WORKING TOGETHER TO IMPROVE HEALTH AND WELLBEING

Issue 3 March 2015

Organisations across **East Riding of Yorkshire** are working together to provide better support at home and earlier treatment in the community so people can remain healthy and independent without the need for urgent hospital care. Issued on behalf of partner organisations, this bulletin provides an update for stakeholders about the Better Care Fund Programme.

SHARING BEST PRACTICE

At the end of March 2015, a Parliamentary event is being held in London both to recognise the hard work being put in by frontline members of staff and to allow people to network and share ideas. We were asked to nominate a member of staff to attend (carer/GP/OT etc.) who has been directly involved in introducing integrated working and who has seen the benefits first hand.

Locally, we recognise that there are many examples of good working and we therefore sent in a range of nominations for consideration:

- **Goole, Howdenshire and West Wolds Locality Rapid Response Pilot**
  Dr Ben White, General Practitioner, GP clinical lead and primary care lead for the Clinical Commissioning Group and Andrew Powell, Community Matron (Humber NHS Foundation Trust).

- **East Riding's Single Point of Contact**
  John Compton, Service Redesign Manager (East Riding of Yorkshire Council) and Val Higo, Project Manager (Humber NHS Foundation Trust).

- **Developing the Better Care Fund Plan and representing Adult Social Care in the Rapid Response Pilot**
  Lianne Therkelson, Area Manager, Adult Social Services (East Riding of Yorkshire Council)

- **Hospital Social Work Team (HSWT) services**
  Vicky Lawrence, Area Manager, Adult Social Services (East Riding of Yorkshire Council) and Scott Rayner, Hospital Team Manager, Adult Social Services (East Riding of Yorkshire Council)

We are delighted to announce that our nominations for the rapid response service and single point of contact were accepted and both Dr Ben White and Val Higo will be attending the event to represent the East Riding of Yorkshire area. A short description of how the nominated programmes of work have helped improve peoples' experience of healthcare is attached to this bulletin (see page 5).

EAST RIDING OF YORKSHIRE COUNCIL

NHS

BETTER CARE FUND PROGRAMME BOARD

It has been agreed that the Programme Board will now meet on a quarterly basis, with a new BCF Programme Team meeting on a monthly basis to oversee implementation of the Plan. The workstreams are also being reviewed to ensure they continue to meet the overall programme needs.

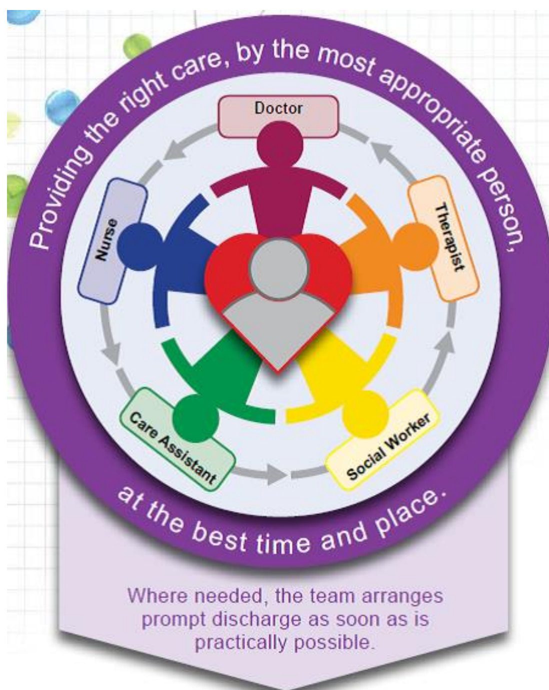
The Programme Board is made up of members of a number of East Riding organisations, including NHS commissioners and NHS providers, GPs, East Riding of Yorkshire Council, Healthwatch, the Carers Advisory Group and the Voluntary & Community Sector Steering Group. To find out who your local lead is, please contact: Donna Dudding, Project Delivery Manager, donna.dudding@nhs.net

WORKSTREAM UPDATES

Ambulatory Care

The lead for this workstream is: Karen Ellis, Assistant Director of Strategy and Planning (ERY CCG)

- **Pocklington Locality Health and Social Care Hub (part of Vale of York CCG)**



Pocklington based patients are now able to access an innovative new health and social care ‘one-stop shop’ which aims to keep local people out of hospital.

The Integrated Care pilot, hosted by Pocklington Group Practice, focusses on delivering the right care by the most appropriate person at the best time and place for patients that have a health and social care need.

Delivered by a joint (multi-disciplinary) team of doctors, nurses, social workers, care assistants and therapists, the service will run between 8am – 6pm, along with the current Out of Hours services that support patients who require care or treatment in the evening and throughout the night.

The team helps patients to have a better understanding of their condition, learn how to stay healthy and ensure the patient’s condition remains as stable as possible.

East Riding of Yorkshire Council is supporting the pilot project by providing three beds in a residential home to help avoid emergency admissions to hospital, reduce hospital stays and where appropriate, enable people to return home earlier and live independently. When admission to hospital cannot be avoided, the team of integrated care specialists will put plans in place for a prompt discharge as soon as soon as is practically possible.

Single Point of Contact

The lead for this workstream is: John Compton, Service Redesign Manager (ERYC)

Phase 1 of the implementation of the Single Point of Contact is well underway with community services and working age adult mental health services now working together from Hessle Grange Health Centre. There is a new single point of contact telephone number – 01482 301701 – together with new NHS mail addresses for mental health and neighbourhood care services.

Work is now underway to seek feedback from General Practitioners and administrators and a stakeholder workshop is being organised for April / May to evaluate the progress made so far and discuss next steps for the workstream.

Prevention and Self-care

The lead for this workstream is: Paul Wolstencroft, Associate Director of Public Health (ERYC)

A social prescribing model has been agreed as the preferred methodology to address health and well-being needs. A multi-agency presentation is being made to the Health, Care and Wellbeing Overview and Scrutiny Committee on 17 March 2015 about initiatives being considered or done to enable healthy independent ageing, including reducing isolation and loneliness. A project to improve the health and wellbeing of older people is being taken forward in Bridlington (see below).

Resource and Infrastructure

The lead for this workstream is: Lauraine Walker, Head of Business Management (ERYC)

An audit of estates, services provided, IT systems and equipment available has been completed across all partner organisations and a register is now being collated. Work is now underway to pull in council and health transport information.

Work continues well towards implementation of a single health and social care IT system, particularly aligning the use of the NHS Number with Council systems.

IMPROVING HEALTH AND WELLBEING OF OLDER PEOPLE

The Programme Board has approved the start of a new 1-year pilot project aimed at improving the health, independence and wellbeing of older people living in Bridlington and reducing hospital admissions. This innovative project proposes to extend healthy active life in old age and encourage older people to take part in activities to help prevent the onset of disease.

Volunteers and staff will offer a range of face to face and telephone assessments to people aged 75 years and over providing personalised help to access services and advice tailored to meet their greatest health and care needs. This person-centred approach may also involve identifying community solutions that are broader than health and social care to help reduce isolation and improve wellbeing. Working initially through two Bridlington GP practices, it is hoped that the project will ultimately identify patterns of behaviour or need that will help improve quality of life for all older people.

The Project Sponsor is Ian Philp, Medical Director at Hull and East Yorkshire Hospitals NHS Trust (Director of the International EasyCare Programme and Honorary Professor of Healthcare for Older People at the University of Hull). Project Management will be led by Judith Long, Older People's Research and Development Manager at Hull and East Yorkshire Hospitals NHS Trust. A Project Team of key stakeholders is now being established to agree the implementation approach.

INVOLVING LOCAL PEOPLE

We are committed to involving people in the co-production of plans and services. Since the last Programme Board meeting, staff have attended the following events to raise awareness and seek views about the Better Care Fund:

Pensioner's Action Group East Riding – February 2015
The Pensioners Action Group for the East Riding (PAGER) promote and campaign on pensioner's rights. Around thirty people attended their conference in Bridlington in February to inform the community about local health developments. Speakers included Brid Inc talking about local GP collaboration to develop sustainable primary care services for the future, York Foundation Trust talking about the Fresh Start event at Bridlington Hospital which is part of the national NHS Perfect Week campaign; and Karen Ellis from the CCG talking about Better Care Fund developments.

If you have any additional ideas for how health can work better with social care to improve the support / service / care people get, please contact us.

NATIONAL MESSAGES

The national team has developed a set of BCF key messages and Q&As for:

- General purpose
- Public
- Health and care staff
- Local leaders

The key messages are in line with our local plans and the Q&As are attached for information.

WEBPAGES

Our dedicated webpages contain information for the wider public about the Better Care Fund: http://www.eastridingofyorkshireccg.nhs.uk/current-work/bettercare/ Partners are welcome to link to these pages from their own sites and the communications team welcome requests for additional information to be added.

WORKING IN PARTNERSHIP

There are a range of organisations that are working together under the leadership of the East Riding of Yorkshire Health and Wellbeing Board. These are:

- East Riding of Yorkshire Council
- East Riding of Yorkshire Clinical Commissioning Group
- Vale of York Clinical Commissioning Group
- Humber NHS Foundation Trust
- Hull and East Yorkshire Hospitals NHS Trust
- GP Federations
- Primary Care Practitioners
- Healthwatch East Riding

A SHARED VISION

Our shared vision is "Better care at, or closer, to home, through integration".

IMPROVING PEOPLES' EXPERIENCE OF HEALTHCARE

- **Goole, Howden and West Wolds Rapid Response Service (GHWW RRS)**

The GHWW RRS started on 29 October 2014 for the 2% highest risk patients in the area. The development of this pilot has involved co-operative working between General Practice, Community Services and Social Services. The service now offers a rapid telephone assessment by a Healthcare Co-ordinator (Band 6 Nurse), followed by a face to face assessment with the most appropriate professional (GP, Community nurse, Social Worker) within 2 hours from the 1st call from the patient. In addition to rapid input from the above agencies, if a patient requires therapy services or domiciliary care then this can be provided on the same day.

A patient journey through the Rapid Response Service:

This patient is an eighty year old lady who lives with her elderly husband in their bungalow. She has comorbidities including; parkinsonism, depression, recurrent falls, impaired cognition, stroke amongst other health conditions.

The patient was first referred to the GH&WW RRS by her GP who had concerns about her reduced mobility and the family were struggling to move and handle her safely. The referral came into the service via the Single Point of Contact (SPOC). Because the patient was on the 2% cohort the referral was subsequently forwarded to the Health Care Coordinator (HCC) who telephoned the patient within 30 minutes to gather further information about their condition.

At the patient's request, the HCC visited her the following day and carried out nursing assessments including; pressure area care, mobility, bladder and bowel, falls, medication and vital signs were recorded. The outcome of the HCC assessment identified the following interventions and ongoing referrals were made the same day:

- Referral to Single Intake Duty Team for social care assessment
- Pressure relieving mattress was ordered for her bed
- Referral to physiotherapy for mobility intervention
- Risk management concerning her medication
- Referral to life line – 6 week free trial

The HCC and Social Care Assessment Officer (SCAO) carried out a joint visit to the patient and, as a consequence, a carer was assigned from Short Term Assessment and Re-ablement Service (STARS) to help her with personal care and hygiene.

The physiotherapist visited the patient. At this visit both patient and the physiotherapist agreed a goal for her to be able to mobilise approximately twenty metres (to the kitchen and back to the bedroom) within an eight week period. Physiotherapist's rehabilitation assistants continued to provide therapy support twice weekly.

The HCC continued to support and monitor the patient over the following week with continuity of care from the physiotherapy team and STARS thereafter.

Due to the Multi-Disciplinary Team approach of the Rapid Response Team, the patient's care was enhanced. This not only facilitated her recovery back to her original independent state (prior to the referral) but also prevented further deterioration and potential admission into an acute hospital bed.

- **East Riding Single Point of Contact (ER SPoC)**

The single point team was put in place in November 2014 and is now the first point of contact for community health and mental health referrals across the area. Other specialist services and social care contacts are being routed in during this year so that by the end of the year all the main health and social care initial contacts will feed in through the single point. The project is being phased with phase one being the community health (from GPs, acute and social care) and mental health referrals, which are now all through one single number.

<table>
<tr><th colspan="2">Feedback from Service Staff, Patients and Referrers:</th></tr>
<tr><td rowspan="2">"We are now into our third month of SPoC and the confidence and the smooth running is amazing; we now regularly receive positive feedback from hospitals and GP practices saying what a good service SPoC is and how having one number is so much better and easier for them. We have had a Community Matron working with our team and this has been hugely beneficial to explain medical terminology and procedures.

We feel excited that we are working in a new service and appreciate the ongoing knowledge and training. We welcome change as we are confident our managers will be with us every step of the process."
Central SPoC Administrators</td><td>"Following a recent operation on my hand I was concerned I would not be able to self-administer my insulin, calling this one number meant my referral to the District Nurses was made and the nurse called me back quickly to confirm when she would visit."
Patient
(This patient personally rang back to thank the staff on the SPoC for their help)</td></tr>
<tr><td>"It is so much easier having one number. We know who to call and have confidence the referral will be dealt with"
Oncology nurse, Castle Hill Hospital</td></tr>
<tr><td colspan="2">"Really like the service, weren't too sure at first but are now really happy to use the SPoC"
GP Practice</td></tr>
<tr><td rowspan="2">"Following an operation I had to receive B12 injections and was told by the hospital that I would need a blood test 4 days after my final injection. I was passed around to numerous people on different numbers until I was finally given the Central SPoC number; the staff were the most helpful of all the people I had spoken to and ensured my referral was made to the right team"
Patient</td><td>"Not having to call local SPoCs based on GP Practice location has made referring so much more efficient. One number covers the whole of East Yorkshire"
Ward Staff, Hull Royal Infirmary</td></tr>
<tr><td>"Really like being able to send referrals by e-mail to a secure NHSmail account, this speeds up the referral process and we receive an e-mail to confirm the referral has been received"
GP Practice</td></tr>
<tr><td colspan="2">"The success of this project to date has been largely due to the flexibility of the staff and their helpful attitude. They have worked above and beyond what would be expected of them and we are extremely appreciative of their ongoing support."
Project Manager and Clinical Lead</td></tr>
</table>

NATIONAL Q&A

Q: Why is the Better Care programme needed?

An ageing population means that more people will be living for longer with more varied health and social care needs, if we do nothing this will place additional strains on resources that will only grow over time. If we are to meet this challenge we need to move from a reactive to a proactive system that focuses on prevention.

Successive governments and leading clinicians have talked about the importance of joining up health and social care for decades. This is a real opportunity for radical change at scale and pace so patients receive the right care, in the right place at the right time. It is an opportunity to make the best use of the resources that are available.

Q: Who is in charge of the Better Care programme?

The changes are being locally led. The Council and local Clinical Commissioning Group(s) have worked together to produce a plan for local service integration. The plan has been signed off by the local Health and Wellbeing Board, checked against a number of nationally set outcomes and targets, and scrutinised by NHS England and the Local Government Association, before undergoing a Ministerial assurance process.

Q: When does it finish?

This is the start of the required change. The Better Care Fund runs for 2015/16, but pooled budgets are likely to be an enduring part of the health and care landscape for the foreseeable future.

Q: What happens after 2015/16?

The Better Care Fund will support local areas to take important steps towards joined up health and care, but this is only the first step. Pooled budgets in every area in 2015/16 will light the starting paper for greater integration of budgets between Local Authorities and Clinical Commissioning Groups.

December's Autumn Statement made it very clear that pooled budgets would be an enduring part of the framework for health and social care past 2015/16. Whilst the structure of the fund may change as progress is made, the principle is very much here to stay.

Q: Is the Better Care Fund new money?

The Better Care Fund is a pooling of existing Local Authority and NHS money, rather than new money. It is designed to incentivise and help local areas to use existing funding more efficiently, while delivering better outcomes for the public.

Q: What will the Better Care Fund be spent on?

Local areas decide how their pooled budget is spent. However, there are conditions associated with how some of the money can be spent. For example, some funding is related to the number of people that are successfully kept out of hospital; it can only be spent on certain kinds of services if the local area meets its target on this front.

In line with NHS reforms, this is about putting local commissioners in charge of decisions to deliver care for local people on the basis of local needs, while meeting high level ambitions that are set for the system nationally. Central government has set out what it expects local integration plans to achieve, but has left how this will be achieved to local commissioners who can design services around their local populations.