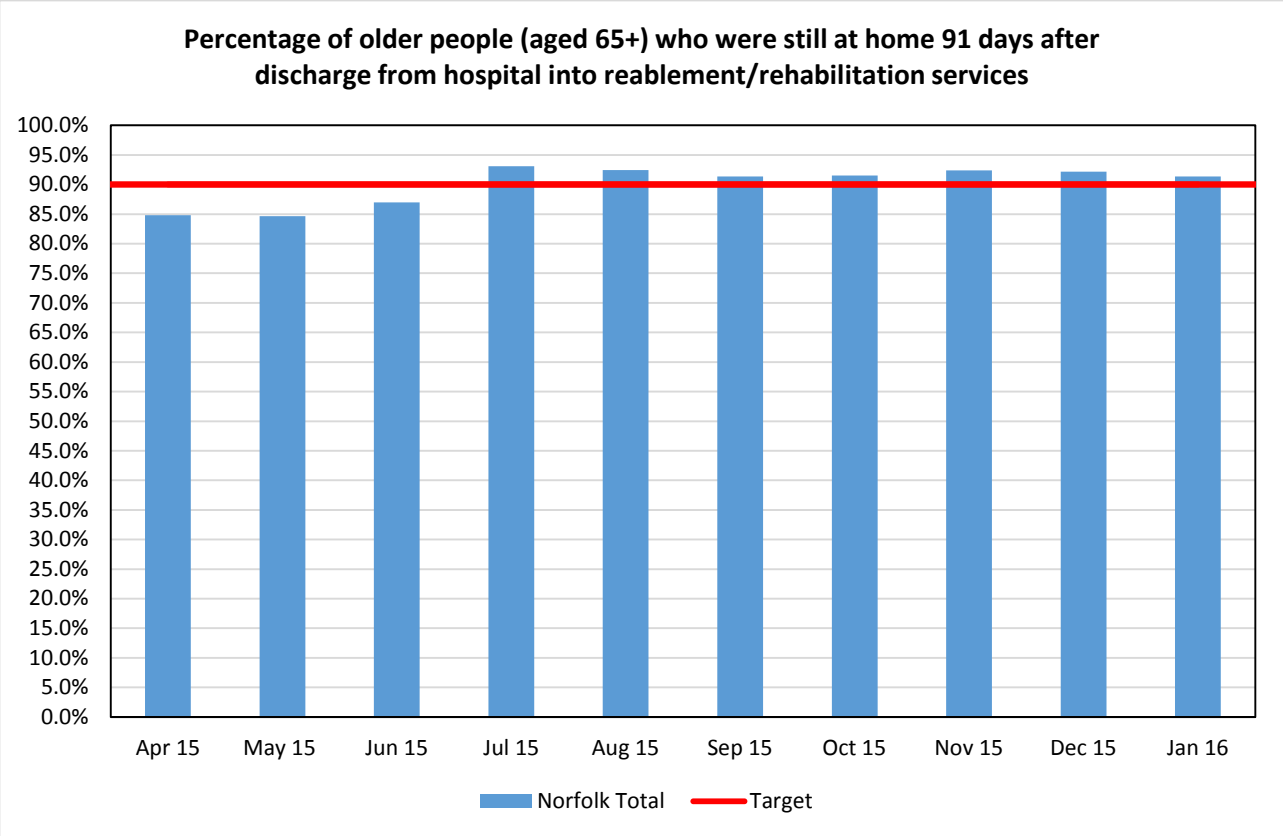


For 2016/17 our target will be a maximum of 1308 permanent admissions. This represents a 5% reduction in the number of admission compared to the 2015/16 forecast of 1377. This target is likely to place Norfolk better than the median for the family group.

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%.

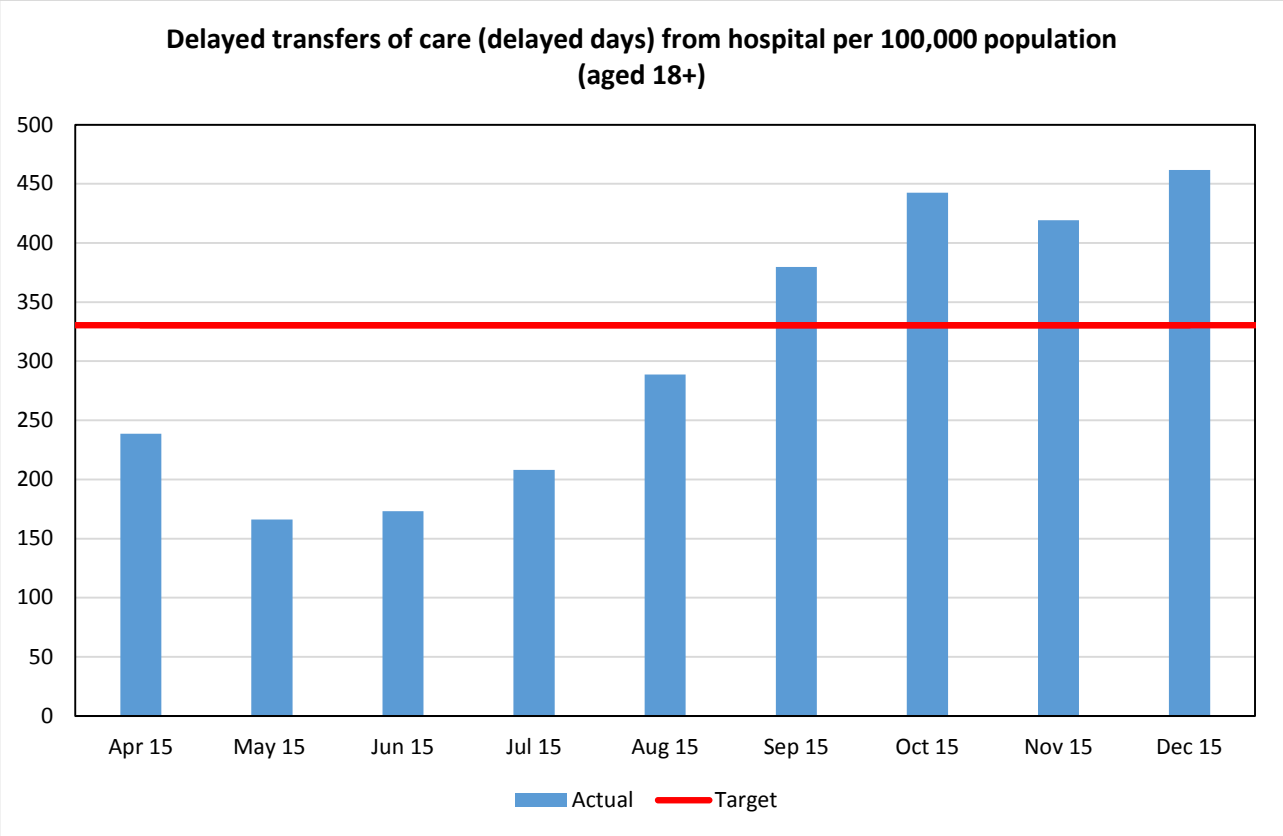
As the chart below shows, this target had been consistently met since Q2 2015/16 and as at January 2016 our performance is 91.4%. There is variation in performance at CCG level, with not all CCGs on track to meet the target.



For 2016/17 our countywide target will remain at 90%, with each CCG having the same localised target. The family group average is 83%, and so 90% represents significantly better than average performance. Given the increasing scope of reablement services in Norfolk, the focus on maximising utilisation of reablement to reduce DTOC and NEA and the planned work to integrate NCC and Health reablement services it would be unrealistic to increase this target for 2016/17.

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.
Review of progress to date
While the Scheme name remains consistent with 2015/16, the activity within it has been updated for 2016/17. A comprehensive evaluation of the schemes revealed that whilst individual work streams should continue to remain live for the CCG, the ambitions for BCF required more transformative pieces of work. Key progress for 2015/ 16 was made in the following areas • Development of joint commissioning intentions across the CCG, Great Yarmouth Borough Council and Norfolk County Council for the support and development of the voluntary and community sector. • Launch of Aging Well community based support intervention in Lowestoft, including establishment of community navigators
The evidence base
This includes:

Community based support interventions, Self-care & self-management - Patient self-management seems to be beneficial for patients with COPD and asthma.[2] [3] [4] 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.[5]

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.[6]

Carer Support Services - A systematic review and meta-analysis of cognitive re-framing for carers of people with dementia showed beneficial effects over usual care for carer mental health.

A report assessing the effectiveness and cost-effectiveness of support and services to informal carers of older people by the audit commission in 2004 showed that Day care, Home/help care and Institutional respite care (but not in all cases) may lead to delayed admissions to institutional care (and may be cost-effective).

Respite Care - A report for the Princess Royal Trust for Carers and Crossroads Care (2011)[7] 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.[8] 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)

[2] 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

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

[4] 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.

[5] 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.

[6] NIACE: Lifelong Learning: Contributing to wellbeing and prosperity http://www.niace.org.uk/sites/default/files/2010-Spending-Review.pdf

[7] The Princess Royal Trust for Carersand Crossroads Care. (2011). Supporting Carers: The case for change.

[8] 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.

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 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.

Marioka et al (2013) putting forward the NESTA Business Case for People Powered Health predict savings of 7% to an average clinical commissioning group based on NHS Level A standards of evidence. However, they suggest this is conservative with the median of all evidence considered suggesting potential savings of 20%. The 7% estimate of savings are predicted to result from reducing expenditure on A&E attendances, planned and unplanned admissions and outpatients admissions and are based on evidence cited by Marioka et al (2013).

Total Benefits	% of Average CCG Budget	Benefit per patient (£)
21	7	113

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

Review of progress to date

Progress to date has included the following;

- The Shape of the System consultation made recommendations that will be used to inform the design of the service.
- The development of South Waveney and Great Yarmouth Out of Hospital Team model following the successful implementation of the Lowestoft.

• There has been a Cost Benefit Analysis developed that enables system providers to measure the impact of this service going forward. This formula is likely to be used to determine the viability of future projects.
The evidence base
This is a continuation of Scheme 2 in the 2015/16 BCF Plan and the evidence base remains the same.

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
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.

Falls Programme

Ensure that there continues to be a clear focus on falls prevention which is clearly aligned to strategic activity happening across each County Council.

Review of evidence to date

While the scheme name remains consistent with 2015/16, the activity within it has been updated for 2016/17. A comprehensive evaluation of the schemes revealed that whilst individual work streams should continue to remain live for the CCG, the ambitions for BCF required more transformative pieces of work.

- Key progress for 2015/ 16 was made in the following areas: development of combined service specification for Home Support (Social Care provision) and Universal Continuing Health Care (Health provision) across Great Yarmouth and Waveney.
- Jointly commissioned providers for the delivery of Domiciliary Care and universal Continuing Health Care in the Great Yarmouth area
- Deployment of additional Nursing resource to support NHS Continuing Health Care, fast track end of life provision
- Co-production of Urgent Care Operational Dashboard including; 111, Out of Hours, Ambulance, Community, A&E Attendance and Emergency Admissions with the aim of sharing system information
- Development of Great Yarmouth and Waveney Integrated System Resilience Plan

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.[9] 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.

[9] Lewin GF et al 2013 - Evidence for the long term cost effectiveness of home care reablement programs. Clin Interv Aging. 2013;8:1273-81.

Glendinning et al (2010) showed that there is a 60% reduction in social care costs for those receiving reablement.[10]

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.[11]

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.[12]

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.[13]

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.[14]

Tele care and Dementia Care: The British psychological Society (2007) recommends that dementia care plans should include environmental modifications to aid independent functioning.[15]

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 traditional care.[16] Tele care in North Yorkshire project evaluation estimates one year savings in care packages of £1 million.[17]

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.

[10] 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

[11] Crocker T Physical rehabilitation for older people in long-term care. Cochrane Database Syst Rev. 2013 Feb 28;2:CD004294.

[12] 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

[13] Muller I, Telephone-delivered cognitive behavioural therapy: a systematic review and meta-analysis. J Telemed Telecare. 2011;17(4):177-84.

[14] E.A. Tchalla, et al The effect of fall prevention and management technologies Gerontechnology 2012; 11(2):347

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

[16] Evaluating telecare and telehealth interventionsWSDAN briefing paper: http://www.kingsfund.org.uk/sites/files/kf/Evaluating-telecare-telehealth-interventions-Feb2011.pdf

[17] 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

The cost effectiveness of Home adaptations – a report by The University of Bristol based on a review of case studies revealed: [18]

- 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. 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.

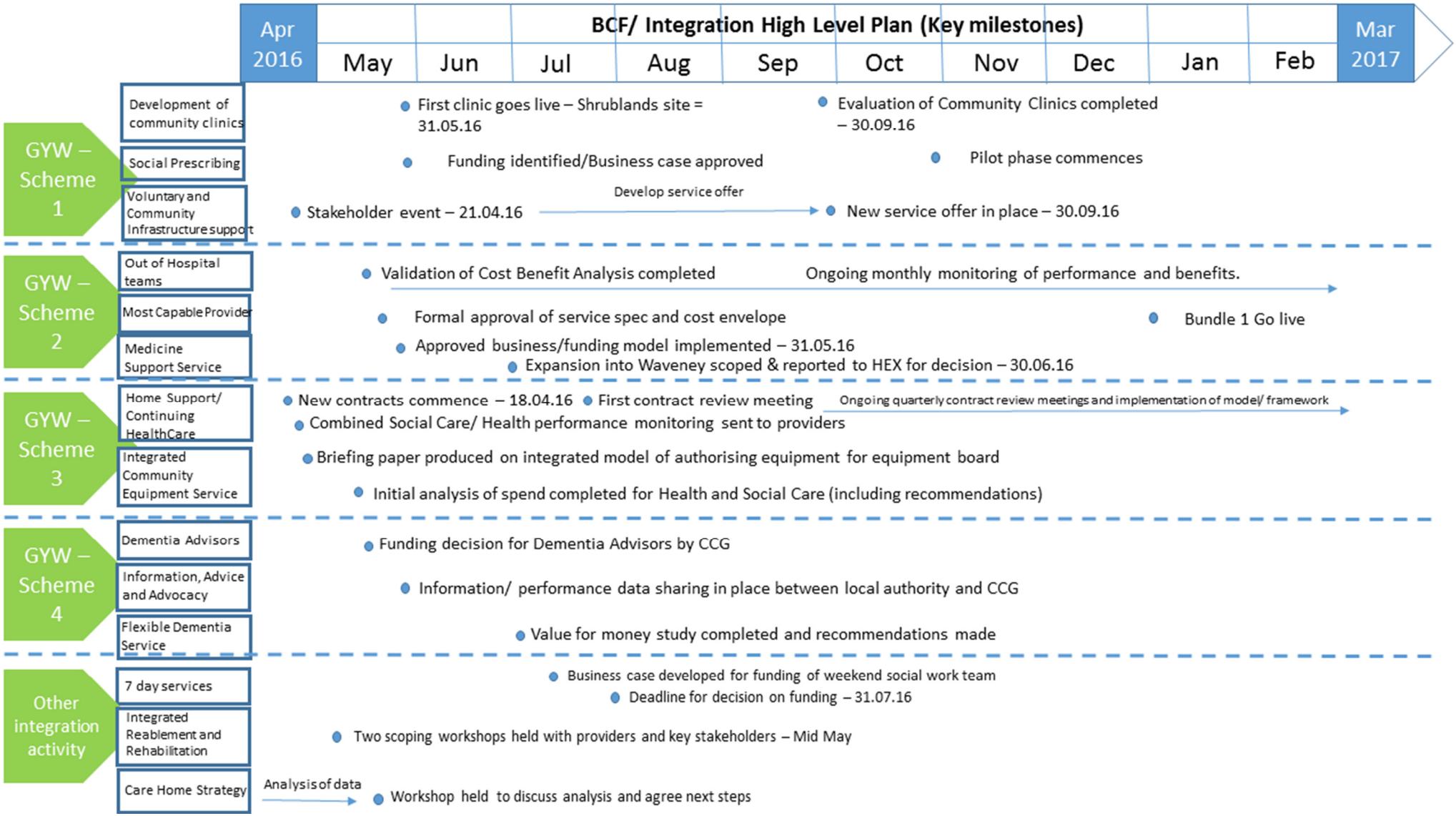
Marie Curie Delivering Choice Programme: The Marie Curie Delivering Choice Programme showed a significant variation in the quality of end of life care and also showed a need to improve the education and training for generalist staff providing palliative and end of life care (Marie Curie Delivering Choice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

[18] 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

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.
Review of progress to date
Progress to date includes the following; • Improvement in Diagnoses rates for dementia due to local actions being implemented • New project being implemented on targeting those with LTC and pain management • Well-being service commencing in Sept 2015 • Enhanced Crisis-Resolution team and Acute Psychiatric Liaison service in place • All individuals who access Mental health service will have a crisis plan and a named care co-ordinator
The evidence base
This is a continuation of Scheme 4 in the 2015/16 BCF Plan and the evidence base remains the same.


BCF/ Integration High Level Plan (Key milestones)
Apr 2016
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar 2017
GYW – Scheme 1
Development of community clinics
Social Prescribing
Voluntary and Community Infrastructure support
First clinic goes live – Shrublands site = 31.05.16
Evaluation of Community Clinics completed – 30.09.16
Funding identified/Business case approved
Pilot phase commences
Develop service offer
Stakeholder event – 21.04.16
New service offer in place – 30.09.16
GYW – Scheme 2
Out of Hospital teams
Most Capable Provider
Medicine Support Service
Validation of Cost Benefit Analysis completed
Ongoing monthly monitoring of performance and benefits.
Formal approval of service spec and cost envelope
Bundle 1 Go live
Approved business/funding model implemented – 31.05.16
Expansion into Waveney scoped & reported to HEX for decision – 30.06.16
GYW – Scheme 3
Home Support/ Continuing HealthCare
Integrated Community Equipment Service
New contracts commence – 18.04.16
First contract review meeting
Ongoing quarterly contract review meetings and implementation of model/ framework
Combined Social Care/ Health performance monitoring sent to providers
Briefing paper produced on integrated model of authorising equipment for equipment board
Initial analysis of spend completed for Health and Social Care (including recommendations)
GYW – Scheme 4
Dementia Advisors
Information, Advice and Advocacy
Flexible Dementia Service
Funding decision for Dementia Advisors by CCG
Information/ performance data sharing in place between local authority and CCG
Value for money study completed and recommendations made
Other integration activity
7 day services
Integrated Reablement and Rehabilitation
Care Home Strategy
Business case developed for funding of weekend social work team
Deadline for decision on funding – 31.07.16
Two scoping workshops held with providers and key stakeholders – Mid May
Analysis of data
Workshop held to discuss analysis and agree next steps

Ref	Date	Scheme number	Risk	Initial Risk Score	Actions in Place	Current Risk Score	Target Risk Score	Progress Update	Project Manager Responsible	Open/ Closed
1	Dec-15	Savings/ Risk Share	**Significant budget pressures / risks to both NCC and CCG if savings not achieved to fund the identified BCF schemes**	15	Close monitoring required and mitigating actions put in place as required	20	2	Agreed that savings would not be achieved and cost pressure esaclated within the CCG and Local Authorities	Chris Scott/ Bob Purser	Closed
2	Dec-15	7 day services	**Current funding of Social Work team at the James Paget University Hospital is only temporay and available until the end of July. If no sustainable funding can be approved, then this weekend service will be unable to continue**	15	Business Case required tro be presented that clealry outlines activity happening at the weekend and how this is supporting timely discharge of patients	15	2	Meeting held with Social Work team and data requirements agreed. Resource identified to work with Social Work team to collate data, complete analysis and present Business Case	Clare Angel	Open
2	Jan-16	Scheme 2	**Unable to extablish clear impact of Out Of Hospital Team to support future development of this servrice**	16	Cost Benefit Analysis tool developed using Treasury approved New Economy Model developed by Manchester University. This has reported clear benefits achieved through this model to both health and social care. Findings presented to BCF Partnership Board in March 16.	9	4	BCF Partnership Board agreed that this tool should be validated. Agreed this validation would be led by the PMO function and reported to the BCF Partnership Board. This validation will also explore the potential uses of this tool in other services to establish cost benefits analysis	PMO	Open
3	Jan-16	Scheme 3	**Delay in Home Support procurement/ re-commissioning for Waveney could result in different types of service being delivered across Great Yarmouth and Waveney**	6	Await outcome of review of roll out of Home Support procurement for the Waveney area. Once timeline is established consider interim arrangements that could be put in place to ensure equitable delivery of this model across the CCG area	6	2	Await outcome of review	Bob Purser	Open
4	Jan-16	Scheme 3	**The re-commissioning of the block contracts for Home Support included an expectation that providers will be approached as the 'preferred provider' for Continuing Health Care universal packages of care at the block rates quoted for social care. Risk that providers will not be able to deliver against this requirement or do not want to due to the lower houlry rate paid for social care packages. Impact is no cost savings realised or improvements to the patient/ service user pathway between health and social care**	16	Briefing session with providers to discuss this key point for their feedback. Ensure robust contract monitoring and management in place to identify areas for discussion with providers	16	6	Briefing sessions held with providers, jointly delivered by Head of CHC and Head of Integrated Commissioning which were well received. Process for effective performance management put in place to ensure we are able to identify where this is happening.	Chris Scott/ Dawn Newman	Open
5	Feb-16	Scheme 4	**Funding for Dementia Advisors for Great Yarmouth area not yet approved**	12	Business Case to be completed and decision by HEX required	12	1	Paper has been drafted and needs to be finalised. To be added to HEX agenda for required decision making	Kim Arber	Open
6	Feb-16	Scheme 4	**Identified that there is a lack of activtiy data for the jointly funded (CCG and Local Authority) Information, Advice and Advocacy services being received by the CCG. Ageed if this continues will be unable to continue to justify funding this service**	15	Commissioning to establish reporting loop between Norfolk County Council and CCG	15	1	Awaiting apointment of Commissioning Support Officer in the Integrated Commissioning Team sp resource can be made available to take this forward	Chris Scott	Open
7	Apr-16	Scheme 1	**Equitable service delivery across Great Yarmouth and Waveney. This is influenced by the funding that the district/ borough councils access and/ or provide to support the development of community resources**	9	Ensure that any funding provided for services by the CCG and/ or Local Authority delivery against agreed strategic principles for community development across Great Yarmouth and Waveney	9	4	Nicole Rickard (Head of Communities) who works in a joint post funded by the CCG and Waveney District Council is involved in the development of the furture support offer to develop community resources within Great Yarmouth	Chris Scott/ Bob Purser	Open
8	Apr-16	Scheme 1	**Lack of awarness of community resources that current exist that support the prevention agenda. This couold result in a lack of being able to support and sign post service users effectively to community resources that are available, impacting on the successful implementation of Community Clinics and Social Prescribing**	12	Within Great Yarmouth, Asset mapping work has started to establish community assets that are available. Need to develop this approach across the whole of Great Yarmouth and Waveney, also need to link resources to depreviation data to inform how commissioners can support the furture development of community resources	12	4	Integrated Commissioning Team to attend presentation on asset mapping work completed by South Norfolk to establish best practice	Chris Scott	Open
9	Apr-16	Scheme 2	**Financial envelope insufficient for new service model/predicted increased demand and the costs associated with transformation. Failure to meet defined process deadlines triggers full procurement exercise.**	15	High quality data in relation to costs should enable discussions with CCG to develop service models to fit the available envelope. If the financial envelope cannot support the proposed service model then further dialogue with the CCG will be required around the next steps. Create plan with clearly defined deadlines, identify both key resources and critical path. Monitor progress once plan established.	12	6	Dialogue Negotiation Phase extended to end of May 2016. Service specification and Cost envelope to be drafted for Governing Body meeting July/August 2016. Contract Managers working to support JV on finalising service line costs.	Fran O'Driscoll	Open
10	Apr-16	N/a	**Resources required to complete data collation/ analysis required to develop market statement concerning commissioning intentions for Care Home market (by the CCG and Local Authorities) across Great Yarmouth and Waveney area**	8	Plan resources required with key people required to complete this work	8	2	Initail conversations held and work postponed until May until resource is available	Bob Purser	Open

Risk Matrix

Consequence (impact) / **Likelihood**

	Rare 1	*Unlikely 2*	*Possible 3*	*Likely 4*	*almost certain 5*
Negligible 1	1	2	3	4	5
Minor - 2	2	4	6	8	10
Moderate- 3	3	6	9	12	15
Major - 4	4	8	12	16	20
Catastrophic- 5	5	10	15	20	25

Low risk	normal risks which can be managed by routine procedures, no injuries, low financial loss.
Moderate Risk	responsibility for assessment and action planning allocated to a named individual. Outcomes – first aid
Significant Risk	urgent senior management attention with action plan – significant injury, business interuption, high environmental implications, high financial loss and loss
High Risk	immediate action required by a Director – fatal risks, to life and business, catastrophic loss.

N.B. if controls are inadequate or uncertain, the current risk stays the same as the initial risk rating. If they are perceived as adequate, then the current risk is reduced.

change in status since last report

same	No arrow	first reporting of risk
increased risk	Score shows previous reported score	
decreased risk		

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:

- 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

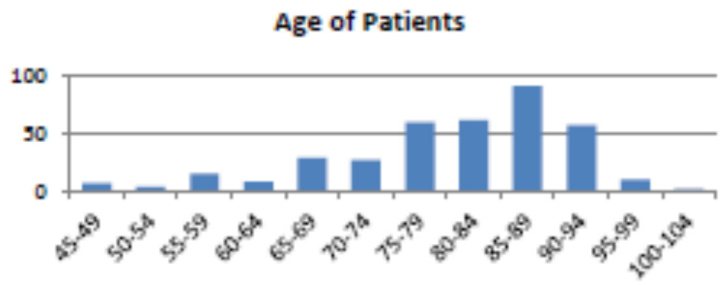
The 2015/16 BCF Dashboard is showing progress towards targets and in particular:

- 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

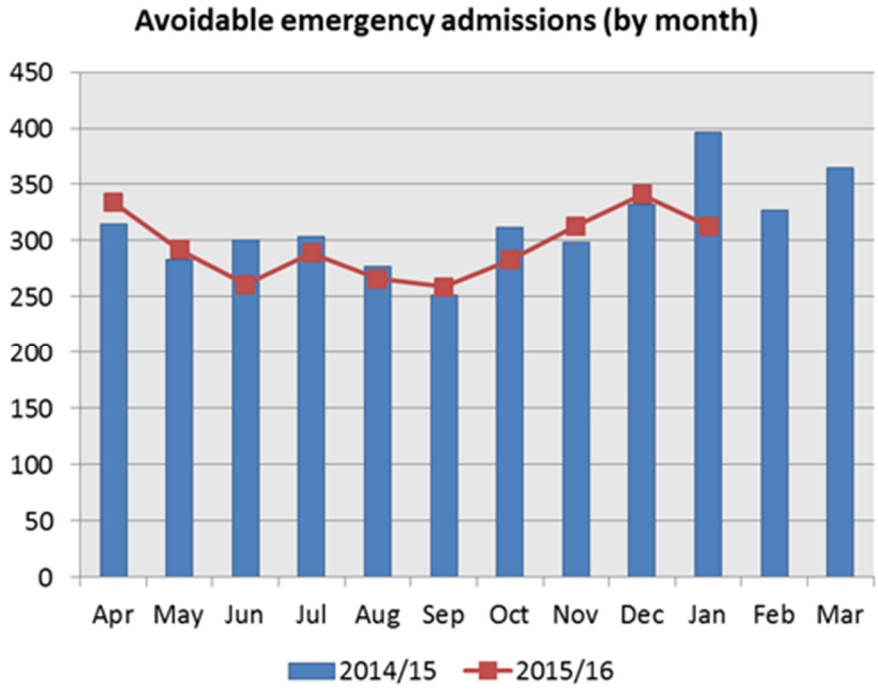
	Emergency Admissions Activity			
CCG Name	2014/15	2015/16	Diff	% Diff
NHS North Norfolk CCG	**12,848**	**12,719**	**-129**	**-1%**
NHS Norwich CCG	14,897	15,687	790	5.30%
NHS South Norfolk CCG	15,841	16,151	310	2.00%
NHS West Norfolk CCG	16,559	17,521	962	5.80%
Total	**60,145**	**62,078**	**1,933**	**3.20%**

- 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 promoting independence, and understands integrated working.	Every funded voluntary sector service can demonstrate how they are supporting people to 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	SAG convened to develop proforma May 2016

patient specific information about their condition easily. Peer Support best practice is researched and a programme for implementation developed.	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
Home support 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 (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

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 standalone 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	**£220,000**

Green Envelop Scheme and the delivery of workshops to develop and implement to LTC pathway.	

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
New primary care model designed and implemented at Bowthorpe Care Village	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:

Scheme budget projected at £707,847 in 2016-2017.

This will deliver:

- A new model of primary care with shared services, extended availability and focus on keeping patients out of hospital.
- Bowthorpe Care Village primary care model with a multi-specialty team providing best practice for dementia, falls and end of life care, and the "active aging" of vulnerable patient cohorts avoiding hospital admissions.
- Integrated care co-ordination ensuring joined-up care across all health and social care professionals.
- Improved medicines management with better targeting and reduction of waste.

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 model takes longer to implement than the BCF project timescale.	3	3	9	Phased rollout of the new model and exemplary practice.
Norwich practices reject the model creating a patchwork of different arrangements.	2	4	8	Project team working closely with each practice and with NPL to ensure transition is beneficial and straightforward. Norwich events held to promote the new model and listen (and act on) concerns raised.
GP Practice time commitment constrained by workload pressures leading to implementation delays.	3	2	6	Project team and NPL working closely with each practice to understand local issues and provide support.
The three main providers in Norwich are undergoing organisational challenges reducing capacity to implement the new model.	3	2	6	Providers actively involved in planning and implementation of project.

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.
- 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 full business case)

Provision of a new, integrated rehabilitation and recovery service offering long-term support to people with complex mental health problems (psychotic illnesses and personality disorders) enabling them to stay well in the community and self-manage their illness. Existing residential beds and supported living placements will be redesigned and a new community reablement model implemented. 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 complex and 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)
New interim model for mental health reablement and rehabilitation rolled out	March 2017

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

Scheme budget projected at £5,531,200 in 2016-2017.

Note that this excludes the Mental Health initiative which is going through the approval process.

This will deliver:

- 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.
- Targeted provision of equipment to ensure people are supported to remain at home reducing need for acute care and premature admission to care homes.
- Social care services providing early intervention and support to prevent health crises. Enabling people with LTCs to manage their conditions at home and timely hospital discharge through Norfolk First Support.
- A new mental health rehabilitation and recovery model with assessment and support for people with mental health problems integrated with health and social care provision. Increased management of mental health problems within the community.

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 may not be agreed by central Norfolk CCGs delaying or stopping the project.	3	3	9	Business case being tabled at each CCG and at Joint Commissioning Executive. Alternative funding arrangements may need to be investigated.

12. NCH3 – Out of Hospital - HomeWard

Scheme ref no:

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
Age UK Promoting Independence service (community reablement and support) integrated into HomeWard	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 out of area community inpatient admissions
- 17% reduction in out of area 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:**

Scheme budget projected at £4,507,800 in 2016-2017.

This will deliver:

- An expanded virtual ward treating more patients in the community, reducing the need for acute hospital beds and associated A&E attendances and ambulance conveyances.
- A community gateway integrating primary, acute and community health and social care (including voluntary and charitable sectors).
- A new rapid response service comprising multi-disciplinary assessment and intervention with emphasis on non-acute pathways.
- Expanded community IV therapy treating patients on specific care pathways, avoiding hospital treatment costs.
- More patients admitted to the Norwich community hospital (Alder Ward) avoiding the additional expense of out-of-area admissions.

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
Additional investment for phase 2 not agreed	3	3	9	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.

A primary delivery is the establishment of a new community engagement model at the Bowthorpe Care Village.

The overall objective of the scheme 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 model for community engagement providing dementia support in residential care homes and housing with care.

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.

Community Engagement Model (Bowthorpe)

A new model of community engagement will be developed with support from the voluntary and charitable integrated with health and social care for people with dementia. The model will include both support in a residential care home and also in a housing with care setting. The engagement model, once evaluated, will be rolled out to other residential homes and housing with care in the Norwich area.

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
- A new community engagement model for people with dementia piloted
- 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

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
- More patients with dementia supported in residential care homes and housing with care schemes reducing placements in nursing homes and admissions to hospital
- 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
- Summary care plan available to all agencies providing health and social care at the Bowthorpe Care Village

6. Key milestones / activities:

Milestone / activity	Timescale
Targets and measures set for year 2 of Promoting Independence pilot	April 2016
Summary care plan shared by all providers of health and social care available for all residents and patients at the Bowthorpe Care Village	September 2016
Community engagement model for dementia support developed and piloted at Bowthorpe Care Village	September 2016
"Help at Home" model implemented for self-care	October 2106
Community engagement model for dementia support evaluated and rollout commenced to other Norwich residential care homes and housing with care schemes	December 2016
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:

Scheme budget projected at £2,667,000 in 2016-2017.

This will deliver:

- Improved and targeted reablement support in the community harnessing local, voluntary and charitable sector organisations. The outcome will be reduced hospital and care home admissions and readmissions. Patients will be supported to manage their conditions in the community.
- Support for carers, improving their own health and wellbeing and that of the people they look after. The need for crisis care will reduce.
- Implementation of the Care Act.
- Earlier health and social care interventions to avoid the worsening of conditions and need for acute care.
- Integration of voluntary sector support into health and social care, providing additional capacity and specific local community support.

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.

Risk Assessment Tool:

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

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

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

1. 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. In this main scheme proposal and in the other proposed schemes the SNCCG locality wishes to maximise the opportunity for joint planning and work with the other Norfolk CCGs and Norfolk County Council where this would be the most cost effective approach and create system wide change at scale.

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 health and social care teams for people with complex needs and ensure that these teams are able to effectively manage a range of long term conditions including physical health, mental health, and dementia
- Support these teams with specialist medical input and effective pathways particularly for older people
- Create flexible and responsive services that offer reduce hospital stay for people who do not have a medical need to be in hospital
- Provide resources and approaches which help people better manage aspect of their own long term conditions through education and mutual help
- Build an infrastructure to support the model which includes the ways 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

The SNCCG locality would want to build on the experiences of coproducing projects by leading a public and consultative approach to the redesign of community services with people living in our communities, GPs and service providers as key participants in this process.

Evidence base

To assist with planning Public Health produced a revised Joint Strategic Needs Assessment - “NHS South Norfolk CCG – Developing an understanding of health and wellbeing, 2016”. This describes the demography, health status and impacts of deprivation on the locality population.

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.

2. 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.

3. 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	July 2016
Understand what the data and information tells us about where the stress points are in respect of supporting more patients at home and avoiding admissions to acute and higher care	July 2016
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	Sept 2016
Lay out options and undertake public consultation	March 2017 with further consultation and a planning framework which allows for wider public involvement in planning
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
Recommission independent health beds on an interim basis to achieve some levels of saving by reducing the block provision	June 2016
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 – some of this work will be undertaken with other CCGs through an SDIP with the community health provider	June2017
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.	Sept 2017

Remodel community based nursing and therapies to ensure there is adequate expertise to support locally based management of long term conditions	Sept 2017
Develop home care as a very responsive service with strong links to locality based health delivery	April 2017
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	July 2017
Fully introduce new community services model	April 2018
Engage in locality based planning approaches with District Council authorities and collaborate on the development of locality based buildings which offer a base for larger integrated care teams, community diagnosis facilities and community resources	April 2020

4. Value for Money

Potential Cost of Scheme/ value of existing services in the SNCCG BCF	Potential Efficiencies
£12,500,000	Reduction in demand for acute beds through increases in preventable admissions, more responsive community services, reduced lengths of stay in bed based care, improved targeting of services and increasing the numbers of skilled and knowledgeable patients and carers

5. 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

6. Metrics

Outcomes	How will this be measured
Individuals are able to remain living independently for longer.	BCF dashboard (reablement measures); health and social care data on numbers of patients using residential and nursing care; provider data on length of stay in temporary bed based care
Avoidable admissions to acute are reduced	SUS data (NHS dashboards)
Admissions to residential and nursing care are reduced as more people are supported to maintain independent living.	health and social care data on numbers of patients using residential and nursing care; provider data on length of stay in temporary bed based care
Reduction in delayed transfers of care	Data on length of stay in acute, community health and social care planning and reablement beds

7. Risks and mitigation

Identified Risks	Likelihood	Impact	Score	Mitigation
Commissioners and providers do not manage to look beyond organisational interests/ concerns and achieve the level of integration needed to transform services effectively	2	4	8	There are already some integrated commissioning and delivery models in place locally and an increasing volume of examples about the approaches taken by other systems to transform and integrate services to draw on
Lack of capacity and high levels of demand mean that contracting and service delivery arrangements are rolled over and transformation is not seriously engaged with	3	4	12	Current delivery arrangements are not affordable and will not impact on demand. Commissioners and providers will need to make capacity to take forward. Timescales need to be adequate
Transformed community services fail to impact demand for bed based care and/ or turn out to be more expensive	3	3	9	Any plans are based on strong modelling of benefits, impacts and costs
There is public and provider opposition to plans which include the closure of beds and other services	3	3	9	It is proposed that any transformation is dome in a very public way with a strong communications and engagement plan
The size of the this plan and the priority accorded by SNCCG to bringing the budget back into balance mean that the plan is unlikely to deliver positive impact on metrics in 2016/17	2	4	8	The will need to be a balance between savings activities and transformative activities (which are also required as part of the expectations for the Sustainability and Transformation plan) allied to strong project management focussing on deliverables within this plan for 2016/17

15. SN2 – Reducing delayed transfers of care

Scheme 2 – Reducing delayed transfers of care

1. 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).

2. 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

3. Key Milestones & Activity

Key Milestone or Activity	Timescale
Establish processes for detailed and common understanding for DTOCs across the acute system	April 2016
Ensure daily validation and review of all for all DTOCs	April 2016
Establish and maintain a smooth process for escalation and actions to unblock DTOCs with each partner clear about their responsibility	April 2016
Ensure that pathways for patient with complex needs are effective including Continuing Health Care pathways and Discharge to Assess	July 2016
Open discussions with NCC regarding attribution of DTOC costs	April 2016
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 (North Norfolk scheme 5).	May 2016
Work with Age UK and NCCG to use underutilised respite service for discharge with reablement	April 2016

4. Value for Money

Potential Cost of Scheme/ value of existing services in the SNCCG BCF	Potential Efficiencies
£500,000	Savings on the reduction in Delayed Transfers of Care

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

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) Care home providers

6. Metrics

Outcomes (from 3 above)	How will this be measured
Reduce Delayed Transfers of Care	Reduction in numbers of beds lost to DTOCs; Increase in daily discharges; Reduced length of stay in acute and community hospital; Improved patient experience (surveys)

7. Risks and mitigation

Identified Risks	Likelihood	Impact	Score	Mitigation
Reductions in bed capacity and emphasis on community discharge without an increase in community resources increases pressures in primary care and community services	3	4	12	
Reduction in bed based care impacts on care homes provider market and makes	2	4	8	Market for care homes is adequate for current levels of demand partly because of

in more difficult to discharge people during periods of crisis				numbers of fee payers but other factors could also reduce this market

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

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

1.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:

A. 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.

B. 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.

2. 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

3.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
Work jointly with central CCGs, Ambulance Trust and 111 to trial access to clinician for homes which make the greatest use of the ambulance service	Establish pilot by Jan 2016 – review and extend if positive impacts on ambulances calls and conveyance to hospital
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	June 2016
Deliver training to care homes in agreed localities and measure impacts	June 2016
Consult with all key stakeholders on preferred care homes support delivery option and adapt proposal in the light of consultation	June 2016
Scope options for an out-of-hours point of contact to support care home providers in managing exacerbations of long term conditions – in light of system wide trials	June 2016
Scope options for providing additional support, clinical advice and guidance to care homes to support a reduction in admissions linked to conditions including UTI's and long term conditions and pneumonia's.	April 2016
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	May 2016

4. Value for Money

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

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

Activity	Provider/s
Training: delivering training to care home staff	Residential care and nursing care providers; Community Matron posts; 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)

6. Metrics

Outcomes (from 3 above)	How will this be measured
Reducing emergency/unplanned acute admissions	Analysis of SUS data on admissions from care homes;
General reduction in costs and use of services such as 999, 111/OOH	Ambulance Trust data on call outs and conveyance to hospital
Reduction in development of particular conditions at the care home level including UTIs and falls related injuries	Frequency to be measured by provider with care home as part of participation through the course of an after training and support programme delivery
Reduction in the level of support needed from primary care to care homes	Information from GP on care home emergency call outs

7. Risks and mitigation

Identified Risks	Likelihood	Impact	Score	Mitigation
Lack of engagement from practices and care homes resulting in an inconsistent approach across the locality	**2**	**3**	**6**	Clear communication strategy to be developed and implemented. Regular reporting of progress to GP Practices and care homes
Lack of capacity within care homes to undertake training and development	**3**	**3**	**9**	Require provider to deliver training at target homes to maximise attendance
The training and direct support has limited impact because there is limited resource to address the volume of admissions to acute which are evenings and weekends	3	3	9	Collaborate with central system CCGs and other stakeholders to deliver and evaluate pilot access to a clinician out of hours for homes managers

17. SN4 – Improved end of life care

Scheme Title - Scheme 4 – improved end of life care

1.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 summarises the evidence from The Kings Fund for structured end of life care pathways and evaluation of Marie Curie community based nursing care.

'Ambitions for Palliative and End of Life Care' (The National Palliative and End of Life Care Partnership – 2015) provides a detailed framework for local priorities and summarises the case for change.

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

2. 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

3. Key Milestones & Activity

Key Milestone or Activity	Timescale
Improve communication for people and their families at end of life	Improve use of yellow folders/ my wishes folders for advanced care planning; Scope how telephone support can be available 24/7 for carers of people who are at end of life – March 2017;
Co-ordination	Fully roll out EPACCS; Establish effective responsibility for leading care co-ordination – March 2017;
Integration	Develop models for how statutory and voluntary sector providers can collaborate to deliver co-ordinated care including hospice at home (linked to SN1 plan for community health and care reconfiguration); ;
Education	Design and prioritise an integration approach to training including having difficult conversations and advance care planning; - March 2017 Ensure care homes have access to "6 steps" education programme – July 2016
Bereavement	Improved information about and signposting to bereavement support – July 2016 Improved pathways for access to bereavement support for all age-groups – March 2017

4. Value for Money

Potential Cost of Scheme/ value of existing services in the SNCCG BCF	Potential Efficiencies
£1,000,000	Potential savings through reduction in preventable admissions and excess bed days in acute and community hospital for patients who are at end of life

5. 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;	Hospice provision; Red Cross Home from Hospital;

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)	Red Cross Older People's Outreach Service; Norfolk Voluntary Services; Red Cross Equipment provision; Macmillan Nurses

6. Metrics

Outcomes (from 3 above)	How will this be measured
Reduction of admissions to hospital and higher care settings;	SUS data; BCF measurement covering admissions to care homes
Increase in numbers of people dying in their preferred place of care	Locally designed measurement to be confirmed

7. Risks and mitigation

Identified Risks	Likeli hood	Impact	Score	Mitigation
There is no new money to invest and the current level of service provision is not sufficient to delivery improved care	3	3	9	There are significant links with SN1 (transformation of community provision) and some of the proposed activities would not require significant additional spend
The ability to increase training and flexible support is compromised by capacity limitations to offer training, for providers, to release staff for training and for flexible support for example through home care	3	4	13	Look to make links with delivery plans for community services redesign and care homes support to build capacity

18. WN BCF 1 – Development of Community Care Teams around GP Practices

What are the strategic objectives of this scheme?

The overarching vision for this scheme is to provide more coordinated, multi-disciplinary, community care support to vulnerable people to improve their experience and outcomes. This will result in reduced use of acute services.

The strategic objectives to achieve this are:

- Risk Stratification

Risk profiling tools will be used to identify at risk people, including:

  - End of Life
  - Complex Case Management
  - Frail, Elderly

- Joint Assessment

Shared access to health and social care records (via ICCs) to enable joint assessment and care planning at MDT meetings.

- Prevention

Generally, MDTs can be reactive, focussing on supporting patients who are already in receipt of acute services. Through optimised risk stratification and joint assessment, a key objective will be to enable MDTs to provide improved support to patients prior to crisis. In particular, there will be a focus on supporting frail, elderly patients, linking in to wider initiatives to support this group, such as through Care Navigators. This will improve patient outcomes and release capacity within the system

- Increased throughput and application of best practice across West Norfolk

Having refined the current MDT approach, in alignment with wider initiatives regarding frailty and intermediate care, it is anticipated that increased numbers of patients can be supported. This will be achieved through making greater use of Integrated Care Coordinator (ICC) capacity (and potentially increasing ICC capacity) and applying best practice more consistently across West Norfolk.

- Enhanced utilisation of community services (including 7 day services)

The scheme will support further development of MDT utilisation of existing community services, including voluntary sector services, across 7 days. This will be achieved through optimising use of the ICC service to arrange services. This will include greater use of services that address non-clinical needs, such as the Care Navigator Service.

What are the intended impacts of the scheme (outcomes)

Objective	Impact
Risk Stratification and Prevention To implement a risk stratification model to identify vulnerable patients in need to MDT support. This will include proactive identification of patients prior to rapid escalation of needs, with a particular focus on frail, elderly people.	Provide a more sophisticated mechanism to identify and manage patients with complex health and social care conditions
Joint Assessment To establish a standard MDT format across all GP practices. This will include mental health and LD	A joint approach to assessment and care planning will ensure that all 'at risk patients' are regularly

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	reviewed and proactively directed to appropriate care for their individual needs
Increased Throughput and Consistent Best Practice To implement a community care team framework around the Practices 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
Enhanced Utilisation of Community Services To audit the ICC referral pathway	Ensure that all ICCs are working is the same way following identified referral routes, optimising use of community services
7 Day Services 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.

What are the key success factors for implementing this scheme

Key Milestone or Activity	Timescale
Updated West Norfolk NCH&C Community, Nursing and Therapy Specification Revisions regarding engagement with MDTs	March 2016
Agree alignment / joint activity with other projects – e.g. regarding Frailty Redesign and Intermediate Care (including Pilot area to trial new approach)	April 2016
Clinical audit of ICC team to review quality and impact of ICC referrals completed and potential benefits from new risk stratification approach. This will inform implementation of the Pilot.	May 2016
Implementation of Pilot of new approach to MDTs in Practices with one cluster of Practices in West Norfolk	June 2016
Completion of Pilot	August 2016
Evaluate Pilot, potentially start recruitment of additional ICC support. Will include gap analysis regarding 7 day service provision	September 2016
Roll out of Pilot across West Norfolk, enabling best practice to be applied more consistently	October 2016

The evidence base

ICC data collected between September 2015 and February 2016 provided an indication of West Norfolk MDT outputs, as follows:

Average number of patients discussed per month	Percentage of Patients whose support from MDT was classified as	Percentage of Patients whose support from MDT was classified as	Percentage of Patients whose support from MDT was classified as	Percentage of Patients whose support from MDT was classified as 'No New Action'

	'Admission Avoidance'	'Complex with Action'	'Non-Complex with Action'	
418	5%	11%	19%	63%

During 2014/15 – 2015/16 there was an average of 440 avoidable admissions per month (as measured by the numbers of patients with Ambulatory Sensitive Care Conditions admitted at the local Acute Hospital).

The 'Commissioning for Value' data set for WNCCG, produced by NHS England, Public Health England and Right Care, identifies that the top 2% of high risk patients account for 16.4% of WNCCG spend (15% is the national average). This equates to 589 patients, the vast majority of whom are aged over 60. Many of these patients already receive MDT support, but there are opportunities to provide this support more systematically.

This information combined indicates that whilst the MDTs already play a role in reducing pressure on acute services, there is still scope to ensure that MDTs provide proactive support to patients prior to their needs escalating significantly. There is also significant variation in relation to the numbers of patients supported by MDTs at Practice level.

There are 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'.

The delivery chain

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

Commissioner or Provider	Role
Commissioning Manager – Integrated Team	Project management, engagement and communications. Chair the operations groups and provide feedback at board level.
WNCCG GP Lead for Long Term Conditions and WNCCG Head of Commissioning	To support alignment with frailty and intermediate care redesign projects being led by WNCCG
GP Practices	Lead in MDT hosting and medical input for both pilot and then roll out across West Norfolk
NCH&C ops teams	To implement 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
QIPP Programme & BCF Boards	To review and monitor impact

Value for Money

Investment Requirements	Potential Efficiencies
The community care teams will be made up by re-arranging the current resources available.	Cost savings made by reducing avoidable emergency admissions to hospital and increased efficiency through joint assessment of need and co-ordinated delivery of care.

There may be some investment required to facilitate risk stratification. Contingency funding has been identified within WNCCG QIPP which could be utilised if required Following the early phases of the scheme, including the pilot phase, ICC resourcing will be considered. The full costs of employing an additional 3 ICCs (in addition to the 4 already in post) would cost c. £101K.	

Impact of scheme

This will be contingent upon scale of implementation across Practices following the initial Pilot. However, it is assumed that there is significant scope to improve acute admission avoidance through optimising MDT working and standardising best practice. Increasing the percentage of admission avoidance activity from 5% (current level = 115 patients over 6 months) to 10% would potentially result in an additional 230 admission avoiding actions being taken.

This figure is considered to be conservative if there is effective engagement with GP Practices to roll out the optimised approach.

230 additional admissions avoided * Average cost of admission (£1490) = £342,700 savings

Risks & Mitigations

Identified Risks	Likelihood	Severity	Score	Mitigation
Lack of Provider engagement (particularly GP Practices)	4	4	16	Pilot with GP Practices willing to trial new approach. This will provide evidence base for wider roll out.
Technical difficulties in developing risk stratification (e.g. in relation to IT)	4	3	12	Involvement of colleagues with technical skills. Utilisation of approaches used elsewhere (e.g. in North Norfolk). Interim measures (e.g. using existing data more effectively) could be applied if necessary.
Increased support of people in the community places results in additional referrals to social care	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

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

Outcomes	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

19. WN BCF 2 – Support to Patients with LTC and high risk of referral to funded/acute care

What is the strategic objective of this scheme?

The overarching vision for this scheme is to provide effective, responsive care and ensure efficient use of resources. E.g. through reduced community nursing and GP visits

The strategic objectives are to:

- Improve quality of life for individual – more choice, control and proactive prevention and management
- Enable cost avoidance from reduced inappropriate hospital admissions
- Increase ability for patients to self-manage their symptoms

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.

What are the intended impacts of the scheme (outcomes)

Objective	Impact
Improve Quality of Life Patients who meet the criteria for this scheme will be able to use electronic equipment in their home to regularly input information about their condition. This will be uploaded to a central data processing point for monitoring and to trigger interventions where required. This will provide patients with reassurance about their health condition, potentially reduce unnecessary health visits and support more independent living.	This scheme will focus on patients with Long Term Conditions and those who are judged to be at high risk of deterioration. It will be available to patients and/or their carers to support self-monitoring and is expected to lead to increased self-management. Patient experience will thereby improve.
Cost Avoidance	Reduced numbers of visits by Community Nursing and Therapy Service and Social Services. This will release capacity to support other patients. This in

Utilisation of telehealth technology will enable health and social care workers to provide support as and when actually required.	turn will improve capability to support patients in the community and avoid unnecessary acute hospital and care home admissions.
Increase Capacity to Self-Manage Patients and their carers will develop a greater awareness and understanding about the patients' condition, including the implications of their lifestyle choices on their health. This will promote improvements to their health and wellbeing	Patients and carers have increased capability to self-manage and adjust lifestyle as required. This will reduce pressure on health and social care services.

What are the key success factors for implementing this scheme

Key Milestone or Activity	Timescale
Agree alignment / joint activity with other projects – e.g. regarding Frailty Redesign and Intermediate Care (including Pilot area to trial new approach)	April 2016
Feasibility study regarding telehealth technology to be utilised	May 2016
Develop process (including patient target group) and resource for Pilot	June 2016 – August 2016
Implement Pilot	September – December 2016
Review and Evaluation Pilot	January 2017
Wider Roll Out	February 2017

The evidence base

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.

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.
WNCCG GP Lead for Long Term Conditions and WNCCG Head of Commissioning	To support alignment with frailty and intermediate care redesign projects being led by WNCCG
GP Practices	Lead in relation to medical input for both pilot and then roll out across West Norfolk
NCH&C ops teams	To ensure alignment of the community nursing team resources to telehealth technology

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
QIPP Programme & BCF Boards	To review and monitor impact

Value for Money

Investment Requirements	Potential Efficiencies
Capital investment is likely to be required for electronic equipment. However, this will be subject to the feasibility study – in some instances it may be possible to utilise patients existing technology. Also, monitoring of the inputted data may require additional staffing, although it is anticipated that this could be undertaken within existing resources (e.g. by Community Matrons)	Cost savings made through more efficient utilisation of community workers who will not need to undertake as many visits to patients utilising the technology. This will enable redeployment to other patients, thereby reducing avoidable emergency admissions to hospital and increased efficiency through joint assessment of need and co-ordinated delivery of care.

Impact of scheme

This will be contingent on the feasibility study to identify the most appropriate technological solutions and the cohorts of patients that may benefit most.

Risks & Mitigations

Identified Risks	Likelihood	Severity	Score	Mitigation
Lack of Provider engagement (particularly GP Practices and NCHC)	4	4	16	Pilot with NCHC and GP Practices willing to trial new approach. This will provide evidence base for wider roll out.
Self-monitoring results in increased requests for support, creating additional pressure on services	3	3	9	Feasibility Study and Pilot to test practical implications.
Technology is prohibitively expensive	3	4	12	Feasibility Study. Focus on use of technologies that are low / nil cost – e.g. Skype for consultations and social networking applications

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

Outcomes	How will this be measured
More people supported at home and in the community	• Reduction in emergency admissions to hospital • Reduction in the number of patients aged 65+ conveyed to hospital by ambulance
Improved patient outcomes	Pilot Patient satisfaction surveys

20. WN BCF 3 – 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. This scheme seeks to:

- Reduce Admissions from Care Homes to Acute Services
- Reduce conversion of intermediate care placements into permanent care home admissions
- Strengthen the role of Care Homes as a key component within the Health and Social Care system

This will be achieved through:

- **Targeted training, advice and information packages** that upskill residential and nursing home staff
- **Mentoring / rotation schemes** that encourage greater awareness and communication between health and care home sectors
- **Quality Scheme** that recognises care home providers that meet standards regarding care and support

What are the intended impacts of the scheme (outcomes)

Objective	Impact
Reduce Admissions from Care Homes to Acute Services 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.	Care Home (particularly residential care homes) access to training support will increase capability to support patients without recourse to Primary Care, Ambulance and Acute Hospital Services.
Mentoring / Rotation Schemes Promoting care home, Acute Hospital and Community Health staff to share experiences / job shadow / mentor, etc., will improve mutual understanding of respective roles and communications between the sectors.	Improvements in appropriate admission to acute hospital and discharge back to Care Homes based on improved communications and

	awareness of others roles and responsibilities.
Quality Scheme Care Homes adhere to standards regarding training, information sharing and receive a local Quality rating as a result, which provides assurance to commissioners and providers about the service provided. Also, agreement about appropriate standards in relation to discharge to Care Homes (e.g. at weekends and evenings) will improve discharge arrangements. This could be achieved through a 'Compact' or voluntary code of conduct.	Increased utilisation of care homes meeting quality scheme standards. Improved discharge planning, improving patient experience.

What are the key success factors for implementing this scheme

Key Milestone or Activity	Timescale
Complete analysis of competencies that are most relevant to admission avoidance	April 2016
Map existing training and support arrangements that could be accessed by Care Homes, including any cost implications	May 2016
Seek expressions of interest from Care Homes	May 2016
Agree and Advertise Training and Support Programme. Trial the 'Quality Scheme' concept through this.	June 2016
Develop and agree Care Home Compact with Health Providers (particularly Acute Hospital)	August 2016
Evaluation	December 2016

The evidence base

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

It is not possible to identify admissions from individual care homes. However, there is data regarding ambulance call outs and conveyances from individual care homes. There is considerable variation in some cases.

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%.

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.
WNCCG	To support alignment with Community and Care Home Matron schemes
Norfolk Independent Sector	Represents Sector and can advise on most effective support to Care Homes
Care Home Providers	Care providers
Norfolk and Suffolk Dementia Alliance	Can advise on dementia related support
QEH	Provides training for staff that could be utilised by Care Homes
NCH&C	Provides training for staff that could be utilised by Care Homes
NCC	Provides training for staff that could be utilised by Care Homes
NSFT	Provides training for staff that could be utilised by Care Homes
QIPP Programme & BCF Boards	To review and monitor impact

Value for Money

Investment Requirements	Potential Efficiencies
This scheme will involve utilisation of existing training and support opportunities already delivered by health and social care providers, wherever possible. If funding is required to enable access then this will be negotiated with Care Homes.	Cost savings made through reduced ambulance call outs, conveyances and reduced hospital attendances and admissions. Reduced delayed transfers of care through Compact arrangements setting out discharge arrangements with Care Homes

Impact of scheme

This will be contingent on the numbers of Care Home providers engaging with the scheme and the willingness of social care and health providers to support this initiative.

Lack of Care Home admission data means that it is not possible to accurately calculate potential benefits from this scheme. However, avoidable admission data indicates that there is significant scope for improvement in relation to health issues that are anecdotally known to arise frequently from some care homes (particularly some residential care homes). Examples:

- Pyelonephritis and kidney / urinary tract infections – 533 admissions - £1.026m cost in 2015/16 (WNCCG)
- Dehydration and Gastroenteritis – 399 admissions - £0.759m cost in 2015/16 (WNCCG)

This excludes Social Care costs (which, according to the WNCCG Value Based Commissioning data report, are likely to be similar)

Risks & Mitigations

Identified Risks	Likelihood	Severity	Score	Mitigation

Lack of Provider engagement (Care Homes, Health and Social Care)	2	5	10	Engagement with Providers to explain mutual benefit of scheme. Work with providers that are willing to engage.
Training and Support is insufficient to improve performance (e.g. due to systemic issues within Care Homes associated with Leadership)	3	4	12	Focus on deliverable programme of training and support that is aligned to known key reasons for hospital admission. Gather intelligence from scheme that can inform other initiatives to support Care Home / Health Provider improvement.

Feedback Loop – how will you measure the outcomes form this scheme	
Outcomes	**How will this be measured**
More people supported at home	• Reduction in emergency admissions to hospital • Reduction in the number of patients aged 65+ conveyed to hospital by ambulance • Reduction in number of specific avoidable admissions (e.g. UTIs)
Reduced Delayed Transfers of Care	• Reduced Delayed Transfers of Care to Care Homes (e.g. specifically in relation to Residential Care Homes as measured in monthly Acute Hospital returns to NHS England)
Improved Provider Satisfactions between Care Homes and Health Providers	Satisfaction surveys

21. WN BCF 4 – Improving Preventative and Crisis Support for Community Alarm Service Users

What are the strategic objectives 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

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.

What are the intended impacts of the scheme (outcomes)

Objective	Impact
Prevention (1) 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.	Service users are supported to access existing health and social care services, enabling earlier access to preventative services.
Prevention (2) 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.	Service users likely to be at high risk of deterioration (in terms of mental and/or physical health) will be referred to existing health and social workers if they are on their caseloads. Those not on an existing caseload will be referred to existing preventative services that help diagnose issues and support self-management. This will reduce pressure on statutory services, including health and social care.
Crisis Response 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.	There will be less unnecessary Ambulance Call Outs (and therefore conveyances to the acute hospital). Patients' outcomes will be improved through more effective crisis pathways.

What are the key success factors for implementing this scheme

Key Milestone or Activity	Timescale
Input to Tender for new Community Careline Contract	February 2016
Involvement in Procurement process and working with new Provider to ensure that Call Handlers have appropriate information to support preventative responses	April 2016
New pathways to be tested and implemented in relation to integrated responses to frequent non-crisis alarm calls from service users. This includes engagement with health and social care teams	May 2016

Audit of Crisis Response pathways and refinement to ensure that unnecessary ambulance call-outs are avoided	June 2016
Monitoring / Refinement / Review	Monthly from May 2016
Evaluation	December 2016

The evidence base

- 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

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.
Borough Council of King's Lynn and West Norfolk	Commissioner of Community Alarm Service. Has oversight of contract and receives regular performance information about individual use of alarms, including frequent alarm calls.
Community Careline Provider	Provides Call Handling service, including arranging responses to alarm calls.
WNCCG	As commissioner of health services to ensure that these services work to provide proactive and crisis support to community alarm users.
NCC	Commissioner and provider of social services. Key to this scheme is the engagement of Swift Response, which regularly provides unplanned care in response to community alarm call outs (e.g. due to a fall)

NCHC Operational Teams	Provides services to community alarm users. Provides (alongside NCC) Integrated Care Coordinator service which can be utilised to enable alarm users to receive appropriate services.
NSFT	Provider of mental health services, which could be linked more effectively to community alarm service
Voluntary Sector services	Provider of multiple services that could be linked more effectively to support community alarm service.
QIPP Programme & BCF Boards	To review and monitor impact

Value for Money

Investment Requirements	Potential Efficiencies
There may be benefit in ensuring that there is additional Swift Response capacity to attend to Community Alarm call outs, where appropriate, as an alternative to Ambulance call outs. However, contingency arrangements are likely to be possible within existing resources.	Reduced Ambulance Call outs, enables Ambulances to be deployed more appropriately. This will also result in reduced admissions to hospital. The preventative elements of this scheme will help service users to self-manage for longer, and ensure that those requiring support are identified and responded to more quickly.

Impact of scheme

The potential benefits of providing a more integrated service to frequent community alarm users requires further analysis as there is no baseline information.

It is known that Call Handlers do not currently routinely refer community alarm users who they speak to about West Norfolk community services. Data about the utilisation of community services will be captured as the scheme is implemented.

During 2014/15, Community Alarms activated due to a fall resulted in 48% of service users being attended by an Ambulance, with 26% being attended by Swift Response. This compares to 22% (Ambulance) and 77% (Swift Response) in the East of Norfolk. There were also significant numbers of occasions where Swift Response did not have the capacity to attend, resulting in Ambulance Call outs. Reducing Ambulance Call out to the East levels would result in approximately 40 less Ambulance Call outs per month.

Risks & Mitigations

Identified Risks	Likelihood	Severity	Score	Mitigation
Alarm Provider does not engage with initiative to support alarm users to access community services	2	3	6	Engagement with new provider and commissioner to ensure that appropriate protocols are in place.
Increased pressure on Integrated Care Coordinators and Community Services newly linked to service	3	4	12	Phased introduction of scheme to ensure that monitoring takes place and potential resource considerations are taken into account. Cost / benefit analysis will be undertaken.

New crisis response pathway results in inappropriate reduction in use of Ambulance services	2	5	10	Clinical engagement to quality assure any proposed changes prior to implementation

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

Outcomes	How will this be measured
More people supported at home	• Reduction in emergency admissions to hospital • Reduction in the number of patients aged 65+ conveyed to hospital by ambulance • Monitoring of frequent users of community alarm users to ascertain whether integrated support results in change • Utilisation of community services (via ICC data collection)

22. WN BCF 5 – 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.

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.

What are the intended impacts of the scheme (outcomes)

Objective	Impact
Community Based Crisis Response • 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	• Maximise independence and improve outcomes for service users

health related social care crisis in their own home (e.g. for up to 48 hours) • 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.	• Reduce inappropriate hospital and residential admissions through crisis intervention and support
Hospital Based Crisis Response • 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 increase weekend service capacity. The team will refer patients to the Community Crisis Response Team where appropriate.	• Reduction in avoidable hospital and care home admissions • Improved support at weekends, linking to 7 day community services

What are the key success factors for implementing this scheme

Key Milestone or Activity	Timescale
Agree alignment / joint activity with other projects – e.g. regarding Frailty Redesign and Intermediate Care (including Pilot area to trial new approach)	April 2016
Develop specific model required, including operating hours, competency requirements, access and referral pathways across health and social care system. Including links between community and hospital based staff	May – July 2016
Implement additional 7 day Rapid Response Working (3 month potential recruitment period)	July 2016 – October 2016
Pilot community based team in alignment with GP Practices / community health and social care teams	August – October 2016
Evaluate Pilot	November 2016
Roll out across West Norfolk	November 2016

The evidence base

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).

In West Norfolk, there are approximately 440 avoidable admissions per month (based on Ambulatory Care Sensitive Care Conditions data).

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.

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.
WNCCG	Ensure engagement and contractual changes needed across health system
QEH	Acute Provider, including part provision of hospital based rapid response team
NCH&C	Community Health Provider, including part provision of hospital based rapid response team
NCC	Social Services provider, including Swift Response service
NSFT	Mental Health provider, including mental health crisis team.
Voluntary Sector providers	Several services are in place that can help manage and stabilise crises that will be linked into this scheme.
QIPP Programme & BCF Boards	To review and monitor impact

Value for Money

Investment Requirements	Potential Efficiencies
£200K has been provisionally allocated to support community based rapid response.	Utilisation of a discrete rapid response team will ensure more effective use of existing social services rapid response services (Swift Response) and reduce

£76K has been provisionally allocated to support additional 7 day hospital based rapid response.	utilisation of Community Nursing and Therapy Services, enabling more efficient utilisation of the service. Community health service responses are currently commissioned for response within 4 hours. An up to 2 hour rapid response service will provide an alternative to Ambulance Service call outs.

Impact of scheme

Hospital Based Crisis Response: 14 admissions avoided per month through enhanced 7 day service. Net financial gain of £175K per annum.

Community Based Crisis Response: TBC on basis of pilot.

Risks & Mitigations

Identified Risks	Likelihood	Severity	Score	Mitigation
Community based rapid response does not significantly affect acute admissions	3	4	12	Review of best practice to inform Pilot to test local benefits.
Inability to establish team with appropriate skill mix	3	4	12	Review of existing resources to ascertain potential to reconfigure existing services. Focus team on what can be delivered within resources (e.g. narrow focus to falls response)
Lack of utilisation by key referrers, e.g. GP Practices and Ambulance Service	3	3	9	Communications and Stakeholder engagement, including SRG and other senior and operational meetings

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

Outcomes	How will this be measured
More people supported at home	• Reduction in emergency admissions to hospital and permanent admissions to care homes • Reduction in the number of patients aged 65+ conveyed to hospital by ambulance • Reduction in number of specific avoidable admissions (e.g. UTIs)
Improved Patient experience	• Measurement of numbers of patients supported by community services as opposed to requiring acute services