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1. Executive summary
1. Executive summary

a. Introduction

The health and social care needs of the population of the East Riding of Yorkshire (ERY) are changing. A combination of an ageing population, the changing expectations citizens now have around the timely care they receive, an emerging evidence base of the benefits of care closer to home, the growing advantages and expectations of technology and a predicted increase in demand will all place additional pressures on this health and social care economy. In particular:

- there is a lack of emphasis on prevention and treatment of patients in an ‘out of hospital’ community setting
- there is a significant increase in the number of frail and elderly people in the population who require higher levels of care
- there is a need for better understanding amongst patients, citizens and professionals of the services available and how to access them

Significant financial constraints also exist, with health budgets only seeing small increases and social care budgets decreasing in real terms. This is compounded by an increasing and ageing population which will put increased demand on health and social care services.

When meeting these challenges, the ERY health and social care system must also account for a combination of factors not typically faced by NHS and social care commissioners:

- a rurally dispersed population spread over 1000mi² (2590km²)
- no acute provider on the CCG patch
- Acute bed base commissioned from 3 different providers – presents a challenge in terms of driving through change
- no A&E on the patch with unplanned care being provided locally through a series of MIUs. There are a range of A&Es positioned around the CCG boundary at Hull, York, Scarborough and Scunthorpe

The CCG has therefore elected to work together with its population, professionals and partner agencies to design a blueprint for the future delivery of services that would meet the needs of the population both now and in the future, and do so whilst operating under the financial constraints that exist.
1. Executive summary

b. Key facts

- The CCG is responsible for a registered population of c.300,000 (Populations data excel spreadsheet provided by ERY CCG')
- The CCG has a commissioning budget of £356m, of which £38m is spent on Community Services
- Community hospital utilisation is low while readmission rates to community hospitals are high
- A significant proportion of bed days in acute hospitals are currently used as emergency beds (JSNA 2013)
- QIPP is not delivering the planned cost savings and service improvements

c. Stakeholder engagement

To ensure our revised community services strategy meets the needs of patients, citizens and health and social care professionals, an extensive engagement exercise has been carried out to inform and shape this strategy.

In doing so we have engaged with over 160 stakeholders from across the health and care economy. This engagement activity ran alongside the CCGs insight polling where we engaged with 1,140 local citizens.

Further detail on the findings of the engagement exercise can be found in section 3 of this document. Through the engagement exercise nine common themes for change were identified. These themes are:

- Common understanding of services
- Delivery of proactive care
- Contracting for quality
- Single IT platform & integrated ECR
- Improved access to specialist services
- Clear role for community hospital
- Co-location and integration
- 24/7 services
- Flexible skilled workforce
1. Executive summary

d. Vision for community services

• The overall vision and direction statement for community services in the East Riding over the next five years is:
  - A truly Integrated Health and Social Care Economy that delivers consistent, systematic, good quality community care by the right person, in the right place, at the right time whilst ensuring the long-term sustainability of the NHS in the East Riding

• Through consultation with the CCG board and engagement with stakeholders the following outcomes have been agreed as the desired impact of the revised community services strategy
  - Health independent aging
  - Consistent quality across all services
  - Home / community is the default care setting
  - Joined up care
  - Widely understood patient pathway
  - Flexible access to services

• A defining feature of the strategy is the development of a community hub within each East Riding locality

• The diagram below outlines our revised approach to commissioning in addition to the seven functions of a community hub
1. Executive summary

e. Enablers

To implement our revised community services strategy there some fundamental changes will need to be made to the way we work, particularly across key enablers. Anticipated areas of change for these enablers are outlined below. Further information can be found in section 6 of this strategy document:

**Finance and Contracting**

- Commissioning based on outcomes with quality incentives built in
- Implementing a ‘draw down contract’
- Longer term contracts – potentially 3 to 5 years
- Capitated budget – where the provider is given a set fee per citizen

**Technology**

- Electronic care records
- Enable clinicians to treat patients remotely
- Patient portals
- Dependent on other enablers being put in place

**Workforce**

- Need to develop an agile workforce that can adapt to new ways of working
- Teams will be multi disciplinary and co-located
- Development of new roles including Case Manager
- Development of an East Riding training programme

**Transport**

- Greater use of elective or timetabled transport to bring high volumes of low intensity patients (who are fit to travel) to the community hubs for their care and support
- Plurality of transport provision including greater use of 3rd sector provision

**Communication**

- Care navigation provided by community hubs
- Development of health pathways – patient pathways agreed between GPs and hospital doctors
- Increased transparency - basket of outcomes publicised
1. Executive summary

Governance

- Strengthened East Riding commissioning localities
- Expanded scope of Local Commissioning Forums
- Greater clarity of governance and accountability

Infrastructure

- Optimisation of existing physical assets such as community hospitals and MIUs where possible
- Review the role, purpose and value of our current infrastructure with a view to developing an economic case for each asset

f. Cost benefit analysis

There is opportunity for savings by taking care that can be delivered more appropriately in the community from the acute budget (currently £191m) and bringing it under the community care contract envelope (currently £38m).

- Implementation of the proposed hub model – assuming a hub is set up in each locality providing all proposed services – could yield gross savings of £2.4m
- The cost base of the hub model will vary based on how the model is implemented. Conservative estimates put the likely costs at between 50 – 60 % of gross savings
- This would deliver a net saving of £1.03m
- The model will also achieve significant qualitative benefits both in terms of management & delivery of community care, and ultimately patient outcomes

g. Implementation timeframe

We include an indicative high level roadmap in Section 9 to provide a view of what the associated detailed design phase and delivery phase could look like.

It sees an extensive programme of work being undertaken over an initial period of 3 years. It consists of a series of projects which run concurrently, controlled and co-ordinated by a programme and change management function.

The focus is on defining clear evidence-based outcomes, designing & commissioning a service to deliver those outcomes, and a rigorous focus on benefits realisation measurement.
2. Context
This document sets out our revised 5 year community services strategy for 2014-2019. It aligns with a number of other documents that will provide the strategic overview of the direction of the CCG including:

- The 2 year plan
- The 5 year plan
- Better Care Fund (BCF)
- Urgent Care Strategy
- Primary Care Strategy
- Health and Wellbeing Strategy
- Further local strategic agendas including the Health and Wellbeing strategy

The decision to revise the community services strategy has been made for a number of reasons including the changing national context – key elements of this are described below

### a. The national context

The context in which the NHS is operating has changed significantly since the development of the initial community services strategy. This strategy was developed in a time of NHS growth. The current context is one of static budgets, significant increase in demand and technological innovation in how care is provided to patients and clients.

- **Integrating health and social care.** A whole systems approach to joining up previously fragmented care for patients and clients. National initiatives such as integration pioneers and the better care fund are supporting this

- **Growing pressures on A&E services.** Nationally, the number of older people being taken to A&E has doubled in the past five years with 11.9m in 2007-08 compared to 18m in 2012-13, a rise of 51%. This is placing unsustainable pressure on the NHS which requires a new approach to urgent care in the community. Source: Health and Social Care Information Centre 2014

- **System struggling to cope with increasingly complex patient need.** A recent report found that ‘interventions to reduce readmissions that focus solely on the principle diagnosis at the time of the index admission are unlikely to receive optimal results’. Source: BMJ 16th December 2013. “Readmission rates”, Joseph P Drozda Jr, Director of Outcomes Research, Center for Innovative Care, Mercy Health, USA

- **Drive towards outcomes based commissioning.** An approach that rewards both value for money and delivery of better, higher quality outcomes that are important to patients and service users
2. Context

- **New CQC community services inspection regime.** In December 2013, the CQC announced a new regime for inspecting health community services. Prof Sir Mike Richards, Chief Inspector of Hospitals, said that the CQC is “determined to strengthen [its] oversight of the sector”.

  It is the CQC’s stated aim to improve the availability of data in community care, to look at the quality & consistency of community care pathways and to assess how well different services are working together. It also expects the use of technology to be used to capture patients’ views and experiences.

- **NHS England Commissioning guidance.** NHS England published draft planning guidance in December 2013 that places an emphasis on the over 75s: “The government has determined that there will be a specific focus during 2014/15 on those patients aged 75 and over and those with complex needs.”

  “The new GP contract secures specific arrangements for all patients aged 75 and over to have an accountable GP and for those who need it to have a comprehensive and co-ordinated package of care.” Source: NHS England Draft Planning Guidance, Dec 2013, Part 1: Our ambition, para 34

- **Growing demand for digital health services** – according to recent research 27% of senior citizens in England are self-tracking some aspect of their health although only a third of healthcare providers offer this possibility. Source: Office of National Statistics

b. Local context

The CCG is facing a number of population, health and financial challenges which combined together make a compelling case for change. Health and care professionals also have a clear view of what needs to change to deliver better patient centred care closer to home. The drivers for this change are detailed in the following pages:

Population challenges

- **The population of East Riding is growing:** by 2021 the population is expected to have grown by 5.6%. This means that there will be an increased demand on health and care services in general (ERY CCG Populations data)

- **The population of East Riding is ageing:** currently 21.6% of the population are over 75. By 2021 this number will 26%. Therefore not only will there be an increased demand on health and care services, patients will be presenting with more age related complex needs (Office for National Statistics)

- **Pockets of deprivation exist:** although East Riding is not a highly deprived area some pockets of deprivation do exist in Bridlington, Goole and Withernsea. (ERDO)

- **Dispersed population:** often with poor transport routes. One impact of this is that clinicians often feel that significant travel time impacts upon their overall productivity
2. Context

Health challenges

- **The prevalence of many sources of demand is rising**: there has been an increase of >30% in obesity, diabetes, cancer, dementia and adults with learning disabilities over the past five years (East Riding of Yorkshire: Disease Prevalence, March 2013, NHS Comparators).

- **Patients needs are becoming increasingly complex**: by 2020 the number of people in East Riding living with a limiting long term illness is predicted to be 31% compared with 16% in 2015 (JSNA 2013)

- **There are some areas where we are ‘significantly worse than average’**: East Riding CCG generally performs well against national indicators although the CCG is classed as ‘significantly worse than average’ in the areas of:
  - Starting breast feeding
  - Obese adults
  - Road injuries and deaths
  - People diagnosed with dementia

Service Challenges

The CCG is split into 5 localities: Goole Howdenshire and West Wolds, Haltmeprice, Beverley and Driffield (known as CHERY), Holderness and Bridlington. These localities are not co-terminus with those of the local authority. The Ambulatory Care workstream has a sub-group that has been tasked to develop a joint agreement between ERY Council and ERY CCG on the definition of a ‘Locality’ for the purposes of strategic planning.
2. Context

Service challenges continued

- **Community hospitals could be better utilised:** the CCG has four Community hospitals (two of which have community wards) and two district general hospitals, one of which has a community ward.

  Feedback from local stakeholders has suggested that these hospitals remain popular with the local population. However, they are under-utilised with low bed occupancy rates on the community wards: e.g. Dec 12 to Nov 13, occupancy rates were in the range 48% - 68% (Source: ERY CS – Community Hospitals Template Dec-13)

- **There is an over reliance on hospital based services:** according to the JSNA 2013 ‘80% of bed days in (acute) hospitals are currently used by emergency beds. Many of these admissions are preventable; by strengthening care in the community and general practice and many patients may never need hospital.’ (Source: Specialty Registrar Public Health, ERY Council, 26th February 2014)

- **There is a gap in service provision to support staying healthy and independent living:** this can be seen when services are mapped against the future model of commissioning (appendix 6, p98)

- There is a wide range of community services in place but in some instances are fragmented and operate in silos

**Financial challenges**

Split of total budget by component services shows that the largest areas of expenditure are acute services (£191m). The amount spent on the community services block contract is just 10% of the total CCG budget (£38m).

In order to meet the ever increasing healthcare demands of the area, we need to use our budget as efficiently as possible whilst securing the best health outcomes. An area of opportunity is to take care that can be delivered more appropriately in the community from the acute budget and bring it under the community care contract envelope.
Summary – local context:
• Increasing population that will place greater demand on services
• Ageing population that will have more complex health needs
• The prevalence of many diseases is increasing
• A lack of services focused on staying healthy
• An over reliance on hospital based services – particularly for urgent care
• Under utilisation of community hospitals
• A need to manage increased demand within the same financial envelope

c. Links with the ‘Better Care Fund’

It is also important that the strategy encompasses and enhances the work being carried out through the Better Care Fund (BCF). The BCF is ‘a single pooled budget to support health and social care services to work more closely together in local areas’ (www.england.nhs.uk). The workstreams that form the BCF are outlined in the table below:

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Sub workstream</th>
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<td>Ambulatory Care</td>
<td>• Case Management</td>
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<td></td>
<td>• End of Life Care</td>
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<td>• Early Supported Discharge</td>
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<td>Prevention and Self-Care</td>
<td>• Option appraisal on individual standard assessments of need e.g. Easy Care</td>
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<td></td>
<td>• Role of Local Area Co-ordinator Post</td>
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<td>Single Point of Contact</td>
<td>• Task and finish group for care co-ordination</td>
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<td>• Prevention and self-care</td>
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<tr>
<td>Resources and Infrastructure</td>
<td>• Co-location and community hubs</td>
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<td>• Single shared electronic health and care record</td>
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d. The purpose of this document

This strategy does not offer a single solution to the challenges associated with the provision of community and unplanned care in the East Riding of Yorkshire. Moreover, it articulates an account of where the pressures lie, what solutions are at hand and where the planned variances and chosen compromises may have to be made.

The Community Hub concept is seen as the vehicle for realising the benefits of the community and unplanned care strategy refresh, with supporting enabling infrastructure put in place.

The ethos of the community hub will have to fit in with the realities of service redesign, with accommodations having to be reached between cost, benefit realisation and the practicalities involved, such as the large geography of the East Riding or the distribution of available NHS real estate.

To that end, this strategy lays out the future model for the commissioning of community and unplanned care in the East Riding of Yorkshire. In doing so, it creates the conditions whereby the more detailed design work can be undertaken into how a community hub may in fact manifest itself on this patch

• physical and/or virtual?
• fixed location or roving?
• generalist and/or specialist?

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<thead>
<tr>
<th>What this document does do</th>
<th>What this document does not do</th>
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<tr>
<td>Details the vision for East Riding community and unplanned care over the next five years</td>
<td>✓ Provide a detailed specification and implementation plan for change in each locality</td>
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<tr>
<td>Outlines the future model of care for community based services</td>
<td>✓ Provide a summary of estates options for the location of services within each locality</td>
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<tr>
<td>Provides a high level view of the benefits that the new model will achieve</td>
<td>✓ Provide a detailed analysis of the financial implications for the broader stakeholders</td>
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<tr>
<td>Sets out a high level road map for delivering the strategy</td>
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3. Stakeholder engagement and input
To ensure our revised community services strategy meets the needs of patients, citizens and health and social care professionals, an extensive engagement exercise has been carried out to inform and shape this strategy.

In doing so we have engaged with over 160 stakeholders from across the health and care economy including:

- CCG Governing Body members, through 3 formal workshops
- The local authority, through a focus group with adult social care professionals
- Members of the public, through open meetings
- Provider staff from Humber FT and Yorkshire Ambulance Service (YAS), through interviews and focus groups
- GPs, through the Local Commissioning Forums
- East Riding Equality Network
- Disability Advisory Monitoring Group
- Secondary care clinicians, through interviews

Through this engagement 9 common themes for change were identified and are outlined below:

- Common understanding of services
- Delivery of proactive care
- Contracting for quality
- Single IT platform & integrated ECR
- Increased access to specialist services
- Clear role for community hospitals
- Co-location & integration
- 24/7 services
- Flexible, skilled workforce

*Electronic Care Record*
Further detail behind the themes are outlined in the table below:

| Common understanding of services | • Understanding of current health services available in the area and how to access them is variable amongst health and care professionals and patients  
• Clinicians do not always understand each other’s roles |
| Delivery of proactive care | • The current system and the pressures on it, due in part to the increased complexity of patients, has led to a reliance on ‘reactive’ care  
• Services are focused on stopping patients from entering the acute system or speeding up exit from hospital rather than keeping them well |
| Contracting for quality | • The current block contract means commissioners are not always clear of the services they are paying for – it is challenging to overlay the budget against activity  
• Lack of detail in service specification drives inconsistency across services |
| Single IT platform & Integrated ECR | • Systems do not connect and health and care professionals often do not understand the systems  
• Access to patient level information from other agencies is based on relationships rather than being granted systematically |
| Increased access to specialist / therapy services | • Existing specialist provision does not match demand, thus waiting lists are generated, e.g. there are only 2 WTE cardiac specialist nurses across the whole of the East Riding  
• Many patients enter the acute system for psychological reasons, e.g. anxiety, which could have been managed in the community |
| Clear role for community hospitals | • Local populations value their local community hospitals and feel a connection with them  
• The role of community hospitals would benefit from re-clarification, especially given that they are seen as a premium rate service or resource  
• There is space / capacity at many community hospitals to do more |
| Co-location and integration | • It is felt that sometimes patients may not get the best care as services are not joined up; e.g. diabetes care: NCTs feel ‘separate’ to specialist services such as diabetes care  
• Community hospital staff find it difficult to provide continuity of care for patients because there are so many services involved in their care |
| 24/7 services | • Seamless services are required for unplanned care  
• Opportunity to expand the OOH nursing model to absorb more community demand and therefore demand on acute care |
| Flexible / skilled workforce | • The workforce is not trained to understand other service areas – this means some will sign post or refer to other services and others will not  
• Health professionals are ‘task orientated’ but need to take a holistic view of the patient: “treat the person, not the diagnosis” |
4. The vision for community care over the next 5 years
4. The vision for community care over the next five years

The overall vision for community care needs to complement the vision for the CCG ‘better care locally through transformation’. The vision emphasises the high importance that the CCG places on integration in addition to the needs for consistently good quality care that is delivered in the most appropriate setting for the patient.

Our vision for community services

‘A truly Integrated Health and Care Economy that delivers consistent, systematic, good quality community care by the right person, in the right place, at the right time whilst ensuring the long-term sustainability of the NHS in East Riding’.

Community hub

A component of this strategy is the development of a community hub within each East Riding locality. The diagram below outlines the seven functions of a community hub which will be explained in greater detail in the next section.
4. The vision for community care over the next five years

Our desired outcomes

The table below outlines our desired outcomes from a successfully implemented community care strategy in addition to what these mean for East Riding.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>What does it mean?</th>
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| Healthy independent ageing        | • Patients and their carers are confident and have the knowledge to manage their health needs where appropriate  
• Patients feel empowered and have the information they need to take control of their own health and social care                                                                                     |
| Consistent quality across areas   | • Good quality care is delivered across all localities against an agreed well recognised East Riding Standard  
• Quality will be the same as it is now or better                                                                                                   |
| Home / community is the default care setting | • As many services as possible are delivered in the home or close to home  
• Local hubs are the focus of local health and social care services and the local community  
• Local health and social care services are co-designed by the community  
• Patients will only be admitted to secondary care when no appropriate alternative is available in the community                                 |
| Joined up care                    | • Teams transcend the boundaries between community, primary, secondary and social care  
• Highly trained, up-skilled flexible teams operate within and between localities                                                                           |
| Widely understood patient pathway | • The range of care services available is well publicised and understood by patients, carers and professionals                                                                                                        |
| Flexible access to services       | • Patients have 24/7 access to good quality care by the right person, in the right place through a range of channels  
• There is a well recognised single point of access with support to citizens, patients and professionals through care navigators |

Better care, more locally, within budget, through transformation
5. How our vision will be achieved
5. How our vision will be achieved

High performing localities with a community hub will be at the heart of delivering our revised community commissioning model.

**What do we mean by a community hub?**

Hubs will have strong interdependences with the wider community as can be seen in the picture above. They will enable and support the delivery of a wider range of services locally and integrated working, across the 5 localities of ERY CCG. They will achieve this by:

- **Localising the most common services** people need for everyday illnesses and injuries

- **Integrating and joining-up clinical services** with others such as social care to intervene earlier along the patient pathway and reduce hospital attendances and admissions over the longer term. This in turn will help to create ‘up stream’ benefits such as fewer acute excess LoS bed days and fewer 30 day acute readmissions i

- **Centralising services currently delivered locally**, where access allows, achieving economies of scale

- **Providing the appropriate infrastructure** so that some services currently delivered in hospital can be delivered locally

- **Providing a point of transition between acute and primary care services** in both directions

- Hubs may include a range of services including wellness teams, diagnostic and rehabilitation services. The vision sees at least one hub within each locality. The size and location of these services is yet to be determined.
### Functions of Locality Hubs

<table>
<thead>
<tr>
<th>Function</th>
<th>Description</th>
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</table>
| **Communication & navigation**               | • An information and co-ordination centre within a community hub  
• Can be contacted by the citizens, patients & healthcare professionals seeking the most appropriate care for their patients  
• Covers statutory & non statutory services  
• Fill gaps between 111, Map of Medicine and NHS Choices |
| **Care co-ordination & personal care planning** | • Development of co-ordinated, integrated and consistent care plans for those who need them  
• These will be managed by a care co-ordinator and primarily but not exclusively aimed at those patients already ‘in the system’  
• Integration of care teams across primary, community and social care to reduce fragmentation and increase consistent and systematic treatment |
| **Wider community support**                  | • Multi-agency initiative – local authority, community and voluntary sector  
• Links to non health related statutory services – for example housing and benefits advice  
• Independent sector organisations will either be delivered or signposted to in the hub |
| **Staying healthy & independent living**     | • Prevention and social inclusion initiatives to better enable independent living  
• Recognition and support for carers to support patients in their own home  
• Promotes self care and management |
| **Community based care**                     | • Efficient planned episodes of care delivered through the hub eg Wound Care  
• Efficient and effective delivery of planned care services separate to urgent care services (when appropriate)  
• 7 day service provision  
• Delivered by integrated community, primary and social care teams |
| **Recovery & re-ablement**                   | • The hub will manage referral to and discharge from hospital more effectively including an efficient discharge to assess system  
• End to end support for patients who require an acute stay |
| **Complex case management & rapid response** | • An urgent response frailty pathway team located at a hub delivering a rapid response to appropriate patients including rapid access to care packages as required  
• Access to rapid access diagnostics and clinic assessments when required  
• A ‘discharge’ to assess’ process in place – patients are discharged when medically fit and assessed in their home environment  
• 7 day service provision integrated with Out of Hours service |
## 5. How our vision will be achieved

### 2. Communication and navigation

| What are the initiatives? | • Creation of an information and co-ordination centre within the community (although not necessarily within each locality) that can be contacted by citizens, by patients and by healthcare professionals seeking the most appropriate route for their patients  
| | • In line with the Single Point of Contact initiative this service will be accessed via a single number and routed to the correct setting (which may be a hub)  
| | • Therefore for citizens ‘navigation’ will be accessed via the Single Point of Access number. Further work is required for a single point of access for professionals  
| | • Covers all services available in all settings (acute, community healthcare, social care and primary healthcare) including non statutory services  
| | • Supports citizens in progressing down a health pathway – for example if they need to alter a health appointment but do not know who to contact  
| | • Linked in to all health providers and allocates patients based upon an understanding of their needs and the resources available  
| | • Includes the development of the Community Directory of Services (C-DoS) and information points within the hub  
| | • There are opportunities for more IT based / digital solutions within the hub to support care navigation  
| What issues does it address? | • Over reliance on hospital based services  
| | • Need for a common understanding of services  
| | • Enables the ‘proactive’ phase of the pathway that see citizens being able to access information and advice about their care and other public sector services  
| Which outcomes does it relate to? | • Consistent quality across all areas  
| | • Home / community is the default setting  
| | • Widely understood care pathways and services  
| What are the financial benefits? | • Reduction in A&E attendances  
| | • Reduction in hospital admissions  
| What are the qualitative benefits? | • Improved, consistent patient experience  
| | • Most appropriate care provided due to an improved understanding of services available  
| Link with the hub | • Navigation will be based in the hub and focus on access to all services delivered in a locality  
| | • Information points on services available to patients will be based in the hub  
| Link to better care fund workstreams | • Single point of contact  

Better care, more locally, within budget, through transformation
### 5. How our vision will be achieved

#### 4. Care co-ordination and personal care planning

| What are the initiatives? | Development of co-ordinated, integrated and consistent care plans for all patients who need them  
|                          | Planning to include, personal care planning for patients who require long term support, dietary advice/support and social prescribing  
|                          | Patients at the top of the risk stratification pyramid who require complex case management will have a care plan  
|                          | Patients in the centre of the risk stratification pyramid who require ‘care navigation’ may have a care plan – particularly if they are suffering from multiple long term conditions or on a sharp trajectory towards the top of the risk stratification pyramid |

| What issues does it address? | Lack of services focused on staying healthy  
|                            | Over reliance on hospital based services  
|                            | Need to deliver more proactive care |

| Which outcomes does it relate to? | Healthy independent ageing  
|                                  | Joined up care |

| What are the financial benefits? | Reduced expenditure on travel  
|                                  | Reduction in duplicated diagnostics  
|                                  | Reduced A&E attendances  
|                                  | Reduced acute admissions |

| What are the qualitative benefits? | Improved, consistent patient experience  
|                                   | Most appropriate care provided due to an improved understanding of services available |

| Link with the hub | Care planning will be supported from the hub through a multi disciplinary community based team  
|                   | A wellness team will be based in the hub to support patient derived planning in line with their own priorities and goals |

| Link to better care fund workstreams | Single point of contact through focus on care co-ordination  
|                                     | Prevention and self-care  
|                                     | Electronic care record |
## 5. How our vision will be achieved

### 1. Wider community support

| What are the initiatives? | • Essential to the success of community hubs will be adopting a multi-agency asset based model of community development. Relevant non health related statutory and non statutory ‘non statutory services’ will be represented in there<br>• Local independent groups and services generally reflect the needs of the community. As a hub becomes increasingly established within the community ‘gaps’ in services may emerge. The Connecting Communities Grant funding is available to support the development of community focused initiatives, led by local people.<br>• Community co-ordinators employed through the local authority will be an essential component for supporting this hub function<br>• Connect to Support developed by the East Riding of Yorkshire Council will provide a data base of available community support this information will be accessible through the hub<br>• Some initiatives may be eligible under the social prescribing initiative (eg exercise classes) whereby GPs can prescribe a course for their patients<br>• An example of a link to statutory services would be a mechanism for patients to access housing and benefits advice and support through the hub – transforming it into a one stop shop for a number of public services<br>• The hub will be a place where independent and voluntary sector services could either deliver their service (for example Citizens Advice Bureau, mind cafes, luncheon clubs and support groups) or where citizens can be signposted to their services (for example local exercise clubs or interest groups) |
| What issues does it address? | • Areas where we are performing ‘worse than average’ including obese adults<br>• Over reliance on hospital based services<br>• Gap in service provision to support staying healthy and independent living |
| Which outcomes does it relate to? | • Healthy independent ageing<br>• Home / community is the default setting<br>• Flexible access to services |
| What are the financial benefits? | • No specific financial benefits attached to this function |
| What are the qualitative benefits? | • People maintaining their independence<br>• Social inclusion |
| Link with the hub | • Advice / support (e.g. benefits advice) may be delivered from the hub<br>• Some independent sector services may be delivered from the hub<br>• Signposting to appropriate services should actively take place within the hub |
| Link to better care fund workstreams | • Prevention and self-care |
### 5. How our vision will be achieved

#### 3. Staying healthy and independent living

| What are the initiatives? | • Prevention initiatives social inclusion initiatives to better enable independent living and an improved quality of life – particularly for older people  
| | • This initiative will support all categories of patients. It also includes a proposed wellness team to pro-actively support the population in keeping healthy and maintaining their independence  
| | • It will also provide services to support people with identified conditions in maintaining their independence, e.g. long term conditions or MSK  
| | • Supporting both patient and professional carers in how to support their patients in managing their conditions at home rather than accessing an acute setting  
| | • Support to change behaviours such as smoking and alcohol misuse in addition to lifestyle information will be a key part of this, as will inclusion of local authority and third sector services provided in the hub as appropriate  
| | • Patients at the bottom of the pyramid will be encouraged to drive and maintain their personal health & wellbeing in pursuit of the wellness and maintain their independence through giving them the confidence to manage their own conditions better. These will not be mandatory but support will be available in the hub to develop these where requested |

| What issues does it address? | • Increase in patients with complex needs  
| | • A lack of services focused on staying healthy |

| Which outcomes does it relate to? | • Healthy independent ageing  
| | • Home / community is the default setting  
| | • Flexible access to services |

| What are the financial benefits? | • Reduced attendances to A&E  
| | • Reduced hospital admissions  
| | • Reduced pharmacy bill  
| | • Reduced travel costs |

| What are the qualitative benefits? | • People maintaining their independence  
| | • People being treated closer to home |

| Link with the hub | • Services to support this function will be co-ordinated and delivered through the hub |

| Link to better care fund workstreams | • Prevention and self-care |
5. How our vision will be achieved

<table>
<thead>
<tr>
<th>5. Community based care</th>
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</thead>
<tbody>
<tr>
<td><strong>What are the initiatives?</strong></td>
</tr>
<tr>
<td>• Where appropriate patients will receive their care in a clinical setting. This may include their own home where a patient is assessed as meeting the definition of housebound guidelines</td>
</tr>
<tr>
<td>• Pro-active and routine generic care delivered in the appropriate setting the definition of housebound guidelines) or in the hub</td>
</tr>
<tr>
<td>• Wound care including chronic wound care, specialist assessments including Doppler assessments, post operative wound care</td>
</tr>
<tr>
<td>• The team would be multi agency, multi disciplinary and co-located including nurses, social care, therapies and older peoples mental health</td>
</tr>
<tr>
<td>• All patients would receive a holistic individualised assessment of their needs; including the identification of carers’ needs</td>
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<tr>
<td>• Where practical the care and support will be joined up, and offered in a ‘one stop visit’ to avoid duplication</td>
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<tr>
<td>• Effective use of the workforce to deliver unplanned care</td>
</tr>
<tr>
<td>• Carrying out pre-operative assessments where appropriate</td>
</tr>
<tr>
<td><strong>What issues does it address?</strong></td>
</tr>
<tr>
<td>• An over reliance on hospital based services</td>
</tr>
<tr>
<td>• The need for co-location and integration</td>
</tr>
<tr>
<td>• Workforce modernisation</td>
</tr>
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<td><strong>Which outcomes does it relate to?</strong></td>
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<td>• Reduced A&amp;E attendances</td>
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<tr>
<td><strong>What are the qualitative benefits?</strong></td>
</tr>
<tr>
<td>• Identifying other medical and social care issues early to prevent admission</td>
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<tr>
<td>• Enhanced patients satisfaction</td>
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<tr>
<td>• Continuity of care</td>
</tr>
<tr>
<td><strong>Link with the hub</strong></td>
</tr>
<tr>
<td>• The community team would be co-located in the hub</td>
</tr>
<tr>
<td>• Services will be developed in the hub where possible</td>
</tr>
<tr>
<td><strong>Link to better care fund workstreams</strong></td>
</tr>
<tr>
<td>• Resources and infrastructure – co-location and community hubs</td>
</tr>
<tr>
<td>• Ambulatory Care – planned /proactive approach to community based care</td>
</tr>
</tbody>
</table>
## 5. How our vision will be achieved

### 6. Recovery and re-ablement

| What are the initiatives? | A planned service based in the community hub, tasked to manage referral to and discharge from hospital more effectively  
|                          | Discharges would be planned by a case manager or care co-ordinator supported by a team that includes social workers, GPs, nurses, physiotherapy, pharmacy and equipment services  
|                          | Facilitated through a local transport service, the vision is that the majority of patients would come to the hub. Those unfit to travel will be seen at home, as will those where home visits are more clinically appropriate  
|                          | The emphasis will be on supporting people to recover from illness / injury to enable them to regain their independence  
|                          | “Discharge to Assess” will be a key principle of the service. When a patient is medically fit for discharge and requires MDT assessment for activities of daily living or minor equipment the patient will be discharged to a home environment and the assessment will be carried out there within 2 hours of arriving home  
|                          | This will be linked to increased appropriate utilisation of community beds |
| What issues does it address? | An over reliance on hospital based services  
|                          | Under utilised community beds |
| Which outcomes does it relate to? | Home / community is the default setting  
|                          | Joined up care  
|                          | The need to manage increased demand within the same financial envelope |
| What are the financial benefits? | Reduced expenditure on travel  
|                          | Reduction in duplicated diagnostics  
|                          | Reduced A&E attendances  
|                          | Reduced acute admissions |
| What are the qualitative benefits? | Reduced “heat” in primary and social care  
|                          | Identifying other medical & social care issues early to prevent admission  
|                          | Facilitated discharge  
|                          | Reduced Length of stay |
| Link with the hub | The discharge team would be based in the hub. Patients would be referred through a case manager  
|                          | Care would be co-ordinated through the hub |
| Link to better care fund workstreams | Early supported discharge |
### 7. Complex case management and rapid response

| What are the initiatives? | • A re-active service based in the community hub to manage patients who have urgent care need closer to home.
|                          | • These patients would be referred to a care – co-ordinator who is supported by a team that includes social workers, GPs, nurses, physiotherapy, pharmacy and equipment services.
|                          | • Facilitated through a local transport service, the vision is that where appropriate patients would come to the hub due to the availability and co-location of services including diagnostics. Where a patient is housebound or coming to a hub would not be appropriate care will be delivered from home. |
| What issues does it address? | • Over reliance on hospital based services
|                          | • Increase in patients with complex needs
|                          | • The need to manage increased demand within the same financial envelope
| Which outcomes does it relate to? | • Home / community is the default setting
|                          | • Joined up care
|                          | • The need to manage increased demand within the same financial envelope
| What are the financial benefits? | • Reduced expenditure on travel
|                          | • Reduced A&E attendances
|                          | • Reduced acute admissions
| What are the qualitative benefits? | • Better patient experience
|                          | • Patient managed closer to home
|                          | • Continuity of care
|                          | • Reduced pressure in primary and social care
|                          | • Identifying other medical and social care issues early to prevent admission
| Link with the hub | • Rapid response teams will be co-located in the hub
|                          | • An appropriate level of diagnostic testing will be available in the hub to support this service
| Link to better care fund workstreams | • Ambulatory care
6. Enabling our new commissioning model
A set of specific key enablers must be deployed in order for our identified approach to be as effective as possible. They are:

a. Finance and contracting
b. Technology
c. Workforce
d. Transport
e. Communication
f. Governance
g. Infrastructure

Over the following pages we describe how these key enablers will change in order to support the delivery of more effective community care for our population.
6. Enabling our new commissioning model

a. Finance and Contracting

Current Challenges

• Current community block contract leads to difficulties in the following areas:
  • evaluating value for money of services
  • deconstructing block contract and understanding what the CCG is actually commissioning and actually receiving from the provider
  • re-allocating funding for service redesign
  • Identifying the quality care being commissioned
• Measuring on impact by numbers going through the system rather than quality of care
• Feeling of inequity of provision between localities

Future direction

• Commissioning based on outcomes with quality incentives built in: outcome based commissioning (OBC) provides a value-driven approach to commissioning that aligns incentives to enable the co-ordinated delivery of outcomes that matter to the public and service users
• Focusing on the **value** of care delivered for patients & the public:

\[
\frac{\text{Health outcomes achieved}}{\text{Cost of achieving those outcomes}} \quad = \quad \text{Value}
\]

• Implementing a ‘draw down’ contract: overarching contract with detail developed, owned and managed within commissioning localities
• Securing longer term contracts, 3 to 5 years, to provide the space for providers to respond
• Developing a capitated budget (where a provider is given a set fee per citizen) e.g. Alzira case study, PwC Spain. Providers must pay 100% of costs for their population attending other providers and receive a lesser % of the price for patients attracted to their services, so that demand is not simply suppressed

Benefits

• Performance measured on quality rather than quantity
• Provider focused on ‘strategic direction’ due to longer term contract
• Less fragmentation due to fewer contracts
• Services more responsive to local population needs due to devolution of budget to localities
• OBC case studies show per capita cost savings in the range of 5% (PACE, USA) to 29% (Roverto Study, Italy). Source: PwC UK
b. Technology

Current Challenges

• Clinicians have no ‘single view of the patient’ and their care journeys
• Lack of care co-ordination within and between care settings which can limit patient flow. For example no electronic discharge information in community hospital
• Information sharing is currently based on relationships rather than defined criteria
• Absence of technological solutions leads to inefficient processes, e.g. district nurses taking notes on paper and returning to office to type them up
• The absence of an integrated ECR makes patient experience and pathways fragmented. Those with complex LTCs face a disjointed service which can lead to unnecessary and costly admissions to and delayed discharges from hospital
• Difficult to carry out proactive or predictive care, so patients receive reactive care. “A reactive approach to treatment is financially unsustainable,” Sir Stephen Bubb. Source: HSJ, 13 Dec 2013
• Lack of real time reporting capabilities limits back office ability to support service improvement. Reliant on ‘lag’ data, i.e. data is 2 to 3 months old before it is available to commissioners
• The demands of the BCF agenda for the CCG to use technology to pursue integration
• No single record for people at the end of their life, resulting in unnecessary and inappropriate admissions to hospital, which may result in non-achievement of preferred place of care
• Lack of mobile data connectivity across East Riding which limits mobile working
• Defining how to address stakeholder information priorities while maintaining budgets In reviewing stakeholder requirements, some clear priorities have been established and these must be addressed for ERY CCG’s new commissioning model to succeed:

Future direction

• Technology will be deployed more effectively to deliver the seven functions of an ERY community hub
6. Enabling our new commissioning model

b. Technology (continued)

- This will be dependent on other enablers being put in place. For example operational redesign, strategic alignment, incentivisation to use the new technology, financial agreements, governance, data sharing agreements etc.

- The use of technology will help clinicians treat patients remotely. For example East Kent University Hospitals NHS Trust uses a range of devices including mobile notifications of vital patient indicators, predictive modelling techniques to highlight potential system blockages in time to allow clinicians to avoid them and data linkage between acute and non-acute settings

Benefits

- Faster diagnosis and decisions
- Reduction in acute admissions. For example Canterbury, New Zealand case study: 6 hour ‘discharge or admit’ target achieved in 95% of cases; 20,000 acute admissions avoided pa, with patients cared for in community settings; 1.5 million days of patient waiting time eliminated. Source: Canterbury District Health Board 2014
- Improved end of life care
- Further benefits are outlined below

ECR supports a whole system approach to health and well being

Prevents duplication of diagnostics, thus improving patient experience, cutting time wastage and avoiding cost for both patient and provider

Option to deploy a Patient Portal to engage patients in their own care and to add to their care record, under guidance

Auditable system with access to and activity within care records recorded, monitored and reported

Through storing patient data on an electronically-based and smartphone capable system, it can be accessible to all authorised users 24/7, concurrently, in multiple locations

Enables more proactive and predictive care

Technology can help overcome remoteness and other impacts of rurality and a geographically dispersed population: “Connected Care”

Increases clinicians’ ability to deliver services in non-acute settings

Improves patient safety and reduces clinical risk

Efficiency gains, e.g. professionals no longer have to chase each other for information because they can access it themselves

Reduction in hospital admissions because clinicians have fuller picture of the patient
6. Enabling our new commissioning model

c. Workforce

Current Challenges

• Workforce not designed to manage the increasing number of complex patients
• Clinicians feel they have a ‘lack of time’ to spend with patients
• Health professionals are ‘task orientated’ – need to take a holistic view of the patient

Future direction

The health and social care economy will need to develop an agile workforce that can adapt to new ways of working. This is a key dependency for both clinical and operational benefits of the new commissioning model to be realised.

The current Neighbourhood Care teams will be developed into locality based (NB: new definition of ‘Locality’ being developed by ERY Ambulatory Care workstream), multi disciplinary co-located, integrated care teams. Key to this will be the development of a number of new roles or functions which will be taken by existing staff. Staff will have the skills, knowledge and experience to work across the teams:

• **Wellness team.** To support the maintaining independence and community support function
• **Discharge team.** To support the recovery and re-ablement function
• **Rapid response team.** To support the rapid response function
• **Planned care team.** To support the care co-ordination and personal care planning function and the community based care function

It is acknowledged that a comprehensive training programme would need to be developed - potentially through ‘advanced training practices’. Developing a comprehensive range of training will support the CCG in attracting and retaining good quality clinicians.

Benefits

• Multi-disciplinary workforce
• More patients treated closer to home
• Attractive and rewarding roles for clinicians – helps attract and retain talent
• Better continuity of care
d. Transport

Current Challenges

• The geographic distribution of the East Riding population leads to patients, citizens and health and social care professionals travelling extensively across the patch. This leads to significant ‘unproductive’ clinical time.

• The frictional effect of distance and travel time can deter patients from accessing more appropriate care, for example an A&E instead of an MIU in the CHERY or North Holderness areas.

• The need for patients to travel to services risks them not being ‘fit for treatment’ once they arrive there – for example pulmonary rehabilitation' patients

• Transport accounts for 4% of CCG expenditure, some £14 million per annum. It is thought that much of this is due to need to travel ‘out of locality’. Inter-locality referrals may be forcing patients to travel further

• Emergency transport costs make up 81% of the total transport budget. Patient Transport Service costs make up 15% and Non-emergency (111) transport costs just 4%

• This analysis implies that emergency response is the most utilised mode of patient transportation

• ERY CCG commissions Yorkshire Ambulance Service (YAS) to provide the significant majority of its Transport. There is “soft evidence” to suggest that existing contractual arrangements can prevent the most effective care being provided. For example PTS must be booked by 12pm daily and is only available Monday to Friday. Thus a patient who is ready for discharge from hospital at 12.05pm on Friday can be held in hospital until some time on the following Monday

Future direction

• Greater use of ‘elective’ or timetabled transport to bring high volumes of low-intensity patients (who are fit to travel) to the community hubs for their care and support, rather than professionals having to travel around the patch so extensively to deliver it

• Greater plurality of Transport provision

• Greater use of 3rd sector to drive vehicles. For example. York NHS FT have volunteers who carry out patient transport duties

• Increased flexibility within contracts to fit transport in around care packages, and not the other way round

Benefits

• Transport enables the proactive care, pre-hab and re-hab of high volumes of low intensity patients and ‘pre-patients’

• Transport is better able to support optimal use of community hubs
6. Enabling our new commissioning model

e. Communication

Current Challenges

• Understanding of current health services available in the area and how to access them is variable amongst health and social care professionals.

• Clinicians do not always understand each other’s roles – for example the distinction between the role of the community nurse vs the role of the practice nurse

• Lack of clarity amongst patients and the public about how to access services – particularly out of hours

Future direction

• Care navigation provided through community hubs / SPA

• Development of health pathways – patient pathways is agreed between GPs and hospital doctors and then utilised within the care navigators and single point of access service

• Pathways and associated information made available to patients through patient portal

• The range of care services available are well publicised and understood by patients, carers and health professionals

• Openness and transparency. In the Alzira model in Spain (which continues to see 91% patient satisfaction. Source; PwC UK), a ‘basket’ of outcome measures, agreed regionally, are reviewed weekly regularly by commissioner and provider and are then published in the local media each week

Benefits

• Commonly agreed view of patient pathways and services between clinicians

• Improved, consistent patient experience

• Most appropriate care provided due to an improved understanding of services available

• Providers can access each others patient information

• Patients provide the information once but it can be used many times

• Informed citizens and patients
6. Enabling our new commissioning model

f. Governance

Current Challenges

• Complexity of governance structures across the NHS and local authority leads to confusion, and potential for gaps in governance to occur

• Ensuring the continued integrity of the ERY system during and following the adoption of the new commissioning model through establishing sound, well-understood governance

Future direction

• Clarity of governance and accountability. “Where patient care depends on various forms of networking/partnerships, clarity of where accountability and responsibility lies is paramount.” Prof David Colin-Thomé, “The Patient Home”, 2011

• The future commissioning model anticipates a range of matrixed services that overlap and interlock. As such there is “no need for rigid rules of separation but (there is a need for) transparent accountability and governance.” Prof David Colin-Thomé, “The Patient Home”, 2011

• Establish shared leadership, e.g. through HWBB or, as in Cornwall, through a Summit: “effective governance arrangements need to be underpinned by senior executive support and dedicated programme management to turn high-level commitments into action. There is likely to be a gap between intentions and impact unless sufficient resources are identified; Source: ‘Making integrated care happen’, King’s Fund, 2013

How this aligns with your current model

• A key principle of this strategy is strengthening the East Riding localities

• Localities are currently governed through the Local Commissioning Forums (LCFs). These forums are for GPs in the locality and are chaired by a GP that has been elected to sit on the CCG board

• The focus of these forums is communication of decisions made at the CCG Governing Body, influencing strategy setting and developing small scale service change using a small funding pot that they are allocated

• There is significant potential to build on this existing structure to deliver the ‘future direction’ both through devolution of responsibility and expanding membership of the forums to include other health and care professionals

• Further detail on this will be determined in the detailed design phase of the strategy

Benefits

• Better understanding of the decision making process at all levels, in all settings

• Defensible governance structure through which decisions about the redesign of the ERY population's health and social care can be made and be seen to be made

• Creating the condition whereby professionals, the public and officials can be confident and assured in how public money is spent and public decisions are made
6. Enabling our new commissioning model

g. Infrastructure

Current Challenges

- The CCG owns and/or has access to a significant amount of physical infrastructure on the patch (for example Community Hospitals, MIUs)
- Evidence suggests that a significant proportion of this infrastructure is under-utilised; for example through low utilisation of community hospital beds
- Under-utilised infrastructure represents both significant cost for the CCG in addition to capacity that could be used for alternative service provision
- A key element of this strategy is for the CCG to develop or enhance how existing infrastructure is leveraged or utilised in such a way as to deliver greater value for its citizens

Future direction

- The key principal of this strategy is the development of community hubs that provide a physical single point of access to health and social care services for patients and integrated provision of services – therefore use of infrastructure will be a key success factor for this strategy
- The strategy will seek to optimise the use of existing assets such as community hospitals and MIUs as far as possible and in-keeping with the key design principles of a hub
- In pursuit of these ambitions, the CCG will review the role, purpose and value of our current infrastructure with a view to developing an economic case for each asset
- This will provide us with a comprehensive position statement of our current infrastructure including a clear plan of how this will evolve over the next five years in line with our refreshed community commissioning strategy

Benefits

- Better utilised estate that provides services closer to home for citizens in ERY
- Cost effective estates portfolio, with some costs released
- A clear purpose and sense of direction for all physical infrastructure within ERY
7. How unplanned care will fit into the new approach
7. How unplanned care will fit into the new approach

Observations on community beds

Challenges

- Bed occupancy rates are low
- Readmission rates to community hospitals are higher than expected against the national target of 5%

<table>
<thead>
<tr>
<th>Data period (Dec 12 - Nov 13)</th>
<th>Withernessa</th>
<th>ERCH</th>
<th>Bridlington MW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed occupancy rates</td>
<td>69.7%</td>
<td>59.4%</td>
<td>59.8%</td>
</tr>
<tr>
<td>Readmission rates</td>
<td>17%</td>
<td>20%</td>
<td>7%</td>
</tr>
</tbody>
</table>

- Accessibility of community beds appears to be an issue. At ERCH, only 80% of patients access a step-up bed within 24 hours and only 72% of patients access a step-down bed within 72 hours of referral

Potential Solutions

- Utilise the block contract to agree an arrangement with the acute trust – community beds could be used as an overflow from acute setting in exchange for other services e.g. community physio; more consultant outreach clinics
- As the community bed base is underutilised, make better use of the space, potentially from a commercial perspective
- Readmission rate signal a potentially inappropriate use of community beds. A review of the case mix could indicate the reasons for this
- Strengthening relationships with Out of Hours services may improve utilisation of community hospital beds and decrease reliance on acute-based services
- There is an overall opportunity to improve pathways to hospital. A community hub could support this
- There is an overall opportunity to reduce bed days in the acute through better utilisation of community beds

How the new community model could impact on community beds

- It is clear from the data that there is and will be in the future demand for community based ‘step up’ and ‘step down beds’
- It is also clear from bed utilisation rates that there is ‘capacity’ or ‘supply’ in the system to begin to meet this
- Through implementation of initiatives outlined within this strategy such as clinician focused care navigation and a shared and better defined patient pathway the desired outcome is greater alignment between demand and supply. We believe that this would result in better and more efficient utilisation of community beds
7. How unplanned care will fit into the new approach

Observations on MIUs

Challenges

- Reasons for difference/variation in service levels between MIUs need to be clear – difference is fine but there needs to be a rationale
- Utilisation of MIUs appears to be low, indicating that these services be used for other things. For example, follow up appointments for patients who have attended A&E could be delivered in an MIU. Staff could be interchangeable between services. Alternatively MIUs could be delivered in a different way
- MIUs could form one part of a more comprehensive service. For example a community hub solution would enable them to be more efficient
- See Appendix 6c for further information

- The MIU model in the Holderness locality should be reviewed; although there are two MIUs in this locality, patients still favour attendance at A&E (see Graph 1)
- The figures in Graph 1 demonstrate that there is still an over-reliance on A&E, given that nationally, only 8% of attendances to A&E are ‘blue light’
- Further analysis of times of day patients attend A&E and MIUs may provide further clarity in this area

Graph 1

Data taken from April 2012 – March 2013
7. How unplanned care would fit into the new approach

Re-visiting the East Riding MIU Offering

In response to the challenges highlighted on the previous page, we have identified the need to re-visit the ERY MIU offering:

- What is the purpose of an MIU in the East Riding?
- How do we sustain high quality and avoid variation across sites?
- How do we best mobilise local engagement with and understanding of MIUs among citizens, clinicians and other local stakeholder groups?

The following section outlines a potential approach, underpinned by a set of guiding principles. It articulates some of the interventions required to develop the East Riding MIU offering over the next 1 to 2 years into a service that meets and exceeds:

- Patient expectations
- Financial viability
- Appropriate clinical standards

Underpinning principles

1. There is a requirement for the clear definition of the core purpose of an MIU in the East Riding of Yorkshire
2. Each MIU requires clear clinical ownership, engagement and accountability
3. Each MIU provides services that reflect the needs of the local population they serve
4. Local clinicians from all care settings understand the role of the MIU, current levels of performance and how they can influence this
5. The use of technology to create a sense of community, identify and ownership around each MIU with the local population it serves (e.g. like Nuffield Health & Wellness centres)
6. The need for an on-going, long term deliberate communications effort to help bring about the necessary shift in awareness and mind-set about MIUs, e.g. similarities with national Smoking Cessation, Healthy Eating, Alcohol Awareness campaigns
7. MIUs to be connected to the ERY integrated ECR system and to use it by default
8. Consideration of innovative use of MIUs and their premises, which could see:
   - MIUs being proactive as well as reactive
   - MIU Outreach
   - Planned/elective MIU service eg Sunday morning drop in Baby Clinic
9. Consideration given to up-scaling MIUs to become part of Community Hubs; making use of existing facilities and space, including receptioning, parking & public transport links, waiting areas, café, existing clinical governance regimes, supply chain, pharmacy etc
10. These principles are based on making the most of what we have. An alternative option is providing the service completely differently
7. How unplanned care would fit into the new approach

We have outlined a potential approach and interventions required to develop the East Riding MIU over the next 1 to 2 years into a service that meets and exceeds:

- Patient expectations
- Financial viability
- Appropriate clinical standards

The relative timescales for these interventions are outlined below with further detail on each of them detailed over the following pages:

Indicative project plan for development & deployment of the revised East Riding MIU offering:

<table>
<thead>
<tr>
<th>Project Area</th>
<th>Q1 - 2014 / 15</th>
<th>Q2 - 2014 / 15</th>
<th>Q3 - 2014 / 15</th>
<th>Q4 - 2014 / 15</th>
<th>Q1 - 2015 / 16</th>
<th>Q2 - 2015 / 16</th>
<th>Q3 - 2015 / 16</th>
<th>Q4 - 2015 / 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construct the East Riding MIU Offer: what do we want from MIUs in ERY?</td>
<td>Define “good” High level design</td>
<td>Detailed design phase</td>
<td>Construct change programme and commence implementation</td>
<td>Implementation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assess financial viability of MIUs</td>
<td>Assess financial viability of current MIUs based on future model</td>
<td>Make decisions based on findings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assess causes of low utilisation &amp; variation between MIU sites</td>
<td>Conduct study Publish findings Apply findings to construction of new offering</td>
<td>Ongoing monitoring &amp; performance management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secure local clinical leadership</td>
<td>Agree local accountability model for MIUs</td>
<td>Identify clinical leadership with each locality</td>
<td>Drive local implementation with involvement from key local stakeholders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical stakeholder engagement and ongoing communication</td>
<td>Agree local approach to ongoing stakeholder engagement &amp; communication</td>
<td>Implement clinical engagement solution</td>
<td>Ongoing engagement and communication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citizen stakeholder engagement and ongoing communication</td>
<td></td>
<td>Implement citizen engagement solution</td>
<td>Ongoing engagement and communication</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>MIU connectivity with ERY ECR</td>
<td></td>
<td></td>
<td></td>
<td>As per ERY BCF programme</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 7. How unplanned care would fit into the new approach

#### Further detail on proposed initiatives

<table>
<thead>
<tr>
<th>1. Construct the East Riding MIU offer: what do we want from MIUs in ERY?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rationale</strong></td>
</tr>
<tr>
<td><strong>Suggested approach</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
| **Benefits** | • Higher utilisation of existing assets and workforce  
• More health services available closer to the citizens  
• Diversion of activity away from acute settings |

<table>
<thead>
<tr>
<th>2. Assess causes of low utilisation and variation between MIU sites</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rationale</strong></td>
</tr>
<tr>
<td><strong>Proposed approach</strong></td>
</tr>
</tbody>
</table>
| | • Quantitative: do those services on offer in the MIU and the times of opening meet the needs of the current population?  
• Qualitative: attitudes of clinicians and citizens to MIUs. What can be done to change these (if necessary) |
| **Benefits** | • Information that would provide a bottom up approach to the development of the revised East Riding MIU offering  
• Services within each East Riding MIU reflect the needs of the local population they serve |
### 7. How unplanned care would fit into the new approach

#### Further detail on proposed initiatives

<table>
<thead>
<tr>
<th>3. Secure clinical leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rationale</strong></td>
</tr>
<tr>
<td><strong>Suggested approach</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Clinical stakeholder engagement and on-going communication</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rationale</strong></td>
</tr>
<tr>
<td><strong>Suggested approach</strong></td>
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<tr>
<td></td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
## 7. How unplanned care would fit into the new approach

### Further detail on proposed initiatives

### 5. Citizen engagement and on-going communication

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Nationally and locally there is evidence to indicate that MIUs are not fully utilised due to citizens being unclear on the role of the MIU or even that they exist. In particular, this includes citizens understanding when MIU attendance would be more suitable or beneficial for them than A&amp;E.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suggested approach</td>
<td>Developing an on-going engagement and communications plan with the aim of raising awareness of the MIU and its functions amongst local citizens. This should include: • Consideration of how to make the MIU part of the community so that it becomes instinctive or the social norm to access an MIU rather than an A&amp;E. For example through social media and having services available at the MIU • A deliberate and on-going effort to build a ‘community’ and identify around the local MIU. Organisations in other sectors recognise not just the value but the pressing need to do this if they are to remain successful. e.g Nuffield Health &amp; Wellness, Starbucks and local government such as “My Tower Hamlets”. • Utilising traditional and non traditional forms of communication – not only leaflets but the media and accessing the local community through for example health trainers, inoculation clinics / events, wellness events and community groups • Considering other non traditional locations for the MIU to ‘go to the public’ – for example shopping centres, in the centre of town on a weekend</td>
</tr>
<tr>
<td>Benefits</td>
<td>• Increased awareness of the MIU amongst citizens • Increased utilisation of the MIU</td>
</tr>
</tbody>
</table>

### 6. MIU connectivity with ERY ECR

<table>
<thead>
<tr>
<th>Rationale</th>
<th>The MIU should be integrated electronically with other health and social care services in order to realise the benefits of an ERY electronic care record. Patients should only need to provide the information once and it should be used many times. When a patient attends the MIU their GP and other relevant health and care professionals should be able to access this information.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suggested approach</td>
<td>• As outlined in Section 7 ‘Enablers’ • MIU services should be integrated with the ERY integrated ECR system and use it by default</td>
</tr>
<tr>
<td>Benefits</td>
<td>• Holistic view of the patient • Reduced risk through health and social care professionals being able to see and understand the medical history of their patient • The use of technology to create a sense of community, identify and ownership around each MIU with the local population it serves</td>
</tr>
</tbody>
</table>
8. Financial benefits of the new approach
8. Financial benefits of the new approach

Financial opportunities

We have estimated the potential financial opportunities (savings) through financial analysis – included within the appendices to this report. We have mapped the savings below according to community hub function and by commissioning locality.

From the modelling and the above analysis, we can see that the hub functions which provide the most financial opportunities are **Care co-ordination and personal care planning (£1.43m)** and **Rapid response (£0.65m)**.

The locality which appears to have the highest potential financial opportunity is **GHWW and Haltemprice**.

Further detail from this analysis may be used to form the basis of an option selection model.
8. Financial benefits of the new approach

Financial Opportunities by Function

Navigation (projected total saving opportunity - £92,000)

- GHWW: 20
- Holderness: 14
- Haltemprice: 20
- CHERY: 18
- Bridlington: 20

Maintaining independence and community support (projected total saving opportunity - £240,000)

- GHWW: 52
- Holderness: 45
- Haltemprice: 48
- CHERY: 48
- Bridlington: 47
8. Financial benefits of the new approach

Financial Opportunities by Function

Care co-ordination and personal care planning (projected total saving opportunity - £1,184,000)

<table>
<thead>
<tr>
<th>Location</th>
<th>Saving Opportunity (£’000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GHWW</td>
<td>255</td>
</tr>
<tr>
<td>Holderness</td>
<td>193</td>
</tr>
<tr>
<td>Haltemprice</td>
<td>255</td>
</tr>
<tr>
<td>CHERY</td>
<td>233</td>
</tr>
<tr>
<td>Bridlington</td>
<td>248</td>
</tr>
</tbody>
</table>

Other community-based care (projected total saving opportunity - £106,000)

<table>
<thead>
<tr>
<th>Location</th>
<th>Saving Opportunity (£’000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GHWW</td>
<td>23</td>
</tr>
<tr>
<td>Holderness</td>
<td>17</td>
</tr>
<tr>
<td>Haltemprice</td>
<td>23</td>
</tr>
<tr>
<td>CHERY</td>
<td>21</td>
</tr>
<tr>
<td>Bridlington</td>
<td>22</td>
</tr>
</tbody>
</table>
8. Financial benefits of the new approach

Financial Opportunities by Function

Recovery and re-ablement (projected total saving opportunity - £185,000)

- GHWW: £40,000
- Holderness: £36,000
- Haltemprice: £36,000
- CHERY: £38,000
- Bridlington: £35,000

Rapid response (projected total saving opportunity - £554,000)

- GHWW: £119,000
- Holderness: £94,000
- Haltemprice: £117,000
- CHERY: £110,000
- Bridlington: £114,000
8. Benefits of the new approach

**Financial costs**

The financial costs associated with the implementation of the locality hubs proposal is highly dependent upon the approach taken.

There are many factors to consider in forming the cost assumptions for this project, and a detailed analysis of cost options is beyond the scope of this work. Factors to consider however include:

- Redeployment of existing staff and estates
- Additional specialities that may need to be brought in
- Initial investment in equipment and vehicles
- ICT and telephony infrastructure required
- Use of Third Sector & volunteers
- Use of private sector services

From PwC’s experience of other community care projects, the cost base ranges from 47% to 73% of gross savings. Due to similarities with projects at the lower end of that range, a good starting point assumption would be a cost base of between 50 – 60% for this project.
8. Benefits of the new approach

Example Financial Profile

Assumption: Each locality forms a hub with all of the six hub functions we have detailed.

**Gross financial opportunity to CCG:** £2.4m
- approximately 6.3% of the Community Care budget
- annual saving

Assumption: The cost base of implementation as per historical expectation (approx. 55%)

**Cost to implement hub model:** £1.37m
- includes both annual and one-off costs

**Net saving:** £1.03m
- approximately 3% of the Community Care budget
- conservative estimate of annual savings

It would be reasonable to expect some proportion of the costs of implementation to fall to the providers since the investment would remove some of the pressures upon both emergency and acute care.

**Note:**
The activity figures used in forming our savings estimates relate to the 2012/13 financial year. This was necessary in order to reduce the impact of seasonality of healthcare provision on the figures. The above savings therefore do not reflect the action taken against the QIIPP targets – which ultimately affect the same pool of patients.

QIIPP schemes already delivering gross savings on acute admissions in 2013/14 are:

- £650,000  Long term conditions schemes (including neighbourhood care and care home schemes)
- £350,000  COPD Pulmonary Rehabilitation service
- £150,000  Intensive hospital team - short stay management

Some of the savings identified above may therefore be eroded by the above progress against QIIPP.
9. Indicative high level road map
We include here an indicative high level roadmap to provide a view of what the associated detailed design phase and delivery phase could look like.

It sees an extensive programme of work being undertaken over an initial period of 3 years. It consists of a series of projects which run concurrently, controlled and co-ordinated by a programme and change management function.

The focus is on defining clear evidence-based outcomes, designing & commissioning a service to deliver those outcomes, and a rigorous focus on benefits realisation measurement.
10. Next steps
10. Next steps

Implementation Critical Success Factors

In order to realise the benefits identified in this commissioning strategy for community services in the East Riding, there will be a number of critical success factors:

1. Clinical and Organisational Leadership

Leadership is the single biggest contributory factor to the success or failure of a complex change programme. In delivering high value care systems, it is essential. Leadership will be required in two forms:

- Clinical leadership - to provide ongoing ownership and focus on the clinical design
- Desired outcomes and organisational leadership - to ensure the system holds itself to account, holds its nerve and retains the principle of being “organisation blind” - focusing on the outcome not the individuals role within an organisation

2. Strong and Deliberative Public Engagement

Engagement with the public will be key to outlining the benefits of this revised Community Services strategy, reducing the risk of opposition to the programme.


As has been well documented in this report, there is a strategic and financial imperative for action. Failing to transform the current system to a sustainable future model of care is simply not an option. A key tool the system will use to underpin the change will be a robust detailed business case.

This will enable the ERY health and social care economy to be rigorous in its pursuit of clinical outcomes and financial benefits. A key output of the next phase of this strategy should be a detailed business case setting out in detail the design, implementation plan, transition costs, re-provision costs and benefits profiles for each intervention.

4. Programme Management & PMO

Rigorous programme management is essential to ensure there is robust implementation plan, a delivery team is in place and the change is effectively governed to enable timely and effective decisions to be made, for them to be documented and risks a&e issues to be managed appropriately.

5. An Integrated Delivery Team

A fully integrated delivery team will be required to deliver and manage the transition to the new ERY commissioning model. Anticipated resources in the delivery team may include representation from the major stakeholder groups, programme management, design, clinical leadership, IIT, estates and workforce transformation.
10. Next steps

Implementation Critical Success Factors - continued

6. Innovative Finance and Contracting

Innovative forms of contracting will also be a critical success factor in the achievement of the new commissioning model. In this context, the ERY system will consider how the key commissioners i.e. ERY CCG and ERY Council can use contracting mechanisms to promote provider collaboration to allow a more cost effective integrated delivery model that drives value for money and improved clinical and care outcomes.

7. Timely access to Data and Systems

All of the interventions proposed in the refreshed commissioning strategy require technology enablement. Implementing systems in line with the delivery plan and providing access to robust information will be critical for achieving outcomes and delivering financial benefits.
Appendix 1

Stakeholder Engagement
A summary of stakeholders engaged with over the course of this project can be found below:

<table>
<thead>
<tr>
<th>Type of engagement</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workshops</td>
<td>3 sessions with GPs / CCG board</td>
</tr>
</tbody>
</table>
| Focus Groups       | NHS Humber FT staff - 17  
                      Social care professionals - 6 |
| Public Meetings    | Public event in Bridlington – 3\(^{rd}\) February  
                      Public event in Cottingham – 6\(^{th}\) February |
| 1:1 Interviews     | ERY CCG – 6  
                      GP Commissioner – 1  
                      Hull CCG – 1  
                      Hull and East Yorkshire Hospitals NHS Trust – 1  
                      NHS Humber FT - 2  
                      North Lincolnshire and Goole NHS Foundation Trust - 1  
                      Yorkshire Ambulance Service – 2  
                      York Hospitals Foundation Trust - 1 |
| Visits             | Bridlington Hospital  
                      East Riding Community Hospital  
                      Withernsea Hospital |
| Other              | Local Commissioning Forums – feedback via questionnaire from GPs |
Appendix 2

Health assumptions
This appendix provides the assumptions that have been used in the construction of this report including formally recognised assumptions from reputable sources.

<table>
<thead>
<tr>
<th>Assumption</th>
<th>Value</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E to Acute conversion rate</td>
<td>25%</td>
<td>CCG Information – MIDAS</td>
</tr>
<tr>
<td>PbR tariff based calculation of admissions</td>
<td>£1,600</td>
<td>CCG Information – BI</td>
</tr>
<tr>
<td>Average cost of A&amp;E attendance</td>
<td>£112</td>
<td>East Riding of Yorkshire CCG A&amp;E Data 2012-13 &amp; 2013-14YTD (BI Job Ref 2170)</td>
</tr>
<tr>
<td>Average Acute bed-day cost</td>
<td>£206</td>
<td>CCG Information – MIDAS</td>
</tr>
<tr>
<td>A&amp;E to Acute conversion rate:</td>
<td>25%</td>
<td>CCG Information – average from MIDAS</td>
</tr>
</tbody>
</table>

*These assumptions were reviewed by our programme clinical lead, Prof David Colin-Thomé and have come from recognised sources as detailed above*

Note:
Our assumptions and key data use 2012-13 figures in order to obtain a ‘whole year’ view (i.e. so that the information used isn’t skewed by seasonal effects). This information therefore does not take account projects that are already reducing the acute activity in 2013/14 some of which will be over the same patient cohort.*
Appendix 3

Financial assumptions
### 11. Appendix 3. Financial assumptions

The appendix provides the financial assumptions that lie behind the financial reporting in this document.

<table>
<thead>
<tr>
<th>Assumption</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Navigation</strong></td>
<td></td>
</tr>
<tr>
<td>% reduction in A&amp;E attendance</td>
<td>2%</td>
</tr>
<tr>
<td><strong>2. Maintaining independence and community support</strong></td>
<td></td>
</tr>
<tr>
<td>% reduction in A&amp;E attendance</td>
<td>0.5%</td>
</tr>
<tr>
<td>% reduction in travel cost budget</td>
<td>1%</td>
</tr>
<tr>
<td><strong>3. Care co-ordination and personal care planning</strong></td>
<td></td>
</tr>
<tr>
<td>% reduction in A&amp;E attendance</td>
<td>5%</td>
</tr>
<tr>
<td>% reduction in travel cost budget</td>
<td>1%</td>
</tr>
<tr>
<td><strong>4. Community-based Care</strong></td>
<td></td>
</tr>
<tr>
<td>% reduction in A&amp;E attendance</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>5. Recovery and re-ablement</strong></td>
<td></td>
</tr>
<tr>
<td>% reduction in travel cost budget</td>
<td>1%</td>
</tr>
<tr>
<td><strong>6. Rapid response</strong></td>
<td></td>
</tr>
<tr>
<td>% reduction in A&amp;E attendance</td>
<td>2%</td>
</tr>
<tr>
<td>% reduction in travel cost budget</td>
<td>1%</td>
</tr>
</tbody>
</table>

*These assumptions are conservative estimates. They were reviewed by our programme clinical lead, Prof David Colin-Thomé. Please note all functions with a % reduction in A&E attendances have a corresponding reduction in non-elective admissions. See appendix 2 for further detail*
Appendix 4

Commissioning locality specific data
Financial

Locality specific data: Bridlington (total community budget: £6.97m)

<table>
<thead>
<tr>
<th>Assumption</th>
<th>Value</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-13 A&amp;E attendances</td>
<td>7,958</td>
<td>CCG information - MIDAS</td>
</tr>
<tr>
<td>2012-13 transport budget (£)</td>
<td>2,424,846</td>
<td>2013-14 Budget Book - East Riding of Yorkshire</td>
</tr>
<tr>
<td>2012-13 pharmacy budget (£)</td>
<td>10,796,787</td>
<td>2013-14 Budget Book - East Riding of Yorkshire</td>
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</table>

Locality specific data: CHERY (total community budget: £7.82m)

<table>
<thead>
<tr>
<th>Assumption</th>
<th>Value</th>
<th>Source</th>
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<tbody>
<tr>
<td>2012-13 A&amp;E attendances</td>
<td>8,021</td>
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<tr>
<td>2012-13 transport budget (£)</td>
<td>2,786,292</td>
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<tr>
<td>2012-13 pharmacy budget (£)</td>
<td>8,815,950</td>
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Locality specific data: Haltemprice (total community budget: £6.70m)

<table>
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</thead>
<tbody>
<tr>
<td>2012-13 A&amp;E attendances</td>
<td>8,999</td>
<td>CCG information - MIDAS</td>
</tr>
<tr>
<td>2012-13 transport budget (£)</td>
<td>2,493,040</td>
<td>2013-14 Budget Book - East Riding of Yorkshire</td>
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</table>
11. Appendix 4. Commissioning locality specific data

Financial

Locality specific data: Holderness (total community budget: £7.06m)

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</thead>
<tbody>
<tr>
<td>2012-13 A&amp;E attendances</td>
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</tr>
<tr>
<td>2012-13 transport budget (£)</td>
<td>2,811,604</td>
<td>2013-14 Budget Book - East Riding of Yorkshire CCG</td>
</tr>
<tr>
<td>2012-13 pharmacy budget (£)</td>
<td>9,946,018</td>
<td>2013-14 Budget Book - East Riding of Yorkshire CCG</td>
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</table>

Locality specific data: GHWW (total community budget: £6.61m)

<table>
<thead>
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<th>Value</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-13 A&amp;E attendances</td>
<td>8,828</td>
<td>CCG information - MIDAS</td>
</tr>
<tr>
<td>2012-13 transport budget (£)</td>
<td>2,906,775</td>
<td>2013-14 Budget Book - East Riding of Yorkshire CCG</td>
</tr>
<tr>
<td>2012-13 pharmacy budget (£)</td>
<td>10,801,783</td>
<td>2013-14 Budget Book - East Riding of Yorkshire CCG</td>
</tr>
</tbody>
</table>
Appendix 5

Examples of community commissioning models from elsewhere
The following slides provide examples of good practice in commissioning from around the world. Some of these models were developed by PwC whilst others are not but all of them give a good idea of what can be achieved when good plans are implemented.

The models are grouped by the following four enablers which ERY CCG could emulate:

• Communication
• Workforce
• IT
• Finance and Contracting
Communication – Canterbury Health System New Zealand - 1

Healthpathways

*Improving interaction between hospitals and general practice*

- Pathways are local agreements on best practice
- They are created by bringing together hospital doctors and GPs to develop the patient pathway for a particular condition
- Pathways spell out the treatments that can be managed in the community, what tests GPs should carry out before a hospital referral, where and how GPs can access resources – including referral to other GPs practices
- Two systems emerged - Healthpathways, an electronic request management system, and Healthinfo, a patient centred website that provides the same information but in lay language
- In total there are 480 pathways which are devised, monitored and updated at a cost of £270k a year
- Changes the pathways have brought include some GPs being trained to remove more complex skin lesions without referral to hospital
- As almost all GPs follow the pathways patients can be sure of consistent treatment no matter which GP they go to

Picture from ‘The Quest for Integrated health and social care – A case study in Canterbury, New Zealand’. Kings Fund Report
Electronic Request Management

*Improving interaction between hospitals and general practice*

- ERMS is an Electronic Referral system between General Practice and other parts of the system – including private care
- GPs can use it to request tests, outpatient referrals, community assessments and specialist advice
- A distinguishing feature of ERMS is that data goes to a central repository and is available for re-routing
- Information also goes into a database of activity that offers possibilities for further analysis of what is happening in the health system, with a view to improving its operation and getting the right capacity in the right place
- The system is designed by GPs and hospital specialists
- There are no financial incentives to use the system but almost all practices do because it makes life easier
- 70% of referrals now go through the system

Picture from ‘The Quest for Integrated health and social care – A case study in Canterbury, New Zealand’. Kings Fund Report
Communication – health and social care system in the Midlands

**Single Point of Access (SPA)**

*Improving communication across the community, social and acute settings*

- A health and social care system in the midlands commissioned the introduction of a Single Point of Access (SPA) service during winter 2011/12
- The objective was to ensure patients receive the right care, at the right time, with the right service and the right people
- The project was led by the NHS Trust
- The SPA provided two key services:

  1. **Clinical Navigation** – Nurse-led telephony service, designed for the use of primary care professionals (i.e. GP’s, Community Matrons) to make unplanned care referrals into community services. This led to an immediate reduction in inappropriate admissions acute care.

  2. **In Reach** – The SPA provided in-reach services to the acute provider to identify and facilitate the timely transfers of patients from the acute care into community care.

- Co-location of the SPA with social services was a critical success factor
- Existing roles of the Admission, Discharge and Transfer teams were redesigned to deliver the SPA service
- SPA provided a single channel for all referrals into community care and social services
- Over 200 inappropriate acute admissions were avoided during winter 2011/12
- SPA model rolled out to neighbouring PCTs following its success
Identification of workforce roles
Identifying the out of hospital workforce model

- A London based CCG has the vision of providing more care closer to home so people can get easier and earlier access to care
- The CCG identified a hub type model whereby clinical services could be co-located and more readily integrated
- The CCG recognised that these changes will require new ways of working, and new roles
- These included:
  - **Case Managers** (which may be a GP or another professional) acting as the first point of contact for care and care planning for patients with a higher risk of hospital admission
  - **Care Navigators** (which may be volunteers) will support patients to navigate between services
  - **Health and Social Care Co-ordinators** (HSCC) will need to develop relationships and work closely with a range of professional groups to ensure patients receive joined-up care. The care co-ordinator role will require knowledge and skills in relation to social care and wider public services, as well as healthcare
Identification of workforce roles

A London based CCG has the vision of providing more care closer to home so people can get easier and earlier access to care. The CCG identified a hub type model whereby clinical services could be co-located and more readily integrated. The CCG recognised that these changes will require new ways of working, which will require further training. Hub type centres will be at the heart of training which will include:

- Multi-disciplinary team collaboration
- Referrals standardisation and peer review to manage referrals
- Administering tele-care and tele-health
- Supported discharge pathways
- Mental health care training for primary care staff (up skilling)

In addition, practices will work together to improve their services through benchmarks, audits and reviews to improve their services. Sharing patients across practices will give all practices an incentive to maintain and improve quality across the patch.
Workforce – health and social care system in the Midlands

New workforce model for integrated care

Teams to support an agile health and social care workforce

- This patch was recognised as having particular challenges regarding quality, a long standing financial deficit and a growing affordability gap. Two CCGs and the County Council’s commissioners came together to produce a Care Blueprint which would create a sustainable health and social care system for the population.

- A key component of the transition is to shift services from acute care into the community and closer to home. This requires associated changes to be made with regard to the location, skill set and skill mix of the workforce. To do this a number of new teams were identified:

  - Locally based integrated care teams – providing proactive care, the low and enhanced categories of intermediate care and supporting self care
  
  - Specialist intermediate care team – focusing on admission avoidance, supporting discharge from hospital and treating people in the community. There are 4 components, with staff rotating through them:
    1. intensive intermediate care
    2. crisis response
    3. single front door at A&E
    4. community discharge

- Clinical navigation – the Care Navigator service is designed to be the first port of call for the care professionals helping them navigate their way through the system.
IT – London Hospital Trust
Clinical and Patient Portals

Portals are playing a key role in delivering integrated care across the full range of healthcare settings

• A London trust is developing a portal approach to information management sharing in the pursuit of integrated care
• Portals provide an integrated view of the patient from the perspective of both the clinician and the patient
• Clinical portals give clinicians, social care workers and other MDT members a unified view of critical patient data across organisations irrespective of systems and varying locations
• Patient portals allow patients to participate actively in their own healthcare, from making informed health decisions and managing personal health services, to engaging in community activities, and managing chronic disease ‘patients are active participants not passive recipients in their care’ ‘no decision made about me without me’
• This solution offers the following benefits:
  o quality of care
  o clinical safety
  o efficiency and cash releasing savings
  o Improved patient experience
Finance and Contracting – Valencia and Madrid, Spain

Outcome based commissioning

*Capitated contracts that cover healthcare for a defined population*

- The Spanish healthcare system is facing similar challenges to the British one, with 16.6% of the population aged > 65, and demand and chronic illness prevalence increasing.
- The Spanish health system has been conducting a series of 'experiments' in using new payment mechanisms and incentives to improve the quality and affordability of healthcare.
- Benefits experienced to date include a significant increase in the quality of the patient experience and a reduction in total cost.

Key features include:

- **Population focus through outcomes based capitated budget** - Providers are paid the same irrespective of whether patients are treated in a hospital, in a clinic, or at home.
- **Openness and transparency** - The government collects a basket of outcome measures, agreed regionally, which are reviewed regularly by commissioner and published weekly in the local media.
- **Incentivising improvement** - Providers are commercially driven to improve. For example long term contracts encourage investment in secondary prevention which will deliver efficiencies in later years.
- **Money follows the patient** - Hospitals pay 100% of the costs for any of their population who choose to attend other hospitals and receive a lower percentage of the established price for patients who are attracted to their hospital, so that demand is not simply suppressed.

Hospital Rey Juan Carlos, Móstoles
Finance and Contracting – Health and social care system in the Midlands

Outcome based commissioning

*Single outcomes based contract for community services*

- This patch was recognised as having particular challenges regarding quality, a long standing financial deficit, and a growing affordability gap. Two CCGs and County Council commissioners came together to produce a Care Blueprint which would create a sustainable future for the population.

- The work covered all aspects of health and social care, with major workstreams on older people, long term conditions, elective care, urgent care and children’s & maternity.

- The process of creating the blueprint focused on population and individual outcomes and involved local patients, members of the public, primary and secondary care clinicians to establish the new patterns of care.

- Once the care blueprint had been created, the commissioners translated the outcomes into detailed service specifications, again working with local patients and clinicians to drive the process through care design groups.

- They are now establishing ways in which primary care can be drawn contractually into the new service.

- With the support of local providers, the commissioners are about to let a single outcome based contract along the lines of the innovative Spanish health system contracts.
The CCG are seeking to commission an MSK service provided via a single contract. Previously there have been multiple providers and 20 contracts required.

A leading independent sector provider is to become the prime contractor with a contract worth £120m over five years. The length of the contract provides the system with the time to develop and deploy the new service model.

The system is due to go live in early 2014.

The CCG reviewed their current approach to provision of MSK services and defined 7 key steps which will be covered in the single contract:

1. Prevention, support for self care and advice to patients, carers and professionals
2. Primary Care assessment, investigation, management, and onward referral
3. Community-based specialist MSK triage, assessment, investigation & management
4. ‘Discharge’ (i.e. transfer) back to support by primary care or supported self-care
5. Hospital-based specialist MSK intervention and immediate rehabilitation
6. Shared decision making, patient choice, surgical listing and fitness for surgery assessment
7. ‘Discharge’ (i.e. transfer) back to support by community-based specialist MSK team, primary care or supported self-care
Appendix 6

The ‘as-is’ document
The ‘As Is’ – baselining the current position

The aim of the “As Is” is to identify the baseline position of current Community and Unplanned Care on the ERY CCG patch with a view to providing a benchmark against which any future service changes can be judged or measured.

This section describes the “As Is” picture and consists of 4 areas:

4a. **“Hard evidence”**, such as performance reports, and data

4b. **“Soft evidence”**, such as verbal feedback through meetings, interviews and workshops

4c. **Unplanned Care**, focusing on MIUs and the community hospital bed base

4d. **Locality profiles**, taking information from the first three sections and applying it to each of the 5 ERY CCG localities, with recommendations

Towards the end of the “As Is”, we identify the gap with the “To Be” future commissioning model. This will inform the options for future “To Be” state that are explored in Section 5.
Appendix 6a

Hard Evidence
The population in East Riding is growing and ageing

- The majority of people living in the county are aged between 45 - 59. It is expected that by 2021 26% of the population will be over 65 years old.
- It is expected that by 2021 the population of ERY will have grown by 5.6%.
- This results in higher levels of age related challenges including Long Term Conditions, general frailty associated with the ageing process and deteriorating cognitive functions.
- Nationally, by 2018, the number of people with three or more long term conditions is expected to rise to 2.9 million; in 2008 this figure stood at 1.9 million.

Source: Populations data excel spreadsheet provided by ERY CCG, Office for National Statistics Data Joint Strategic Needs Assessment (JSNA) 2012, Department of Health (2012)
Pockets of deprivation exist and must be taken into consideration

- In the Health Profile 2013 for the East Riding of Yorkshire the health of the population is described as being ‘varied’
- It highlights that deprivation is lower than average, however about 7,400 children are living in poverty
- As can be seen from the map there are some locations that fall into the most deprived quintile
- Life expectancy is 6.8 years lower for men and 4.1 years lower for women in the most deprived areas of the East Riding of Yorkshire than in the least deprived areas

- Death rates across the CCG area have been decreasing except for the most deprived 20%
- To address the specific needs of residents in these areas services should be developed and delivered as locally as possible in line with the identified principle of an East Riding locality - ‘equity’

Source: ONS Health Profile for East Riding 2013, Joint Strategic Needs Assessment (JSNA) 2012
This map shows population density down to a Parish level.

This could be helpful in targeting where services should be provided to be accessible to as many people as possible.

Notably the community hospitals at Hornsea and Withernsea are surrounded by sparsely populated areas.

This information can be combined with deprivation and health needs data to further refine the placement of services. For example, a densely populated but largely healthy and wealthy area may have fewer health needs than a deprived area.
Better care, more locally, within budget, through transformation

Disease prevalence across localities

- Hypertension is the most prevalent condition across East Riding of Yorkshire with almost 50,000 people suffering from it
- Obesity, diabetes, and Coronary Heart Disease are the 2\textsuperscript{nd}, 4\textsuperscript{th}, and 6\textsuperscript{th} most prevalent conditions respectively

**Source:** East Riding of Yorkshire: Disease Prevalence (QOF Disease Registers) March 2013
Disease prevalence across localities

Number of people with diseases in 2012-13 and % change since 2008-09

- Most diseases have seen an increase in prevalence since 2008/09
- There has been a significant increase (30% of more) in obesity in adults, diabetes, cancer, dementia, adult learning disabilities and palliative care
- Four diseases have seen a decrease in prevalence, with only depression seeing a statistically significant decrease of 30%

Source: East Riding of Yorkshire: Disease Prevalence (QOF Disease Registers) March 2013, NHS Comparators
Predicted increase in disease prevalence across ERY

<table>
<thead>
<tr>
<th>% increase in population with disease or other ailment</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged 65+</td>
<td>16</td>
<td>30</td>
<td>45</td>
<td>62</td>
</tr>
<tr>
<td>Aged 65+ with a limiting long term illness</td>
<td>16</td>
<td>31</td>
<td>48</td>
<td>67</td>
</tr>
<tr>
<td>Aged 65+ with a longstanding health condition</td>
<td>16</td>
<td>30</td>
<td>47</td>
<td>65</td>
</tr>
<tr>
<td>Aged 18+ with a longstanding health condition caused by a stroke</td>
<td>12</td>
<td>24</td>
<td>37</td>
<td>50</td>
</tr>
<tr>
<td>Aged 65+ with a longstanding health condition caused by bronchitis and emphysema</td>
<td>16</td>
<td>31</td>
<td>46</td>
<td>64</td>
</tr>
<tr>
<td>Aged 65+ with dementia</td>
<td>14</td>
<td>37</td>
<td>65</td>
<td>99</td>
</tr>
<tr>
<td>Aged 18+ with diabetes</td>
<td>9</td>
<td>19</td>
<td>27</td>
<td>37</td>
</tr>
<tr>
<td>Aged 65+ with depression</td>
<td>16</td>
<td>30</td>
<td>44</td>
<td>62</td>
</tr>
<tr>
<td>Aged 75+ with a moderate or severe visual impairment</td>
<td>14</td>
<td>35</td>
<td>70</td>
<td>91</td>
</tr>
<tr>
<td>Aged 65+ with a bladder problem at least once a week</td>
<td>15</td>
<td>31</td>
<td>49</td>
<td>69</td>
</tr>
<tr>
<td>Aged 18+ with a moderate or severe learning disability</td>
<td>3</td>
<td>8</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>Aged 18+ with a learning disability</td>
<td>4</td>
<td>9</td>
<td>14</td>
<td>20</td>
</tr>
<tr>
<td>Aged 65+ predicted to be admitted to hospital as a result of falls</td>
<td>14</td>
<td>34</td>
<td>62</td>
<td>82</td>
</tr>
<tr>
<td>Aged 65+ helped to live independently</td>
<td>16</td>
<td>30</td>
<td>45</td>
<td>62</td>
</tr>
</tbody>
</table>

- This table shows the predicted increase in people suffering from various diseases or ailments, and also the over 65s.
- Notably, by 2030 it is expected that the number of people over 65 with dementia will almost double (99% increase), as will those over 75 with a moderate or severe visual impairment (91% increase).

Source: Joint Strategic Needs Assessment (JSNA) 2012
The CCG performs well against national indicators but there are opportunities for improvement

<table>
<thead>
<tr>
<th>Significantly Better than Average</th>
<th>Deprivation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Proportion of children in poverty</td>
</tr>
<tr>
<td></td>
<td>Obese children (year 6)</td>
</tr>
<tr>
<td></td>
<td>Alcohol-specific stays (under 18)</td>
</tr>
<tr>
<td></td>
<td>Teenage pregnancy (under 18)</td>
</tr>
<tr>
<td></td>
<td>Adults smoking</td>
</tr>
<tr>
<td></td>
<td>Hospital stays for self harm</td>
</tr>
<tr>
<td></td>
<td>Hospital stays for alcohol-related harm</td>
</tr>
<tr>
<td></td>
<td>Drug misuse</td>
</tr>
<tr>
<td></td>
<td>New cases of tuberculosis</td>
</tr>
<tr>
<td></td>
<td>Acute sexually transmitted infections</td>
</tr>
<tr>
<td></td>
<td>Male life expectancy</td>
</tr>
<tr>
<td></td>
<td>Smoking related deaths</td>
</tr>
<tr>
<td></td>
<td>Early deaths: cancer</td>
</tr>
<tr>
<td>Better than average</td>
<td>Physically active adults</td>
</tr>
<tr>
<td></td>
<td>Early deaths: heart disease and stroke</td>
</tr>
<tr>
<td></td>
<td>Female life expectancy</td>
</tr>
<tr>
<td></td>
<td>Infant deaths</td>
</tr>
<tr>
<td>Worse than average</td>
<td>Smoking in pregnancy</td>
</tr>
<tr>
<td></td>
<td>Increasing and higher risk drinking</td>
</tr>
<tr>
<td></td>
<td>Healthy eating adults</td>
</tr>
<tr>
<td></td>
<td>Hip fracture in 65s and over</td>
</tr>
<tr>
<td></td>
<td>Excess winter deaths</td>
</tr>
<tr>
<td></td>
<td>Incidence of malignant melanoma</td>
</tr>
<tr>
<td>Significantly worse than average</td>
<td>Starting breast feeding</td>
</tr>
<tr>
<td></td>
<td>People diagnosed with diabetes</td>
</tr>
<tr>
<td></td>
<td>Obese Adults</td>
</tr>
<tr>
<td></td>
<td>Road injuries and deaths</td>
</tr>
</tbody>
</table>

- The table above highlights ERY CCG’s performance against national indicators as set out in the ONS Health profile for 2013
- Overall the CCG performs well. For 14 out of 28 of these national indicators ERY performs significantly better than the England average, 4 are not significantly better, 6 are not significantly worse and only 4 are significantly worse
- Both ‘obese adults’ and ‘people diagnosed with diabetes’ are in the significantly worse than average section. Each of these areas can have a knock on effect on the wider health of the population and could potentially be addressed through services in community hubs
### Reasons for patients attending and being admitted from A&E

<table>
<thead>
<tr>
<th>Top 10 reasons: A&amp;E attendance</th>
<th>Cost £000</th>
<th>%</th>
<th>Top 10 reasons: A&amp;E admittance</th>
<th>Cost £000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 ‘Not Known’</td>
<td>132</td>
<td>19.6</td>
<td>‘Not Known’</td>
<td>73</td>
<td>21.9</td>
</tr>
<tr>
<td>2 ‘Diagnosis not classifiable’</td>
<td>82</td>
<td>12.2</td>
<td>‘Diagnosis not classifiable’</td>
<td>54</td>
<td>16.2</td>
</tr>
<tr>
<td>3 Gastrointestinal conditions</td>
<td>78</td>
<td>11.6</td>
<td>Gastrointestinal conditions</td>
<td>43</td>
<td>12.9</td>
</tr>
<tr>
<td>4 Dislocation/fracture/joint injury/amputation</td>
<td>77</td>
<td>11.4</td>
<td>Cardiac conditions</td>
<td>36</td>
<td>10.8</td>
</tr>
<tr>
<td>5 Soft tissue inflammation</td>
<td>69</td>
<td>10.3</td>
<td>Respiratory conditions</td>
<td>29</td>
<td>8.7</td>
</tr>
<tr>
<td>6 Central nervous system conditions (excluding strokes)</td>
<td>64</td>
<td>9.5</td>
<td>Central nervous system conditions (excluding strokes)</td>
<td>27</td>
<td>8.1</td>
</tr>
<tr>
<td>7 Laceration</td>
<td>48</td>
<td>7.1</td>
<td>Dislocation/fracture/joint injury/amputation</td>
<td>22</td>
<td>6.6</td>
</tr>
<tr>
<td>8 Respiratory conditions</td>
<td>43</td>
<td>6.4</td>
<td>Urological conditions (including cystitis)</td>
<td>20</td>
<td>6.0</td>
</tr>
<tr>
<td>9 ‘Nothing abnormal detected’</td>
<td>40</td>
<td>5.9</td>
<td>Local infection</td>
<td>17</td>
<td>5.1</td>
</tr>
<tr>
<td>10 Sprain/ligament injury</td>
<td>40</td>
<td>5.9</td>
<td>‘Nothing abnormal detected’</td>
<td>13</td>
<td>3.9</td>
</tr>
</tbody>
</table>

A number of diagnosis not classifiable cases are likely to have been for people who attended A&E when they need not have. This is likely to be the case for some of the soft tissue inflammation, laceration, and sprain cases also. (Stewart Bentley – ERY CCG)

**Source:** PwC analysis 2012-13 A&E attendance data
The 15-29 years age group has most attendances at A&E with 14,000

- This analysis shows a age-group breakdown of A&E attendances by locality
- The age group with the most attendances is the 15 – 29 age group, closely followed by the 75 – 85+ group
- The 15-29 age group has the highest number of A&E visits because it is the age bracket with the most people in it

- When weighted for population it is the 75-85+ age bracket that has the highest number of attendances – roughly 20% more than the 15-29 group and 50% higher than the lowest group
- Bridlington has the most A&E attendances in every age bracket
- These figures can help in targeting care to the localities and age groups where it is needed the most

Source: PwC analysis 2012-13 A&E attendance data
11. Appendix 6. The ‘as-is’ document

Map of “As Is” service provision

Better care, more locally, within budget, through transformation
Overview of Health Services in East Riding

Good practice that already exist and making use of the existing estate should be at the heart of the development of a refreshed community services strategy for East Riding.

**Primary Care**

There are currently 36 GPs practices across the CCG.

**Community Services (Neighbourhood Care Services)**

There are seven Neighbourhood Care Services Teams. Boundaries are co-terminus with social care and the East Riding localities. Teams are co-located and cover; district nurses, falls level 2 services, older peoples mental health, community matrons, wound care and diabetes care. Teams and locations are:

- Beverley NCS – ERCH (East Riding Community Hospital)
- Bridlington NCS – Bridlington Hospital
- Driffield NCS – Alfred Bean Hospital
- Goole and Howden NCT – Goole Hospital site
- Haltemprice NCS – The Grange
- North Holderness NCS – Hornsea Cottage Hospital
- South Holderness NCS – Withernsea Community Hospital

**Community Services (specialist services)**

A number of specialist services are delivered across East Riding. NCSs refer patients to these services as their needs become more complex.

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Source: NHS ERY – GP CC Localities in the East Riding of Yorkshire
Current good ideas delivered locally that could be developed and / or replicated through the strategy

Through the development of the strategy a number of interesting ideas currently being delivered locally have emerged. The CCG and providers are keen that the community strategy refresh provides a platform to build on good practice as much as possible.

**Community Equipment Service**
- Jointly commissioned through the CCG and the local authority
- Joint budget developed
- Joint contract in place
- Model could be applied to other services

**‘Organic Integration’ at Bridlington**
- Soft evidence that professionals are “naturally cross-pollinating” across organisational boundaries for the benefit of patients as a result of being co-located or adjacent to each other
- How could this be replicated through this strategy

**Local area coordinators**
- The local authority is piloting ‘local area co-ordinator roles’
- These roles will identify services in the community that address gaps not currently filled by statutory organisations and bring them together
- Could play a role in a community hub

**Neighbourhood Care Services**
- NCS will bring older peoples physical health and mental health services together in one team
- Will reduce duplication and provide a better experience for the patient
- Further areas to replicate this could be identified

**Social prescribing**
- Social prescribing schemes are currently being developed in ERY
- Provides a good example of pro-active care that could be built on in pursuit of the new ERY commissioning model

**Out of hours nursing**
- The ERY Out Of Hours Community Nurse service is in place but is seen as not providing the required benefits
- There is an opportunity to review how this service is provided in the context of the refreshed commissioning strategy for community care and the new ERY commissioning model
11. Appendix 6. The ‘as-is’ document

Mapping services against the future model of commissioning demonstrates a gap in services focused on ‘staying healthy and Independent living’

Staying Healthy & Independent Living

Rehab and Re-ablement

Community Care at Home

Complex Case Management

Unplanned Care

Key

[1] Provided by Humber FT
[2] Commissioned by CCG and Provided by ERY Council
[3] Independent Provider
[4] Doctor in community clinic
[5] Commissioned by ERY Council and provided by ERY Council
[6] Commissioned by ERY council and provided by voluntary sector
[7] Part of NCSs

[1] Tissue Viability Specialist service
Falls level 3
Bladder and bowel health
Older Peoples MH in patient services
[3] Hospice care (x4)
Macmillan Clinical Nurse Specialists
Granville Court – community based nursing home focused on learning disabilities
[7] Community matrons

[2] Level 1 falls service (ERY council and voluntary organisations)
E-enabling project
Health Trainers
Telecare
Public health

[3] Care In the Home – British Red cross

[1] Pulmonary Rehabilitation
Cardiac Rehabilitation
Stroke Rehabilitation
Musculo Skeletal service
[5] Re-ablement beds – Applegarth in Bridlington
Short Term Assessment and Re-ablement (STARS)
Practical Home Support Equipment Services

[3] Speech and language therapy
[1] Adult Mental Health Services
Dietetics

[1] Community pain services
Community beds
Beverley – ERCH
Community beds – Withernsea
Community beds – Bridlington

[7] Diabetic care
District nursing
Wound care
Falls level 2
[1] Home oxygen service
Adult learning disability services
[3] Community care at home
Hospice care (x7)

[7] Older people MH Services
Podiatry
Respiratory specialists

[2] Emergency Duty Team
[1] OOH Nursing
GP OOH

Better care, more locally, within budget, through transformation
Split of total budget by component services shows that the largest areas of expenditure are in acute services and prescribing.

- Acute services: 39%
- Prescribing: 14%
- Community services: 10%
- Mental health: 7%
- Transport: 4%
- Other non 'PbR' Block: 13%
- Non NHS: 5%
- Other: 8%

Total budget = £355m

- As expected, the two largest component services detailed within the 2013-14 Budget Book are for Acute services and Prescribing – together making up 53% of the overall budget.
- Non ‘payment by results’ (PbR) costs make up around 34% of the overall budget.

- To provide further detail we have split out Community services (10%), mental health and learning disabilities (7%), and transport (4%).
- The strategy recognises the desired default care setting to be Home/Community therefore we would expect to see a shift.
- Progress against this objective could reduce costs under the PbR mechanism by bringing the costs of care under the block contract.

Source: PwC analysis of the 2013-14 Budget Book

Better care, more locally, within budget, through transformation
Transport costs account for 4% of the total budget and is relatively stable across localities

- Transport costs make up 4% (approximately £14m) of the total budget
- We have analysed the costs and split the headline figure by both locality and transport service
- Emergency transport costs make up 81% of the total transport budget. Patient Transport Service costs make up 15% and Non-emergency (111) transport costs just 4%
- This analysis implies that emergency response is the most utilised mode of patient transportation
- Areas to consider include:
  - Potential that expensive Emergency Response transport being used for non-emergency situations
  - Inter-locality care referrals may be forcing patients to travel further

Source: PwC analysis of the 2013-14 Budget Book
There is a considerable amount of ‘movement’ between localities

This analysis shows care costs which are ‘imported’ or ‘exported’ between localities

For example, a GP in Haltemprice may refer a patient to a care provider in nearby Beverley. This referral would be shown here as an export from Haltemprice and an import to CHERY.

The graph shows that GHWW is the largest exporter of care whilst CHERY is the largest importer of care, closely followed by Holderness.

We have used this to highlight some key themes:

1. The impact that this level of travel may have on patients – particularly the elderly.
2. It may indicate that some localities do not have access to appropriate levels of services locally. One example of this is Withernsea hospital where there is often capacity as people are reluctant to travel there.

Flattening the graph may result in equity of provision and travel time.

Source: PwC Community Budget Analysis
Note: Only costs which could be directly attributable to another locality included in this analysis.
Appendix 6b

Soft Evidence
To build our ‘as is’ picture we engaged with over 160 stakeholders

The CCG is committed to putting the views of patients, the public and health and care professionals at the heart of the community strategy refresh. To do this we engaged with over 160 stakeholders from across the health and care economy including:

- 25 board / CCG members through two workshops
- 6 members of the local authority via a focus group
- 7 members of CCG staff through interviews and meetings
- 48 members of the public through public workshops
- 24 provider staff from Humber FT and YAS through interviews and focus groups
- 52 GPs through the Local Community Forums
- 1 secondary care clinician

We have used the information gathered from these engagement sessions in three ways:

- Identifying 9 common areas for change – primarily through the views of health and care professionals
- Identifying key services and features of a community hub – primarily through involvement in 2 community workshops and the results of a telephone insight poll of over 1,000 members of the public
- Developing specific recommendations for localities in the ‘locality profile’ section through feedback from the local community forums.
What Health and Care Professionals would like to change

Over the course of our engagement health and care professionals were both keen to be involved in developing the future direction of health and care services in East Riding and very clear about how they felt services needed to evolve and change to provide better, more holistic care for the patient. The diagram below list nine common areas that health and care professionals felt a community strategy refresh should address.
## What Health and Care Professionals would like to change

### Area of Change: Delivery of proactive care

**Explanation**
- The current system and the pressures on it, due in part to the increased complexity of patients, has led to a reliance on ‘reactive’ care. It is felt that:
  - Services are focused on stopping patients from entering the acute system or speeding up exit from hospital rather than keeping them well – for example better management of long term conditions
  - Stretched services mean that often ‘whoever shouts the loudest’ receives the care

**Linked opportunities**
- More consultant level practitioners working in the community
- Educate the public to empower them and reduce demand. Schools, health classes, pre- and neo-natal classes, not just leaflets
- Define specific pathways for common high volume areas coming through NHS 111 that prevent the community team from focusing on planned care
- Bring back community matrons focussed on managing long term conditions
- Increased care planning

**Impact of no change**
- Increased reliance on acute care as patients are less likely to be managed before they get ‘into the system’
- Less ‘holistic care’ seeing the patient as a whole – as relationships with clinicians are more transactional due to stretched services

### Area of Change: Common understanding of services

**Explanation**
- Understanding of current health services available in the area and how to access them is variable amongst health and care professionals
- Clinicians do not always understand each other’s roles – for example the distinction between the role of the community nurse vs the role of the practice nurse
- GPs are not always clear about how to access beds in community hospitals – ‘they feel frustrated around the lack of clarity on admission rights’

**Linked opportunities**
- Define and communicate a community services strategy and plan with clarity on the role of each part of the system needs to play in it
- When a new service is commissioned communicate this to other providers being clear about how it fits into the overall health economy
- A dispatcher or care navigation role being introduced to co-ordinate access to care across the system. A ‘living Directory of Services (DoS)’?
- Greater co-location of services

**Impact of no change**
- Duplication across services due to lack of role clarity. Increased referrals to acute hospitals due to lack of clarity around alternative community service provision
## What Health and Care Professionals would like to change

### Area of Change: Single IT Platform

**Explanation**
- Systems do not connect and people often do not understand the systems
- Access to patient level information from other agencies is based on relationships rather than being granted systematically
- IT systems impact upon the patient experience. For example professionals not having access to patients care plan impacts upon their ability to die in their place of choosing
- No electronic discharge from the community hospitals means there is an information delay with the information going to the GP / Consultant

**Linked opportunities**
- Common IT platform for all services
- Having a hand held device to enter notes into would save time and ensure information can be accessed in real time
- Information governance – sometimes agencies think that the can’t share information that they actually can – opportunity for training in this area

**Impact of no change**
- The clinician is often not aware of the full picture when treating the patients – leading to increased risk
- Insufficient IT systems has led to inefficient processes – e.g. paper based and more open to error

### Area of Change: Contracting on quality

**Explanation**
- The current block contract means commissioners are not always clear of the services they are paying for – it is challenging to overlay the budget against activity
- Lack of detail in service specification drives inconsistency across services
- Current system counts ‘widgets’ rather than focusing on quality
- The number of providers and contracts has led to fragmentation in the system

**Linked opportunities**
- Shared objectives across all providers
- Identify a lead provider with a single contract who sub contracts where appropriate
- Further clarity on roles provided in service specifications
- Service specifications to include SMART quality objectives / outcomes.
- Incentivise commissioning / financial integration

**Impact of no change**
- Variation in service quality. Services not ‘joined up’
- Teams ‘picking up everything they are asked to do’ rather than focusing on what their role is in the system
### What Health and Care Professionals would like to change

<table>
<thead>
<tr>
<th>Area of Change</th>
<th>Increased access to specialist services</th>
</tr>
</thead>
</table>
| **Explanation** | • Low numbers of specialists means waiting lists are often long. E.g. Cardiac specialist nurses – where there are only two FTE for the patch  
• Many patients enter the acute system for psychological reasons e.g. anxiety which could have been managed in the community  
• There is not the capacity to support patients following a period of therapy meaning many patients re-present in a crisis situation |
| **Linked opportunities** | • Refresh capacity planning to get a clearer view of the volumes of therapies needed  
• One larger team of multi-disciplinary specialist workers that covers all the localities – with sufficient skills for complex cases  
• Psychological services should underpin community services  
• Certain services (e.g. acute dementia care) are currently provided out of area and are expensive  
• Through investing in therapies stroke turnaround has been reduced from 35 – 40 days in Hull to 3 – 5 days |
| **Impact of no change** | • Increased re-admission rates  
• Patients staying in step up / step down community beds for longer due to lack of availability of therapies  
• Patients being put on waiting lists where the opportunity for ‘pro-active care exists – but due to the wait are often not seen until a crisis situation occurs |

<table>
<thead>
<tr>
<th>Area of Change</th>
<th>Flexible, skilled workforce</th>
</tr>
</thead>
</table>
| **Explanation** | • The workforce is not trained to understand other service areas – this means some will sign post / refer to other services and others will not  
• Many carers do not have the required level of training and therefore dial 999 when there may not be a need to  
• Health professionals are ‘task orientated’ but need to take a holistic view of the patient |
| **Linked opportunities** | • Professionals that can handle co-morbidities would reduce demand on ambulance service and therefore acute admissions  
• Professionals working across care settings to develop a flexible workforce.  
• Build put aside dedicated time for clinical leadership and service development into job plans  
• ‘Train together ‘  
• Some roles may have to change /e.g. the development of care co-ordinators |
| **Impact of no change** | • Increased attendances for acute services as the workforce is not always equipped to see the ‘patient as a whole’ and understand how to keep the patient in their own home |
# What Health and Care Professionals would like to change

<table>
<thead>
<tr>
<th>Area of Change</th>
<th>Co-location of services and integrated teams</th>
</tr>
</thead>
</table>
| Explanation     | • It is felt that sometimes patients do not get the best care as services are not joined up. For example NCTs feel ‘separate’ to specialist services such as diabetes care  
• Would like to see more continuity of care for patients – this is difficult when a number of services are involved in their care  
• Patients are often taken to an acute trust for social need rather than the medical issue – integration with Social Care may help this |
| Linked opportunities | • Community nurses able to do ‘head to toe’ care – having the role to signpost to other services  
• Co-location of services – in some areas such as MacMillan Wolds unit this has happened ‘organically’ and is working to good effect  
• The development of multi disciplinary team – nursing, therapies, diagnostics, pain, secondary care, social care, primary care  
• Generation of GPs with Special Interests linked to ‘hub’ or NCS |
| Impact of no change | • Services appearing ‘disjointed’ to patients  
• Patients experiencing multiple assessments that are not joined up |

<table>
<thead>
<tr>
<th>Area of Change</th>
<th>24/7, consistent services</th>
</tr>
</thead>
</table>
| Explanation     | • Need seamless services for un-planned care  
• There is a lack of consistency in MIUs (between MIUs and with the same MIUs) - should be available out of hours |
| Linked opportunities | • Opportunity to expand the OOH nursing model to absorb more community demand and therefore demand on acute care  
• A ‘night sitters’ service – particularly to support palliative care  
• 365 day support – allowing nurses / community matrons time to care for patients  
• A mechanism for GPs to assess patients quickly before calling for an ambulance |
| Impact of no change | • Increased attendances at A&E / Acute Trust without appropriate services being available at all times of the day |
## What Health and Care Professionals would like to change

<table>
<thead>
<tr>
<th>Area of Change</th>
<th>Clear role of community hospitals</th>
</tr>
</thead>
</table>
| **Explanation**      | • People the community value their hospitals and connect with them.  
• We need to be clearer about their role or they will continue to be seen as an expensive resource
• There is capacity at many of the hospitals to do more. For example at WCH there is space behind the hospital to locate new buildings and/or services,
• Needs greater clarity around how a consultant / GP should interact with the hospital |
| **Linked opportunities** | • Community hospitals could be community hubs. These could include day care, rehab, physical therapy, occupational therapy, IV, wound care, and be a one stop shop for services  
• Hubs are a good idea based on the differences between localities and the rural population
• Community beds could be better used in order to avoid acute admissions and flex according to needs
• Community hospitals could be a GP led and delivered service. There could be a lead practice and the hospital be run by them
• Have 2 super central hubs where have smaller services – e.g. learning disabilities services |
| **Impact of no change** | • Hospitals continue to be seen as an ‘expensive’ resource by many.  
• Under utilised space that could be used to greater effect |
The below identifies the key findings from the telephone insight poll that provide direction for the community services strategy.

**‘What kind of services would you value if they were provided in a one stop shop/hub’?**

- 75% GPs
- 50% minor injuries service
- 42% tests available to avoid going to hospital

**‘What support and information do you feel you or your family would find most useful to help you to maintain your independence and to keep you healthy?’**

- 58% advice from a GPs practice
- 46% a telephone helpline
- 34% a named key person to contact

**‘Are there any services which are not available at the moment that could help ensure people are able to remain in their own home and independent for longer?’**

- 48% access to advice from GP
- 46% support in the home such as meals, sitting services, and befriending
- 32% rapid access clinic for patients with long term conditions
What patients and the public want from a community hub

The concept of a community hub was shared at the two patient and public events that were held in Cottingham and Bridlington. The general opinion was that a community hub would be beneficial for the community. A number of stories were shared that illustrate the type of role patients and the public would like a hub to play:

‘When I got divorced I felt I had nowhere to turn to. I felt very depressed and couldn’t talk to my family – a service in a hub might have helped’

‘I have a friend with arthritis. She found out by accident about fitness classes in the local leisure centre – she saw her GP who prescribed it to her – classes helped keep her mobile and independent’

‘I attend a better health support group in Hull. They give me diet advice and once fitted aids to my bath to stop me from falling – it kept me in my own home’

‘Memory cafes are held across Hull and East Riding. Often take up of the service is low in villages as ‘people know what you are there for (stigma attached to it)’. If you entered a hub people would not know what you are there for’

Using information from the patient insight poll and the public engagement events 5 key services for a community hub features for an East Riding hub have been outlined below:

<table>
<thead>
<tr>
<th>5 key services for a hub from the perspective of patients and the public</th>
<th>5 key features of a hub from the perspective of patients and the public</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 GPs services – potentially with a focus on long term conditions and longer slots that usual</td>
<td>1 Support with navigating the system and accessing services</td>
</tr>
<tr>
<td>2 Simple tests – INR, Cholesterol that do not need to be administered in the hospital</td>
<td>2 Care co-ordination</td>
</tr>
<tr>
<td>3 Minor injuries – ‘mild urgent cases’</td>
<td>3 Co-location with other public services ‘it should be a town facility not a health facility’ social services was particularly mentioned</td>
</tr>
<tr>
<td>4 Services providing emotional support – voluntary organisations, day care, befriending service, ‘champions service’</td>
<td>4 Consistent offering across the borough with ‘a few local differences depending upon location’</td>
</tr>
<tr>
<td>5 Support to access prescriptions / equipment so you don’t have to travel a long way for it</td>
<td>5 Some element of service 24/7 ‘to keep people out of hospital’</td>
</tr>
</tbody>
</table>
Appendix 6c

Unplanned Care
Community hospital beds in East Riding

Poor management of chronic diseases leads to wasteful use of high intensity resources. 80% of bed days in the acute hospitals are currently used by emergency beds. Many of these admissions are preventable; by strengthening care in the community and general practice and many patients may never need hospital.

Three hospitals have community beds East Riding Community Hospital (ERCH), Macmillan (Bridlington and District Hospital), and Withernsea Community Hospital.

East Riding Community Hospital’s new service specification is being drafted and states that there are 30 in-patient beds:

- 26 for stroke care, step up/step down and severe chronic conditions/ palliative/ nursing respite
- 4 for day care

There are 12 in-patient beds at the Macmillan Wolds Unit at Bridlington. Feedback to the CCG said that due to the legacy Macmillan branding of the hospital many practitioners think that the beds are for cancer patients only, and so do not send patients with other conditions.

Feedback from stakeholders indicates that the 12 in-patient beds at Withernsea are often unfilled due to the distance of the hospital from the various population centres in East Riding. The data in this section shows that Withernsea beds have the highest average utilisation of the three hospitals. There is a system whereby patients will be placed at Withernsea and then moved when space is available nearer their home if they require, though this is apparently not used as patients do not believe they will be moved.

Source: ERY CS – Community Hospitals Template 2013-14
East Riding Community Hospital service specification 6.2.14 (DRAFT), JSNA 2012
Community hospital bed usage varies month to month

Community hospital bed occupancy has been measured from December 2012 to November 2013. The graph shows total monthly community bed usage from the following hospitals:

- East Riding Community Hospital
- Withernsea Community Hospital
- Bridlington & District Hospital (Macmillan Wolds)

Occupancy across the three hospitals peaked at 68.5% in March 2013 and reached its lowest point in September 2013 with only 42.3% occupancy.

The average occupancy figures for the 12 month period are as follows:

- Withernsea – 66.2%
- ERCH – 49.8%
- Bridlington – 57.6%

One caveat for these figures is that only 12 beds were open at ERCH between June – November 2013. Patients were transferred to Withernsea during this time.

Source: ERY CS – Community Hospitals Template 2013-14

Better care, more locally, within budget, through transformation
Community hospital bed information

- The length of stay graph shows the length of stay in each of the community hospitals with beds.
- Notably there are spikes in the length of stay month to month.
- Trend lines have been plotted and for each hospital show a progressive decrease in length of stay over time for each hospital.
- The data shows no effect of seasonality on the number of admissions.

- The readmissions graph shows the percentage of community hospital bed users who are readmitted to community hospital within 28 days.
- The target for readmissions is 5% and is missed by all three community hospitals.
- Better community support for patients who are discharged may decrease this readmission rate – the Joint Strategic Needs Assessment (JSNA) states that ‘…admissions are preventable; by strengthening care in the community and general practice’.

Source: ERY CS – Community Hospitals Template Dec-13
Joint Strategic Needs Assessment (JSNA) 2012
Community hospital bed information

- These graphs show targets for how long a patient has to wait for a bed after a referral has been made
- The target for step up access is 24h
- The target for step down access is 72h
- For both graphs, the target set by the CCG is that 90% of patients can access care within the respective time limits
- None of the community hospitals meet these two accessibility targets
- Discussions could be held with acute providers to see if they are willing to exchange services required by the localities for the use of the hospital beds

**Step up patients able to access a community hospital bed within 24h of referral**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Percentage of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>ERCH</td>
<td>71%</td>
</tr>
<tr>
<td>Macmillan</td>
<td>83%</td>
</tr>
<tr>
<td>Withersea</td>
<td>82%</td>
</tr>
</tbody>
</table>

**Step down patients able to access a community hospital bed within 72h of referral**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Percentage of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>ERCH</td>
<td>76%</td>
</tr>
<tr>
<td>Macmillan</td>
<td>88%</td>
</tr>
<tr>
<td>Withersea</td>
<td>88%</td>
</tr>
</tbody>
</table>

Source: ERY CS – Community Hospitals Template 2013-14
11. Appendix 6. The ‘as-is’ document

MIU Opening Times

This section of the report focuses on MIUs, of which there are six in East Riding CCG’s patch, these are detailed below. Three areas which may reduce the use of MIUs have been identified and are discussed in detail below. These areas are:

• Opening times and lack of knowledge thereof
• Awareness of conditions which can be treated in MIUs
• Distance from MIU and/or an A&E department

<table>
<thead>
<tr>
<th>Name</th>
<th>Locality</th>
<th>Opening Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Withersea Community Hospital</td>
<td>Holderness</td>
<td>9:00 - 17:00</td>
</tr>
<tr>
<td>Hornsea Cottage Hospital</td>
<td>Holderness</td>
<td>9:00 - 17:00</td>
</tr>
<tr>
<td>East Riding Community Hospital</td>
<td>CHERY</td>
<td>9:00 - 18:00</td>
</tr>
<tr>
<td>Alfred Bean Hospital</td>
<td>CHERY</td>
<td>9:00 – 18:00</td>
</tr>
<tr>
<td>Goole and District Hospital</td>
<td>Goole, Howdenshire &amp; West Wolds</td>
<td>0:00 - 24:00</td>
</tr>
<tr>
<td>Bridlington and District Hospital</td>
<td>Bridlington</td>
<td>8:00 - 21:00</td>
</tr>
</tbody>
</table>

• The table shows the variable opening hours of MIUs around the patch
• Goole and District hospital has a 24-7 services whereas Withernsea only has a 9-5 service running Monday to Friday
• This inconsistency may cause patients to go straight to A&E as a default reaction to an injury
• The information is available on the CCG website but this may be unlikely the be considered in the event of an injury

Source: ERY CCG website
## Top ten reasons for attendance at an MIU

<table>
<thead>
<tr>
<th>Description</th>
<th>Attendances</th>
<th>Cost £</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis not classifiable</td>
<td>2,899</td>
<td>160,293</td>
<td>18</td>
</tr>
<tr>
<td>Laceration</td>
<td>2,521</td>
<td>138,919</td>
<td>15</td>
</tr>
<tr>
<td>Soft tissue inflammation</td>
<td>2,196</td>
<td>120,627</td>
<td>13</td>
</tr>
<tr>
<td>Dislocation/fracture/joint injury/amputation</td>
<td>2,906</td>
<td>119,367</td>
<td>13</td>
</tr>
<tr>
<td>Contusion/abrasion</td>
<td>1,941</td>
<td>106,647</td>
<td>12</td>
</tr>
<tr>
<td>Sprain/ligament injury</td>
<td>1,319</td>
<td>72,717</td>
<td>8</td>
</tr>
<tr>
<td>Muscle/tendon injury</td>
<td>1,089</td>
<td>54,458</td>
<td>6</td>
</tr>
<tr>
<td>Local infection</td>
<td>882</td>
<td>48,753</td>
<td>5</td>
</tr>
<tr>
<td>Ophthalmological conditions</td>
<td>1,135</td>
<td>47,761</td>
<td>5</td>
</tr>
<tr>
<td>Not Known</td>
<td>3,321</td>
<td>43,072</td>
<td>5</td>
</tr>
</tbody>
</table>

- The challenges with the MIU data are the same as the A&E data. 31% of the attendances to MIUs are for reasons which are unclassifiable or unknown.
- These 31% of attendances make up only 18% of the cost but are still a large proportion to investigate.
- The average cost per case is much lower in an MIU than A&E; £45 versus £112 if paying PBR.
- If some minor injuries are treated at A&E there is significant room for cost savings by moving those cases out to MIUs.
- Establishing the actual cost of running an MIU would be beneficial in terms of establishing a future direction for the MIUs.

*Source:* PwC analysis 2012-13 A&E attendance data
The graph shows the number of attendances per 1000 people to MIUs and A&E by locality.

GHWW and Bridlington have a higher rate of MIU attendance than A&E attendance that could be attributed to the following:

- They have the longest opening hours
- Proximity – Both have population centres near to their MIUs and are quite far away from the nearest A&E department

Haltemprice and Holderness have A&E attendance rates well in excess of their MIU attendance:

- Haltemprice does not have an MIU of its own and is close to the A&E at Hull Royal Infirmary
- Holderness has a high population concentration along the banks of the Humber river whilst Withernsea and Hornsea MIUs are on the coast, therefore making it easier for most Holderness residents to access the A&E at Hull Royal Infirmary

Source: PwC analysis Data taken from April 2012 – March 2013

A&E attendance data

Better care, more locally, within budget, through transformation
The following themes around urgent care have emerged via stakeholder engagement

<table>
<thead>
<tr>
<th>Theme</th>
<th>Detail / impact</th>
<th>Suggested action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of consistency across MIUs</td>
<td>Due to inconsistency in opening times and offerings within each MIU across the ERY patch often people go / get taken A&amp;E. There can be inconsistency within the same MIU.</td>
<td>Develop a core offer for MIUs. Agree ‘urgent’ pathways with clinicians.</td>
</tr>
<tr>
<td>Ambulance is often used as a ‘safety net’ as it is unclear what alternative options are</td>
<td>Care assistants often call for an ambulance as they don’t know what else they could do. YAS estimate that 40% of ERY patients who called ambulance called another health and care professional first</td>
<td>Up-skill more primary / community based staff in urgent care. ECPs – enabling the patient to be assessed before the decision to call an ambulance is taken (one in each hub?). These are currently being piloted in several localities and feedback is positive. Geriatric specialist advice available in a locality.</td>
</tr>
<tr>
<td>Confusion on the process for accessing an MIU</td>
<td>Patients have been told that to access an MIU you must call 111 first. There have been instances where they have not done this and been told to attend an A&amp;E.</td>
<td>Clear protocol around the process for attending an MIU communicated to patients.</td>
</tr>
<tr>
<td>Lack of local transport</td>
<td>MIUs are reluctant to take complex patients if they can’t guarantee transport home for them. This means patients often get diverted to an acute.</td>
<td>Develop a local community transport scheme to enable ‘complex patient to be seen and taken home by an MIU</td>
</tr>
<tr>
<td>Many patients attend A&amp;E for ‘social reasons’ rather than medical reasons</td>
<td>Often the real reason for attendance to A&amp;E is an inability to ‘cope’ at home rather than a medical one</td>
<td>Allow ambulance crews to refer to a local authority home support team directly.</td>
</tr>
</tbody>
</table>
Appendix 7

Profile for each locality
### Bridlington – key facts

**Locality – key facts**

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>42,000 (21,562 with RISC registered GP)</td>
</tr>
<tr>
<td>Most prevalent diseases</td>
<td>Hypertension, Obesity, Diabetes</td>
</tr>
<tr>
<td>Top reasons for going to A&amp;E</td>
<td>Not classifiable, Gastrointestinal conditions, Nothing abnormal detected</td>
</tr>
<tr>
<td>Top reasons for going to MIU</td>
<td>Laceration, dislocation/fracture/joint injury/amputation, contusion/abrasion</td>
</tr>
<tr>
<td>Spend on transport</td>
<td>£2.43m</td>
</tr>
<tr>
<td>Number of GPs practices</td>
<td>6</td>
</tr>
<tr>
<td>Estates</td>
<td>OOH, GP Walk In Centre and MIU at Bridlington District Hospital</td>
</tr>
</tbody>
</table>
Based on ERY CCG RISC data for GP surgeries which are signed up to the scheme. Number of patients in each level shown, left:

Level 3 – Top 0.5%
Level 2 - 4.5%
Level 1 - 20%
Level 0 (no LTCs) - 75%
11. Appendix 7. Profile for each locality

Bridlington

Key themes from local commissioning forum

5 themes arising from local commissioning forum:

1. Need more therapy services – physiotherapy, psychology and addiction services
2. Waiting times for services are too long – they frustrate patients and staff
3. Need to provide better support to elderly people – longer consultation times – better integrating the GPs and Neighbourhood teams would help to support this
4. Increase the community workforce – would support us in providing more holistic care to housebound patients
5. Better IT infrastructure – reduce the administrative burden.

Strengths

- Highest spend per capita of all localities
- Small locality with population centred around Bridlington town should allow easy access to local services
- Significant existing infrastructure within the locality – including a Community Hospital
- Attendance at MIU is proportionally higher than A&E within the locality
- Lower re-admission rates for community hospital beds than the other community hospitals (6% against a target of 5%)

Weaknesses

- One of the higher levels of deprivation across the patch
- Disease levels in a number of areas are higher than the East Riding average
- Low bed occupancy rate at the community hospital – 57.6% December 12 – November 13
CHERY – key facts

<table>
<thead>
<tr>
<th>Population</th>
<th>69,000 (57,889 with RISC registered GP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most prevalent diseases</td>
<td>Hypertension, Obesity, Asthma</td>
</tr>
<tr>
<td>Top reasons for going to A&amp;E</td>
<td>Not known, diagnosis not classifiable, gastrointestinal conditions</td>
</tr>
<tr>
<td>Top reasons for going to MIU</td>
<td>Not known, dislocation/fracture/joint injury/amputation, soft tissue inflammation</td>
</tr>
<tr>
<td>Spend on transport</td>
<td>£2.79m</td>
</tr>
<tr>
<td>Number of GPs practices</td>
<td>9</td>
</tr>
<tr>
<td>Estates</td>
<td>OOH and MIU at ERCH MIU at Alfred Bean Hospital</td>
</tr>
</tbody>
</table>
CHERY – key facts

Based on ERY CCG RISC data for GP surgeries which are signed up to the scheme. Number of patients in each level shown, left:

- Level 3 – Top 0.5%
- Level 2 - 4.5%
- Level 1 - 20%
- Level 0 (no LTCs) - 75%

Disease Prevalence

Condition

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage of Population with Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>17.0%</td>
</tr>
<tr>
<td>Obesity</td>
<td>16.0%</td>
</tr>
<tr>
<td>Asthma</td>
<td>12.0%</td>
</tr>
<tr>
<td>Depression (ages 18+)</td>
<td>11.0%</td>
</tr>
<tr>
<td>CHD</td>
<td>10.0%</td>
</tr>
<tr>
<td>COPD</td>
<td>9.0%</td>
</tr>
<tr>
<td>CVD</td>
<td>8.0%</td>
</tr>
<tr>
<td>Stroke</td>
<td>7.0%</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>7.0%</td>
</tr>
<tr>
<td>COPD</td>
<td>6.0%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>6.0%</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>5.0%</td>
</tr>
<tr>
<td>PAD</td>
<td>4.0%</td>
</tr>
<tr>
<td>Dementia</td>
<td>4.0%</td>
</tr>
<tr>
<td>LD (ages 85+)</td>
<td>3.0%</td>
</tr>
<tr>
<td>HF LVD</td>
<td>2.0%</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>2.0%</td>
</tr>
<tr>
<td>Palliative</td>
<td>1.0%</td>
</tr>
</tbody>
</table>
CHERY

5 themes arising from local commissioning forum
1. Better communication across agencies – including sharing of information.
2. Greater integration of agencies across the locality. Become more ‘joined up’ providing more holistic care for the patient.
3. Greater access to services to keep patients out of hospital – diagnostics, physiotherapy, scans
4. 7 day working
5. Fewer restrictions on admission to Beverley hospital (ERCH)

Strengths
• Significant infrastructure - new community hospitals at Beverley
• Largest importer of healthcare from other localities - suggests good service provision locally
• Lower prevalence of many diseases than the East Riding average
• No significant areas of deprivation in the locality

Weaknesses
• Lowest per capita spend on healthcare provision
• Communication / joined up services was a re-occurring theme for improvement at the local commissioning panels
• Low bed utilisation for East Riding community hospital - 49.8% between December 2012 to November 2013
• Significant levels of readmission to community hospital – 21% in December 2013 against a target of 5%
• Inaccessibility of community beds – 71% of GPs able to access step up beds within 24 hours against a target of 90% and 76% of GPs able to access step down beds within 72 hours against a target of 90%

Key themes from local commissioning forum
‘There are too many restrictions on admission to beds in Beverly hospital’
‘I would like patients to benefit from closely integrated care with meaningful and friendly communication between agencies’
‘I have repeated experience of lack of feedback from referrals. Long waiting times i.e. for routine physio / mental health.’
Locality – key facts

<table>
<thead>
<tr>
<th>Population</th>
<th>78,000 (62,883 with RISC registered GP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most prevalent diseases</td>
<td>Hypertension, Obesity, Diabetes</td>
</tr>
<tr>
<td>Top reasons for going to A&amp;E</td>
<td>Diagnosis not classifiable, nothing abnormal detected, not known</td>
</tr>
<tr>
<td>Top reasons for going to MIU</td>
<td>Diagnosis not classifiable, contusion/abrasion, laceration</td>
</tr>
<tr>
<td>Spend on transport</td>
<td>£2.91m</td>
</tr>
<tr>
<td>Number of GPs practices</td>
<td>7</td>
</tr>
<tr>
<td>Estates</td>
<td>MIU and OOH at Goole District Hospital</td>
</tr>
</tbody>
</table>
Better care, more locally, within budget, through transformation

GHWW – key facts

Based on ERY CCG RISC data for GP surgeries which are signed up to the scheme. Number of patients in each level shown, left:

Level 3 – Top 0.5%
Level 2 - 4.5%
Level 1 - 20%
Level 0 (no LTCs) - 75%

Disease Prevalence
GHWW

Key themes from local commissioning forum

‘We need a clear and consistent approach to community nursing with a simple SLA’

‘We should provide care for in One Stop Shops for frail elderly - in a building with housing, GP / Community nurses, LA, diagnostics, input from secondary care’

‘Patients have to travel long distances for dialysis - this becomes their life.’

5 themes arising from local commissioning forum

1. Greater consistency amongst services – particularly community nursing. There is too much local interpretation
2. Greater access to specialist services – heart failure nurses, podiatry, physiotherapists
3. More integrated teams – teams at present are ‘too disjointed’
4. Provide a greater number of services closer to home to avoid patients accessing acute services – rapid access clinics, diagnostics and x-ray
5. Greater access to secondary care consultant to provide support in the community – particularly for frail elderly.

Strengths

• 24/7 access to MIU based at Goole and District Hospital
• Lower prevalence of diseases compared with East Riding average
• Proportionally the population accesses the MIU more often that A&E

Weaknesses

• Highest care exporter to other localities (by number of GP referrals)
• Levels of obesity higher than CCG average
• Inconsistency of services was a key theme for improvement highlighted by the local community forum
## Haltemprice – key facts

![Map of Haltemprice]

<table>
<thead>
<tr>
<th>Locality – key facts</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>69,000 (53,816 with RISC registered GP)</td>
</tr>
<tr>
<td>Most prevalent diseases</td>
<td>Hypertension, Obesity, Asthma</td>
</tr>
<tr>
<td>Top reasons for going to A&amp;E</td>
<td>Not known, soft tissue inflammation, diagnosis not classifiable</td>
</tr>
<tr>
<td>Top reasons for going to MIU</td>
<td>Diagnosis not classifiable, soft tissue inflammation, laceration</td>
</tr>
<tr>
<td>Spend on transport</td>
<td>£2.49m</td>
</tr>
<tr>
<td>Number of GPs practices</td>
<td>10</td>
</tr>
<tr>
<td>Estates</td>
<td>A&amp;E at Hull Royal Infirmary</td>
</tr>
</tbody>
</table>
Based on ERY CCG RISC data for GP surgeries which are signed up to the scheme. Number of patients in each level shown, left:

- Level 3 – Top 0.5%
- Level 2 - 4.5%
- Level 1 - 20%
- Level 0 (no LTCs) - 75%

Disease Prevalence

- **Haltémprice**
- **CCG-wide**
11. Appendix 7. Profile for each locality

Haltemprice

Key themes from local commissioning forum

- ‘End of life patients feel unsupported in this area’
- ‘No Macmillan nurse is responsible for this area’
- ‘Your foot has to be hanging off before you can see a podiatrist’

5 themes arising from local commissioning forum

1. Better availability and consistency of Macmillan services
2. Improve access to services so patients get their issues resolved at the right time – potentially through a community hub
3. Empower patients to self-care – potentially through a community hub
4. Improved end of life care and palliative support – through better co-ordinated teams with more resources
5. Better support for children and young people with behavioural issues that do not meet the CAMS threshold – commission a service with a lower threshold.

Strengths

- Highest GP to patient ratio of all the localities
- Close proximity to Hull Royal Infirmary
- Across the majority of diseases there is a lower prevalence than the East Riding average

Weaknesses

- Lack of local infrastructure - no community hospital (MIU or OOH)
- Proportionally higher A&E utilisation amongst the population than MIU utilisation
- Availability of services and access to services was a common theme for improvement raised by GPs at the local community forum
Holderness – key facts

<table>
<thead>
<tr>
<th>Locality – key facts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
</tr>
<tr>
<td>Most prevalent diseases</td>
</tr>
<tr>
<td>Top reasons for going to A&amp;E</td>
</tr>
<tr>
<td>Top reasons for going to MIU</td>
</tr>
<tr>
<td>Spend on transport</td>
</tr>
<tr>
<td>Number of GPs practices</td>
</tr>
</tbody>
</table>
| Estates                      | OOH at Rosedale                           
|                               | MIUs at Hornsea and Withernsea            |
Holderness – key facts

Based on ERY CCG RISC data for GP surgeries which are signed up to the scheme. Number of patients in each level shown, left:

- Level 3 – Top 0.5%
- Level 2 - 4.5%
- Level 1 - 20%
- Level 0 (no LTCs) - 75%

Disease Prevalence

<table>
<thead>
<tr>
<th>Condition</th>
<th>Holderness</th>
<th>CCG-wide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>18.0</td>
<td>14.0</td>
</tr>
<tr>
<td>Obesity</td>
<td>16.0</td>
<td>12.0</td>
</tr>
<tr>
<td>Diabetes</td>
<td>14.0</td>
<td>10.0</td>
</tr>
<tr>
<td>Asthma</td>
<td>12.0</td>
<td>8.0</td>
</tr>
<tr>
<td>CHD</td>
<td>10.0</td>
<td>6.0</td>
</tr>
<tr>
<td>CVD</td>
<td>8.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td>6.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Cancer</td>
<td>4.0</td>
<td>1.0</td>
</tr>
<tr>
<td>CDPD</td>
<td>2.0</td>
<td>0.5</td>
</tr>
<tr>
<td>COPD</td>
<td>1.0</td>
<td>0.1</td>
</tr>
<tr>
<td>Stroke</td>
<td>0.5</td>
<td>0.1</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>1.0</td>
<td>0.5</td>
</tr>
<tr>
<td>PAD</td>
<td>0.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>0.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>0.1</td>
<td>0.0</td>
</tr>
<tr>
<td>LD (ages 18+)</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>MCI</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Dementia</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>HF LVD</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Palliative</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Osteoporosis (ages 50+)</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>
Holderness

Key themes from local commissioning forum

Every day patients complain about the physio service – you are lucky to be seen within 6 months – exercises are sent to patients in the post,’

‘There is not enough support for palliative care patients’

‘There is a lack of communication with some of the community team’

5 themes arising from local commissioning forum

1. Greater access to specialist services including physio, pulmonary rehabilitation and musculoskeletal services. Patients go on the waiting list and ‘go into panic’

2. Greater communication and clarity on role of NCT – particularly District Nurses

3. Up-skill patients and carers – particularly in physiotherapy

4. Greater access to community hospitals and acute consultants to support keeping patients out of hospital

5. Greater number of specialist nurses – palliative care and diabetic services particularly.

Strengths

- Significant infrastructure – two community hospitals at Hornsea and Withernsea
- Lower disease prevalence than the East Riding average across the majority of areas

Weaknesses

- Community hospitals appear to not be placed near the areas with the highest population density
- Despite two MIUs being placed on the patch the proportion of the population that access A&E is significantly higher than the proportion that access the MIU
- This may be due to restricted opening times (9am -5pm)
- Withernsea hospital community beds have a significant 28 day re-admission rate (13% against a target of 5%)
- Withernsea hospital has a higher occupancy rate (66.2% for Dec 2012 – Nov 2013) than the other community hospitals but this is still lower than would be expected
- Poor public transport provision in the area
Appendix 8

Index of references to unplanned care
11. Appendix 8. Index of references to unplanned care

<table>
<thead>
<tr>
<th>Ref no</th>
<th>Reference</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Reference in executive summary ‘no A&amp;E on the patch..’</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>National context – ‘Growing pressure on A&amp;E services..’</td>
<td>10</td>
</tr>
<tr>
<td>3</td>
<td>Service challenges – reference to emergency beds</td>
<td>17</td>
</tr>
<tr>
<td>4</td>
<td>How unplanned care will fit into the new approach</td>
<td>45 - 47</td>
</tr>
<tr>
<td>5</td>
<td>Appendix 2. Health Assumptions. A&amp;E based assumptions</td>
<td>63</td>
</tr>
<tr>
<td>6</td>
<td>Appendix 4. Commissioning locality specific data. Includes A&amp;E assumptions</td>
<td>67 - 68</td>
</tr>
<tr>
<td>7</td>
<td>Appendix 5. Examples of community commissioning models from elsewhere. Reference to ‘single front door at A&amp;E’</td>
<td>76</td>
</tr>
<tr>
<td>8</td>
<td>Appendix 6. Reasons for patients attending / to be admitted from A&amp;E</td>
<td>91</td>
</tr>
<tr>
<td>9</td>
<td>Attendance at A&amp;E by age group</td>
<td>92</td>
</tr>
<tr>
<td>10</td>
<td>Appendix 6c. Unplanned care data</td>
<td>111 - 119</td>
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</table>
Appendix 9

Glossary of abbreviations
## 11. Appendix 9. Glossary of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
<th>Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
<td>LCF</td>
<td>Local Commissioning Forums</td>
</tr>
<tr>
<td>BCF</td>
<td>Better Care Fund</td>
<td>LTC</td>
<td>Long Term Condition</td>
</tr>
<tr>
<td>BI</td>
<td>Business Information</td>
<td>MIDAS</td>
<td>Electronic data management system</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
<td>MDT</td>
<td>Multi Disciplinary Teams</td>
</tr>
<tr>
<td>C-DoS</td>
<td>Community Directory of Services</td>
<td>MH Services</td>
<td>Mental Health Services</td>
</tr>
<tr>
<td>CHERY</td>
<td>East Riding locality covers Beverly and Driffield</td>
<td>MIU</td>
<td>Minor Injuries Unit</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>MSK</td>
<td>Musculoskeletal Services</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
<td>NCT</td>
<td>Neighbourhood Care Teams</td>
</tr>
<tr>
<td>ECR</td>
<td>Electronic Care Record</td>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>ERCH</td>
<td>East Riding Community Hospital (Beverley)</td>
<td>OBC</td>
<td>Outcomes Based Commissioning</td>
</tr>
<tr>
<td>ERMS</td>
<td>Electronic Referral System</td>
<td>OOH</td>
<td>Out Of Hours</td>
</tr>
<tr>
<td>ERY</td>
<td>East Riding of Yorkshire</td>
<td>PMO</td>
<td>Programme Management Office</td>
</tr>
<tr>
<td>FT</td>
<td>Foundation Trust</td>
<td>PTS</td>
<td>Patient Transport Service</td>
</tr>
<tr>
<td>GHWW</td>
<td>Goole, Howden and West Wolds – East Riding Locality</td>
<td>QIPP</td>
<td>Quality, Innovation, Productivity and Prevention</td>
</tr>
<tr>
<td>GPs</td>
<td>General Practitioners</td>
<td>SPA</td>
<td>Single Point of Access</td>
</tr>
<tr>
<td>HWBB</td>
<td>Health and Wellbeing Board</td>
<td>WTE</td>
<td>Whole Time Equivalent</td>
</tr>
<tr>
<td>IT</td>
<td>Information Technology</td>
<td>YAS</td>
<td>Yorkshire Ambulance Service</td>
</tr>
<tr>
<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
<td></td>
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</tbody>
</table>

Better care, more locally, within budget, through transformation