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:	11/02/14 (Draft submission) 02/04/14 (Final submission)
Date submitted:	14/02/14 (Draft submission) 04/04/14 (Final submission)
Minimum required value of BCF pooled budget: 2014/15	£6,627,000
2015/16	£22,478,000
Total agreed value of pooled budget: 2014/15	£6,627,000
2015/16	£22,478,000

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	04/04/14

Signed on behalf of the Clinical Commissioning Group	NHS Vale of York CCG
By	Dr Mark Hayes
Position	Chief Clinical Officer
Date	04/04/14

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	04/04/14

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	04/04/14

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 the BCF Programme Board (responsible for the delivery of the workstreams that underpin the plan) includes representation from providers from a

number of sectors, namely health (acute, primary care, community and mental health), in-house social care providers and the voluntary sector. The Vale of York CCG are also represented on the BCF Programme Board and the East Riding Health and Wellbeing Board. The BCF Plan is based on the East Riding of Yorkshire Council 'footprint' that includes Pocklington which sits within the Vale of York CCG.

Future engagement will be through the:

- Social Care Provider Forum – on-going 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 in section 2(e) Governance) 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 coordinated by the East Riding Voluntary Action Services (ERVAS).

As well as extensive engagement in the BCF programme arrangements, our plans are underpinned by contractual agreements with acute providers, for example the activity shifts expected from the acute to community through the delivery of the ambulatory care pathway are reflected in contractual agreements with providers in terms of shift of activity and financial contract values.

In terms of other providers outside of the planning unit but with which there is a significant contract, we have excellent engagement via regular meetings which include provider representation and other CCGs who are major commissioners. Representation is at Chief Officer or Director level. This covers Northern Lincolnshire and Goole NHS Foundation Trust and York Teaching Hospitals NHS Foundation Trust.

There is sign up and commitment to the BCF at the most senior level in organisations through sign up to the BCF Concordat. Additionally the Chief Officers within the Humber area including East Riding of Yorkshire CCG, East Riding of Yorkshire Council, Hull CCG, Hull City Council, Humber Foundation Trust and Hull and East Yorkshire Hospitals NHS Trust (reflecting the boundary of the East Riding CCG agreed planning unit) meet on a regular basis ensuring synergy with the aims of the BCF Plans for both Local Authorities.

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. To inform our plan going forward we have continued 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 in assessment and access to services.

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. The intention is to do more of these events to get wider coverage throughout the East Riding;
- 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, who are an advisory body on disability issues, and the East Riding Equality Network, who provide advice on equality issues across a number of protected groups such as the black and minority ethnic groups and older people;
- 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. The focus is on this group of patients due to them being the main focus of the model that is being developed.

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
"Pioneering Excellence for Older People" Pioneer Application June 2013	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.
Joint Health and Wellbeing Strategy (JHWS) 2013	The BCF plan is aligned with the JHWS strategy, particularly around the aims of reducing preventable admissions and achieving healthy independent ageing.
Joint Strategic Needs Assessment (JSNA) 2011 Plus JSNA update from 2013	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.
Joint Adult Commissioning Strategy 2012	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: • Prevention and Staying Healthy; • Urgent Care and Recovery; • Continuing Support and Managing Long Term Conditions.
Older People Strategy 2010	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: • Improved health and emotional wellbeing; • Increased independence, choice and control; • Increased community involvement and reduced isolation.
Carers Strategy 2010	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.

East Riding Health and Social Care Concordat for the delivery of the BCF Programme 2014	This document establishes the principles of joint working and demonstrates the commitment of partner organisations to work effectively and collaboratively for the benefit of the population of the East Riding.
Better Care Fund Programme Board Terms of Reference 2013	Sets out the membership of the Board, its principles and governance arrangements.

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. There are three central elements that we will see in our integrated health and social care system, namely:

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 King's 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 % from their current rate, 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) by October 2015. This would result in gross savings in the East Riding of circa £2.2 million per annum which would cover the transitional and on-going costs of establishing the ambulatory care services.

In developing our ambulatory care model we are looking at a phased implementation; work is currently on-going to develop the phased approach for the next 18 months. This will be based on a combination of the number of long term conditions, the level of frailty and the patient's age.

In terms of admission prevention, we will:

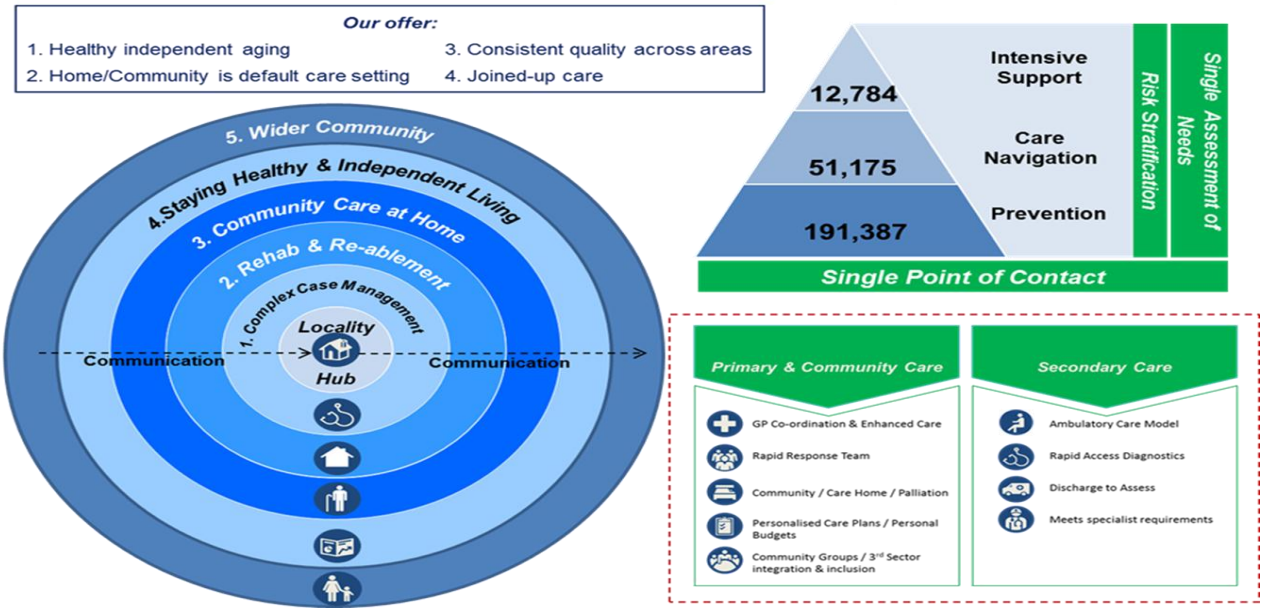
- Deliver care at home, or in the community, wherever possible;
- Assess better before admission, through the creation of rapid response, assessment and support services;
- Facilitate rapid access to one stop ambulatory clinics, key diagnostics, medication/medication review and expert advice;
- Implement a tiered model for individuals accessing a range of services;
- 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.

Mental health is viewed as an integral element of our ambulatory care model. Further to this, we are signing up to replicate the principles of the Crisis Care Concordat and have an elected Councillor to champion mental health in the East Riding.

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 through improved access to alternative models of care, such as reablement, intermediate care or community hospitals;
- 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:



The impact that implementing the ambulatory care model will have on residents of the East Riding is best illustrated through looking at two case studies. These highlight the experience individuals currently have, compared with the experiences they will have following the successful implementation of the ambulatory care model.

Gladys is 80 years old, with Chronic Obstructive Pulmonary Disorder (COPD), diabetes, increasing breathlessness, frailty and dizzy spells. Gladys lives independently, with daily domiciliary care support, following the death of her husband. Gladys also has a small family network in her local community.

Care Pathway 2013/14	Care Pathway 2015/16
• Relative rings 999 as anxious about Gladys • Ambulance sent, Gladys taken to A&E • Reviewed in A&E then moved to AAU for observation • Following observation in AAU admitted to ward for 4 days • Once medically fit assessed for discharge, waits a further week for therapy assessment • Now disorientated and becoming dependant upon staff • Concerns raised that unable to cope at home any more based on hospital observation • Relatives and Gladys start considering a care home package	• Has dedicated number to contact to access support knowing her PCP is in place • Intensive support team assess her at home within 2 hours of call, liaise with her GP and confirm care management based upon agreed protocols • Additional health and social care packages put in place to support during period of illness • Following day Gladys condition not improving, seen in rapid access chest clinic – joint care plan between all sectors with secondary care following up remotely • Supported at home over acute phase and enabled to retain independance

Henry is 70 years old, has hypertension, chronic renal failure and vascular dementia. Henry lives alone in his own home and is admitted to HRI following an episode of acute

renal failure, which is the result of dehydration.

Care Pathway 2013/14No	Care Pathway 2015/16
• Henry is given IV and oral fluids to rehydrate him, his renal function is monitored, etc • After 4 days he is identified as medically fit for discharge, but because of his dementia he has become increasingly disorientated and dependant upon ward staff, • Social care and community health services are notified at this time and discharge planning starts – Henry remains in hospital a further 7 days whilst services are identified – he continues to loose self-care skills and confidence • On discharge Henry's confusion persists, and more intensive health and social care packages are required	• Henry is given IV and oral fluids to rehydrate him, his renal function is monitored, etc • He is identified shortly after admission as requiring additional support on discharge • He is discharged as soon as medically fit (4 days) for assessment & reablement • A discharge support worker is waiting for him at home to support him whilst waiting for initial home assessment (within 2 hours of arriving home) • An intensive 6 week agreed plan of care is developed to support him in regaining his independence and confidence to self care within his own home • After 6 weeks the intensive care plan is gradually withdrawn and ongoing care needs return to the levels prior to admission

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;
- Expand integrated health (physical and mental) and social care teams to be directly accessible by care navigators and through the single point of contact;
- 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 physical/mental 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

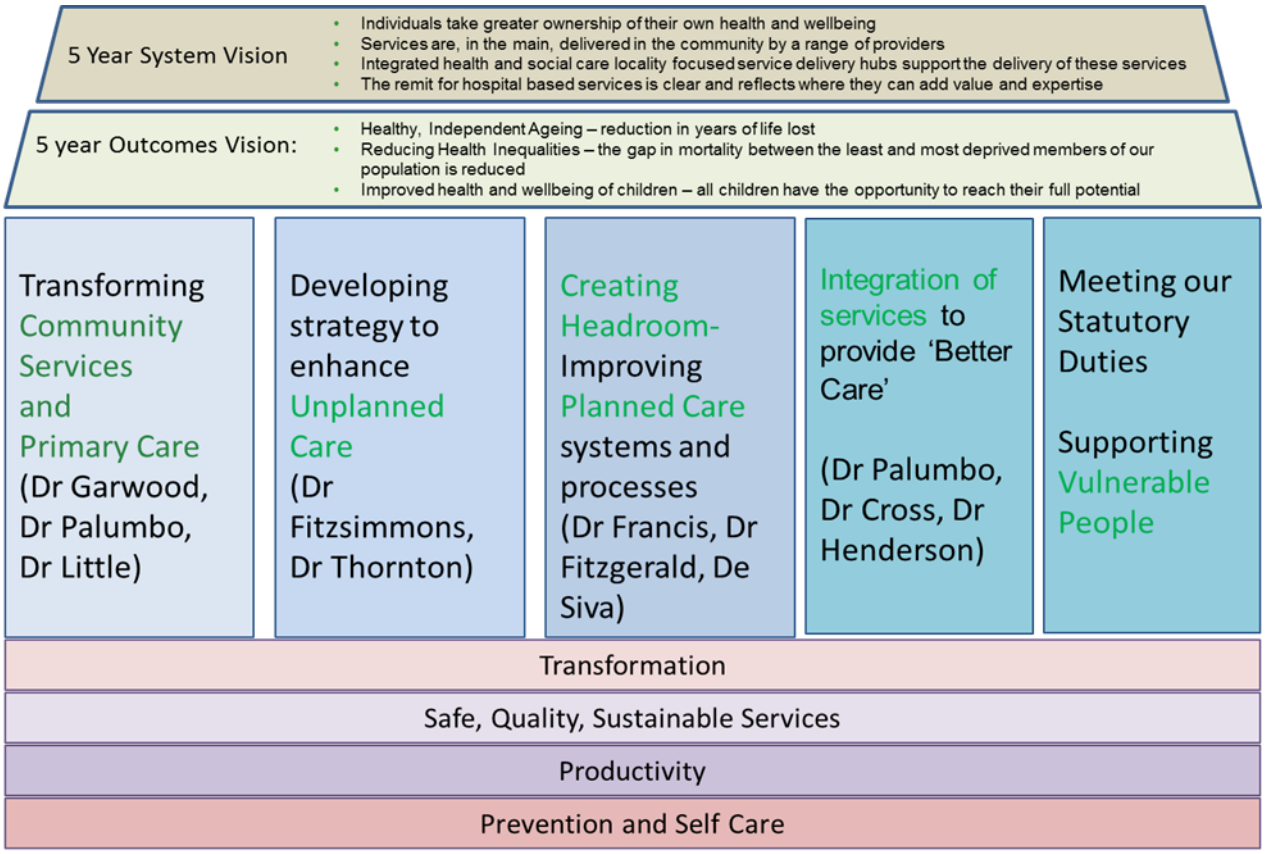
would benefit from a more intensive approach;
- Underpin this with the implementation of a holistic and standardised assessment of need across physical/mental health and social care.

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.

The key strands of the BCF Programme are also embedded within the overarching CCG five year strategic plan, as evidenced in the diagram below:



Summary

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 physical and mental 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 the quality and consistency of outcomes across health and social care including reduced emergency admissions and better reported service user experience.

Working with our partners 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 (physical and/or mental) 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 physical and mental 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

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

Local

- Reduced emergency readmissions within 30 days of discharge from hospital.

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

Workstream leads are developing a range of additional outcome measures that will also be used locally to determine the success of the BCF Programme.

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

- Developed a Concordat, signed by the key stakeholders, setting out the principles and intentions for integrated working;
- Initiated the workstreams responsible for delivering the BCF plan;
- Established baseline performance metrics and monitoring mechanisms;
- Finalised and agreed the draft BCF Plan for sign off by the Health and Wellbeing Board.

April 2014 to March 2015

- Finalise and agree the final BCF Plan for sign off by the Health and Wellbeing Board;
- Develop the programme plan including interdependencies/milestones, associated risk register and issue log;
- 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, IT, 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

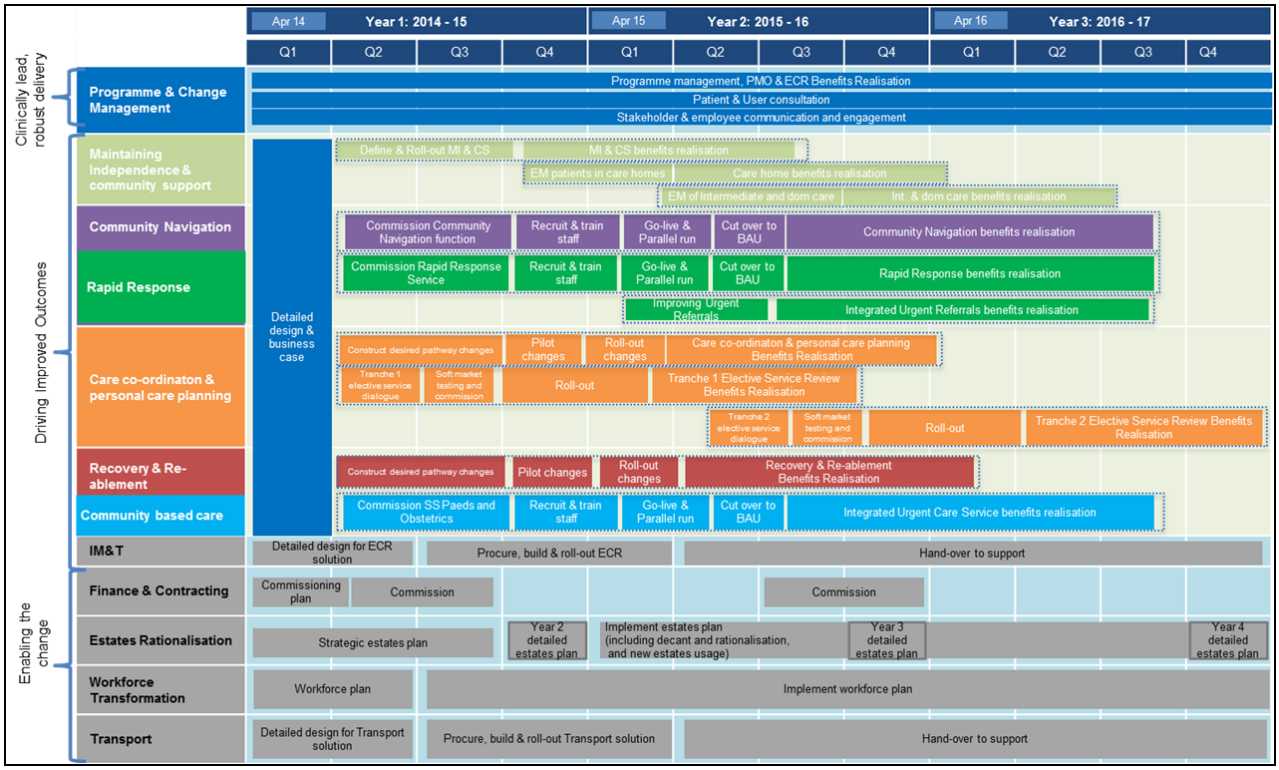
- Full roll out of schemes underpinning the BCF plan;
- Monitor impacts of BCF implementation against the agreed metric trajectories and undertake appropriate mitigating action as required.

The vision for the delivery of integrated care is embedded within key health and social care strategies and plans such as the JSNA and the JHWS as well as the strategies for Joint Adult Commissioning, Older People, Carers and Community Services. Alongside this the BCF is the key delivery mechanism for the CCG's two-year operational plan. 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.

The following roadmap shows a high level design and delivery plan for the BCF programme, as part of the wider CCG strategic plan. This shows an extensive programme of work being undertaken over the next three years; consisting of a series of projects, which will be running concurrently. These projects will be controlled and co-ordinated by a programme management office (PMO). The focus is on defining clear evidence based outcomes, designing and commissioning a service to deliver the outcomes, with a rigorous focus on benefits realisation.



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.

As well as extensive engagement in the BCF programme arrangements, our plans are underpinned by contractual agreements with acute providers, for example the activity shifts expected from the acute to community through the delivery of the ambulatory care pathway are reflected in contractual agreements with providers in terms of shift of activity and financial contract values. The contracts for 2014/15 and 2015/16 will be based on the activity and associated financial assumptions set out in Appendix B of the BCF Plan.

The stakeholder organisations involved in the creation of this plan have recognised the challenges that the adoption of an integrated service model will bring but remain committed to pushing the programme through to completion. A Concordat has been cooperatively developed to establish the principles of joint working that partner organisations will sign up to, evidencing the commitment of these organisations to work effectively and collaboratively for the benefit of the population of the East Riding.

These organisations are also exploring contracting options that will help establish shared risk agreements ensuring that provider and commissioning organisations are provided with some assurance as we develop and implement the required changes. 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.

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.

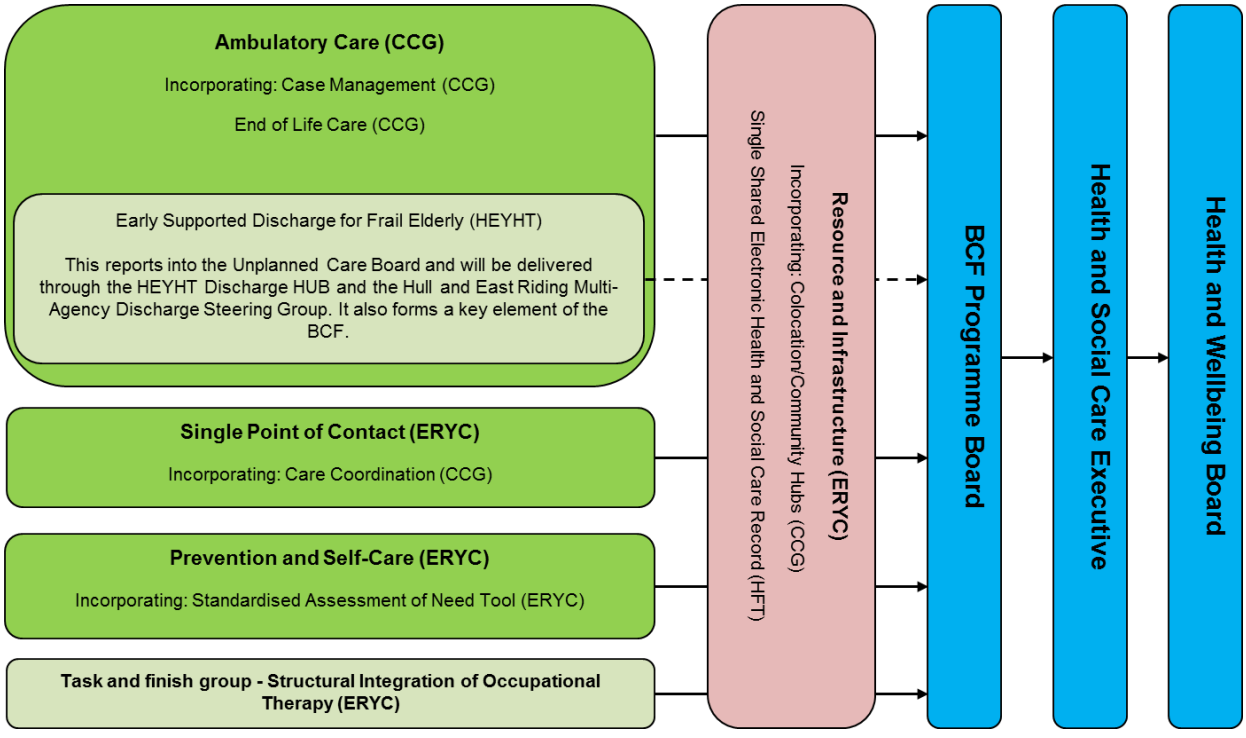
e) Governance

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 has been developed, 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 the 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:

BCF Programme and 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 has been developed for all key stakeholder organisations.

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. 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 has been developed. 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

Working with our providers 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 Care 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 has been developed.

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. Interim processes to enable the appropriate sharing of information will be developed to bridge the gap between now and 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 and in line with Caldicott 2. 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 12,784 people 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, will provide a real difference to peoples' care and are both key principles of the Better Care Fund Concordat that has been 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	We have modelled our assumptions using a range of available data, including metrics from other localities and support from the National Collaborative. In 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications.
The national timeframe to plan and implement the whole system changes across health and social care, including all providers, are ambitious.	High	Robust governance arrangements are in place to support delivery, from assessment of the draft template through to on-going programme overview through the Health and Wellbeing Board. Concordat signed by all key stakeholders, evidencing commitment to delivery of the BCF plan.
The financial risk of increased costs linked to the 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 to underwrite the creation of Programme Management Office (PMO) function and resourcing the workstreams appropriately.
Issues around recruitment and development needs.	High	Creation of a flexible workforce. Introduction of staffing champions/leaders. On-going supervision and support. Training needs assessment to identify new skills required (if applicable).
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	Integrated IT systems and information sharing agreements. Information governance issues are being considered by the single shared electronic health and social care

		record workstream who are 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.