**Designing care for the future**

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**Background and context**

Since September 2012, the Triangles have been charged with identifying their priorities for action for the immediate and medium term in order to reach sustainability of services across the health and social care system for North East Lincolnshire.

The context of this work is informed by emerging local need and national policy, not the least of which is the £20billion Nicholson challenge, of which NELCCG will need to identify £26million in efficiency savings by March 2015, i.e if we continue to commission the same services in the same way we will generate a financial deficit of £26million.

This provides a driver for radical change locally and a need to ensure that these changes maintain quality but also meet future demographic and service user needs.

We also need to consider the efficiency savings to be generated through Adult Social Care in order to meet Local Authority savings targets over the same period. The Adult Social Care Strategy outlines the directions and actions required to meet those targets and dovetails with the actions outlined in the matrix below.

As previously articulated the context for our strategy and action planning must be increase in quality where deficits have been identified, reductions in cost and best value for money.

Following the service leads meeting held on Thursday 22nd November and input from the senior team, the following high level aims have been identified:

**Pillars of the strategy – from March 2013**

* Moving towards 24/7 working ***across the system***
* Quantum shift from unplanned to planned care

-Better management of Chronic disease/Long Term conditions

-Self care and community based care

* Development of Extra Care Housing
* Resolve the question of single site working for Maternity services
* Improve End of Life Care

**Must dos**

* Moving to PBR in Mental health and reshaping provision to ensure sustainability
* Shift to Personalisation of budgets in the medium term

**Cross cutting enablers**

* Optimum prescribing practice
* Supporting Carers and Communities
* Emergency response consolidated across service areas
* Improved signposting
* Technology-enabled care
* Access to diagnostics
* Work on wellbeing and prevention
* Supporting people to live independently as long as possible

Each of these high level items is supported by a raft of initiatives designed to enable the achievement of the aims as identified.

The matrix below sets out the proposals identified by the Triangles and where each of these fits into the high level aims

Where there are gaps identified or initiatives that do not align with the aims, further debate is required to focus capacity for greatest impact.

**Questions for consideration:**

What criteria do we apply to determine which of these priorities/initiatives we think will have the biggest impact?

What does this mean for our vision for sustainability – i.e. how do we describe our future state?

Will this vision be acceptable to the wider clinical and lay community?

How do we reshape our work/capacity to deliver these changes in the time frame required?

**Interrelationship between Triangle plans**

| Area | Moving towards 24/7 working ***across the system*** | Quantum shift from unplanned to planned care | Better management of Chronic disease/Long Term conditions | Development of Extra Care Housing | Resolve the question of single site working for Maternity services | Improve End of Life Care | Self care and community based care | PBR in Mental Health |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Prevention | Prevention cuts across all dimensions and is highlighted in blue | | | | | | | |
| Older People | Better interface between primary, intermediate and secondary care (could be assisted by mechanisms for remote consultation, e.g. Skype interfaces)  Admissions to 2ndary care only when absolutely appropriate  Discharge mechanisms operational out of hours  Hospitals to be age friendly and geriatricians available in A and E to assess patients for admission |  | Dementia – Earlier diagnosis  Continuation of work to reduce prescription of anti-psychotics  See and treat and hospital at home  Utilisation of digital means to assist care, e.g. telehealth assessment and  Redesign organic and functional services at Navigo | Contributes to helping older people remain in their place of residence to stay healthy for longer and receive care in their place of residence |  | Older people in the last stage of life admitted to hospital only when medically appropriate – care at home is the first option | Continue to commission high quality, cost effective and outcomes-based carers support services which are responsive to local carers’ needs |  |
| Women and Children |  | Working with practices to review their paediatric attendances and referral behaviour  Tackling high rates of admission | Closer working with secondary care  Paediatric Community Nursing  Better management of paediatric diabetes |  | Further work to identify the quality issues and positions for each site and to fundamentally establish the argument for single site maternity services (or not) |  | Children’s health and wellbeing – prevention and safeguarding  Breastfeeding, smoking cessation in pregnancy  Childhood obesity |  |
| Mental Health and Disabilities |  | Reduction of acute admissions by commissioning low level of mental health support in primary care  Focus on prevention – developing better co-ordinated approach with providers  Review the role of all the liaison services – develop one resource for vulnerable people to gate-keep admissions and get early discharge | | Market shaping project work. |  |  | Prescribing practice to be reviewed with provider  Have a more joined up approach to counselling/IAPT pathways  Develop social prescribing in primary care to stop the levels of self-referrals  Review the role of GPs in mental health care pathways More joint working with dual diagnosis teams  Consider removal of self-referral to access services | Reshape access to mental health to ensure we stay within available resources once PBr is introduced  Triage separated from provision to ensure appropriateness of referrals |
| Unplanned Care | Primary care led “front-door” assessment and triage at A and E | Access to urgent appointments in normal working hours  Access to urgent diagnostics  Consolidated Rapid Response – further development required in relation to consolidation of existing commissioned services | Consistent application of mechanisms to identify and deal with “frequent flyers” to urgent care – enhancing care planning to avoid acute episodes |  |  |  | Consideration of the development of Minor Injuries Units  Links with the Ambulance Service to agree protocols around alternatives to transporting to A and E |  |
| Planned Care |  | Routine non-emergency management of chronic disease  Maintenance of patients in care homes | Supported living and focus on good health and wellbeing – ensuring checks include carers |  |  | Optimum experience and delivery of end of life care | Reduction in outpatient follow ups (utilising digital alternatives and other low-tech solutions, e.g. follow up by phone)  Specialist Nursing available at home |  |
| Prescribing |  |  | Access to medicines from joint formulary in both primary and secondary care without patient ending up in middle. Providers take responsibility for decisions and prescribe appropriately without trying to shift costs into primary care or vice versa |  |  |  | What can people/communities do for themselves? Reducing primary care demand – self management of minor ailments with signposting to appropriate healthcare professionals where necessary. Link to Public Health campaigns. |  |

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| **Equality Impact Risk Analysis: Insert title of Designing care for the future** | | | | |
| **Policy / Project / Function/Service:** | Strategy | | | |
| **Date of Analysis:** | 26 November 2013 | | | |
| **Analysis Rating:**  **(**Please Tick ✔)  (See Completion Notes) |  |  | √ |  |
| **Red** | **Red /Amber** | **Amber** | **Green** |
| **Type of Analysis Performed:**    Please Tick ✔ | **Systematic Policy Analysis** | | | √ |
| **Consultation** | | |  |
| **Meeting** | | | √ |
| **Service Proposal** | | |  |
| **Other** | | |  |
| **Please list any other policies**  **that are related to or referred**  **to as part of this analysis** | Adult Social Care Strategy | | | |
| **Who does the policy, project function or service affect ?**    Please Tick ✔ | **Employees** | | | √ |
| **Service Users** | | | √ |
| **Applicants** | | |  |
| **Members of the Public** | | | √ |
| **Other (List Below)** | | |  |

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| **Equality Impact Risk Analysis:** | | |
| **What are the aims and intended**  **effects of this policy, project or**  **function ?** | The strategy provides a driver for radical change locally and a need to ensure that these changes maintain quality but also meet future demographic and service user needs. Pillars of the strategy are:  • Moving towards 24/7 working across the system  • Quantum shift from unplanned to planned care  -Better management of Chronic disease/Long Term conditions  -Self care and community based care  • Development of Extra Care Housing  • Resolve the question of single site working for Maternity services  • Improve End of Life Care | |
| **Is any Equality Data available**  **relating to the use or**  **implementation of this policy,**  **project or function ?**    (See Completion notes) | Yes | √ |
| No |  |
| Where you have answered yes, please incorporate this data when performing the *Equality Impact Assessment Test* (the next section of this document). | |
| **List any Consultation e.g. with**  **employees, service users,**  **Unions or members of the**  **public that has taken place in**  **the development or**  **implementation of this policy,**  **project or function** | Clinical Leads  Service Leads  Partnership Board | |
| **Financial Analysis**    If applicable, state any relevant cost implications  (e.g. expenses, returns or savings) as a direct result  of the implementation of this policy, project or  function | **Costs (£m) \***  Implementation £  Projected Returns £  Projected Savings £26m in efficiency savings needs to be identified | |

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| **Equality Impact Risk Assessment Test:** | | | | |
| **What impact will the implementation of this policy, project or function have on employees, service**  **users or other people who share characteristics protected by *The Equality Act 2010* ?** | | | | |
| **Protected**  **Characteristic:** | **Neutral**  **Impact:** | **Positive**  **Impact:** | **Negative**  **Impact:** | **Evidence of impact and if applicable, justification**  **where a *Genuine Determining Reason* exists** |
| **Gender**  (Men and Women) | √ |  |  | The proposed initiatives will not have a negative impact on either men or women, neither is any actively positive impact envisaged.  In NEL 51% of the population are female and 49% male – the same as the national average |
| **Race**  (All Racial Groups) | √ |  |  | All changes to services will be adequately supported in terms of language and cultural sensitivity  NEL population has a higher percentage of people identifying as white: English/Scottish/Welsh/Northern Irish/British (95.4%) than England as a whole (79.5%);  All other ethnic group population percentages are below the England average; |
| **Disability**  (Mental and Physical,Sensory impairment, Autism, mental health issues) |  | √ |  | Market reshaping in relation to learning disability is designed to have a positive impact on patient experience  Number of people in NEL with a limiting long term illness is higher than the national average ( 19% vs. 17.6%); |
| **Religion or Belief** | √ |  |  | All changes to services will be adequately supported in terms of religious sensitivity  There is a smaller percentage Muslim population and a larger percentage (30.4%) population who state they have no religion than in England as a whole |
| **Sexual Orientation**  (Heterosexual, Homosexual  and Bisexual) | √ |  |  | All changes to services will be adequately supported in terms of sexual orientation  Based on national figures 1.5% of the male population and 0.7% of the female population in NEL would define themselves as gay or lesbian, 0.3% male and 0.5% female as bisexual and 93.6% male and 94.2% female as heterosexual |

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| **Protected**  **Characteristic:** | **Neutral**  **Impact:** | **Positive**  **Impact:** | **Negative**  **Impact:** | **Evidence of impact and if applicable, justification**  **where a *Genuine Determining Reason* exists** |
| **Pregnancy and**  **Maternity** | √ |  |  | No direct changes to maternity services are planned during 2013/14  The NEL under 18 conception rate per 1000 females of 47.2 is significantly above the national average of 32.0 despite reductions in recent years; |
| **Transgender** | √ |  |  | All changes to services will be adequately supported in terms of transgender |
| **Marital Status** | √ |  |  | All changes to services will be adequately supported in terms of marital status  Of people aged 16 & over in NEL in 2011: 45.2% married, 33% single, 0.14% in a civil partnership – all are slightly lower than the England average; |
| **Age** |  | √ |  | Measures to ensure that all age groups can benefit from new models of care incorporating new technology will need to be put in place. Changes proposed to paediatric community nursing will result in a better service for under 16s  Fewer working age adults in NEL than England average and a higher older population;  Life expectancy at birth in NEL is lower than for England - males 76.5yrs vs. 78.2yrs, Females 81.8 yrs vs. 82.27yrs |

**This Equality Impact Risk Analysis was completed by: Lisa Hilder**

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| **Action Planning:** | | | | |
| **As a result of performing this analysis, what actions are proposed to remove or reduce any risks of**  **adverse outcomes identified on employees, service users or other people who share characteristics**  **protected by *The Equality Act 2010* ?** | | | | |
| **Identified Risk:** | **Recommended Actions:** | **Responsible Lead:** | **Completion Date:** | **Review Date:** |
| **Whilst carrying out service change care must be taken to ensure that there isn’t a detrimental effect on any of the protected characteristic groups** | **Equality Impact assessments need to be undertaken on all service proposals** | **Service Leads** |  |  |
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| **Completion Notes:** | |
| **Analysis Ratings:** | After completing this document, rate the overall analysis as follows:  **Red:** As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share *Protected Characteristics.* It is recommended that the use of the policy be suspended until further work or analysis is performed.  **Red Amber:** As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share *Protected Characteristics.* However, a genuine determining reason may exist that could legitimise or justify the use of this policy and further professional advice should be taken.  **Amber:** As a result of performing the analysis, it is evident that a risk of discrimination (as described above) exists and this risk may be removed or reduced by implementing the actions detailed within the *Action Planning s*ection of this document.  **Green:** As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share *Protected Characteristics* and no further actions are recommended at this stage. |
| **Equality Data:** | Equality data is internal or external information that may indicate how the activity being analysed can affect different groups of people who share the nine *Protected Characteristics* – referred to hereafter as *‘Equality Groups’.*  Examples of *Equality Data* include: (this list is not definitive)  1: Application success rates *Equality Groups*  2: Complaints by *Equality Groups*  3: Service usage and withdrawal of services by *Equality Groups*  4: Grievances or decisions upheld and dismissed by *Equality Groups* |
| **Legal Status:** | This document is designed to assist organisations in *“Identifying and eliminating unlawful Discrimination, Harassment and Victimisation”* as required by *The Equality Act Public Sector Duty 2011.* An Equality Impact Analysis is not, in itself, legally binding and should not be used as a substitute for legal or other professional advice. |
| ***Genuine***  ***Determining***  ***Reason*** | Certain discrimination may be capable of being justified on the grounds that:   1. *A genuine determining reason exists* 2. *The action is proportionate to the legitimate aims of the organisation*   Where this is identified, it is recommended that professional and legal advice is sought prior to completing an Equality Impact Analysis. |