Item Number:

GOVERNING BODY MEETING **Meeting Date: 26 November 2014**	NHS *Scarborough and Ryedale Clinical Commissioning Group*
Report's Sponsoring Governing Body Member: Kath Halloran	**Report Author: Jenny Carter**

1. Title of Paper: Integrated Palliative Care Service Business Case

2. Strategic Objectives supported by this paper:
(check those which apply)

- ☒ To create a viable & sustainable organisation, whilst facilitating the development of a different, more innovative culture
- ☒ To commission high quality services which will improve the health & wellbeing of the people in Scarborough & Ryedale
- ☒ To build strong effective relationships with all stakeholders and deliver through effectively engaging with our partners
- ☐ To support people within the local community by enabling a system of choice & integrated care
- ☒ To deliver against all national & local priorities incl QIPP and work within our financial resources

3. **Executive Summary:**

The purpose of the Business Case is to seek support for the development and funding of an integrated palliative care service, which has at its heart a hospice at home model, for the Scarborough and Ryedale CCG population. This business case builds on the work of those local services currently provided by St Catherine's Hospice and the existing Marie Curie services and their history of joint working. It will also complement and interface with the existing services operating within the area.

The business case brings together four current services into one integrated hospice at home model. The four current separate components are set out below:

Service	Funding basis	Current funding stream
Care Home Link Nurses	Project/pilot based (end date 31/3/2015)	Reablement (health and Local Authority)
Palliative Care Nurse Led Beds	Project/pilot based (end date 31/3/2015)	CCG sole funding
Marie Curie Evening Nursing/Care service (multi visits service)	Pilot based (end date 31/3/2015)	CCG funding matched like for like funding from Marie Curie
Marie Curie Planned care service	Recurrent funding	CCG funding matched like for like funding from Marie Curie

The fifth component comprises of St Catherine's Hospice developing the Hospice to Home model to deliver a 24/7 service. Re-modeling the five components as an integrated whole enables the CCG to develop, with our partners, a fully integrated hospice at home service that is not dependent on where a person resides.

The proposed model will provide an integrated solution for the provision of high quality palliative care

for people being identified as being at the end of life. All identified patients will have their needs assessed and care planned to enable them to live well until they die, in their preferred place where possible.

4. **Risks relating to proposals in this paper:**
Please see attached

5. Summary of any finance / resource implications:
The costs of the proposed options in year 1 (2015/16) is shown in the table below. The financial support for option 3 makes it the same cost as Option 1, and cheaper than option 2. Option 3 has double the quality score of Option 1.

The scheme is proposed to run as a pilot, and the impact of Option 3 would need to be assessed for its delivery of the additional savings on non elective admissions, with continuation of the programme for future being dependent upon either additional savings to at least the value of the reduction in subsidy, or a revised model to deliver the service within the same resource envelope from the CCG. Failure to deliver the target reduction in non elective admissions would require a review of the total scheme.

	Option 1	Option 2	Option 3 (Year 1)
Cost of Service	£80	£616	£1,025
foregone savings	£250	£0	£0
(Savings)	£(38)	£(247)	£(487)
Net Cost	£292	£369	£538
Financial Support (Year 1)			£(240)
Cost 2015/16	£292	£369	£298
Quality Score	15	21	33
Patients	44	565	645

The current services (Option 2) are currently funded through the CCG budgets and Carers/ reablement funds. This funding is planned to continue through the CCG budgets and the Better Care Fund. Consequently deciding to commission Options 2 or 3 is affordable within current budgets, and Option 1 would release funds, although it is expected there would be an an increase in non elective admissions (contrary to our aim with the better care fund), with associated costs.

Therefore Option 3 is supported.

6. Any statutory / regulatory / legal / NHS Constitution implications:
N/A

7. Equality Impact Assessment:
Attached to Business Case

8. Any related work with stakeholders or communications plan:
The scheme was developed in partnership by St Catherines Hospice, Marie Curie and the CCG.

9. Recommendations / Action Required
.The Governing Body is asked to approve Option 3 within the Business Case as described which seeks

funding for the Integrated Palliative Care Service.

Endorse the preparation of a business case detailing the roll out of the service to Ryedale in 2015/16 for consideration at a future Business Committee meeting, and hold £130k in reserve to fund the rollout subject to business case

10. Assurance

Business case development

For further information please contact:

Name:	*Jenny Carter*	*Title:*	*Service Improvement Manager*	☎*: 01723 343668*	

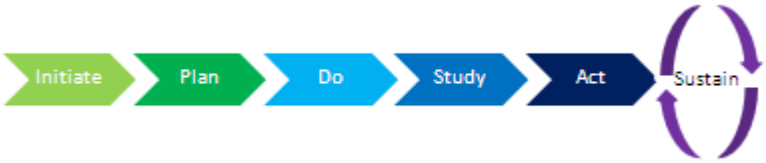
NHS
Scarborough and Ryedale
Clinical Commissioning Group

Business Case

Integrated Palliative Care Service

Sponsored by: Kath Halloran

Lead Officer: Jenny Carter



Date Last Updated: 10 November 2014
Version 2.0

Version Control

The following is a record of the changes/updates that have occurred on this document:

Version	Section	Changes / Updates	Date of Change	Author	Signed-off Date	Signed-off by
1.0		Initial draft of integrated Case	10/11/14	J. Carter	26/11/2014	Governing Body
2.0		Re-drafted to further describe integrated model	13/11/14	J Carter C Wollerton	26/11/2014	Governing Body
FINAL						

The following individuals have contributed to the formulation of this document:

Name	Title
Jenny Carter	**Service Improvement Manager, SRCCG**
Carrie Wollerton	**Executive Nurse, SRCCG**
Richard Mellor	**Chief Finance Officer, SRCCG**
Dr Kath Halloran	**GP Governing Body Lead**

Strategic Objectives supported by this work:
(check those which apply)

Check	Objective
✓	To create a viable & sustainable organisation, whilst facilitating the development of a different, more innovative culture
✓	To commission high quality services which will improve the health & wellbeing of the people in Scarborough & Ryedale
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The approval process for this document is (final document should be electronically or physically signed before approval):

Name	Title	Signed
Kath Halloran	**GP Sponsor**	
Kath Halloran	**Clinical Lead**	
Jenny Carter	**Project Delivery Manager**	

The following documents (if applicable) have already been presented and signed off as part of the Service Improvement Process:

Document	Committee	Date approved at Committee
Service Improvement Proposal (SIP)	**Business Committee**	**Authorisation to Proceed to Business Case approved at Business Committee 1 October 2014 and 5 November 2014**
Case for Change (CfC)	**Business Committee**	**Authorisation to Proceed to Business Case approved at Business Committee 1 October 2014 and 5 November 2014**

Business Case

1. General Information

Service area title: Integrated Palliative Care Service

CCG Priority: Strengthening Community systems, integrated and partnership working

2. Introduction

The purpose of the Business Case is to seek support for the development and funding of an integrated palliative care service, which has at its heart a hospice at home model, for the Scarborough and Ryedale CCG population. This business case builds on the work of those local services currently provided by St Catherine's Hospice and the existing Marie Curie services and their history of joint working. It will also complement and interface with the existing services operating within the area.

The business case brings together four current services into one integrated hospice at home model. The four current separate components are set out below:

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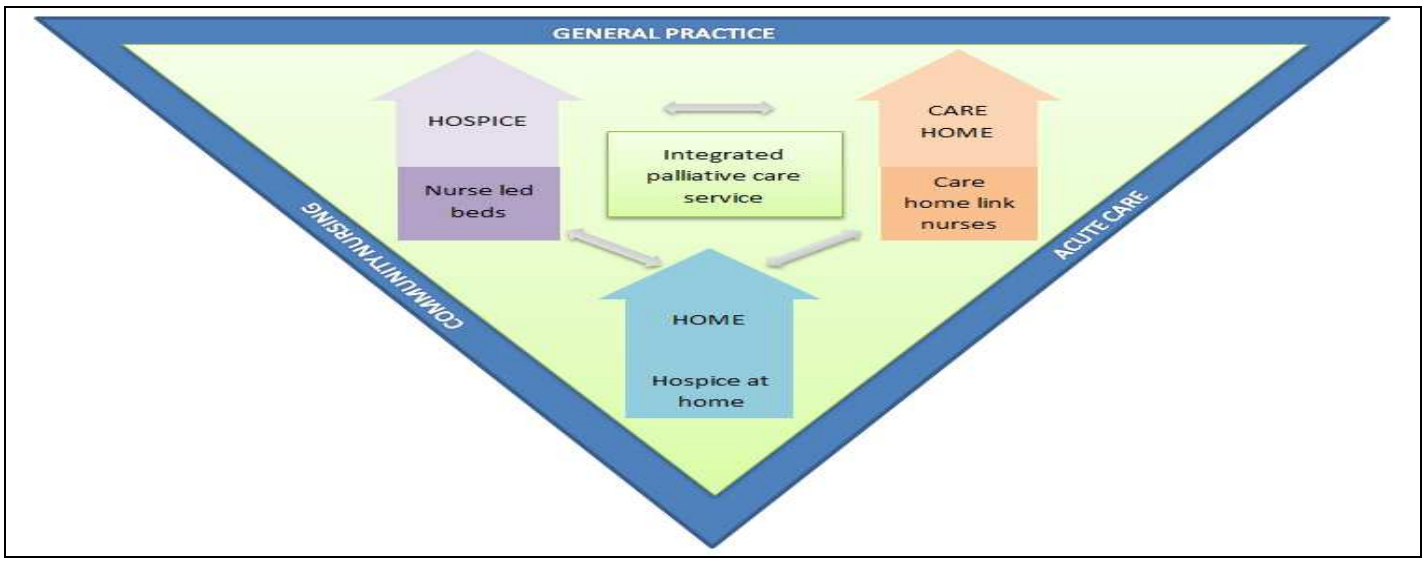
Re-modeling the four components as an integrated whole enables the CCG to develop, with our partners, a fully integrated hospice at home service that is not dependent on where a person resides.

The proposed model will provide an integrated solution for the provision of high quality palliative care for people being identified as being at the end of life. All identified patients will have their needs assessed and care planned to enable them to live well until they die, in their preferred place where possible.

The Integrated Palliative Care Service Model



3. The Strategic Case

3.1 Strategic Context

It is clear that no single organisation can tackle the challenge of good end of life care in isolation. End of life care spans many care settings and sectors, and requires an integrated approach.

We know that changing demographics and an improved understanding of patients' preferences will influence changes in end of life care provision. This will result in greater demands upon services to make more efficient use of their resources and a changing commissioning landscape to drive more integrated working around end of life care.

The case for spending against the Better Care Fund includes prioritising of good End of Life Care. This includes better coordination of care and consideration of the scope for cost savings through reduction of emergency admissions. This proposal supports the willingness of the local health and social economy to work closely with the third sector and make this happen.

Marie Curie Cancer Care has a history of working with Saint Catherine's Hospice in Scarborough and given the respective strengths of each organisation there are benefits to patients and the CCG of them working more closely together.

This partnership model aligns with the deliverables of the Scarborough and Ryedale CCG Strategic Plan and the draft Scarborough and Ryedale CCG and Vale of York CCG Palliative Care Strategy (2014 to 2019)

- Developing integrated services around a community hub model of care to enable patients to be cared for as close to home as possible;
- Using innovative solutions to link primary, secondary and community services to encourage patient centred services;
- Reducing the need for patients to attend and/or be admitted to secondary care by providing suitable alternative services in primary or community settings

With an acknowledgement of the growing palliative and end of life care needs for people with non-cancer diagnosis, and the national themes supporting the redesign of Palliative and End of Life care, the service will enhance the delivery of end of life care whilst adhering to the direction of:

- National End of Life Care Strategy (2008)
- NICE End of Life Quality Statements (2011)
- National Institute for Clinical Excellence - NICE (2011) Quality Standards for End of Life Care
- National Institute for health and Clinical excellence (2012) End of Life Care for People with Dementia Commissioning Guidelines
- Health and Social Care Act (2012)
- Royal College of General Practitioners Commissioning Guidance in EOL Care (2013)

The National End of Life Care Programme has published a report entitled 'Reviewing end of life care costing information to inform the QIPP End of Life Care Work stream' and draws together the various work (57 documents in total) that has been undertaken to date on the subject of the costs associated with providing end of life care

The key findings suggest:

- That the cost per day of providing end of life care in the community is at least comparable to and often lower than the equivalent hospital inpatient cost.
- That the overall cost of care at the end of life (using the median of the range of costs) tends to be less in the community than if the patient had died following admission to an acute hospital

Long term epidemiological predictions undertaken in a study by Gomes and Higginson indicate that if the trend in home death proportions observed over the last five years continues, less than 1 in 10 people will die at home by 2030. Institutional deaths would increase by 20% rising from 440,000 to 530,000 per annum. This study, "Where people die: past trends, future projections and implications for care" B Gomes, I J Higginson; Palliat Med Jan 2008 22:33-41, is used extensively in the National End of life Care Strategy 2008 and has shown that the majority of patients do not wish to die in an Acute Trust setting. Over half of all deaths in the UK occur in the hospital setting despite clear evidence that the majority of patients would prefer to die elsewhere, usually at home.

At this moment, about 25% of all hospital beds are occupied by someone who is dying. The National Audit Office estimates that at least 40% of those people have no medical need to be there. Apart from the significant distress caused to the dying person and their family at not achieving their preferred place of care, there is a considerable cost to the healthcare sector. Marie Curie's "Understanding the cost of end of life care in different settings" document *(http://www.mariecurie.org.uk/Documents/HEALTHCARE-PROFESSIONALS/commissioning-services/understanding-cost-end-life-care-different-settings.pdf)* has demonstrated that a transfer of end of life care from the Acute to the primary care sector would result in significant cost savings for the NHS.

We know that around 18% of deaths in England occur in care homes and that the North of England has the highest number of care home beds per 1,000 population aged 75 years and over (ONS 2008-10 data, What we know Now, 2013). Within the Scarborough, Filey and Ryedale area, there are a total of 1,549 care home beds (comprising of 1,066 residential beds, 425 nursing beds and 58 beds which can be either). The median period from admission to the care home to death is 462 days or 15 months (Age UK, 2011).

The case mix in care homes comprise of residents who require general nursing care within a nursing home or require care from a largely non registered nursing workforce in residential care homes. In 2011-12 the SRCCG had 486 emergency admissions to hospital from care homes. 95 patients died during their stay in hospital and 30% died within 48 hours of admission.

There is scope to increase the number of people who, at the end of their life, are enabled to die in their

care home, by improving the training of staff in care relevant to end of life and extending specialist palliative care services for those that need them, regardless of their condition (National Audit Office, 2008). An evaluation of a care homes training programme provided to 64 homes in Somerset over 2 years demonstrated reduced hospital admissions (116 per year), 30% reduction in hospital deaths, and 20% reduction in hospital admissions (What we know Now, 2013).

The CCG is a partner in the Better Care Fund across North Yorkshire, which has specific aims for reduction of non-elective admissions, but also targets the effectiveness of reablement, admissions to residential and care homes, delayed transfers of care and patient experience. The plan for 2015/16 for the Scarborough and Ryedale CCG area includes funding to support care home support and palliative services, with an aim of reducing length of stay in the acute setting, avoiding admission where possible, and improving the patient experience. This case proposes services to support that ambition.

3.2 Current Service Provision

The current services that will be combined within the new integrated model are as follows:

Care Home Link Nurses
The main aims of the pilot have been to improve the quality of care for residents in nursing and care homes nearing the end of their lives, improve collaboration between GP's, hospitals, primary care teams and reduce the number of unnecessary admissions to hospital at the end of life, enabling residents to die in their 'home' where this is their preference. This has been achieved through a model of care including both clinical, case management and educational input on an individual patient basis, and through delivering sessions on themes to wider groups of care staff. The team work on a 7 day service model supporting clinical practice and providing liaison and coordination between services.

Palliative Care Nurse Led Beds
The nurse led beds provide an opportunity for any patient in Scarborough Hospital who is felt to be in their last week of life, regardless of diagnosis, whose care needs can be met by experienced nursing staff, to transfer to St Catherine's Hospice for end of life care. These patients are unlikely to be previously known to specialist palliative care services and do not have 'specialist' palliative care needs (e.g. intolerable symptoms, severe distress). They may not have considered their preferred place of death until the last few days, during which time it may not be feasible for a patient to be discharged home from hospital.

Working collaboratively with Scarborough Hospital, the project has been successful in developing the skills of health care professionals in hospital to identify dying patients and reduce the number of patients who die in Scarborough Hospital. Following the identification that a patient may be dying by the clinical team in the hospital, a referral is made to the hospital based Specialist Palliative Care Team. Following their assessment of the patient and discussion with the patient and their family the option of transfer to the hospice and to a Nurse Led Bed is offered. If the patient and family wish to accept, the Specialist Palliative Care Team will contact the hospice and arrange admission. Saint Catherine's Hospice Nurse Led Bed Service is available 7 days a week and patients can be transferred from the acute hospital to an available nurse led bed at the hospice on any day of the week, up to 9pm.

Marie curie Evening Nursing/Care service (multi visits service)
This service delivers high quality planned end of life health and social care to patients with a life limiting

illness within a community setting in order for the patient to achieve their preferred place of care.

The service operates from 4pm to 11pm, 7 nights a week. The referred patient must have primarily palliative care needs and wish to be nursed in their preferred place of care, usually in their own home. The current service configuration is designed to support patients within the immediate urban areas of Scarborough & Filey, with an estimated total population of c65,000 (approximately two thirds of the adult population of Scarborough and Ryedale CCG). The team consists of both registered nurses and care workers.

Marie Curie Planned Nursing/Care Service
Marie Curie currently provides a planned nursing service across Scarborough and Ryedale CCG which is delivered by a skill mix of Marie Curie Nurses (30%) and Healthcare Assistants (70%). This is an overnight service with care provided between the hours of 10pm to 7am. The referral is made in advance by the District Nurse or Clinical Nurse Specialist to the Marie Curie referral centre. The nurses and healthcare assistants are experienced in caring for people with terminal illnesses and can help them to cope with their symptoms such as nausea, pain or anxiety. They also offer advice and emotional support to family members and carers, such as discussing their concerns about the patient's illness.

The activity for the planned service has remained consistently high for the past 2 years and it is estimated that an additional 140 hours per month would be needed to bring the actual activity in line with commissioned activity. Marie Curie have indicated that the current level of over performance is not sustainable.

3.3 The Case for Change

The National End of Life Care Programme has published a report entitled 'Reviewing end of life care costing information to inform the QIPP End of Life Care Work stream' and draws together the various work (57 documents in total) that has been undertaken to date on the subject of the costs associated with providing end of life care

The key findings suggest:

- That the cost per day of providing end of life care in the community is at least comparable to and often lower than the equivalent hospital inpatient cost.
- That the overall cost of care at the end of life (using the median of the range of costs) tends to be less in the community than if the patient had died following admission to an acute hospital

We know that in our area more people are dying in hospital than should be the case (based on national metrics) and that we can improve this position by offering a greater range of integrated service for people who are coming to the end of their life.

It has also been highlighted that it can be difficult to discharge patients home from hospital or maintain patients within their own home who have both health and social care needs at the end of life due to limited social care capacity.

This integrated service will respond to both health and social care needs. The current separate services

already has Health Care Assistants working across Health and Personal Care and it is envisaged that staff will continue to provide both elements of care to enable patients to remain at home. Patients with increased social care needs can experience higher levels of anxiety when appropriate support is not available and this can result in unnecessary hospital admissions. This service will aim to address this and provide an integrated response based on need.

National research supports the business case highlighting what patients want in relation to end of life care. 'A time and a place' research report from Sue Ryder investigates the elements of end of life care that are important to individuals to ensure we have a better understanding of what qualifies a good death.

What do people want at the end of life?	**Home**
78% being free from pain and discomfort 71% being surrounded by loved ones 53% having Privacy and Dignity 45% being in familiar surroundings and being in a calm and peaceful atmosphere	63% of people want to die at home 78% of people said that their main priority at the end of life was being pain free 27% only felt that home was a place where they would be free from pain during their final days

SRCCG has a relatively elderly population with 21.9% of its population aged over 65, many of which have co-morbidities. Over 50% of the CCG population lives in the most deprived population quintile of North Yorkshire. The demographic profile of SRCCG provides the combined challenge of an elderly population with high health resource usage as well as significant areas of deprivation with associated poor health outcomes. In response there is a need for joined up end of life care service provision.

We also know that patients with a non - malignant condition often have a high number of emergency admissions to hospital at the end of life.The disease trajectory for non-malignant disease is such that individuals with a non cancer diagnosis can suffer acute exacerbations in their condition as they approach the end of life. It is necessary to ensure that people have access to timely and effective interventions to prevent unnecessary hospital admission during an exacerbation and a well-managed discharge as early as possible to enable an individual to return home. The proposed service treats people nearing the end of life with any condition or diagnosis and will facilitate supported earlier hospital discharge because services will be working together and joined as one.

There is also often carer breakdown when supporting this group of patients and their associated long term condition. The high number of elderly people that move to retire Scarborough and Ryedale also may not have family support /extended family around them to help at the end of life

Across England people average around 2.1 hospital admissions in the last 12 months of life accounting for on average 30 bed days. However the number of admissions in the last year of life rises in relation to frailty. Almost a third (32.6%) of all hospital admissions in last year of life occur in the last 30 days before death, and 40% of people admitted had no medical need with the admission related to crisis with carers and social circumstances.

In summary, the need for change includes:

- Too few people locally dying in preferred place of care/usual residence

- Not enough choice for end of life care
- Gaps in current services including out of hours and fragmentation of services
- Care largely uncoordinated between services
- Limited support for care homes in providing good end of life care
- Limited, and gaps in crisis intervention leading to unplanned admissions to acute care and attendances at AE
- Need to maximise use of available resources on recurrent basis
- Lack of strategic commissioning for palliative and end of life care

4. The Options

4.1 Identifying the Options

Options were identified through stakeholder meetings and discussions between clinical members of the Governing Body and lead Officer.

Option 1 (Do Nothing)

Doing nothing will result in:

- The ceasing of the Care Home Link Nurse Service on 31 March 2015 (including redundancy of staff if current provider cannot absorb and relocate)
- The ceasing of the Marie Curie evening service on 31 March 2015 (including redundancy of staff if current provider cannot absorb and relocate)
- The continuation of the Marie Curie Planned service with current hours
- The closure of the nurse led beds with the loss of opportunity to transfer people quickly into this facility from an acute bed or A&E
- Palliative care services will remain fragmented and the CCG will not be able to maximise opportunities for partnership working and co-funding
- The aspirations set out in the draft end of life and palliative care strategy will not be realised
- Financial risks may be reduced, however any saving by not investing in out of hospital care could be offset by increased acute hospital care.

Option 2 (re-commission specific service elements as stand alone services)

The CCG could elect to recurrently commission parts of the palliative care services as stand alone elements. This would mean:

- Secure the services and staffing but not maximise the benefits of integration
- Each service would be assessed separately on value for money
- Consideration for levels of planned Marie Curie service would be needed, to either continue at current levels, or commission for need.
- Increase financial commitment as benefits of working together and sharing resources not realised
- Services would remain fragmented however this would go some way to meeting the aspirations set out in the draft end of life and palliative care strategy
- Services would continue to give limited coverage in terms of whole CCG patch

Option 3 (Integrated model)

The CCG elects to commission an integrated palliative and end of life care service, combing each element of the service through a lead provider model. This means:

- Secure the services and staffing and realise the benefits of a fully integrated service

- Maximise finances through securing elements of matched funding and enabling the sharing of resources within integrated model
- Formal partnership working between Saint Catherine's Hospice and Marie Curie
- Phased approach to covering all of Scarborough and Ryedale patients
- Support the aspirations within the draft end of life and palliative care strategy
- Reduction in acute hospital activity including avoided admissions and A&E attendances and reduced length of stay
- Demonstrates strategic commissioning approach
- Opportunities to work with neighbouring CCGs to help reduce 'postcode lottery' associated with CCG boundaries and different commissioning decisions

4.2 Method of Option Appraisal

Update and presentation given about Commissioning End of Life Care and authorisation to bring Business Case to November Business Committee agreed by all present at Business Committee on 1 October 2014

Full discussion and consideration of 3 business cases providing details of the three elements of the service and a cover paper at the November 5, 2014, Business Committee.

The clinically led option appraisal was carried out following the Business Committee meeting using an evaluation methodology which separated out the qualitative discussion from the financial analysis (accepting that in the case of strategic priorities, affordability does play a part).

The clinical team have had extensive discussions in particular focusing on the added value of bringing together groups of services from different partners into an integrated model which adds value and maximises opportunities for service developments from a qualitative and quantitative perspective.

The evaluation criteria selected are based on a combination of CCG priorities and the strategic direction set by various national documents:

- Fit with CCG priorities
- Equity of service and efficiency of delivery across CCG
- Supports national objectives and targets around end of life care and patient choice
- Quality of care focused on patient and carer experience and adding value

- Affordability

A number of members of SRCCG were involved in the evaluation and scoring of the option appraisal following the November Business Committee in preparation for the Governing Body meeting.

- Dr Kath Halloran – Clinical Lead
- Dr Peter Billingsley – GP Quality Lead
- Carrie Wollerton – SRCCG Executive Nurse
- Sue Peckitt – Quality and Safety Manager
- Jenny Carter – Service Improvement Manager

Following the scoring of each option from a qualitative perspective a fiscal appraisal of each option was then applied by the finance team to return a final score.

4.3 Option appraisal

Summary of rationale applied to scoring

Option 1 (Do Nothing)

Fit with CCG priorities
(score 10 being best – 1 being least fit)

- *The ceasing of two of the services that have been running on a project/pilot basis over past few years is likely to increase the need for patients to attend and/or be admitted to secondary care and weakens rather than strengthens our out of hospital services.*
- *The withdrawal of the services is likely to attract negative public criticism and media interest.*
- *Reduces the ability to build partnerships and coordinate care.*

Equity of service and efficiency of delivery across CCG
(score 10 being most equitable– 1 being least)

- *Current services do not cover whole patch as pilot/project based, so in part doing nothing would reduce inequity by withdrawing specific services from whole patch*
- *Current fragmented delivery would continue*

Supports national objectives and targets around end of life care and patient choice *(score 10 being best fit and 1 being least)*

- *Reduction in patient choice and a poorer patient experience through admission to hospital for periods of care including for final period of care*
- *Reduction in support for care homes with a poorer patient experience as a result*
- *Reduces support for the CCGs end of life and palliative care strategy*

Quality of care (in particular patient experience and added value)
(score 10 offering the best patient and carer experience and added value of integration, and 1 the least)

- *Reduction of quality associated with withdrawal of services*
- *Missed opportunity to maximise benefits of working together and creating an innovative partnership*

Option 2 (re-commission specific service elements as stand alone services)

Fit with CCG priorities
(score 10 being best – 1 being least fit)

- *Some opportunity to work in partnership model, but limited opportunity to flex between services*
- *Maintain improved performance demonstrated through pilots but looses ability to go further faster in developing stronger partnerships and strengthening community based services*

Equity of service and efficiency of delivery across CCG
(score 10 being most equitable– 1 being least)

- *Current services do not cover whole patch as pilot/project based, in agreeing option 2 the CCG would need to decide on whether to recurrently fund services as stand alone and as current coverage, or invest to ensure cover across whole CCG on equitable basis*
- *Delivery would continue in a fragmented way with limited opportunity to flex resources*

Supports national objectives and targets around end of life care and patient choice
(score 10 being best fit and 1 being least)

- *Would continue to support CCGs approach to end of life care but miss chance to take a strategic and integrated approach*
- *Would continue to support the improvement of quality in care homes*

Quality of care (in particular patient experience and added value)
(score 10 offering the best patient and carer experience and added value of integration, and 1 the least)

- *Clear and strong evidence of good patient experience demonstrated through pilots, this would be retained and developed*
- *Each service would continue to work with a patient centred approach and with a focus on continuous improvement cycle*

Option 3 (Integrated model)

Fit with CCG priorities
(score 10 being best – 1 being least fit)

- *innovative solutions to link primary, secondary and community services to encourage patient centred services; (partnership model, flexibility between services)*
- *reducing the need for patients to attend and/or be admitted to secondary care by providing suitable alternative services in primary or community settings*
- *Strengthening community based services*

Equity of service and efficiency of delivery across CCG
(score 10 being most equitable– 1 being least)

- *Provides a planned phased approach to covering the whole of the CCG patch on an equitable basis including working with neighbouring CCGs to minimise 'postcode lottery'*
- *Efficiencies maximised through development of an integrated services with single point of access*
- *Lead provider takes responsibility for delivery of full service*

Supports national objectives and targets around end of life care and patient choice
(score 10 being best fit and 1 being least)

- *Integrated service model and components meet with recommendations in majority of national guidelines and documents, in particular in relation to integrated care, supporting the improvement of quality of care in care homes, patient choice at the end of life, and providing services in the community setting over 24 hours, 7 days a week*

Quality of care (in particular patient experience and added value)
(score 10 offering the best patient and carer experience and added value of integration, and 1 the least)

- *Pilots have demonstrated clear and strong evidence of good patient experience*
- *Includes patient stories and feedback, in particular in relation to responsiveness and avoiding admissions*
- *Qualitative evaluations used to improve care in continuous improvement cycle*
- *Links all care sectors and coordinates generalist and specialist care and identifies gaps in knowledge and training and provides educational support in and out of care homes*
- *A one stop shop that will facilitate discharge from hospital, manage the needs of patients in Care home and ensure that patients die in their preferred place. It will ensure that we get it right first time and those that are already involved in the care (GP, District Nurse etc) will feel supported to manage the patient*

at home 24 hours a day 7 days a week.

Summary Options Table

Benefit	Option 1 Score 1-10	Option 2 Score 1-10	Option 3 Score 1-10
1. Fit with CCG priorities	3	6	8
2. Equity of service and efficiency of delivery across CCG	6	4	8
3. Quality of care (in particular patient experience and added value)	4	6	9
4. Supports national objectives and targets around end of life care	2	5	8
SUB TOTAL	15	21	33

4.4 Financial Appraisal of Options

Option 1 (Do Nothing)

Do not rcommission Marie Evening Service, Nurse Led Beds and Care Home Link Nurses from April 2015.

This has the potential to:

- increase numbers of unplanned hospital admissions and A&E attendances
- significantly increase pressure on evening district nursing service
- increase in demand on local authority care services
- increased demand on pallcall and hospice
- increased out of hours calls to primary care and ambulance
- increase demand on hospice beds

It is estimated that the services to be ceased, at a cost of £522,000, avoid an estimated 100 emergency admissions a year, reduce hospital LOS for patients who are admitted by approximately 1000 days pa, and support 240 patients to die out of hospital, as well as keeping up to a further 290 in their homes or care homes for longer. Not all of this has a saving to the CCG, but it is estimated that the additional costs in costs of admissions and LOS are c. £250,000.

Option 2 (Status Quo)

The CCG would continue funding of existing services, and retain the financial benefits of any currently avoided admissions, as well as the quality benefits for current patients. The potential benefits offully integrating all elements of the service would not be realised, potentially this includes:

- in terms of QIPP a failure to build on opportunities for efficiency and improving clinical quality and outcomes
- retain status quo re unplanned admissions and A&E attendances
- electing to make a recurrent investment that was only applicable to part of the CCG area

The services to be retained cost £616,000 pa, and are estimated to avoid c. 100 admissions which would cost c. £173k. They reduce hospital LOS for around 240 patients by a total of 1000 bed days pa, and support 240 patients to die out of hospital who would otherwise die in hospital, as well as keeping up to a further 290 in their homes or care homes for longer. Additional avoided admissions, and savings through

short stay patients, are estimated at £74,000.

Option 3 (Integrated model)

Commission on a recurrent basis an integrated palliative care service. Potentially this includes:

- reduction of numbers of unplanned hospital admissions and A&E attendances
- reduction in number of admissions from care homes
- increased out of hours calls to primary care and ambulance
- increase demand on hospice beds

The total cost of this model, excluding an extension into Ryedale, is £778k. This is mitigated by a contribution from the Hospice in 2015/16 of £240,000.

	2015/16	2016/17	2017/18	Future years
Cost of services	£1,272	£1,272	£1,272	£1,272
Subsidy	£(487)	£(367)	£(295)	£(247)
Cost to the CCG	£785	£905	£977	£1,025
Identified Funding				
CCG current services	£280	£280	£280	£280
Better Care Fund	£322	£322	£322*	£322*
Additional funding required	£173	£303	£375	£423

Figures in £ 000's *Better Care fund is not agreed for these years

Expected activity is 120 patients utilising nurse led beds, 185 individual patients cared for by the care home link nurses (excludes educational sessions to wider groups), 200 patients in receipt of planned care at home (across 7 days a week, over 24 hours) (figures do not include activity associated with the full roll out from September 2015 into Malton and Ampleforth areas).

Estimated savings from the care home link nurse are c. 100 avoided admissions, saving around £173k. The model is expected to deliver at least the same savings as option 2 from reducing LOS of hospital patients and avoided admission, estimated at £73k. Estimated impact of the Hospice at Home is 200 additional patients being supported to avoid hospital admission, who currently are admitted at some point in their end of life care, expected savings £250k.

For future periods, the CCG is proposing to cap the net contribution to the same level. Throughout the first year, the service will be monitored to identify avoided admissions, and short stay admissions due to the operation of the service, and which yield cost benefits to the CCG. The cost of the service to the CCG will only increase to the levels quoted above for future years if savings equivalent to the additional cost are received.

5. The Preferred Option

5.1 The Preferred Option in detail

Option 3 (Integrated model)

Aims of the service

The Integrated Palliative Care Service will focus on clinically managing patients who have palliative care needs within the last year of life but do not need require hospital admission. The aim is to reduce hospital attendances and unplanned admissions and ensure that we provide responsive, needs led care for patients and their carers. Utilising the full scope of this service will enable patients have choice about where they are cared for and where they want to die. This includes the patients home/care home and the Hospice. The proposal supports a phased roll out and a plan to include all Scarborough and Ryedale

patients by September 2015. Co-location at St Catherine's hospice will promote good communication, co-ordination and provision seamless care.

Service Outline
A single point of contact will ensure that patients can easily access the service. The full range of high quality services include

- Symptom management
- Alleviation of anxiety
- Support, information and advice
- Educational support to Residential, Nursing and domiciliary providers
- Planned care
- Multi visit short episodes of care - Personal and social care
- Crisis intervention/ fast response
- Liaison and coordination between generalist and specialist palliative care services
- Development of shared care protocols
- Respite for carers and family
- Facilitate discharge from inpatient care settings
- Support and care at the time of death and immediately after death care
- Step up and step down facilities
- 24/7 response
- Promote the use of Advance Care Planning and effective use of end of life tools

Service Description
The service will assist in achieving patients' preferred place of care at the end of their life by providing a generalist and specialist nursing response as well as access to specialist medical support. Working collaboratively with other key stakeholders including the GP and District Nurse care can be wrapped around the patient 24 hours a day 7 days a week. A package of care can be provided dependent on assessed clinical and priority of need. Regular reviews will be undertaken and resources will be prioritised based on patients who are dying or in the unstable phase of their illness. Provision of education is an implicit part of the service and will impact in terms of building confidence in the workforce specifically around anticipating the needs of the dying patient and the importance of a coordinated response. The nurse led beds will provide the hospital with an alternative environment for dying patients and their carers but will also provide step up beds for the integrated service if appropriate.

Referral Criteria

- Patients must be 18 years of age or above and require end of life care
- Patient are thought to be within their last 12 months of life and in the deteriorating phase of their illness
- Patients are accepted with cancer and non-cancer conditions
- Patients must consent to referral to the service or a best interest decision made
- Patients must have a Scarborough or Filey GP initially. From September 2015 this will include all Scarborough and Ryedale CCG GP patients subject to agreement in principle of a roll out plan which will be developed.
- Referrals will be accepted to support a patient on discharge from hospital or hospice if the patient meets the above referral criteria
- If health and/or social care is required, the patient must have a palliative healthcare need
- The service is available to patients in their own home and care homes

Outcomes

- Improved quality of life for patients and family/carers.

- Enable more people at the end of life, to die in their usual place of residence.
- To increase the number of patients who die in their preferred place of care/usual place of residence
- Reduce the number of inappropriate hospital and hospice admissions
- Increase numbers of patients with a palliative diagnosis other than cancer being cared for at home.
- To increase the number of patients who spend their last weeks of life in their preferred place of care.
- To decrease the number of patients who die in hospital.
- Meet all national standards for End of Life Care.

Quantitative outcomes and targets (expectations will be increased in line with roll out plan to Ryedale)

- Approximately 120 patients per annum utilising nurse led beds
- Nurse led beds occupancy rate of at least 70%.
- Approximately 185 individual patients cared for by the care home link nurses (excludes educational sessions to wider groups)
- Approximately 200 patients in receipt of planned care at home (across 7 days a week, over 24 hours)
- Recording of patients in the service, how they accessed the service and whether hospital admission was avoided.
- Recording of patients preferred place of Death, and actual place of death, if using the service.

St Catherine's will manage wider communication and engagement with key stakeholders from the community and hospital which will form part of the project working group to understand how the new service interfaces and complements existing services.

A full operational policy with referral and patient pathways to underpin the detail of the service will be developed as part of the project working group to ensure there are clear processes in place. A name for the integrated service will also be decided, building upon the reputation of both organisations.

5.2 Key benefits

The benefits from implementing the Integrated Palliative Care Service for Scarborough and Ryedale are:

- The patient is seen and treated effectively by the most appropriate service; improving patient outcomes and experience.
- Patients are appropriately and safely cared for, reducing the number of inappropriate admissions and increasing the numbers of patients that die inappropriately in hospital.
- The CCG is commissioning a safe, improved quality service that reduces costs across the health economy as a whole.
- The service is able to reduce worry and anxiety for patients and their family, that patients have adequate input into decisions about their care and are treated with dignity and respect.

5.3 Benefits realisation

In addition to the information outlined in the guidance, please see Appendix 3 which provides a template for a Benefits Realisation Plan which can be included depending on the size of the case

Benefit	Impact	Realisation	Owner
Assess validity of new service model	Potential to have new service offering in future	Design service model fit for purpose	JC
Increase in the numbers of patients dying in their preferred place of death	Patient and family	Delivery of service	JC

Reduction in hospital costs of palliative care patients	Evaluation of data	Delivery of service	JC
Increased patient and family experience	Patient and family	Providing greater opportunities for transfer to preferred place of care, more community care and increased identification of palliative patients	JC

5.4 Method of delivery

The service will be contracted to the existing Service Level Agreement and aligned with the core contract that the SRCCG holds with St. Catherine's Hospice.

The model of delivery will be through shared resources from the 2 organisations working within an integrated service and will include registered nurses, health care assistants and health and personal care assistants to deliver care, supported by a team leader, senior nurse and medical /AHP support. They will be linked with the multi-disciplinary team and through shared communication and a single point of contact.

5.5 The Implementation Plan

Full implementation

SRCCG's Project Team will meet monthly to review the integrated service and ensure that the evaluation meets expected timelines.

Members of Project Team – to be finalised

Jenny Carter – Service Improvement Manager
Kath Halloran – Clinical Lead
Carrie Wollerton – SRCCG Executive Nurse
Vanessa Burns – Deputy Chief Finance Officer
Steve Jordan – Head of Contracts
St Catherine's Hospice Representative
MCCC Representative

Activity	Dates	Who required/actions
Business Case to Business Committee.	5 November 2014	Business Committee approval Required
Project Team meet to finalise details of pilot and timescales including evaluation parameters	January 2015	All members of Project Team
Agree on review date for pilot	January 2015	All members of project team
Project Team to meet bi monthly to review phasing of service	January 2015 – March 2016	Project Team. Updates at QIPP Steering Group
Table Evaluation of pilot for August 2015 Business Committee following 6 month pilot	July 2015	Jenny Carter
Agree next steps and roll out to	July 2016	Project Team

Ryedale		

The Multi Visit evening service and planned service will be integrated to form the full integrated model from April 2015 (or earlier dependent upon SRCCG direction), although planning will commence before this time. Full roll out to include Ryedale will start in September 2015 subject to further approval of a costed roll out plan.

A full project management plan will be provided subject to approval including a communications and engagement strategy.

6. The Financial Case

6.1 Contractual and activity changes

Contractual changes will be agreed following approval of business case.

6.2 Cost analysis

	Option 1	Option 2	Option 3 (Year 1)
Cost of Service	**£80**	**£616**	**£1,272**
foregone savings	**£250**	**£0**	**£0**
(Savings)	**£(38)**	**£(247)**	**£(487)**
Net Cost	**£292**	**£369**	**£785**
Financial Support (Year 1)			**£(487)**
Cost 2015/16	**£292**	**£369**	**£298**
Quality Score	**15**	**21**	**33**
Patients	**44**	**565**	**645**

The table above shows that for the first year option 3 is the most cost effective in terms of quality score and number of patients seen. However, to achieve this level of viability, the service needs to deliver an additional £240,000 (c. 200 patients) savings from non elective admissions in the first year, and subsequent investment would be dependendent upon further savings beyond this level being developed. Alternatively, the cost of the service needs to be reduced as the subsidy is withdrawn.

6.3 Capital Costs

Any capital costs are included in overall prices

7. Risk Plan

Risk identified	Likelihood (a)	Impact (b)	Risk score (a x b)	Mitigation
Planned model does	2 - unlikely	3 - moderate	6 - low	Ensure best fit during

not adequately address gaps in the existing service provision				planning and implementation by liaising with all stakeholders. Ensure accurate reporting and monitoring of service activity and implementation and take appropriate action to resolve/ improve ASAP. Engage with staff in existing service. Use Feedback from patients and carers.
Planned model meets current unmet need and does not realise potential efficiencies	3 - possible	3 - moderate	9 - moderate	Ensure that the formal evaluation captures both qualitative and quantitate data so that the benefits can be realised for patients and a reduction against inappropriate admissions for people at the end of life
Insufficient / inconsistent resources: staff / finance / time	2 - unlikely	3 - moderate	6 - low	Robust planning and monitoring of delivery, rapid response to unmet need. Maximise use of staff across both services in area.
Failure to deliver evidence to improve services	3 - possible	3 - moderate	9 - moderate	Clear data collection requirements and robust data gathering processes in place. Seek advice from analytics evaluation depart.
Potential for staff employed by 2 different organisations but working in integrated team – issues around separate working/standards	2 - unlikely	3 - moderate	6 - low	Joint management posts to oversee teams and create culture of joint working Clear governance arrangements in place to support consistent work practices and standards – a management board with representation from both organisations with very clear terms of operation
Issues around joint working	2 - unlikely	3 - moderate	6 - unlikely	Robust links to be made with communications teams

				for both partner organisations to plan and develop a communications plan that is acceptable to both parties.

8. Post Implementation Review

Steering group will oversee implementation and agree outcomes and reporting schedule

9. Recommendations

The Governing Body is asked to approve Option 3 within the Business Case as described which seeks funding for the Integrated Palliative Care Service at the levels identified above.

Endorse the preparation of a business case detailing the roll out of the service to Ryedale in 2015/16 for consideration at a future Business Committee meeting, and hold £130k in reserve to fund the rollout subject to business case.

10. Equality Impact Assessment (EIA) and Sustainability Assessments

Please complete the Equality Impact Assessment and Sustainability assessment as attached at Appendix 1 and 2. If these are incomplete the Business Case will not progress.

Full details on how to complete the EIA is included in the overall Business Case process guidance documentation.

Sign off by:	**Sign off date:**	**Outcome (tick which applies)** *(NOTE: dependent on outcome this may need to come back for decision to future meeting – if so record initial decision and insert new line for each return to Committee)*	**Agreed Option**
Business Committee	*(DD/MM/YY)*	☐ Accepted - take to Governing Body for formal approval	(Insert here the option agreed by the Business Committee)

		☐ More information required before decision to progress/decline made ☐ Decline	

Next Steps
Once the Business Committee have decided on the option to take forward, the Business Case should then be presented at the next Governing Body for formal approval. It can then progress to implementation phase where a project charter, task schedules will be completed and formal Steering Group set up.

APPENDIX 1

Equality Impact Analysis: Form

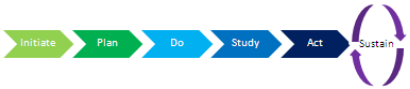
September 2013

For support with completion of this documentation, please see the accompanying guidance and/or contact the Equality Lead in the North Yorkshire and Humber Commissioning Support Unit

1. Equality Impact Analysis	
Policy / Project / Function:	Integrated Palliative Care Service
Date of Analysis:	18 November 2014
This Equality Impact Analysis was completed by: (Name and Department)	Jenny Carter
What are the aims and intended effects of this policy, project or function ?	The purpose of the Business Case is to enable Scarborough and Ryedale Clinical Commissioning Group to seek funding for the delivery of an Integrated Home Palliative Care Service (Hospice at Home) across Scarborough and Ryedale in partnership with Marie Curie Cancer Care (MCCC) and St. Catherine's Hospice. The proposed model will provide an integrated solution for the provision of high quality palliative care for people being identified as being at the end of life. All identified patients will have their needs assessed and care planned to enable them to live well until they die, in their preferred place where possible. The service aims to; ✓ Improve end of life care for patients in the local area by providing an integrated service which reduces duplication for patients and their families/carers as well as streamlining pathways for professionals; ✓ Improve patient outcomes and experiences; ✓ Increase the number of patients dying in their preferred place of death; ✓ Reduce the number of hospital deaths; ✓ Increase numbers of patients with a palliative diagnosis other than cancer being cared for at home; Reduce the number of inappropriate hospital attendances and admissions in the last year of life; Scarborough and Ryedale Clinical Commissioning Group to seek funding for the delivery of an Integrated Home Palliative Care Service (Hospice at Home) across Scarborough and Ryedale in partnership with Marie Curie Cancer Care (MCCC) and St. Catherine's Hospice.

Please list any other policies that are related to or referred to as part of this analysis?	Draft Vale of York and Scarborough and Ryedale Clinical Commissioning Group End of Life Care strategy
Who does the policy, project or function affect ? Please Tick ✔	Employees ☐ Service Users ☒ Members of the Public ☒ Other (List Below) ☐

2. **Equality Impact Analysis: Screening**					
	Could this policy have a positive impact on…		Could this policy have a negative impact on…		Is there any evidence which already exists from previous (e.g. from previous engagement) to evidence this impact
	Yes	No	Yes	No	
Race	☐	☐	☐	☒	
Age	☒	☐	☐	☒	No
Sexual Orientation	☐	☐	☐	☒	
Disabled People	☒	☐	☐	☒	No
Gender	☐	☐	☐	☒	
Transgender People	☐	☐	☐	☒	
Pregnancy and Maternity	☐	☐	☐	☒	
Marital Status	☐	☐	☐	☒	
Religion and Belief	☐	☐	☐	☒	
Reasoning					
If there is no positive or negative impact on any of the Nine Protected Characteristics go to Section 7					



3. Equality Impact Analysis: Local Profile Data

Local Profile/Demography of the Groups affected (population figures)

General	For the 117,500 patients who are registered with 17 GP practices in Scarborough and Ryedale
Age	21.3% of the population (Joint Strategic Needs Assessment) are aged 0-19. The CCG has a relatively elderly population with 21.9% of its population aged over 65 (Joint Strategic Needs Assessment).
Race	The Census 2011 indicates the race of the population in Scarborough & Ryedale CCG as: White 97.5% Mixed 0.8% Asian 1.2% Black 0.2%
Sex	The gender split in the Scarborough and Ryedale CCG area is 49.6% male and 50.4% female (Joint Strategic Needs Assessment).
Gender reassignment	There are not any official statistics nationally or regionally regarding transgender populations, however, GIRES (Gender Identity Research and Education Society - www.gires.org.uk) estimated that, in 2007, the prevalence of people who had sought medical care for gender variance was 20 per 100,000, i.e. 10,000 people, of whom 6,000 had undergone transition. 80% were assigned as boys at birth (now trans women) and 20% as girls (now trans men). However, there is good reason, based on more recent data from the individual gender identity clinics, to anticipate that the gender balance may eventually become more equal.
Disability	19.5% of S & R CCG population are living with a limiting long term illness or disability.
Sexual Orientation	In relation to sexual orientation, local population data is not known with any certainty. In part, this is because until recently national and local surveys of the population
Religion, faith and belief	Christian 67.0% Buddhist 0.3% Hindu 0.1% Jewish 0.1% Muslim 0.5% Sikh 0.0% Other religion 0.4% No religion 24.3% Religion not stated 7.4%
Marriage and civil partnership	
Pregnancy and maternity	

4. Equality Impact Analysis: Equality Data Available

Is any Equality Data available relating to the use or implementation of this policy, project or function? Equality data is internal or external information	Yes ☐

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* 5. *Previous EIAs*	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	N/A
Promoting Inclusivity **How does the project, service or function contribute towards our aims of eliminating discrimination and promoting equality and diversity within our organisation**	N/A

5. Equality Impact Analysis: 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:	No Impact:	Positive Impact:	Negative Impact:	Evidence of impact and if applicable, justification where a *Genuine Determining Reason* exists
Gender (Men and Women)	x			
Race (All Racial Groups)	x			
Disability (Mental and Physical)		x		the service has the potential to increase access to end of life and palliative care services for all people nearing the end of life from whatever cause thereby positively impacting on people with a disability
Religion or Belief	x			
Sexual Orientation (Heterosexual, Homosexual and Bisexual)	x			

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:	No Impact:	Positive Impact:	Negative Impact:	Evidence of impact and if applicable, justification where a *Genuine Determining Reason* exists
Pregnancy and Maternity	x			
Transgender	x			
Marital Status	x			
Age		x		the service has the potential to increase access to end of life and palliative care services for all people nearing the end of life from whatever cause

				which is likely to have a positive impact on older people, particularly with long term conditions other than cancers.

6. 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:

7. Equality Impact Analysis Findings				
Analysis Rating:	☐ Red	☐ Red/Amber	☐ Amber	☐ Green

		Actions	Wording for Policy / Project / Function
Red **Stop and remove the policy**	**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.	**Remove the policy** Complete the action plan above to identify the areas of discrimination and the work or actions which needs to be carried out to minimise the risk of discrimination.	No wording needed as policy is being removed
Red Amber **Continue the policy**	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.	**The policy can be published with the EIA** List the justification of the discrimination and source the evidence (i.e. clinical need as advised by NICE). Consider if there are any potential actions which would reduce the risk of discrimination. Another EIA must be completed if the policy is changed, reviewed or if further discrimination is identified at a later date.	As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentiona or otherwise) to one or more of the nine groups of people who share *Protected Characteristics.* However, a genuine determining reason exists which justifies the use of this policy and further professional advice. ***[Insert what the discrimination is and the justification of the discrimination plus any actions which could help what reduce the risk]***

Equality Impact Findings (continued):		
	Actions	Wording for Policy / Project / Function

Amber **Adjust the Policy**	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* section of this document.	**The policy can be published with the EIA** The policy can still be published but the Action Plan must be monitored to ensure that work is being carried out to remove or reduce the discrimination. Any changes identified and made to the service/policy/ strategy etc. should be included in the policy. Another EIA must be completed if the policy is changed, reviewed or if further discrimination is identified at a later date.	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* section of this document. ***[Insert what the discrimination is and what work will be carried out to reduce/eliminate the risk]***
Green **No major change**	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.	**The policy can be published with the EIA** Another EIA must be completed if the policy is changed, reviewed or if any discrimination is identified at a later date	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.

Brief Summary/Further comments	

Approved By		
Job Title:	Name:	Date:
Service Improvement Manager	Jenny Carter	18 November 2014

Appendix 2

INSTRUCTIONS FOR COMPLETING THE SUSTAINABILITY IMPACT ASSESSMENT

Sustainability is one of the CCG's key priorities and consequently the CCG has made a corporate commitment to address the environmental effects of its activities across all service areas. The purpose of the Sustainability Impact Assessment is to record any positive or negative impacts that a Policy / Board Report / Committee Report / Service Plan / Project is likely to have on each of the CCG's sustainability themes. The Sustainability Impact Assessment enables any relevant impacts to be identified and potentially managed.

The Sustainability Impact Assessment is based on assessing the impact of the activity against a series of criteria covering environmental sustainability issues. It would be most desirable for activities to score positively in as many areas as possible, although it is likely that some areas will score positively against some themes, and negatively against others.

Using the Sustainability Impact Assessment template

To complete the Sustainability Impact Assessment template, you should consider whether the Policy / Board Report / Committee Report / Service Plan / Project will have a positive or negative impact on each of the themes by placing a mark in the appropriate column. When you think there is likely to be an impact, please provide some annotations regarding the nature of the impact, and any actions that will be taken to address that impact. Users should note that not every theme will be relevant. Where this is the case the 'No Specific Impact' column should be marked. Users should also consider the following tips:

1. Make relative not absolute judgements (e.g. a new energy efficient service would score positively even if it consumes more energy than if no service were provided).
2. Be aware that small positive changes could be outweighed by negative ones (e.g. new energy efficient lighting in the short term may outweigh the benefits of maintaining current lighting).
3. If there are both positive and negative impacts, these need to be recorded in order to give a balanced view. Be objective and unbiased.
4. Concentrate on the most key significant issues - there is the potential to consider the appraisal in a very detailed way. This should be avoided at this stage.
5. Judge a proposal over its whole lifespan and remember that some impacts may change over different timescales.

If you require assistance in completing the Sustainability Impact Assessment please contact CSU Sustainability Lead

SUSTAINABILITY IMPACT ASSESSMENT

Staff preparing a Policy/ Board Report / Committee Report / Service Plan / Project are required to complete a Sustainability Impact Assessment. Sustainability is one of the CCG's key priorities and the CCG has made a corporate commitment to address the environmental effects of activities across CCG services. The purpose of this Sustainability Impact Assessment is to record any positive or negative impacts that this activity is likely to have on each of the CCG's Sustainability Themes. For assistance with completing the Sustainability Impact Assessment, please refer to the instructions below.

Policy / Report / Service Plan / Project Title:				
Theme (Potential impacts of the activity)	**Positive Impact**	**Negative Impact**	**No specific impact**	**What will the impact be? If the impact is negative, how can it be mitigated? (action)**
Reduce Carbon Emission from buildings by 12.5% by 2010-11 then 30% by 2020			x	
New builds and refurbishments over £2million (capital costs) comply with BREEAM Healthcare requirements.			x	
Reduce the risk of pollution and avoid any breaches in legislation.			x	
Goods and services are procured more sustainability.			x	
Reduce carbon emissions from road vehicles.		x		as part of this service is treating people in their own homes as opposed to a hospital admission there is a potential increase in the use of cars for staff to travel to patients homes. Such impact is likely to be small.
Reduce water consumption by 25% by 2020.			x	
Ensure legal compliance with waste legislation.			x	
Reduce the amount of waste produced by 5% by 2010 and by 25% by 2020			x	
Increase the amount of waste being recycled to 40%.			x	
Sustainability training and communications for employees.			x	
Partnership working with local groups and organisations to support sustainable development.			x	
Financial aspects of sustainable development are considered in line with policy requirements and commitments.			x	

Appendix 3

Benefits Realisation Plan

Ref	Benefit Area (refer to options appraisal)	Specific Benefit/Quantitative (Qn) or Qualitative (Ql)	Key Performance Indicator (Target value)	Baseline Measurement	Measurement/ Source of Evidence	Benefit Owner (Monitoring/ Management Assurance)	Target Realisation Date(s)