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	**City of York Council**
Clinical Commissioning Groups	**NHS Vale of York**
Boundary Differences	**City of York Council sits entirely within the footprint of NHS Vale of York CCG. However the CCG also sits within the boundaries of both North Yorkshire County Council and East Riding of Yorkshire and the CCG is working across organisational boundaries to ensure all plans align**
Date agreed at Health and Well-Being Board:	**29/01/2014**
Date submitted:	**14/2/14**
Minimum required value of BCF pooled budget: 2014/15	**£3,354K** Which comprises: Health Gain Transfer £2,744K Better Care Funding 14/15 £610K
2015/16	**£12,127,000**

Total agreed value of potential pooled budget: 2014/15	**£4,665K** Which comprises: As above £3,354K Reablement Funding £915K Carers Funding £396K
2015/16	**£12,127,000**

b) Authorisation and signoff

Signed on behalf of NHS Vale of York Clinical Commissioning Group	
By	Dr Mark Hayes
Position	Chief Clinical Officer
Date	13/2/14

Signed on behalf of City of York Council	
By	Kersten England
Position	Chief Executive
Date	13/2/14

Signed on behalf of York Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Tracey Simpson-Laing
Date	13/2/14

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

All major providers and commissioners are already signed up to our vision for person centred, integrated health and social care at the highest level via York's Health and Wellbeing Board (H&WB). Our main providers sit on this board. Our integration plan proposed in this submission is absolutely consistent with this vision and the core principles set out in York's Joint Health and Wellbeing Strategy.

A Collaborative Transformation Board (a sub-committee of H&WB Board) has been running since May 2013, chaired by City of York Council (CYC) Deputy Chief Executive and attended by senior representatives from commissioner and provider organisations including NHS Vale of York CCG (VoY), York Teaching Hospitals Foundation Trust (YTHFT), Leeds York Partnership Foundation Trust (LYPFT) and CYC Adult Social Services and representatives from the voluntary sector and health watch. Neighbouring Local Authorities who link with the Vale of York CCG are also represented.

YTHFT is fully committed to our plans. As our main provider of acute and community services the Trust has supported our system wide reablement and winter schemes and is playing a strong role in shaping and resourcing our BCF schemes. The Trust is also

committed to our vision by running a care hub pilot in Selby and sharing workforce with other 'hub' pilots as well as reshaping its provision to reflect changing demand as our proposed schemes start to take effect.

We have also prioritised improvements in mental health services (details of new schemes proposed as part of initial BCF plans are explained later in this submission) as a core part of reforming the care system and Leeds and York Partnership FT (LYPFT) are active partners in helping us re-design and deliver our models of care.

Our Joint Delivery Group (a CCG and CYC group which is responsible for driving the delivery of the BCF) meets fortnightly and is supported by 2 senior programme leads who work collaboratively across health and social care commissioners and providers; this collaborative approach, managed through our Joint Delivery Unit, has allowed significant progress to be made in building sustainable relationships which are translating into joint plans and agreed actions.

Our GPs are closely involved in developing our plans; we already have plans in place for one GP led care hub in York and another hub which will work across York and North Yorkshire is currently being developed. GPs sit on all of the project teams and also provide clinical input into the JDG.

On 16th December 2013, CYC and VoY co-hosted a Health and Social Care Integration Workshop, attended by many our local stakeholders. The event was part of our communication and engagement to help draw on local experiences, prioritise and develop support options for whole-systems integration. The workshop was also an opportunity to share learning about different ways people themselves had managed to overcome barriers to integrated care already.

The common theme from this workshop was that we needed a sustainable joined up approach to care; this was the highest priority for our residents. This means health and social care staff working together in multi-agency operating teams. We have built our plan on this theme and working with our providers both in health and social care, we believe we can make significant improvements to the way care is delivered. Through these engagement processes, we are building on our system wide successes and using the BCF to both embed what is working well and develop more improvements.

Following on from this workshop, the Health and Wellbeing board held a joint engagement event on 10th March 2014 where the detail around the BCF plan was discussed with over 90 members of the public and local providers. Feedback from this event has focussed our attention on the requirement to turn our plans into actions and to continue to engage at all levels on a regular basis. We have acted on this feedback and specific responses are detailed later on in this submission.

We also have a number of existing programmes with a range of health and social care providers including our voluntary and community sector, and they too are fully engaged in the development of our plans.

By fully engaging with our health and social care providers we have jointly delivered our reablement programme over the past two years and this engagement and co-design has been pivotal to the success of this year's sustainability plan over the winter period and our planning for substantial integration going forward.

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 based on what people have said is most important to them. Over the past 2 years, with the establishment of the CCG and the Health and Wellbeing Board and our first Joint Health and Wellbeing Strategy, both City of York Council and VoY have engaged extensively with patients and carers, residents, and the workforce across the public, private and voluntary sectors on the vision and priorities for health and social care. York's Health and Wellbeing Board remains committed to this level of engagement and hosts at least two stakeholder events per year. The most recent event in March 2014 focussed on integrating health and social care, transforming adult social care and the Joint Strategic Needs Assessment (JSNA). There has been a high level of lay person input into both the initial JSNA and its refresh and this input will continue through the lifecycle of the plan.

The CCG also has a robust programme of engagement and communications across the Vale of York population to ensure we continue to build on this momentum. We host the Patient and Public Engagement steering group which includes Health Watch and lay members, to ensure we can capture the voice of our patients and residents in our strategic and operational planning.

A number of our General Practices host patient participation groups and as a CCG we are committed to at least two wider open forums per year and a number of engagement events focused on specific projects, i.e. long term conditions.

The CCG have held a series of 'world café' events to work with residents to identify their priorities and their key messages. These events have focussed on how we can develop better together making sure we feedback to those involved and learn how we can improve our engagement programme.

We have also hosted a joint Public and Patient Engagement (PPE) event to focus solely on joining up services and what this means to individuals, their supporters and the wider community. People told us it was important to them to 'tell my story once' and 'to have a joined up system, they could move through easily'. We will continue to build on this as we take our joint plan forward. All the partner agencies have committed to joint communications and engagement events to maintain the focus on working together better. As part of this commitment we are developing a joint communications strategy, led by the H&WB Board, which will ensure we continue to engage and consult across our resident population.

Within York, there is an active voluntary and community sector with partner organisations such as University of York, St John's University and Joseph Rowntree Foundation based here. Such organisations can offer research and evidence that is very valuable to developing our plans for integration. We intend to build on our relationships with these organisations and develop a specific work stream to work on this.

The National Voices research provides us with information for continuing to develop our patient, service user and public engagement. Both the CCG and our partners are committed to doing this and to progress our vision towards joined up, person centred support.

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
Terms of Reference for York Health and Wellbeing Board	This sets the strategy by which our plans are being delivered
Joint Strategic Needs Assessment (JSNA)	Joint local authority and CCG assessments of the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities.
Joint Health & Wellbeing Strategy.	The Joint Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out in the period 2013 to 2016.
Health Gain Plan	Joint agreement to invest health gains money in areas that deliver both Adult Social Care capacity and improved health benefits
Winter Pressures Plan	Additional funding from NHS England to assist patients through the health and social care system during what was anticipated to be an extremely busy period. Plans jointly agreed.
Financial Plan	Appendix to main BCF submission which outlines financial plans and performance metrics
Outcomes Framework	We have an agreed outcomes framework to support the delivery of our programme of work.

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?**

We recognise that in times of increased demand and additional pressures on budgets and other resources, we need to make sure the health and social care system works as efficiently and effectively as possible.

We know that all the different parts of the system (GPs, Hospitals, Mental Health, Social Care, Community Based Services and others) need to change the way they work to ensure we can continue to deliver the right care at the right time in the right place. Specifically we need to ensure:

- That individuals are able to access the right level of care and support in community based settings to help avoid unnecessary admissions to hospital.

- That if individuals do have to go to hospital, we have the right teams in place to speed up their journey through the hospital and to make sure they can leave the hospital as soon as it is safe for them to do so.

- Once individuals are discharged from hospital, we have joint teams of health and social care professionals who support them to regain their independence and return to the best level of health possible.

- That people are able to live in the place of their choice for as long as possible and that when they need to move to a different care setting, this happens quickly and effectively, involving individuals, their cares and families at every step of the way.

Our vision is to bring together a comprehensive range of health and wellbeing services to provide Care Hubs for local people that are:

- Dedicated to their needs
- Coordinated for their convenience and effectiveness
- Consistently delivering high quality, successful outcomes.

ENID'S STORY - NOW

Enid has standard health care reviews with her GP. Social care provision is reactive. She has problems with slowly deteriorating lung function as a result of COPD and she also has mild dementia.

Enid begins to feel unwell over a weekend and goes to bed. Her daughter finds her and calls NHS111. She is admitted after a long wait in AE. She is given antibiotics for a chest infection. Like many patients she is at risk of further infection and loss of her normal function. She is discharged back home in the evening after a long stay in hospital. Her GP is unaware of her arrival home until her family call stating that she is struggling and confused. Her medications were altered by the hospital team, including an addition of anti-psychotic medication used to control her agitation whilst admitted.

She is visited by her GP and a District Nurse who requests Social Care input from the rapid access and reablement teams. She remains at increased risk of admission over the weekend and during the night.

The reablement process falters and Enid is referred for placement in a Care Home. Whilst waiting Enid falls and breaks her hip and is admitted back into hospital.

The system failed Enid through a lack of continuity of care and a lack of joined up services, working together to meet Enid's needs and aspirations.

ENID'S STORY – THE FUTURE

The Care Hub Team identify Enid as a risk for admission and proactively assesses and manage her health status with her own case manager. Every opportunity is taken to help her to remain independent in her own home.

Enid receives a comprehensive care plan with a care worker that she and her family and contact for support. When she contacts the NHS111 and the OOH GP her medical details are available. Alternatively during the week she is seen by her GP or an ECP who steps up her care to the local Community Hospital

When she is admitted the AE Team has her records and then inform the Care Hub Team that she has been admitted. They begin her discharge planning within 2 hours of her admission. Her discharge process is fully integrated with the Care Hub Team who signal that they are ready to receive her in the community. She is discharged with a clear emergency care plan, updated DNACPR Form.

She has social care provision and additional services such as physiotherapy. Enid is assessed as having a risk of falls and is provided with risk mitigation support. The Care Hub Team adjust her management plan and involve her family to anticipate risks in her disease trajectory.

Enid has benefitted from joined up services that fit around her; they support her continued independence through an integrated team of health and social care professionals who share information and involve Enid and her family in decision making.

Our joint vision is for a health and social care system that places individuals at the centre with accessible, responsive and effective services built around them to achieve the best health and wellbeing for everyone in our community.

To do this we need to change the way individuals' access services, both in and out of hospital, so we can deliver Right Care, Right Place, and Right Time, and "making every contact count". If we succeed we will see reduced hospital based activity and a much greater use of community and home based support.

In order to achieve our vision we know that significant system and process changes will need to happen. We will do this by focussing on partnership working and innovations that are more financially effective.

We are also mindful that to achieve true transformation for all of our residents we will need to address the difficult issues of more collaborative Local Authority work and the challenges this will bring. Specifically we will need to address how the various Local Authorities which work with VoY CCG can work more closely to develop shared services where appropriate.

The key themes we will see in our integrated health and social care system will be the development of:

Care Hubs – We will develop Care Hubs, whose key responsibility will be to assess, diagnose and activate solutions to enable individuals to remain at home, or return there at the earliest opportunity, following a period of exacerbation or crisis. These hubs will be developed using national and international evidence, ranging from earlier Polysystem models in Redbridge through to fully integrated community models in Canterbury, New Zealand and 'Extensivists' in the USA.

The hubs will be staffed by a multi-disciplinary, multi-agency team who will act as the enablers to ensure care and support packages are put in place as quickly as possible and in the best interests of the individual and their carers. New funding models to incentivise providers to deliver this approach will ensure they truly deliver transformed models of care as alternatives to admissions to hospital or care homes.

Shared Care Records – People tell us they "only want to tell their story once". We fully support this and see this not only as one of the greatest impacts the new services can provide it is also one of the greatest challenges we face. We need to join up our different information systems so we can work with partners and the wider business community to look at how we can do this. It will mean new ways managing data and working across organisations, to share relevant information and we will use the NHS number across both health and social care.

Single Contact Point – we will have one care record, and move to a single contact point for residents to contact us. This could be a GP, a care manager, a district nurse, a community matron, an OT or specialist MH worker or any other health and social care practitioner with whom the person has regular contact. This person will retain accountability for their client and will act as the facilitator to all other services and interventions. Clearly when an individual is admitted to a hospital setting, clinical responsibility will transfer to the relevant hospital clinician but the single contact point will still have an accountable role for in-reach and discharge planning.

These key themes will be supported by additional enabling schemes which are explained in more detail later in this submission.

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?**

With our new approach we aim to improve quality of support, better outcomes and overall improved experiences for residents and be able to measure these. The specific measurable aims of our new model are:

- A reduction in the proportion of delayed discharges and lost bed days from acute settings for those patients medically fit for discharge.

- Less demand for emergency placements.

- A reduction in the length of stay for residents who do require an emergency placement where no other alternative is available.

- A reduction in the proportion of residents being admitted to care homes, from both acute and community settings.

To support this we will also expect to see significant improvements through joined up support. Initial aims we expect to deliver are:

- Residents only having to tell their story once.

- Faster response times and more joined support to individuals and their carers/families

- Positive feedback and customer satisfaction reports

Measuring success

We aim to put in place a multi-agency programme team who will be responsible for the planning and implementation of the models across the health economy. This team will also be tasked with developing a suite of monitoring and reporting mechanisms (monthly and quarterly) that will allow us to analyse the impact of the new approach. Specifically, these reports will need to identify:

- The impact on our local acute provider on a case by case basis. This level of detail will be crucial in order to release resources sustainably and increase the scale of our potential funding model of pooled budgets we hope to be able to achieve, significantly beyond the minimum requirement for BCF.

- The impact on the local authority, specifically in the Adult Social Care Sector, focussing on the financial implications of any intervention.

- The impact on GPs, wider primary care and the voluntary sector.

- The more appropriate allocation of care packages to identify how our model has enabled a greater level of appropriate independence.

- How activity has moved through the system in order to help future proof the model and identify new opportunities.

- The level of satisfaction from people who have used the new system. We intend to further develop relationships with York University and other industry providers to investigate new and more effective ways of capturing, understanding and building on the feedback received.

An early piece of work that is currently being undertaken is to establish a base-line of current activity and expenditure, in both health and social care settings, so that we can clearly measure and report on the impact our new service models are having. A robust evidence base to support change and measure delivery is crucial to our overall vision and we intend to build the necessary partnerships to develop this evidence base.

A key measure of our success will be delivering our vision and the aims and outcomes detailed earlier in this document. We recognise that we will have to work more closely across organisational boundaries to help drive out the inefficiencies and duplication of work that currently happens on a regular basis. By integrating systems, processes and where required workforces, we will be able to achieve truly transformational changes for our residents.

The truest measure of success will be a financially balanced system where the shift of spending from the acute sector to community settings has supported transformation and allowed acute providers to re-configure under their terms to ensure their on-going financial viability. To ensure the risks in reaching financial balance are fully mitigated, we will develop a shred risk agreement between health and social care organisations. We will work closely with colleagues in health and social care, through the Collaborative Transformation Board, to ensure this measure is achieved.

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**

CARE HUBS

The main scheme which sits at the core of our joint work programme is the introduction, through a series of pilots, of a refreshed model of integrated health and social care provision based on Care Hubs.

In the first two years, the most significant change we are proposing to the way health and social care is currently delivered is the development of the principle of Proactive Care.

Our vision for this approach is about working with individuals to identify their current and prospective health and care needs, whilst working actively with them to promote independence and reduce risk of escalation and/or relapse in health and well-being. Early and proactive care will be delivered through a multi-disciplinary and multi-agency team, based in a community setting and with all the necessary infrastructure in place to deliver rapid, safe and sustainable services. This approach will help us deliver the outcomes for residents we identified earlier and will be a key contributor to making our joint vision work.

In order to ensure we gain maximum learning and innovation from this approach, we do not intend to be too proscriptive on how Care Hubs and Proactive Care should be delivered. We will however, expect potential providers of these models to work within a clear framework that identifies the outcomes we want to achieve and the impact we expect their respective models to have. Specifically we expect to see rapid and measurable evidence that the following have been delivered:

- A reduction in the proportion of residents being admitted to care homes from both acute and community settings
- A decrease in the proportion of delayed transfers of care and excess bed days from acute settings for those patients medically fit for discharge
- A reduction in the number of emergency department attendances
- A reduction in the proportion of admissions following an emergency department attendance
- A reduction in the requirement for emergency placements
- A reduction in length of stay for individuals where emergency placements are necessary
- A reduction in the proportion of attendances at emergency departments for individuals presenting with mental health problems
- A reduction in the number of patients known to the Community Mental Health Team attending emergency departments
- A reduction in the number of falls related injuries for residents over the age of 65
- A shared care record for each individual accessing the Care Hub
- A named single contact point for each individual accessing the Care Hub

We will also expect our service providers to evidence how they will engage with and involve key partners in the development and delivery of their proposed service model. Specifically we will expect to see plans which include (but are not limited too):

- Local Authorities
- Acute Providers
- Mental Health Providers
- The Voluntary Sector
- Health Watch

We intend to pilot the approach in 2 or 3 areas, with a range of different providers. Providers will be expected to use formal joint Action Learning Sets so that we can identify shortcomings and share best practice to make sure our long term model is as efficient as possible.

The Care Hubs will be supported by a range of services and interventions in both community and hospital settings. Many of these already exist, in both health and social care and some will be the subject of community services procurement and refresh.

A key work stream during the implementation of the proposed model will be working with partners to ensure existing and future interventions are fit for purpose and capable of reacting to the pace and accessibility we require the new service to deliver.

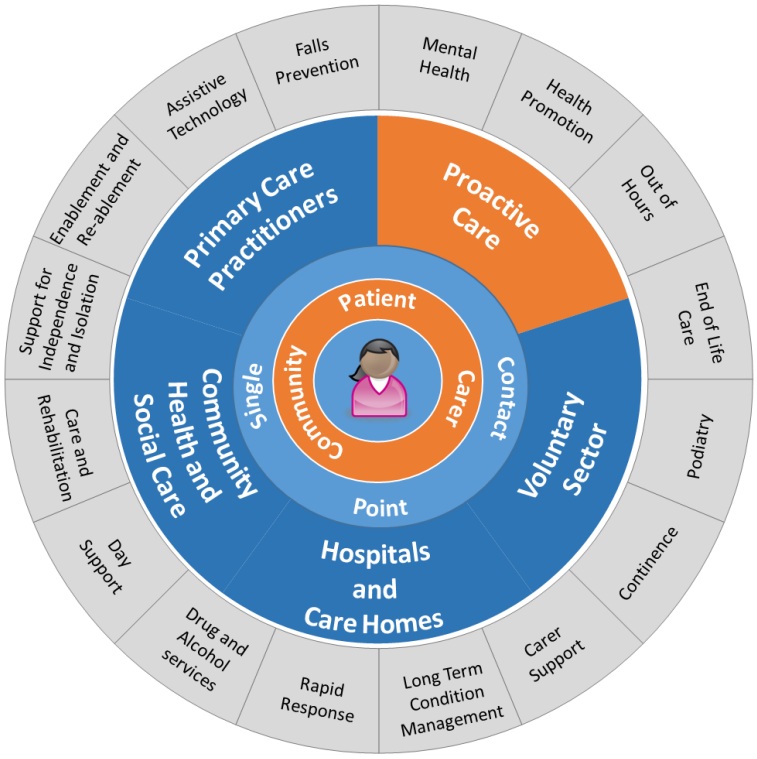
We will also require our providers to develop 7 day working. Not all health and social care services will be required to be available 7 days a week and we will focus on those services which have the biggest impact for our residents.

Where residents are registered with GP practices that are not taking part in the initial phase of Care Hubs we will use our best endeavours to achieve the same level of quality and outcomes, taking the experiences from the Care Hubs to shape their required service provision.

We intend to launch our pilots as soon as possible after 1 April 2014 and will put in place fortnightly progress meetings and formal quarterly reviews where we will evaluate the successes and failures of each pilot. At the end of September 2014 we will formally re-align the pilots based on the issues identified to that point and our intention is that we will be in a position to go live across the health economy by 1 April 2015.

We expect that this element of our overall joint work programme is where the majority of resource will be allocated, both during the pilot stage and, once the service is embedded and delivering the outcomes we expect, over the coming years. We anticipate that as the new model takes effect, we will be able to make a greater shift of resource from existing hospital and care home spend to this new integrated model.

The diagram and notes below show how we envisage the Care Hub model working and explain how the various elements of the model will work together.



- In this model, the individual sits at the heart of all we do and the various services and interventions work around their needs and what they want to achieve.

- We recognise the vital importance that individuals' own support networks play in their overall support and we intend to continue to focus on supporting carers, with a special focus on child carers, to minimise the requirement for emergency interventions.

- The role and impact of the single contact point will be crucial in making the whole system work.

Specific Scheme Details

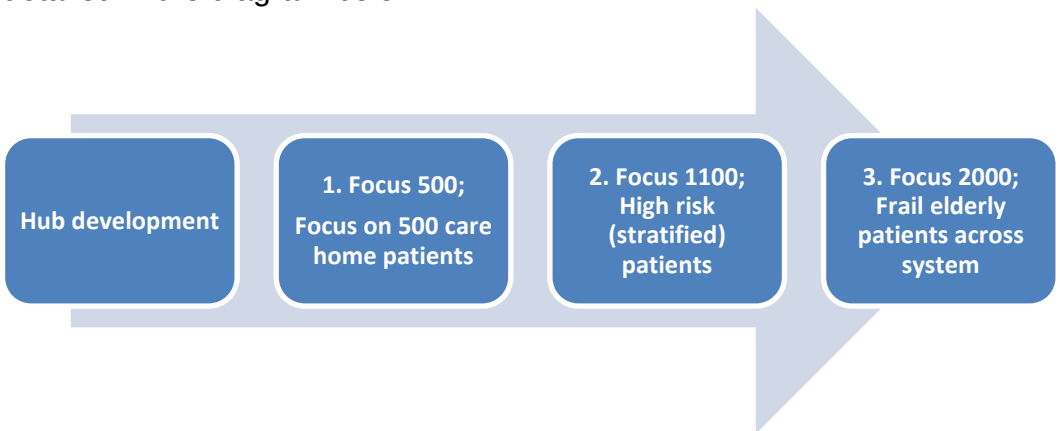
The specific schemes we intend to implement in 14/15 are:

Care Hub – Priory Medical Group

The care hub will be a scalable, proactive and responsive care model that seeks to continually improve health and care outcomes, whilst reducing the cost burden on the local health and care economy. The aims of this model are:

- To put service users at the *centre* of hub delivery
- To *improve* defined population-based health and care outcomes
- To *reduce* population-based healthcare costs, social care costs and associated costs
- To *improve* the quality and equity of health and care services for the hub population as measured through defined information/outcomes
- To *provide* proactive and preventative healthcare and health promotion through, for example, self-care and measures of patient independence

This model will take a phased approach to delivering its strategic aims over 2014/15 as detailed in the diagram below.



This is a primary care led scheme, but is being delivered in partnership with CYC Adults Social Care and YTHFT Community Services. Additional input from York CVS and other voluntary organisations will be sought as the project develops.

Mental Health Street Triage

This scheme is intended to enable timely and appropriate interventions to individuals at their point of contact with the police. It is based on a similar scheme which is being successfully run in Leeds, Leicester and Cleveland. Other pilots are also being rolled out across the country.

The scheme involves creating a small team of skilled mental health professionals who are available to be deployed by the police to provide initial assessment and advice for individuals with mental health related issues. It will complement the recent investment in the Health Based Place of Safety for Mental Health Act detainees in York and help avoid unnecessary detentions under the Act.

The scheme will be open and accessible to people of all ages, where it is believed they may have a mental health illness, learning disability, personality disorder or are abusing substances, who come into contact with the police outside of custody. The objective is to divert people from the Criminal Justice System (where appropriate) and provide access to community-based services, thereby ensuring that their health and social care needs are known and provided for by appropriate services.

This scheme is led by North Yorkshire Police in a partnership with LYPT. It is proposed it will be joint funded with North Yorkshire County Council as part of the CCGs BCF submission to the North Yorkshire H&WB Board.

Emergency Care Practitioners

As part of the winter pressures projects an additional three members of staff from the Yorkshire Ambulance Service have been employed to work alongside regular ambulance crews to attend falls, faints and minor injuries. They are working on a roving basis around the City of York and are called to both emergency calls to improve response times and to less urgent calls where they have appropriate skills. This service aims to see, treat and where required refer onwards individuals in the home or at the scene instead of providing conveyance to hospital.

Similar pilots in Sheffield have shown a 50% reduction in conveyance to the ED for minor call outs. This scheme has been ongoing since 2nd December 2014; a total of 268 calls attended were recorded up to the end of December and 173 in January. 35% of patients were not conveyed to ED during December 2013 and 44% in January 2014. This activity positively impacts on reducing ED attendance, admission and discharge planning requirements.

Modelling has been done to show the potential impact on the specific areas where ECP's are shown to have a significant intervention rate; these are the green 2 and green 4 types of call which include falls, fits, abdominal pain, breathing problems and convulsions. It is anticipated that the three ECP's in City of York will continue to cover this area, and additional ECP's and supporting administrative staff would be required to work in the wider NYCC and ER areas. These staff working outside City of York may follow a different model where they have a specific GP base and work to support community teams.

It is intended to continue to fund this project through the BCF.

Hospice at Home

St Leonard's Hospice will be working with numerous stakeholders across the Vale of York (incorporating the City of York Council, and those parts of East Riding of Yorkshire Council and North Yorkshire County Council areas within the Vale of York) to develop its Hospice at Home service and is dependent upon their full support, engagement and motivation.

The project aims to focus on those clients who are approaching the end of their life and who wish to die at home/usual place of care. The team provides a response to crisis service, a terminal care service, a rapid discharge support service and a service at home whilst clients await a hospice bed. The service provision is co-ordinated through a hub so that clients are assessed and resources are deployed to generate the most effective and co-ordinated response. The approach to service users will be to examine their likely holistic needs and requirements as well as their carers' and in addition will look to survey their experience of the developing services as well as the experiences of other stakeholders.

Progress will be measured by the project team and monitored by health and social care commissioners. Risks and issues will be identified, managed and where required escalated to commissioners/project delivery group.

Psychiatric Liaison

This model will provide a dedicated Acute Liaison Psychiatry Service (ALPS) to the Emergency Department of YTHFT 24 hours a day 7 days per week. The model would provide one Band 6 Registered Mental Nurse on duty 24 hours a day to conduct lone mental health and self-harm assessments.

The ALPS team will assess patients aged 18-65 who present to the ED with mental health difficulties and following presentations of self-harm. They will also provide a self-harm assessment service to the acute medical areas of YTHFT, when the medical consequences of self-harm cannot be managed within the ED.

This is a joint project between YTHFT and LYPT, with additional co-funding from BCF allocations from CYC and NYCC.

Alignment with existing plans and strategies

The York Health and Wellbeing Board provides leadership for continued partnership working between VoY, local authorities, providers, commissioners, the voluntary sector and Healthwatch to ensure our strategic plans for health and social care remain consistent in their aims and objectives. The JSNA was the basis from which our Joint Health and Wellbeing Strategy was developed and subsequently this has influenced the operational and commissioning plans of the CCG and local authority social care.

We now need to join up our systems, funds and teams to ensure that our strategic ambitions for integration can be achieved practically. The Health and Wellbeing Board have a major role here. They will approve our plans for integration and through this governance they will use their decision making powers to move towards this joint

approach, i.e. agreements to share risk and reward and to pool budgets. We intend to work more closely with members of the Health and Wellbeing Board as our integration plans develop to ensure they are aware of the impact and consequences, equipped to make timely decisions and can confidently fulfil their core purpose of leading the local health and social care system towards integration. We also recognise that we need to replicate this partnership working at every level. Below the Health and Wellbeing there are a number of partnerships to facilitate and deliver our joint approach, we are working hard to ensure that this becomes the norm, rather than the exception.

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.

The key drivers for understanding the implications on the acute sector is that the funding to support BCF is already committed and the necessary shift of demand and related funding is most likely to shift from our spend with acute providers. We have not underestimated the impact this will have and have shaped our joint plans accordingly. These are reflected in our 5 year commissioning plan and in YTFT's 5 year strategy.

Modelling is underpinned by the assumption that spending on hospital based activity can and will be reduced; this will require a seismic change in the way we deliver care and manage wellness and we believe that partners across our local area understand and accept this challenge. YTFT acknowledge that the success of BCF and our wider Care Hub strategy will lead to significantly reduced demand for hospital beds, both in the immediate and longer terms. We would work with the Trust to develop a multi user approach to using any vacated hospital estate (DGH and community hospitals), as appropriate to local need and to minimise financial risk to the system.

The main purpose of our joint plan is that those individuals at high risk of health and social care interventions are proactively managed and supported to avoid the requirement for hospital based interventions. We recognise that in order to make both the BCF and our joint longer term sustainability a reality, we have to reduce the overall spend in the acute sector in order to properly fund our integrated out of hospital model. From our joint workshop and series of meetings with our main acute provider we have agreed the proposed model which will help us achieve this; the key to success will be in turning this high level plan into real actions that allows all partners to reshape their model of service provision accordingly. We believe that that we have a joint approach to addressing this issue and at a recent joint meeting, colleagues from YTFT re-iterated their commitment to reduce their footprint, based on scalable change in the way services are provided outside of hospital. This joint understanding and acceptance of how we might now deliver sustainable and transformational change is a significant step towards being able to operationalize our proposed model.

Specifically we will aim to target our efficiency savings around:

- Admissions avoidance
- Reduced length of stay
- Reduction in delayed discharges

Admissions avoidance

Our proposed Care Hubs will play a pivotal role in admissions avoidance. Through risk stratification, patients could have an advance care plan – making sure those at most risk of defaulting to acute services have the necessary support packages in place – and rapid intervention when their needs are acute, to enable return to their normal place of residence as soon as possible.

Our plans for augmented Emergency Care Practitioner Teams will also significantly address the key deliverable of admissions avoidance.

Whilst the impact of subsequent levels of service provision are currently being worked up, we envisage acute providers making significant cost efficiencies through refreshed models of service delivery based around footfall changes and related activities. In our discussions with providers, it is clear that they are committed to shaping their services to reflect the impact of the expected changes. Together we recognise the challenges this might create if we are to sustain high quality hospital care for our residents and we will continue to work in partnership to minimise this risk.

Length of Stay/Delayed Transfers of Care

For those patients who have to be admitted to hospital, we want to ensure their stay is of high impact and as short as possible. We aim to plan discharges as soon as possible following unplanned admission and return patients to home, with a care package where necessary, as soon as they are medically fit and it is safe to do so. Current blocks to this such as delays to care packages, limited support over weekends and other system inefficiencies will all be addressed through the Care Hub, where local practitioners will follow patients from home into hospital and back home again. We believe our new model will secure much greater level of cooperation between organisations and will ensure any blocks to discharge are identified and removed as soon as practicably possible.

Our new approach to a single contact point will have a key role to play in this scenario, as will the introduction of 7 day a week working across organisations. We are under no doubt about the challenges this system change will bring but our joint commitment to making the necessary changes will help us to deliver the change we need.

Risks

We recognise that what we are proposing carries an element of risk for both health and social care commissioners and providers. Collectively we need to ensure that our new model delivers the necessary shift away from hospital based activity to community based activity that enables individuals to retain independence and wellbeing in a place of their choice. We are developing a risk share strategy to help us fully understand and manage these risks and will progress this at pace through individual project boards and the CTB.

e) Governance

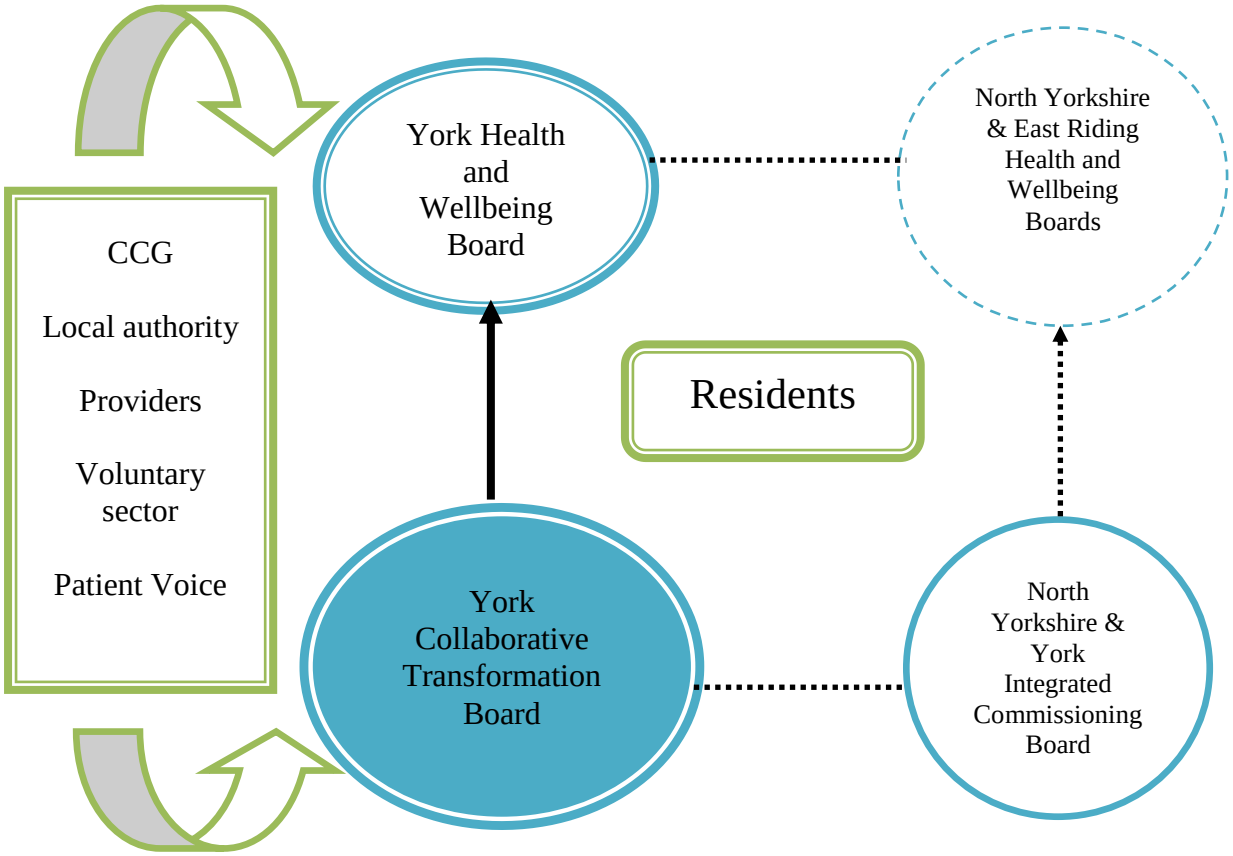
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The York Collaborative Transformation Board has been established to progress and govern our integration plan. The Collaborative Transformation Board reports directly to York's Health and Wellbeing Board, who hold ultimate responsibility and governance for integrating health and social care locally. It also provides assurance to both the CCG and the Council for the delivery of the BCF and the wider integrated health and care agenda.

The CTB is chaired by the Director of Adult Social Services, who reports progress on BCF to the HWB.

Because the CCG works alongside 3 Local Authorities, we are actively exploring opportunities to work across geographical boundaries, particularly with North Yorkshire and East Riding local authorities, ensuring our plans are aligned across the whole CCG footprint.

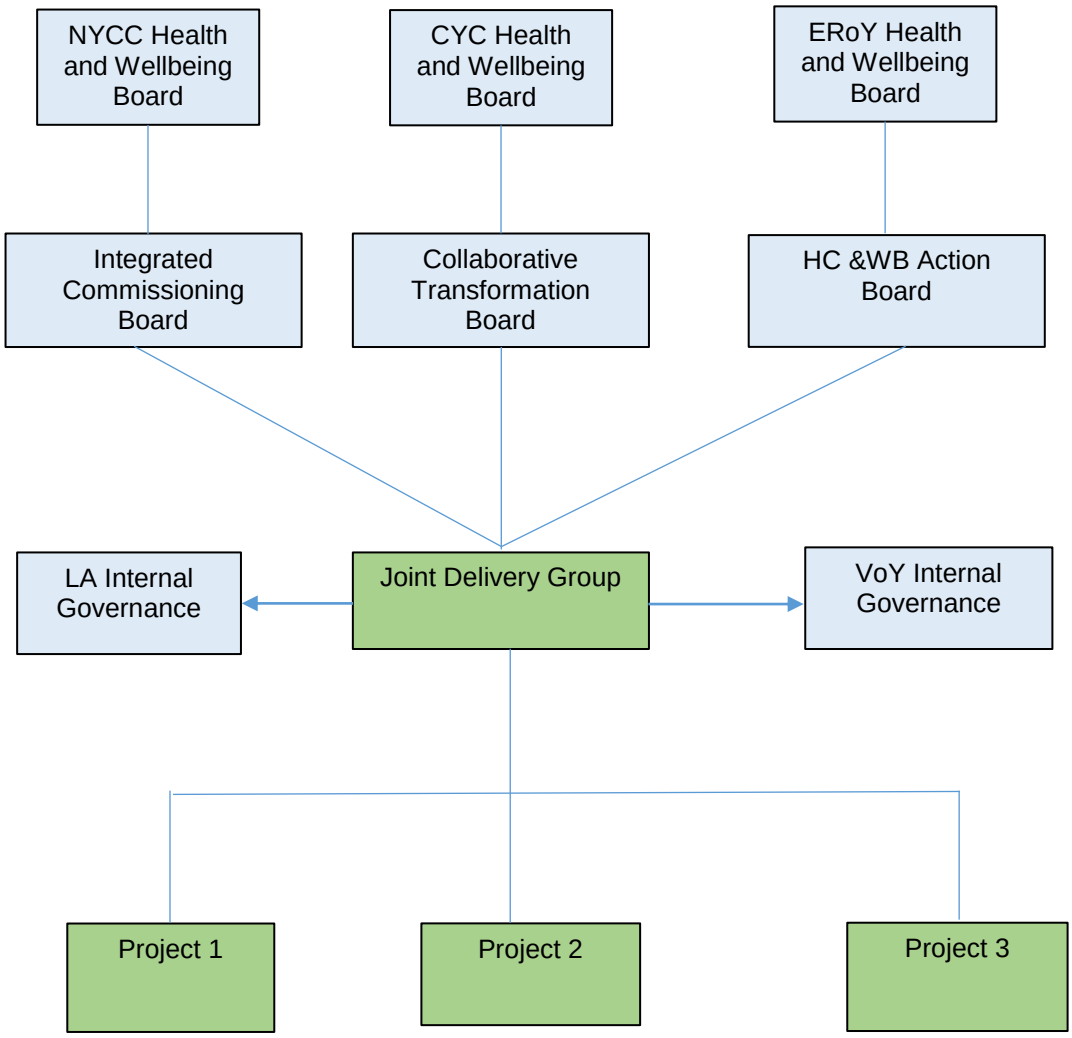
The diagram below illustrates current governance arrangements for our integration plan.



BCF is a significant component in securing our joint vision for health and care, which we envisage will be delivered through Care Hubs across the system in the longer term. We have therefore produced a more detailed delivery framework, driven through a Joint Delivery Group which sits below the Collaborative Transformation Board. This will provide robust and systematic programme management, assurance and scrutiny of proposed plans and will be the forum for joint learning and problem solving.

In developing this framework we have taken into account the additional complexities faced by the CCG in having to work with 3 Local Authorities and 3 Health and Wellbeing Boards. We believe our proposed framework represents a pragmatic approach which avoids duplication of effort whilst securing arrangements to deliver the LA accountability for BCF and providing a realistic level of assurance and challenge to all partner organisations.

We also recognise that there are issues that cut across Local Authority boundaries and we are keen to develop a series of overarching work streams that act as enablers to deliver the overall programme. In the diagram below, these enablers and the new boards and groups that need to be put in place are identified in green.



IT and Data sharing

Communications, Consultation and Engagement

Organisational Development

We recognise the time pressures that many people within the CCG and Local Authority face and in order not to commit people to too many meetings, we propose the following composition for the new boards and groups identified above:

Joint Delivery Group

The Joint Delivery Group (JDG) is responsible for ensuring the delivery of the proposed BCF schemes and will hold providers to account for the delivery of their respective programme plans. The Group has an agreed set of Terms of Reference, an agreed reporting process and has already started to meet and agree processes for monitoring and support with providers.

The JDG is co-chaired by the Vale of York and City of York. Membership includes senior empowered managers from both organisations as well as clinical and social care leads who provide professional oversight and scrutiny to the developing schemes.

Project Teams

Project Teams for each scheme will be responsible for the day to day management and delivery of their respective work. We do not intend to dictate to providers how they should manage the delivery of their projects, however we are clear that the levels of engagement and involvement highlighted earlier in this paper will form a crucial part of their success. We intend to work closely with our potential providers to help them establish these Project Teams and have already agreed additional resource for them to help maintain rigour and traction in the delivery process. We have also put in place weekly and monthly reports which will focus on the delivery and benefits realisation of the projects. These reports (initially for the JDG) will form the basis of more formal reporting to the CTB and the H&WB Board and will also provide internal assurance to both the CCG and CYC.

In order to benefit from shared learning we have also established 6 weekly Action Learning Sets (ALS) where we will use external expert support to ensure we continue to support our projects to deliver at pace. The first of these ALS was held in March, supported by a team from the NHS England Analytical Services (Policy and Commissioning).

3) NATIONAL CONDITIONS

a) Protecting social care services

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

Locally we have agreed that protection of adult social care services means that we will initially continue to fund the social care support funded to date by the 'health gain' money. These services will be reviewed as we develop the Care Hubs, with the expectation that they will be realigned to fit with the Care Hub model. We have also agreed that for 2015/16, the elements of the reablement and carers funding, which have not historically been made available from health commissioners, will now be included in the BCF fund.

The fund will be used to support adult social care services within the local authority, which also have a health benefit. It will be incumbent on social care to work closely with health colleagues to transform the way their services are currently delivered and this is being addressed through the City of York Transformation programme.

We will develop our detailed plans and agree as partners how this existing money will be used to protect current innovations within services and help to develop future commissioning models and practices within health and social care. We will put in place clear measures and outcomes to help us monitor the fund.

In order to help protect social care services in York we must ensure that those in need within our local communities continue to receive the support they need, in a time of growing demand and budgetary pressures. Whilst maintaining current eligibility criteria is one aspect of this, our primary focus is on developing new forms of joined up care which will help ensure that individuals remain healthy and well, and have maximum independence, with benefits to both themselves and their communities, and the local health and care economy as a whole.

We will take a proactive early intervention approach to divert crisis situations and emergency admissions to hospitals for those residents who currently present with the highest level of demand. However, we recognise that this is not always possible in which case we will ensure the named worker for that individual is made aware of their situation at the earliest point and is then able to coordinate their early discharge and procure the support and equipment they may need to re-establish them back at home.

Our preventative agenda aims to support people at the earliest opportunity by providing relevant information and advice in a timely and accessible way, signposting people to the most appropriate resource for their particular needs. We will encourage appropriate self-help options and only become more actively involved when requested or required. Supporting people to remain well, and facilitating the self-management of their own wellbeing and wherever possible enabling them to stay within their own homes is a key priority for us and our focus will be on protecting and enhancing quality of life by tackling the causes of ill-health and poor quality of life, rather than simply focussing on service options.

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

As local organisations we recognise the need to take urgent action to make integrated care happen. We believe person centred coordinated care and support is key to improving outcomes for individuals. Too often services have not been 'joined up' and we haven't communicated well with each other. We have innovated in some areas and are working hard to develop a person focussed approach for all service areas. This approach was used to establish more capacity within our reablement services that promote independence and self-help. The funding for the care hubs will allow joint purchase of support, including through personal budgets and early intervention, which will include a social care offer. This will enable the council to protect the reablement home care service contract and will enable the support to carers to be developed in preparation for Care Bill responsibilities.

Funding currently allocated under the Social Care to Benefit Health grant has been used to enable the local authority to sustain the current level of eligibility criteria and to provide increased assessment capacity within hospital and locality care management teams and review and commissioned services to clients who have substantial or critical needs and information and signposting to those who are not FACS eligible. This will need to be sustained, if not increased, within the funding allocations for 2014/15 and beyond if this level of offer is to be maintained, both in order to deliver 7 day services and in particular to meet the increased demands arising from the new Social Care Bill requiring additional needs and financial assessments to be undertaken for carers and self-funders.

It is proposed that additional resources will be invested in social care to deliver enhanced support to help reduce hospital admissions, delayed discharges and admissions to residential and nursing home care.

We are carrying out a contracts and project audit to identify current projects that are delivering successful outcomes and financial benefits. We would wish to retain these and build on the knowledge base they have started to provide for us. This will enable us to develop local market intelligence, provide good reference points and help us contribute to the wider region within the health and social care markets.

b) 7 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). 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

By improving access, assessment processes and introducing self-help options we believe we can work towards a 7 day service model. This will be an integral part of our development during the first year.

A work stream will be established to identify current commissioning, operational and service delivery patterns, establishment and budget for health and social care. This will help evaluate the "as is" position and inform the "to be" development. This approach was approved at the Health and Wellbeing Board on the 29th January 2013.

Development of a 7 day service will be centred around the person, based on the needs of local people and their communities helping to secure best value. Building on what is 'working well' within current service models and exploring partnerships / joint ventures with the private sector, public and third sector.

c) Data sharing

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

Whilst we are not currently using the NHS number as the prime identifier, our systems have the capability to do this and we will rapidly develop a work stream to facilitate this national condition by April 2015. To support his work stream we have put in place a dedicated resource in CYC, who is working closely with colleagues in the CCG. This has been a recent appointment and whilst a detailed plan is currently under development, the key deliverables of this plan include:

- Ascertain current level of live clients within Framework i that do not hold NHS number against them
- Identify NHS numbers for those identified as missing
- Update records within Framework i to ensure 100% NHS number compliance
- Investigate and implement NHS number mandatory field within Framework i
- Work with colleagues (communicate/educate) the necessity/ benefit realisation of NHS number identification

This work will be subject to the same overview and scrutiny afforded to other projects within BCF through the Joint Delivery Group and the Collaborative Transformation Board.

The CCG has also been selected to be one of 6 pioneer sites to work with Monitor as a pilot for the Payment Innovation and Local Support (PILS) project and is sending a joint team from the CCG, CYC and 2 of our care hubs to the launch event in April. This is seen as a significant enabler to our plan and will help drive pace and innovation in overall delivery plan.

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

As above

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 confirm our commitment to work towards this by April 15.

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, and professional clinical practise and in particular requirements set out in Caldecott 2.

We will comply with all current and future IG issues and will develop a specific IG work stream as part of our overall programme plan. This will also incorporate compliance with Caldecott 2 and other national conditions.

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 methodology and integrated model proposed in this submission will enable us to identify a single contact point for every person with whom we engage within the programme. “Telling my story only once” is what our residents tell us they want us to achieve through integrated working. We will work towards a single assessment process and data share where it is appropriate.

Acting as the single contact point for an individual will enable the worker (whether they are health or social care) to act as the coordinator of the individuals support. They will be enabled through access to the pooled budget to purchase care and equipment when required in a far more expedient way. They will be able to signpost to other professionals and points of relevant advice and information if required. This will require us to identify and pool budgets which under current legislation will need to be managed through the local authorities mechanisms.

In order to help identify those high risk residents, we have a series of procedures in place. These include:

- Social Care Eligibility Criteria
- Risk and Exception Panels
- GP Practice Quality and Outcome Framework (QOF) registers
- Adult Safeguarding Board
- Risk assessment and identification built in to provider contract and monitored through contract management groups
- Joint Strategic Needs Assessment
- Neighbourhood Teams

Whilst we acknowledge that each of the above has a part to play in risk identification, we do require a more structured and joint approach to risk stratification and this will form a key work stream of our overall plan for 2014/15.

We have identified that new approaches to allocating and managing budgets across health and social care, both at the micro and macro levels, are crucial to the success of our joint plans and we intend to pursue putting in place the right financial models to incentivise the right level of support at the right time whilst at the same time maximising the overall efficiencies across the system.

We will work together and put in place joint agreements to achieve this. This will inform and help us to plan and develop future commissioning contracts with providers in all sectors. Our focus will be on outcomes and improved performance. We will put measures in place to monitor these funds and explore contractual options which may include PBR (payment by results), alternative market development and management models. Our risk stratification plan will be developed detailing joint and shared responsibility.

This is an exciting opportunity and has clear synergies and links with the developments of the Transformation programme now underway within the City York Council. We anticipate the learning from this initiative will also inform the future delivery models for the programme.

We believe focussing on high intensive current users of health and social care within our area addresses this question and will provide us with the maximum impact and benefit from the fund in our joint work towards sector improvement and resident satisfaction. Creating and maintaining a positive environment within which we can transform and integrate local health and social care services

4) 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
The proposed plans do not deliver the activity shift required.	Probability: 3 Impact: 5 Risk Score: 15	Programme plans and delivery models scrutinised and agreed by Collaborative Transformation Board (CTB). Action learning and frequent review during implementation year (14/15). Rapid escalation from JDG to CTB.
Agreed system changes between partners are not realised	Probability: 2 Impact: 4 Risk Score: 8	Clear governance, including MOUs and contracts to ensure delivery. Risk/Reward schemes in place to incentivise all involved. Monitoring by CTB and H&WB Board
Impacts of the model do not have sufficient benefits for the Adult Social Care agenda	Probability: 3 Impact: 5 Risk Score: 15	Continuous performance monitoring through JDG. Rapid escalation to CTB. Formal quarterly benefits realisation review.

7 day a week working cannot be achieved because of HR issues	Probability: 3 Impact: 4 Risk Score: 12	Development of an Organisational Development (OD) plan agreed with partners.
The shift of activity from Acute to community settings increases the pressures on Primary Care	Probability: 3 Impact: 3 Risk Score: 9	Modelling of the role and impact of Care Hubs, linked to CCG Primary Care Strategy should mitigate any adverse impact.
Pace of implementation of models impacts on in year financial delivery	Probability: 3 Impact: 4 Risk Score: 12	Additional PM resource and capability provided to project teams