

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net


To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.


1) PLAN DETAILS


a) Summary of Plan


Local Authority	East Riding of Yorkshire Council
Clinical Commissioning Groups	NHS East Riding of Yorkshire CCG NHS Vale of York CCG
Boundary Differences	The Pocklington Group Practice sits within the East Riding of Yorkshire Council boundaries but is aligned with the NHS Vale of York CCG. The Vale of York CCG have been engaged in the development of the East Riding Better Care Fund (BCF) plan. They are also members of both the Health and Wellbeing Board and the BCF programme Board who are responsible for the governance of the programme.
Date agreed at Health and Well-Being Board:	11/2/14
Date submitted:	14/2/2014 Draft submission
Minimum required value of BCF pooled budget: 2014/15	£6,627,000
2015/16	£22,442,000
Total agreed value of pooled budget: 2014/15	£6,627,000
2015/16	£22,442,000

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS East Riding of Yorkshire CCG
By	 Alex Seale
Position	Director of Commissioning and Transformation
Date	14/2/14

Signed on behalf of the Clinical Commissioning Group	NHS Vale of York CCG
By	 Dr Mark Hayes
Position	Chief Clinical Officer
Date	14/2/14

Signed on behalf of the Council	East Riding of Yorkshire Council
By	 Rosy Pope
Position	Head of Adult Services (Director of Adult Social Services)
Date	14/2/14

Signed on behalf of the Health and Wellbeing Board	 East Riding Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Jonathan Owen
Date	14/2/14

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

Service provider engagement has been embedded into the East Riding's Better Care/Integration agenda from the outset. Providers from all sectors, including the voluntary sector, were involved in the initial integration workshops which helped provide a steer for the vision and direction of the East Riding's BCF planning. This is also reflected in the governance structure that has been created to help deliver the BCF plan. The membership for both the BCF Programme Board (responsible for the delivery of the workstreams that underpin the plan) and the BCF Executive Steering Group (time limited

group responsible for the delivery of the submitted plan) have representation from health (acute, primary care, community and mental health), in-house social care providers and the voluntary sector.

Future engagement will be through the:

- Social Care Provider Forum – meetings with independent domiciliary and residential care providers across the East Riding;
- BCF workstreams (Ambulatory Care, Single Point of Contact, Prevent and Self Care and Resources and Infrastructure, as outlined on page 13) have specific project-level engagement ensuring active provider involvement throughout the process;
- BCF Programme’s Communication Strategy will ensure that providers across all sectors are engaged;
- Council of Members representing the 36 GP practices in the East Riding;
- Voluntary sector event

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Our vision is for individuals and their carers to be placed at the heart of a joined up care and support system which places their home as the default setting for care. This vision is based on what people have told us is important to them. We continue to gather opinion through a range of engagement opportunities which include:

- Workshops – With representation from a range of organisations and groups including the East Riding Voluntary Action Service, Age UK, the Carers Advisory Group, Healthwatch and East Riding Health Forum;
- Insight Polling – Gathering circa 1,000 peoples’ views about integrated services. This included seeking opinion on:
 - Single point for access to services;
 - Access to seven day services to prevent admissions and support timely discharge;
 - Service preferences for inclusion within community hubs;
 - Access to advice and information to support independence;
 - Requirements for end of life support;
 - Identifying opportunities to reduce duplication and delays;

Feedback from patient, service user and public engagement will be used to inform and refine development of the ambulatory care model and the work of the supporting programme workstreams.

From this we know that what people want is for their care to be built around their needs and provided at home or as close to home as possible. To ensure on-going patient, carer, service user and public engagement we are developing a communications strategy that will include:

- A series of ER wide engagement events, starting with Bridlington and Cottingham in early 2014, to seek the views of the wider East Riding population;
- Holding a Third Sector day to ensure that partners in the voluntary sector are fully engaged with, and integral to, our transformation programme;

- Seeking the views of, and attendance at, the Carers Advisory Group, the 'Our Say' Learning Disability Consultation Group and the Health and Wellbeing Action Group;
- Providing updates to the Disability Advisory and Monitoring Group and the East Riding Equality Network;
- Closer working with Healthwatch to identify other engagement opportunities; including representation on the BCF Programme Board;
- Undertaking a survey of ambulatory care patients to seek their views on integrated services.

We are engaging with local health and care providers, East Riding residents and associated private and voluntary and community sector groups, to co-design models of care that will meet peoples' needs.

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
<p>“Pioneering Excellence for Older People” Pioneer Application June 2013</p>	<p>The original vision for integrated care and support for older people in Hull and East Riding. The application, submitted by the ERYC, Hull City Council, ER CCG and Hull CCG, highlights the commitment from local partners to embed person-centred care in all services.</p>
<p>Joint Health and Wellbeing Strategy (2013)</p>	<p>The BCF plan is aligned with the JHWS strategy, particularly around the aims of reducing preventable admissions and achieving healthy independent ageing.</p>
<p>Joint Strategic Needs Assessment (2011) Plus JSNA update from 2013</p>	<p>These documents link in to the development of the BCF Plan with a particular focus on prevention, supporting independent living for older people and reducing avoidable admissions to acute hospitals.</p>
<p>Joint Adult Commissioning Strategy (2012)</p>	<p>The key objectives highlighted in this strategy, developed by ERYC Adult Services and the ERY CCG, are fully aligned with the development of integrated services within the BCF programme. In summary they are:</p> <ul style="list-style-type: none"> • Prevention and Staying Healthy. • Urgent Care and Recovery. • Continuing Support and Managing Long Term Conditions.
<p>Older People Strategy (2010)</p>	<p>The key objectives highlighted in this strategy, targeted at people aged 50 and over in the East Riding, are aligned to the development of integrated services within the BCF programme. In summary they are:</p> <ul style="list-style-type: none"> • Improved health and emotional wellbeing. • Increased independence, choice and control. • Increased community involvement and reduced isolation.
<p>Carers Strategy (2010)</p>	<p>The BCF Plan is linked in to the Carers Strategy with a particular focus on access to timely information and advice, access to integrated and personalised services and support to help carers stay mentally and physically well.</p>
<p>Better Care Fund Programme Board Terms of Reference</p>	<p>Sets out the membership of the Board, principles, governance arrangements etc.</p>

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Better care, at or closer to home, through integration.

Our vision is to put individuals and their carers at the heart of a new joined up care and support system; being cared for in their home as a matter of course. We will work together with people of the East Riding to make sure we provide the right support to deliver the best outcomes and provide value for money.

In order to achieve our vision, we will change the way people access services both in and out of hospital. Success will mean a reduction in acute hospital based activity and an increased use of home based and community interventions and support.

Our outcomes will optimise the health and wellbeing of people, delaying the point at which they become frail and vulnerable, reducing the need for hospitalisation, keeping people well in their own homes and preventing admissions to long term care.

Our vision is aligned with the NHS, Adult Social Care and Public Health Outcome Frameworks and we will introduce services that demonstrate delivery, emphasising quality and outcomes experienced by the individual and best value for money. In delivering our vision, we expect significant cultural change, which will be evidenced through our shared innovations, person-centred behaviours and how we commission services.

Significant system and process changes will be needed to deliver this vision. The key changes that we will see in our integrated health and social care system will be:

Ambulatory Care Services

Our approach to ambulatory care forms the backbone of our vision to place individuals and their carers at the heart of a joined up care and support system; which delivers appropriate seven day services in, or as close to, their own home as possible without the need for admission into acute care.

As per the Kings Fund definition we are classing Ambulatory Care Sensitive (ACS) conditions as conditions which can be actively managed to prevent acute exacerbations and reduce the need for hospital admissions. Despite admissions being largely preventable, a significant proportion of all acute hospital activity is related to ACS conditions. In the East Riding of Yorkshire ACS conditions accounted for 6,803 (24.8%) of all emergency hospital admissions (27,444) at a cost of £13.6m in 2012/13.

According to the King's Fund estimates; emergency admissions for ACS conditions could be reduced by between 8 and 18 percent simply by tackling variations in care and

spreading existing good practice. Our ambition is to reduce our ambulatory care related acute activity by 15.9% (1,080 admissions per year). This would result in savings in the East Riding of circa £2.2 million per annum.

In developing our ambulatory care model we plan on taking a phased approach:

- Phase 1: Focussing on the over 75 population for commencement in Quarter 4 of 2014/15, with full year delivery in 2015/16;
- Phase 2: To expand the age range to include all adults aged 18 +; with a particular focus on people with multiple long-term conditions, e.g. Chronic Obstructive Pulmonary Disorder (COPD), dementia. These long term conditions can be mental, physical or a combination of both.

In terms of admission prevention, we will:

- Deliver care at home, or in the community, wherever possible;
- Assess Better Before Admission (ABBA), through the creation of rapid response, assessment and support services;
- Facilitate rapid access to one stop ambulatory clinics, key diagnostics, medication/medication review and expert advice;
- Implement a tiered model of coordinated care for individuals accessing a range of services;
- Expand integrated health and social care teams to be directly accessible by care navigators and through the single point of contact;
- Deliver suitable levels of seven day a week services offering timely assessment, intervention and access to appropriate services;
- Develop a personalised plan covering health and social care, including exacerbation management;
- Deliver individualised and responsive specialist palliative care and support to individuals and their families in the last months of their lives.

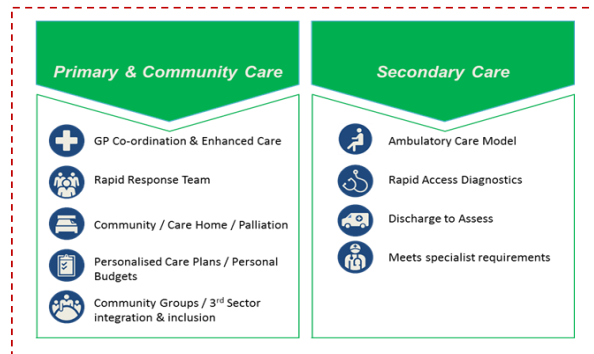
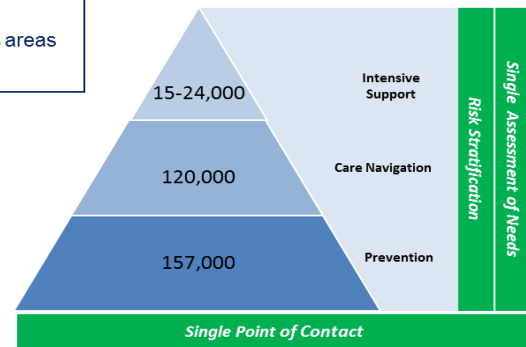
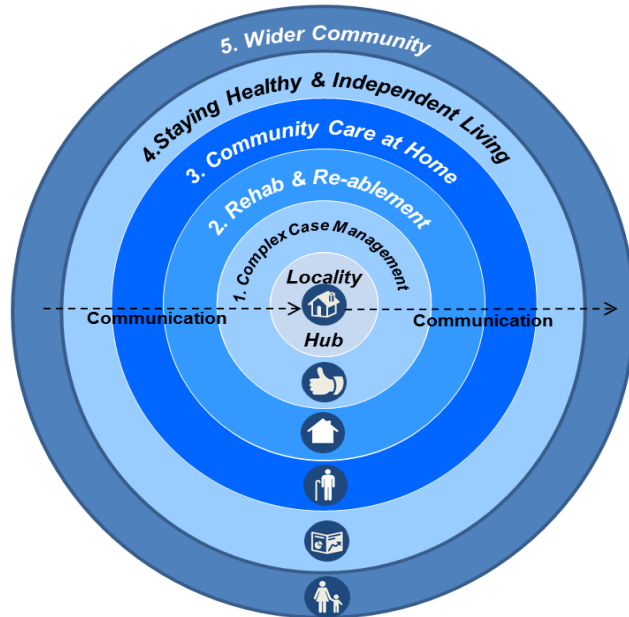
In terms of facilitating timely discharges, we will:

- Optimise recovery with personalised reablement/rehabilitation, to support the regaining of skills/development of self-care skills;
- Ensure patients are only in hospital for an appropriate length of time;
- Work to improve hospital discharge planning with partners across Health and Social Care through improved access to alternative models of care, such as reablement, intermediate care or community hospitals;
- Work with providers to deliver an improved approach to managing bed pressures;
- Introduce 'discharge to assess' practices to support timely discharges and ensure assessments take place in the most appropriate setting.

The ambulatory care model, and how it links in to the wider provision of care, is reflected in the following figure:

Our offer:

- 1. Healthy independent aging
- 2. Consistent quality across areas
- 3. Home/Community is default care setting
- 4. Joined-up care



Single Point of Contact

Developing a single point of contact across health and social care in the East Riding is also key to delivering the vision of seamless access to integrated services.

We will:

- Rationalise the various points of entry into local community health and social care services;
- Improve triage, assessment, sign-posting and outcomes;
- Provide access to seven day a week services;
- Introduce a standardised approach to case management and support for people with complex needs.

Prevention and Self-Care

Delaying or reducing demand for statutory health and social care services is an essential element of delivering better care. Taking a coordinated approach to prevention and self-care will help us to address the trend of increasing demand for services and associated financial pressures.

We will:

- Further develop the capacity and capability for a community based approach to improving health and wellbeing and promoting independence;
- Promote independence and self-care; enabling individuals to have control over their health and wellbeing requirements so that they can continue to actively participate in society for as long as possible;
- Utilise insight and risk management tools to identify individuals and groups who would benefit from a more intensive approach;

- Underpin this with the implementation of a standardised assessment of need instrument.

Resource and Infrastructure

Underpinning the BCF programme will be a workstream providing an overview on the resource and infrastructure implications for the whole BCF programme. Specifically:

- The Human Resources, Financial, Legal, Information, Management and Technological implications of the programme;
- Delivering access to a single shared electronic record utilising the NHS number as the primary identifier;
- Exploring opportunities to deliver co-located and integrated health and social care services e.g. through the creation of community hubs. We will work with other public sector and partner organisations to ensure strategic asset alignment.

In summary, over the next five years community healthcare and social care teams will work together in an increasingly integrated way, with single assessments for rapid and effective joint responses to identified needs, provided in and around the home. Our teams will work with the voluntary and community sector to ensure those not yet experiencing acute need, but requiring support, are helped to remain healthy and independent.

We will empower East Riding residents through effective care navigation, education and self-care. We will maximise their independence and wellbeing; and we will help identify and combat social isolation, as a determinant on their overall health and wellbeing.

The BCF will enable us to start to release acute health funding to develop accessible health and social care services in the community, and enable us to:

- Protect adult social care services; including carer and reablement services;
- Implement appropriate seven day services;
- Deliver high quality case management with lead accountable professionals;
- Work with all stakeholders to reduce long-term dependency across the health and care systems, promoting independence and driving improvement in overall health and wellbeing;
- Work with high risk individuals to improve demand management within both the health and social care systems, through earlier and better engagement and intervention;
- Improve access to services through a single point of access;
- Improve quality and consistency of outcomes.

The volume of emergency activity in hospitals will be reduced through alternative community-based services. Additionally an improved discharge pathway into community-based services will reduce delays in transfers of care and pressures in our A&E units and wards, ensuring that people are helped to regain their independence after episodes of ill health as quickly as possible. By improving the way we work with people to manage their conditions, we will reduce the demand not just on acute hospital services, but also the need for nursing and residential care.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

The overarching aims and objectives of delivering our integrated approach to health and social care are to:

- Provide an integrated response that takes a holistic view of individual need, to maintain independence, to prevent admission to acute hospital care or support timely discharges through an ambulatory care model;
- Proactively manage and divert clinically appropriate individuals presenting at A&E into alternative ambulatory care pathways;
- Provide rapid access to specialist support, diagnostics and interventions;
- Maximise the use of reablement/rehabilitation to optimise peoples' skills and abilities to maximise independence, prior to establishing final care needs;
- Deliver a single point of contact across community health and social care services to provide an increased focus on improved triage, integrated assessment and signposting;
- Promote prevention and self-care to maximise health, wellbeing and independence;
- Deliver improved outcomes and positive reported experiences of care.

Successful implementation of this model will be measured through achievement of our targets against the following national and local metrics:

National

- Admissions to residential and care homes (aged 65 or over) per 100,000 population;
- Effectiveness of reablement. Proportion of older people (65 +) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services;
- Delayed transfers of care. Total days of delays per 100,000 population aged 18+;
- Avoidable emergency admissions. Emergency inpatient spells per 100,000 population;
- Patient/service user experience.

Local

- Emergency readmissions within 30 days of discharge from hospital.

Appendix B describes how we expect to deliver on these performance measures.

The key measure of success will be a financially balanced system where the shift in spending from the acute sector to community settings has supported transformation and delivered tangible benefits to the residents of the East Riding.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

A high-level overview of the BCF timeline for the East Riding is:

Up to March 2014

- Develop a concordat, signed by the key stakeholders, setting out the principles and intentions for integrated working;
- Initiate the workstreams responsible for delivering the BCF plan;
- Develop the programme plan including interdependencies/milestones, associated risk register and issue log;
- Finalise and agree the BCF Plan for sign off by the Health and Wellbeing Board;
- Baseline performance metrics and establish monitoring mechanisms.

April 2014 to March 2015

- Embed BCF plan in new organisational strategic plans;
- Assess resource and infrastructure implications of the new model and address the associated issues. This will include the workforce, estate, financial and legal consequences of the plan;
- Complete detailed planning to implement the integrated model;
- Develop a robust approach to provider engagement to support the BCF transformation agenda;
- Test models and share learning;
- Monitor financial flows in shadow budgets to evaluate the financial impact of the test models on different providers and on the total cost to commissioners;
- Ensure new models are aligned with commissioning plans and embedded in the contracting round for 2015/16; including plans to decommission services in the acute sector.

From April 2015

- Full roll out of schemes underpinning the BCF plan;
- Monitor impacts of BCF implementation against the agreed metric trajectories and undertake appropriate mitigating action as required.

The vision for the delivery of integrated care is embedded within key health and social care strategies and plans such as the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy as well as the strategies for Joint Adult Commissioning, Older People, Carers and Community Services. Crosscutting themes include:

- Access to timely information and advice, to integrated and personalised services and support;

- Increasing independence, choice and control;
- A focus on prevention, self-care and supporting independent living;
- Increasing community involvement and reduced isolation;
- Reducing avoidable admissions to acute hospitals.

Working closely with stakeholders across health (acute, primary care, community and mental health), social care and the voluntary sector will ensure that we deliver our vision. This will ensure that our services are aligned to provide the right care, in the right place, for the residents of the East Riding.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Delivery of the BCF is dependent upon a shift of funding from the acute sector into alternative home and community based services. In order to make the transition to a lower level of activity in the acute sector possible, investment will be made in community health and social care services. We have not underestimated the impact that this will have on our acute providers and we have focussed our contract discussions and formulated our joint plans accordingly. Whole system change on this scale has not been undertaken before in the UK and timescales are ambitious, however, all stakeholders remain committed to delivering the BCF programme in the East Riding. The focus for this plan is to ensure that individuals are proactively managed and supported to avoid unnecessary admissions to the acute sector and to support timely discharges.

The services that we are jointly developing will release efficiency savings in:

- Admissions avoidance;
- Reduced demand on A&E services;
- Reduced length of stay;
- Reduced numbers of delayed discharges.

Admissions avoidance/reduced demand on A&E

The developments proposed below, and covered in section 2(a), will play a pivotal role in admissions avoidance and reducing demands on A&E, through:

- Better assessment before admission;
- Rapid response, assessment and support services;
- Rapid access to ambulatory clinics, diagnostics, medication and expert advice.
- Improved care coordination and planning;
- Individualised and responsive specialist palliative care and support;
- The expansion of integrated health and social care teams.

Length of stay/delayed discharge

For those patients that have been admitted we will ensure that they have clear discharge plans and that the necessary support packages to ensure rapid discharge are in place. This will be delivered through:

- Personalised reablement and/or rehabilitation;
- Improved hospital discharge planning with access to alternative models of care, such as reablement, intermediate care or community hospitals;
- An improved approach to managing bed pressures.

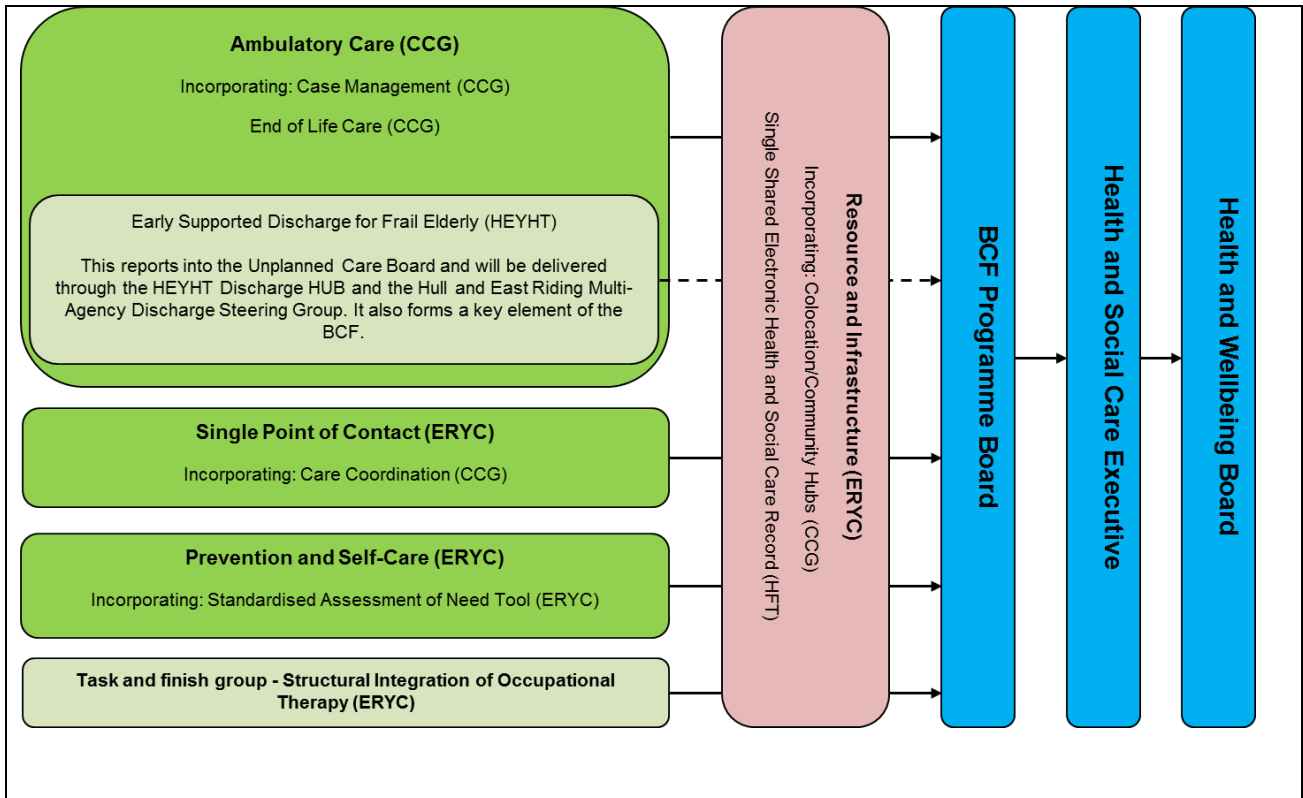
These developments will be underpinned by appropriate levels of seven day services and through the use of the single point of access to community health and social care services. Where possible services will be delivered at, or as near to, home as possible.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

A BCF Programme Board has been established to provide leadership and to manage the delivery of the workstreams. Each workstream has produced a draft Project Initiation Document and Terms of Reference for their projects; enabling the BCF Programme Board to assess progress, manage programme interdependencies and assess issues and risks as they arise. The workstreams will then be providing monthly updates to the Programme Board on project progression. A time limited Executive Steering Group has also been created, tasked with delivering the BCF Plan by April 2014. A concordat is being developed that will be signed by the key stakeholders setting out the principles and commitments for integrated working.

Overall responsibility for the successful delivery of the BCF and integrated services sits with the East Riding of Yorkshire Health and Wellbeing Board with both the BCF Programme Board and Health and Social Care Executive Group providing assurance to them on progress against the Plan. The following diagram provides details of the on-going governance structure:



3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

Protecting adult social care services in the East Riding of Yorkshire means ensuring that those most in need within our local communities continue to receive support, in a time of growing demand and budgetary pressures. The Care Bill is proposing a national Fair Access to Care Services (FACS) eligibility criteria that we will have to comply with. The impact of this should not be underestimated as it is likely to lead to more people being eligible for publically funded care. The Care Bill will also promote a new asset based model of social work and duties for prevention and early intervention. However, the focus continues to be on looking at new models of integrated care and enhancing the quality of care by tackling the determinants of both ill-health and poor quality of life, rather than focussing on the supply of services.

The protection of adult social care services is a key principle of the Better Care Fund concordat that is being developed for all key stakeholder organisations to sign up to.

Please explain how local social care services will be protected within your plans

Funding currently allocated via Health to Social Care has been used to enable the Local Authority to sustain the current level of FACS eligibility criteria to:

- Support development and delivery of reablement services, including:
 - Integrated and Enhanced Hospital Teams;

- Short term assessment and reablement services (STARS);
- Telecare;
- Bed-based services;
- Practical home support;
- Provide community equipment and adaptations;
- Provide support to carers;
- Provide access to a range of preventative services.

Agreement has been reached for 2014/15, which is also essential to support the thrust of the Care Bill; which requires additional assessments to be undertaken for people who did not previously access social care services. There is an assumption that the implications arising from the Care Bill will be fully funded. It is also proposed that additional resources will be invested in community health and social care services which will reduce hospital admissions/readmissions, support timely discharges and reduce admissions to residential/nursing care homes.

b) Seven day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy).

All partners are committed to providing appropriate seven day health and social care services. This commitment is evidenced by the seven day services that we currently offer, including:

- Integrated Hospital Team made up of clinicians and social workers;
- Reablement services;
- Overnight community nursing service across the East Riding;
- Out of hours GP service;
- Carers' emergency response service.

These services all help to prevent admissions and to facilitate timely discharges, particularly during evenings and weekends.

Access to appropriate services seven days a week is a key component of the Care Bill and further work is being undertaken to understand the adult social care customer journey. The provision of seven day services to support discharge is a key principle of the Better Care Fund concordat that is being developed for all key stakeholder organisations to sign up to. Our commitment to this will be overseen by the BCF Programme Board, and has the full support of our local Health and Wellbeing Board.

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

We are committed to the further development of seven day services to support the move to the new ambulatory care model discussed earlier. This integrated approach will

ensure the delivery of timely assessments and appropriate levels of access to services 365 days a year, to prevent admissions and to support discharges.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

All health services use the NHS patient number as the primary identifier. Our NHS contracts specify the use of the NHS number and associated financial penalties for not doing so.

Currently Social Services within the East Riding do not use the NHS patient number; however there is a commitment to adopt this.

The commitment to data sharing, and working towards the use of the NHS patient number as the primary identifier, is a key principle of the Better Care Fund concordat that is being developed for all key stakeholder organisations to sign up to.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Development of the single shared electronic health and social care record will be based on using the NHS number. The aim is to implement the shared system by 2018.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We are committed to developing and adopting systems based on open APIs and open standards. We already use SystmOne, EMIS Web and the Adult Information System to allow practitioners to add, view and share information on a range of electronic records.

To enhance integrated working across organisations we will develop interfaces between our systems. We are also exploring the creation of a shared database that will aggregate data from different sources into a consistent format. This will provide one view over the whole systems of health and social care, and allow queries and analyses to take place across multiple, separate systems.

All stakeholder organisations use either NHS mail or GSI, both of which are secure e-mail services.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

All integrated services will be delivered within the requirements of our Information Governance framework. We are committed to ensuring that patient and service user confidentiality is maintained.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

The East Riding has implemented a risk profiling and care management model. This methodology provides a local health and social care multi-disciplinary approach to jointly assess and coordinate care for those people that are at risk of hospital admission and who would benefit from proactive case management. An early assessment of the East Riding indicates that there are between 15,000 to 24,000 people (4.5 to 7.2% of the population) that would benefit from intensive support. Care navigation and case management are integral to our BCF programme and project teams have been established to deliver on these aims. There are clear synergies between the objectives of these teams and the wider vision, as set out by the BCF Programme Board, linking into the joint Health and Wellbeing Strategy. The aims of the model are to:

- Allocate a lead professional responsible for the coordination of care; so people know who to turn to and where they go for support, if their condition worsens;
- Provide appropriate support in a timely fashion;
- Design care together with the users of services and their carers - to have a really good, supportive planning process around their care and treatment;
- Provide a responsive service that includes carers as well as the people they are caring for;
- Deliver a tiered approach to the coordination of care to support a range of individual needs;
- Improve signposting to help people to access the support they need and promote independence;
- Support individuals to understand their own conditions to enable them to take a more proactive and equal role in managing their own care;
- Support individuals by helping them to better understand and navigate the health and social care system;
- Provide individual case management support for individuals with complex needs;
- Identify opportunities for using technology to support individuals.

The creation of a joint assessment process, and the allocation of an accountable lead professional providing a real difference to peoples' care, are both key principles of the Better Care Fund concordat that is being developed for all key stakeholder organisations to sign up to.

RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
Improvements in the quality of community-based integrated services fail to deliver the required reductions in acute activity by 2015/16; impacting on the overall funding available to support statutory and other core services.	High	<p>We have modelled our assumptions using a range of available data, including metrics from other localities and support from the National Collaborative.</p> <p>In 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications.</p>
The national timeframe to plan and implement the whole system changes across Health and Social Care are ambitious.	High	<p>Robust governance arrangements are in place to support delivery, from assessment of the draft template through to ongoing programme overview through the Health and Wellbeing Board.</p> <p>Concordat signed by all key stakeholders, evidencing commitment to delivery of the BCF plan.</p>
Financial impact of dual/duplication of costs in maintaining existing services whilst developing new ones.	High	Robust programme plan to assess financial implications and costed financial model.
Shifting of resources to fund new integrated community-based services may destabilise current service providers, particularly in the acute sector.	High	Acute representation on the BCF Programme Board and sign-up to the BCF plan and concordat.
Organisational pressures will restrict the ability of our workforce to have the capacity to deliver the BCF workstreams.	High	BCF Programme Board discussing the creation of Programme Management Officer (PMO) function and resourcing the workstreams appropriately.
Issues around recruitment and development needs.	High	<p>Creation of a flexible workforce.</p> <p>Introduction of staffing champions/leaders.</p> <p>On-going supervision and support.</p> <p>Training needs assessment to identify new skills required (if applicable).</p>
Delivering two significant change programmes concurrently; there are competing and conflicting demands on Adult Social Care in terms of the BCF and the Care Bill.	High	Where appropriate workstreams will be aligned and there will be congruent governance arrangements to identify and address pressures.
Staff being resistant to the cultural change required to deliver new models of care.	High	Early involvement of staff to ensure that they feel engaged in the design of new models.
Information governance barriers to sharing information between organisations.	High	<p>Integrated IT systems and information sharing agreements.</p> <p>Information governance issues are being considered by the single shared electronic health and social care record workstream who are</p>

		developing solutions.
Issues around charging for social care services embedded within integrated teams.	High	A resource and infrastructure work group, including representation from legal and financial services, has been created to ensure that all issues are assessed and mitigated for.
Incompatible IT systems.	High	IT system issues are being considered by the single shared electronic health and social care record workstream who are developing solutions.
Funding linked to the Care Bill being incorporated into the overall BCF and potential impact on the ERYC adult social care to meet its statutory responsibilities.	High	Explore ring-fencing of Care Bill element of the BCF. To be factored in pooled BCF.
Failure to achieve the BCF improvement trajectories.	Medium	The information will be scrutinised on a monthly/quarterly basis (dependent on the target) by the BCF Programme and Health and Wellbeing Boards. Slippage in achieving targets will result in the implementation of recovery actions.
East Riding residents do not change their view of health from a dependant to a proactively self-managed model of thinking	Medium	Involvement of patients, carers, involved groups, wider residents to help build the proposed model. Proactive communications to raise awareness. Improved usage of personal health budgets. Clinical model that ensures patients are central to decision making.
The CCG and Local Authority do not have co-terminus boundaries.	Medium	The Vale of York CCG have been engaged in the development of the East Riding BCF plan. They are also members of both the Health and Wellbeing Board and the BCF programme Board who are responsible for the governance of the programme.
The programme fails to fully engage with all providers.	Medium	Communication plan to be developed to include participation and engagement of key providers. Key providers to sign up to the concordat.
Lack of capital/revenue for estates provision and/or development.	Medium	A co-location/community hubs project team has been created within the resource and infrastructure workstream. They will be responsible for assessing and coordinating the estate requirements and opportunities to deliver integrated services.