Better Care Plan

2016 – 2017

Hull City Council

NHS
Hull Clinical Commissioning Group

Introduction

Hull's Better Care plan outlines the joint intentions of NHS Hull CCG and Hull City Council in delivering the outcomes of the Better Care Fund supported by Hull's Health & Wellbeing Board.

Since the original plan was submitted to NHS England in 2014 progress has been made delivering the eight BCF schemes. As part of the review and planning for 2016/17 we have involved our key partners in the development through the Hull 2020 partnership to embed our local vision further.

We have consulted with front line staff from organisations across health, social care and the third sector and developed our schemes for 2016/17

Having reviewed our performance for 2015/16, we have met our non-elective admissions target, but the local challenges of reducing reliance on hospital and creating a more coordinated community response remains the same. We will therefore continue our focus on falls as our local indicator and progress the plans to reduce residential care admissions and delayed transfer of care. Areas of development and full implementation this year will be increasing the range and access to out of hospital services and reablement schemes

To focus our objectives this coming year the 8 BCF schemes has been split into four headline areas each with their own strategic objective and outcomes to meet the national performance measures and objectives:

- Prevention
- Intervention
- Rehabilitation
- Rapid Community Response

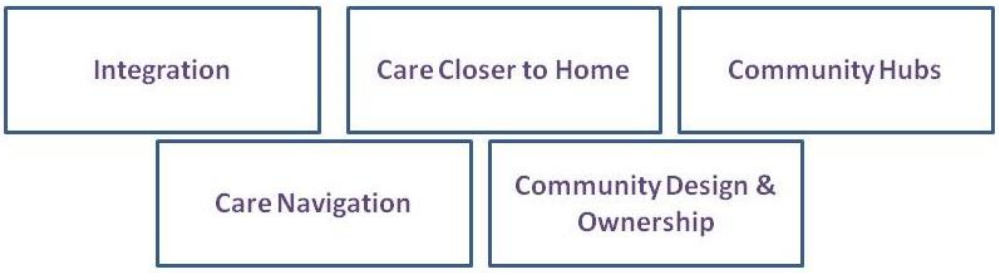
Through these schemes we will work with our partners to consistently aim to keep people out of hospital, support them on discharge and provide a stronger community focus which maximises independence and resilience.

As part of our plan for 2016/17 we have put consultation and engagement with the public and people who use the services at the heart of what we will be doing as we progress our plans and deliver change locally.

1. The local vision

"People in Hull can expect better care and better care will be organised around them"

Better Care will be the local enabler to responsive, joined up support for people living in local communities.



Hull CCG and Hull City Council are committed to the integration of services and share a clear purpose of what integrated care will achieve, underpinned by our organisations' own visions:

"Creating a healthier Hull"

"A life, not a service"

The impact of the BCF alongside broader strategic plans and the changes that people in Hull will see and will be able to test their experience against are described below

- There will be easier access to care: informed choice and more control will be central to enable people to live independent, active lives and are able stay in their own home.
- Care will be delivered through a network of multi-disciplinary services within local communities and closer to home promoting prevention, self-care and resilience.
- People and professionals will have the resources and information to understand local services because they will be instrumental in the development of how these should look and be delivered in Hull through co-design and co-production.
- Local health and social care services will not look the same by 2020. Organisational and professional boundaries will be broken down to ensure that care is co-ordinated across all care settings

Hull's Better Care plan is aligned to the Hull 2020 transformational programme which sees Hull's public services working together as partners.

The Hull 2020 vision is:

"In 2020 we will work together better to enable the people of Hull to improve their own health, resilience, wellbeing and to achieve their aspirations for the future

Our Better Care Plan is one of the key delivery vehicles for the following Hull 2020 objectives

- Delivering clearly defined, equitable and 7-day services available on the basis of need
- Ensuring people are aware of the services available to them, and confident they can access them when they need them
- Ensuring information is shared across public services to speed up and coordinate care and support and reduce duplication of assessment, planning and provision
- Making the best use of available money in public services to the needs of local people
- Creating a workforce that is fit for the future to meet the needs of the population

Hull 2020
Making a better future together

Partners

Hull City Council

NHS
Hull Clinical Commissioning Group

Hull and East Yorkshire Hospitals NHS
NHS Trust

healthwatch
Kingston upon Hull

City Health Care Partnership CIC
a co-owned business

Humber NHS
NHS Foundation Trust

HUMBERSIDE
Fire & Rescue Service

Yorkshire Ambulance Service NHS
NHS Trust

The following diagram shows the interdependency between the city of Hull's three major strategic plans and how our Better Care plan sits within the centre to deliver some of the required changes through integration, community resilience, prevention and support.

Integrated commissioning processes will be underpinned by our Better Care plan and future Sustainability and Transformation plans to act as an enabler involving local people at the forefront of commissioning, service design and provision (see section 4.4 regarding our 2016/2017 consultation plans).

1.1 Sustainability and Transformation

Hull is also a partner in the Humber Coast and Vale Sustainability and Transformation Plan (STP) governance arrangements are being agreed at STP level that will support the joint planning and delivery of the STP programme. This governance will recognise that each individual partner organisation is a statutory body in its own right and will require formal systems and processes to evidence and support the discharge of these duties. This includes the establishment of a CCG Joint Committee with delegated authority to facilitate collaborative commissioning decisions (Integrated Commissioning Board)

The STP provides another opportunity to align strategic plans with the five year forward view and to influence and design services across the patch that are ambitious, accessible, safe and sustainable alongside delivering the clinical and financial outcomes we require for the local population.

Both NHS Hull and Hull City Council are committed to contributing to co-production of the STP and its outputs and supporting the wider population engagement that will need to take

place across this boarder planning foot print. The BCF plan will work with the STP to align our priorities and support the local contribution to planning and delivery.

One of the priorities of the Humber Coast and Vale STP is the development of out of hospital services, this is central to the Hull BCF and we will be seeking to link into opportunities that support development of resilient out of hospital care services in Hull that patients and the public want to and do utilise.

In Hull we are part of the Hull & East Riding 'COG' of the Humber Coast and Vale STP and are working to the Hull and East Riding Transformation Board to support system wide transformation and increase opportunity for joint approaches to out of hospital care.

1.2 The Care Act

"A life, not a service"

The advent of the Care Act 2015 provides the local authority with the requirement to ensure a continued focus on increasing customer choice and promoting well-being. Most of the changes are about the way things get done and are intended to make sure the customer has more control and receives a service which is flexible, innovative and is designed around them.

The main themes of promoting wellbeing, to prevent or delay the development of needs, to make sure the customer has as much control as possible and to make sure everyone works together are synonymous with the aims and objectives of the Hull BCF.

These are some of the main improvements –

- there will be one national set of eligibility criteria so that people with the same needs get the same level of support wherever they live in the country
- anyone who appears to need support will be able to get an assessment which will be based on risk and the impact their needs have on their life
- carers will be entitled to more services in their own right. This will be based on risk and the impact that caring has on their life
- it will be easier to get information and advice about what services and support are available, and what choices are available
- there will be a cap on the amount of money each individual is expected to contribute towards the cost of their care, which may be set at different levels for people of different ages
- people will be able to get help earlier and will be supported to stay independent and in control. When people do need support, there will be a limit on how much they will have to pay towards this over their lifetime

2. Case for change

Hull's Better Care plan (2014) was informed by the application of the following questions:

- What are the **problems?**
- What should our **priorities** be?
- What **progress** have we made?
- What are the **plans?**

Our original plan can be viewed at:

http://www.hullccg.nhs.uk/uploads/chronicler/document/document/173/03f_NHS_Hull_CCG_Final_bcf-plan_for_web.pdf

As part of refreshing our plan, the CCG and Hull City Council have revisited the initial questions and reviewed the analysis. Hull's Better Care plan (2016) takes further the shared ambitions to integrate care and commissioning to ensure co-ordinated provision .

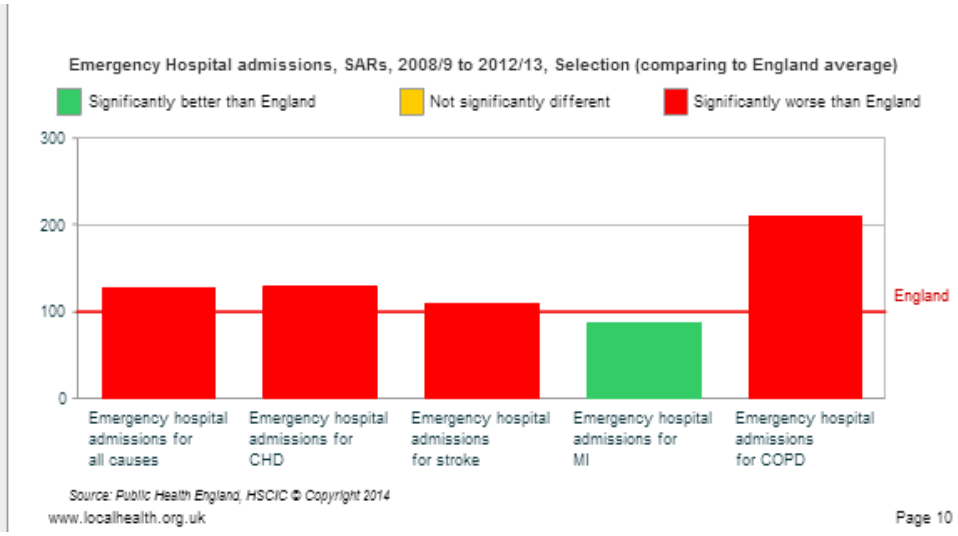
2.1 Problems

Hull is the third most deprived city in the UK and is predicted to see a 17% increase in older people by 2030.

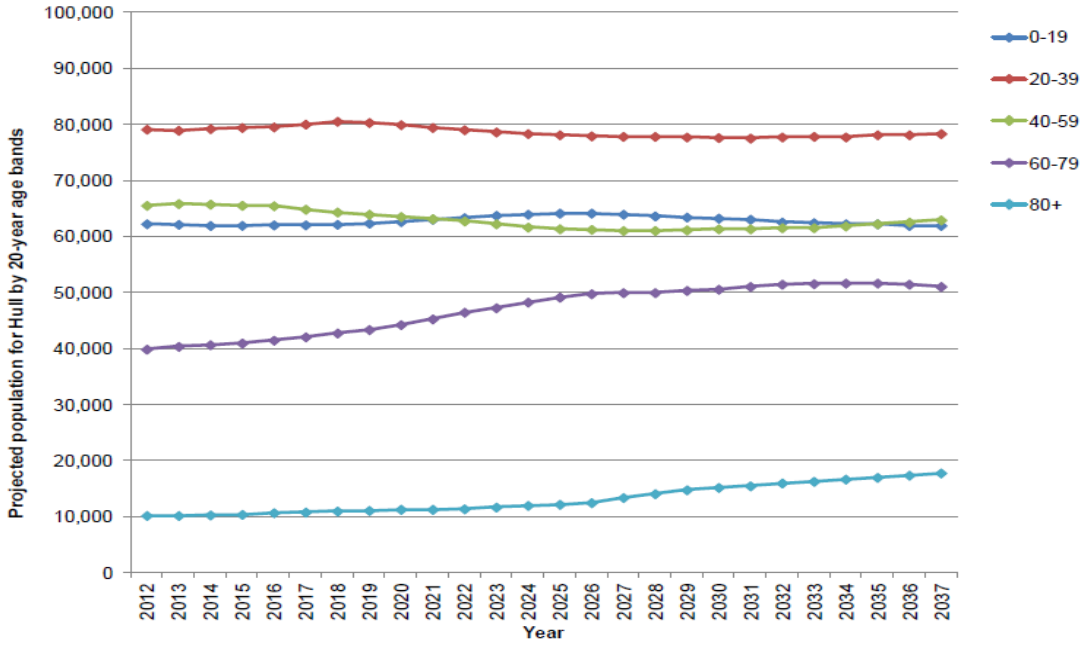
Hull's population is approximately 258,000 and the Clinical Commissioning Group's GP registered population is approximately 290,000.

Life expectancy in Hull is lower than the UK average (77 years for men, 80 years for women). Prevalence of long-term conditions is high but people tend to seek support late in their disease progression resulting in a reliance on secondary care services and a need to raise health expectations, support self-care and create a co-ordinated community response to health and social care needs.

In addition, a default to hospital care and residential care has often been seen as the first resort when care needs increase at home or following a hospital admission. Overall, communities have been very dependent on both health and social care statutory services and one of the local ambitions is to improve community resilience and increase use of third and voluntary sector support.



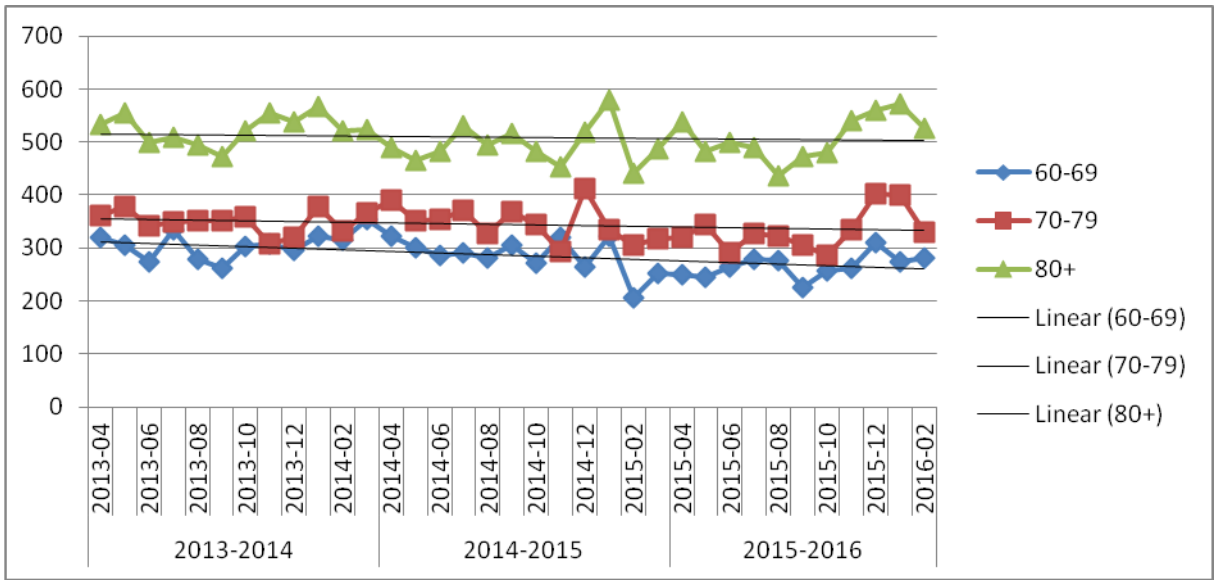
The percentage of people aged 65+ years in Hull out of the total population is currently estimated to be around 14% but is expected to increase to 17% by 2030; the percentage aged 85+ years is currently around 1.8% in Hull and is expected to increase to 2.5% by 2030.



Without any intervention in the service provision this group will present our greatest challenge in managing demand for hospital and social care. We also know that an admission to hospital for older people quickly reduces ability so that rehabilitation and reablement potential is diminished which in turn results in high risk of admission to permanent residential care and we have listened to and understand from public consultation that people would rather stay in their own homes to have care whenever possible.

Demographic growth, low health expectations and disease linked to high levels of deprivation is the rationale and local evidence base for our Better Care plan. The plan has an initial focus on the needs of the elderly with schemes designed to improve primary care **prevention** (BCF 1), **intervention** (BCF 2), **rehabilitation** (BCF 3), and **rapid community response** (BCF 4) to prevent unnecessary hospital admissions and support rapid discharge following a hospital attendance

The following graph shows the emergency admissions in Hull of people over 80:



Within these admissions a number are for falls in people over 65. There was a 12% increase in emergency admissions for injuries due to falls in 2013/14 – an average of 82 emergency admissions per month – compared with the previous year. This has informed the local metric of reducing falls-related admissions by 12% by 2017.

A signifcant number of the elderley popuation admitted to hospital in Hull will also have dementia but are not necessairly diagnosed on pratice registers.

These factors combined present the rationale for our focus on elderly care falls and dementia services.

2.2 Priorities

As we come into 2016-17, our priorities remain the same as our original plan in 2014. We will build on our success and implement the plan further through our refreshed schemes.

The priorities established between the CCG and Hull City Council are aligned within each organisation's operational/business plans. However, we acknowledge that to address the wider context of need in our city, in addition to the local population needs, there are a number of whole-system priorities that also need to be tackled within our plan:

- There is a need to address a perceived **culture of dependency** in some parts of the community.
- The cost of services and the complex challenges the system currently faces needs to be clearly understood and balanced to achieve better outcomes in meeting **ever increasing need and demands**.
- The current **structure** of services and organisations does not lend itself to supporting individuals; instead it is based around fragmented core services. These services should be built around the needs of individuals. For example, health services are currently too focused on who is providing the service, rather than reflecting the need to operate in a more joined up way to reduce duplication and confusion.

- In terms of **public expectations**, there is a need for more informed lifestyle choices among members of the public, this will require an understanding by commissioners and service providers of an individual's life choices and their aspirations. There is a
- need to explore options which enable people to solve their own problems as well as provide community resources.

- Public health **messages** need to evolve to be more "do" rather than "do not", supported by open and honest conversations with the public regarding the cost of services.
- There is a need to improve frontline, day-to-day **communication** between professionals in order to deliver a seamless blend between service providers and service sectors.
- In terms of the **resources** available, there is a need to improve efficiency and deliver services for the 21st century. In addition, a major challenge is to recruit and retain a highly skilled workforce, in particular primary care services face major challenges in recruiting and retaining staff. The public sector is the largest employer in Hull and being proactive with schools such as the newly established St Mary's Health & Social Care Academy can encourage local people to train and work in Hull to deliver excellent public services.
- Measures and metrics for performance of services should be **cross-sector and jointly owned.** The role of the Hull Health and Wellbeing Board will be a critical enabler for these changes, particularly with regards to driving forward the integration agenda.

3. Progress

Key successes 2014-2016

From the inception of the plan in 2014, local health and social care partners have built on existing joint working arrangements generated from section 256 agreements and developed new schemes in line with the views and engagement of people who use health and social care services and their carers.

The successes of some of the Better Care schemes to date include:

- **85%** of the older people discharged into reablement services in Hull were still living at home 91 days after discharge from hospital, higher than for England, and the region
- **5.5%** reduction in residential home admissions
- **9.6 %** reduction in emergency admissions
- **9.5%** reduction in the number of hospital admissions due to falls
- Delayed Transfer of Care (DTOC) for adults in Hull was delayed for 7.6 per 100,000 population, lower than for England and the region and all but one comparator local authority
- Less than one in ten DTOC attributable to social care. Only one comparator local authority had a lower rate of delayed transfer of care attributable to social care

The following table presents a high level review the original eight BCF schemes and associated initiatives, with progress so far. Our intention is to build on these and develop our schemes further through our refreshed plan.

Scheme	Initiatives	Outputs / Progress	Outcome – What will people see?
Prevention	• Community hubs • Develop the See and Solve model for adult social care • Ageing well • Loneliness, social isolation and befriending	The community hub concept has developed around a local blueprint for primary care and the organisation of health and social care around GP practice populations. The adult social care 'see and solve' model has been agreed and team established, the model will be implemented in 2016. Investments have been made in local ageing well projects. A group led by Age UK has been established to tackle loneliness and isolation. Several events have taken place including an intergenerational choir and a baseline of people's perceptions and experiences of loneliness completed.	A more joined up approach to delivering health and social care around GP practices, people will only tell their story once. People will receive high quality information, advice and support removing the need for more formal care and utilising community assets. People are encouraged to join active groups provided by the third sector. A network across health, social care and the third sector will be established to support people when identified as lonely or isolated – this will include carers and the bereaved.

Primary Care and Self- Care	• Development of Care Coordination roles • Implement risk stratification across GP practices • Telecare and Telehealth – increasing use	A pilot of care coordination took place in 2015. All GP practices embedded the RAIDR risk profiling tool. The outcomes of the pilot informed the specification of new community contract that will deliver a single point of access, care coordination and multi-disciplinary team (MDT) working from April 2016. The use of telehealth and telecare is central to this service model and is a priority as a system enabler for 2016-17.	People will be identified early through risk stratification and assigned a care coordinator to be their single point of contact to promote self-care, independence and build on resilience. Professionals will work in an MDT way to support care planning for people. Technology will support people to live in their own homes.
Falls	• Develop falls prevention and awareness across the city • Development of an integrated falls pick up service/rapid response	A falls steering group formed in 2015 and set the direction for more local public engagement led by Age UK. The formation of a falls prevention strategy and the development of an integrated falls pick-up services working with Humberside Fire and Rescue Service alongside existing health and social care teams.	People will be made more aware of the risks of falling in their own home and what they can do to reduce the risks. People will receive a rapid response when fallen and will receive follow up wellbeing checks, reducing the need for an Emergency Department attendance.
Reablement	• Increase capacity at Thornton Court reablement units and Highfield Resource Centre • Review reablement pathway for more care at home	Reablement options have been increased at Highfield Resource Centre and the Thornton Court reablement flats. Resource in the social work team has also been increased.	People will be supported home from hospital to regain independence. People will be supported by offering alternatives to a hospital attendance or admission when vulnerable but medically stable.
Ambulatory Care	• Ambulatory Care Unit • Elderly Assessment Unit • Community model (expected early 2018)	The ambulatory care pathway commenced at Hull Royal Infirmary in December 2014 and successfully reduced non-elective admissions throughout 2015. The agreed model for elderly assessment was implemented in part and will be further developed in 2016.	People with ambulatory sensitive conditions will be assessed and sent home, not admitted to hospital unless necessary. People will be assessed by a MDT, offering clinical, occupational therapy and social care assessment to support rapid discharge to their own home.

		The new community contract from April 2016 will provide an assess-to-admit service and rapid community response this will develop more alternatives to admission in line with the development of the Hull Integrated Care Centre in March 2018.	People with ambulatory sensitive conditions will be assessed in the community, closer to home.
Residential & Home Care	• Extra Care • Home Care hubs	Hull City Council established a new process to ensure all transfers of care from hospital were assessed before permanent residential placements were made. Over 300 Extra Care tenancies have been designed and are currently being built; these will be available from 2017.	People are supported from short-term residential placements back to their own home. People will be offered Extra Care to support independent living.
Long Term Conditions & Dementia	• Care Navigator • CANTAB • Personal Budgets • Dementia Collaborative	The CCG introduced the CANTAB screening tool into primary care to support GPs to screen for dementia. This has supported the achievement of a **77%** recorded prevalence rate in Hull. The dementia collaborative has been established under BCF and a new pathway is being piloted in 2016 for primary care.	People will be diagnosed earlier with dementia and offered support. Health, social care and the third sector will work together to provide specialist support for people living with dementia.
Mental Health	• Integrated health and social care teams	Social care teams from Hull City Council transferred under the BCF section 75 into Humber FT, the aim being that integrated mental health teams were established with the CCG as lead commissioner.	Single teams will deliver health and social care services.

3.1 Plans: Refresh 2016-17

In November 2015 the Better Care team undertook a review of the eight Better Care Fund schemes starting with a local conference to consult on progress and plans. The review of the eight original schemes has resulted in four programmes that will capitalise on existing work and joint commissioning. The intention is to ensure that the progress to date is taken forward as business as usual across health and social care.

A high level representation of the four schemes is shown in table 2; further details of our schemes can be seen in Section 6.

Prevention (BCF 1)	• Community Hubs (See and Solve) • Ageing Well • Befriending • Extra Care housing • Home Care • Falls Prevention • Information Sharing/Systems Integration
Intervention (BCF 2)	• Care Coordination (Risk Profiling) • Social Prescribing • Multi-Disciplinary Team long-term condition management • Single Point of Contact across Health & Social Care (trusted assessments) • Carers' Service • Dementia Collaborative • End of Life • Mental Health
Rehabilitation (BCF 3)	• Reablement • Falls Recovery • Health & Social Care Discharge to Assess • Intermediate Level of Care (Thornton Court/Highfield Resource Centre)
Rapid Community Response (BCF 4)	• Hull First – Falls Response • Integrated Care Centre • Ambulatory Care

We have developed a number of "I" statements which outlines what people should expect to see as whole from the implementation of Better Care:

The "I" statements will be used within public and people engagement groups to measure our success (see section 3.5 for further information on our consultation and engagement).

4. Integrated commissioning –

In 2016-17 the CCG and Hull City Council will explore options for taking integration further under a new joint committee structure. The existing local examples of lead commissioning arrangements will be reviewed and expanded upon.

Both organisations recognise the benefits of greater integration as a potential way to use resources more efficiently, in particular by reducing avoidable hospital admissions and facilitating early discharge.

The CCG and Hull City Council have identified senior manager leads for BCF/Integration and have invested in a joint BCF Officer post that has responsibility for programme managing the plan.

Since January 2016 a series of Integrated Commissioning meetings have been taking place to agree the governance arrangements for a new committee structure that can work across both organisations , it is envisaged that this will take joint commissioning forward across both children's and adult social care.

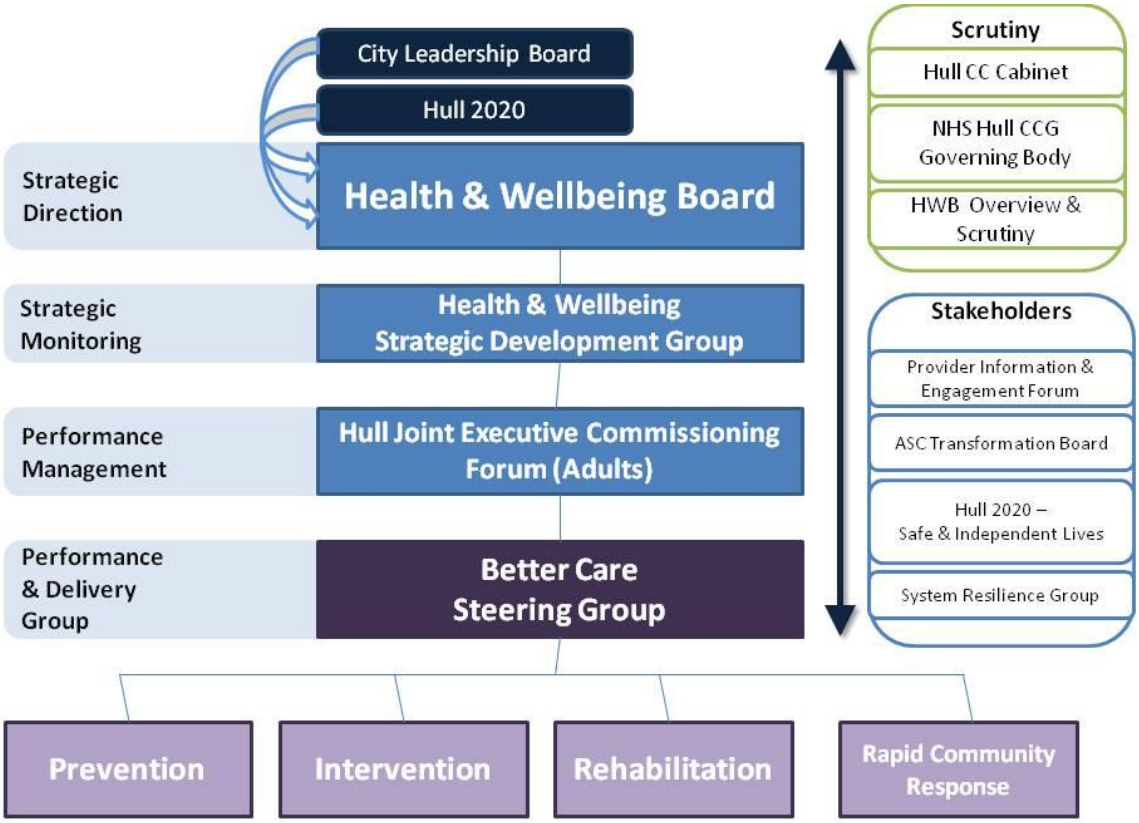
4.1 Integrated commissioning milestones -

In Q1	In Q2	In Q3	In Q4
Map current joint and lead commissioning arrangements. Conclude the work of the current joint commissioning forum. Agree governance and terms of reference for new Joint Commissioning committee. Variation to section 75 risk sharing agreement as required.	Take Joint Committee arrangements through respective organisational forums to agree delegated decision making, resource and accountability framework.	Meeting of the Integrated Commissioning Board Establish integration work plan to subsume BCF with outcomes framework. Agree a set of metrics to assess the overall performance of the local system. Explore contracting vehicles for place based commissioning.	Publish market position statement and commissioning intentions based on integrated commissioning structure.

4.2 Governance

The Better Care steering group provides the operational and performance management of the Better Care Fund and the schemes on a monthly basis. It is chaired by BCF-accountable officers from either the CCG or Hull City Council and has representatives from each organisation's finance, business intelligence and programme management teams.

Decision making and developing integrated/joint commissioning proposals currently take place at the Joint Executive Commissioning Forum. Recommendations and decisions that need ratification will be taken from there to each organisation's governing bodies and, ultimately, the Health and Wellbeing Board.



Each scheme has a number of delivery sub groups which are aligned to the transformational Hull 2020 programme of public services to focus on workforce, estates, IM&T and finance.

Provider engagement is provided through the Hull 2020 Safe and Independent Lives group which reports directly to the Health and Wellbeing Board.

The statutory responsibilities of the Better Care Fund and governance of the financial elements of the plan are overseen by the Health and Wellbeing Strategic Development Group with the Joint Executive Commissioning Forum and Better Care Steering Group reporting in for sign-off on the use of resources and performance reporting against the plan. Quarterly updates in line with the NHS England submissions will be reported through this route to the Health and Wellbeing Board, including financial and performance delivery and any issues.

4.3 Programme and performance management

The CCG and Hull City Council has a Better Care Fund Accountable Officer in each organisation, as described in the Section 75 agreement, who act as sponsors for work undertaken as part of the plan.

A joint funded programme team has been established and are employed by the council.

The Better Care Steering Group meets on a monthly basis to monitor projects, finance and performance.

Representatives from the following teams within NHS Hull CCG and Hull City Council sit on the steering group:

- BCF Accountable Officers
- Finance
- Performance/Business Intelligence
- Commissioning
- Programmes/Projects

4.4 Consultation and engagement

The Better Care plan in 2014 was developed in consultation with our partners of Hull 2020 and Hull's Older Peoples Partnership, which is a partnership of over 40 organisations delivering services to older people in Hull, predominantly the third sector.

In November 2015 we held an annual conference to showcase our plans and work so far. This was attended by a wide variety of stakeholders including providers, the voluntary sector, people who use services and the wider public.

An overview of the day can be seen here: http://www.hullccg.nhs.uk/pages/better-care-in-hull-conference-6-november-2015 . The presentations of work under 2014-16 schemes can be seen at: http://www.hullccg.nhs.uk/bettercare

As part of the conference we held a workshop after the presentations, called "Keep, Change, Create", we have used the feedback from this to inform our priorities for 2016-17.

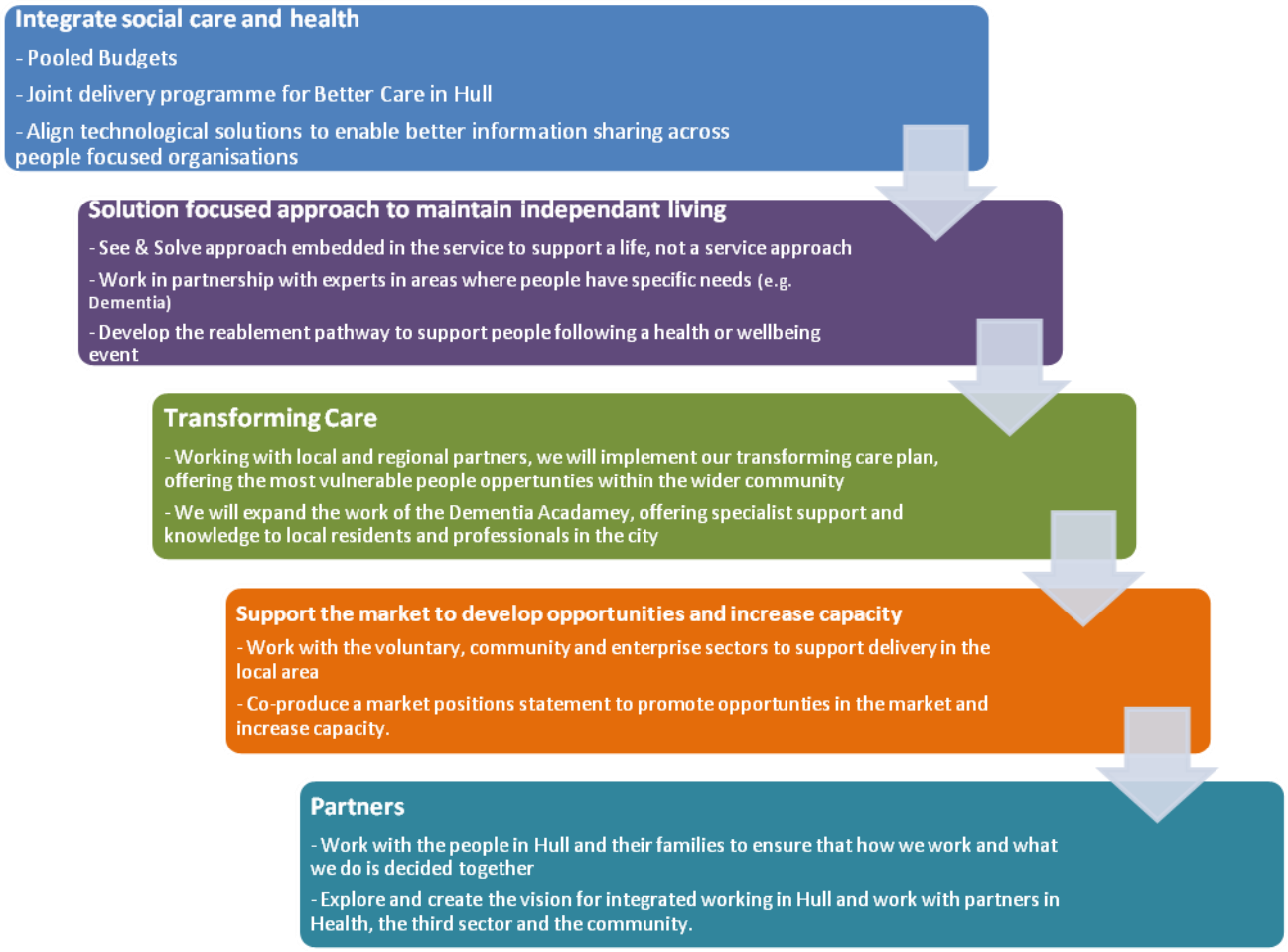
4.5 Consultation Milestones

As we move into 2016-17 our consultation and engagement activity will be provided for by Hull's Older Peoples Partnership. Our priorities for consultation and engagement are linked to our planned deliverables for this year.

In Q1	In Q2	In Q3	In Q4
Single point of contact for Adult Social Care and Health Services **Key Questions** *"What will people expect to see?"* *"Do people know how to contact social care?"* *"Do people know how to contact community health?"* *"Care Coordinator: What does this mean?"*	Engagement on rapid community response **Key Questions** *"What will keep people out of hospital?"* *"Who do people expect to see?"*	Our annual conference showcasing our work and engaging with frontline staff/professionals to make change happen – a workshop aimed at: "What can I take back to my organisation to aid further integration/joint working/relationship building?" Consultation and Engagement on our rehabilitation pathways to redesign the current pathway *"What will get me home quicker following a hospital attendance/ admission?"*	7-day services gap analysis **Key Questions** *What is lacking in service?"* *"What experience have people had of 7 day services – health and social care?"*

4.6 Adult social care business plan

Hull City Council's adult social care business plan outlines the delivery of change in 2016/17 which moves towards working in an integrated way with the CCG, including commissioning and market development which underpins meeting the national condition of maintaining social services (4.1):



The full adult social care business plan is attached as Appendix 2.

5. National conditions

The following section describes the Hull Better Care plan's response to the national conditions for 2016-17.

5.1 Maintaining social services

Hull City Council will maintain social care services in order to support eligible adults to remain independent in their own home, promoting choice and control which will support people to live full and active lifestyles following our vision *"to have a life not a service".*

The Better Care schemes will identify people sooner and assessments will be timelier, thereby ensuring targeted interventions promote self-care and achieve continued independence.

Local adult social care services will continue to be supported within plans that are consistent with 2015-16 and confirm that the level of protection will not destabilise the local social and health care system.

We will do this by:

- Targeting resources to keep people at home
- Align to health providers to avoid duplication
- Embedding the Care Act, which will promote the new model of social work; recognising the duties of prevention, early intervention and increase in assessments will be a cost pressure, we have factored this into our BCF plan and recognise that this focus on integrated models of working will realise efficiencies in delivering the Care Act duties
- Tackling lifelong care needs with more early intervention and thereby reducing health inequalities
- Increasing reablement and rehabilitation options to prevent long-term residential/formal care.

A number of joint projects between the CCG, Hull City Council and providers are underway and will be delivered in 2016/17:

Project	Description
See and Solve	See and Solve will provide first point of contact to social care services and offer early help and prevention for people to maintain their independence in their own home. It will support people to find their own solutions, using their own informal networks and links to communities. It will provide a link to health, housing and follow up people to ensure they have activated solutions, increased their self-resilience and prevented need for long-term formal care. A multi-disciplinary team offering support with direct access to and from health colleagues to ensure people have access to quality information and advice, and access support, if needed, in a timely manner. Phase 2 of the roll-out of See and Solve will see social work integrate with health colleagues in the community and hospital to provide a holistic approach to supporting people maintain independence.
Discharge to Assess	Discharge to Assess will support people home from hospital by offering a rapid discharge and follow-up assessment in their own home for people with care and support needs. This will be integrated with health partners to provide a holistic approach and promote independence in people's own home and active recovery following a hospital attendance or admission – unplanned or planned. It will focus on the reablement and rehabilitation of people following their immediate discharge to home. Once home, discharge to assess will consider appropriate care and support packages of care in people's own home environment

Extra Care	The development of three Extra Care sites will continue in 2016-17 offering 300 placements. The first site is due to go live in January 2017 with 100 people being housed within the Extra Care scheme, with the other two sites going live in Quarter 1 and Quarter 2 of 2017/18. These sites will incorporate facilities for clinics to be held by primary care, community health and activities provided by community and voluntary sector in an integrated way providing care closer to home and promoting health and wellbeing to its residents.
Reablement/Intermediate care	Focus community health and social care on reablement and rehabilitation of people, especially those discharged from acute/residential settings.

	Mandatory Funding £'000	Additional Contribution £'000	Total £'000
DFG	1.968	nil	1.968
Care Act 2014	779	nil	779
Former Carers Break Funding	445	nil	445
Reablement	3.390	nil	3.390

5.2 Seven-day services

The Better Care plan is aligned to all the other CCG and local authority programmes for adult services and delivery of 7-day services.

In 2015-16 the new community contract for the majority of adult services was successfully procured. The main specification set the expectation of integrated working over seven days including single point of access, care coordination and a rapid community response.

Hull City Council is working with the provider, City Healthcare Partnership CIC (CHCP), to align delivery of social care with the new services. The service specifications on associated service improvement plans within the contract (SDIPS) have KPIs to measure the impact on hospital admission and transfer of care.

5.3 7-day services milestones

Q1	Q2	Q3	Q4
Single point of access 7-day services across new integrated community services	Assess-to-admit model in place Urgent care service with rapid community response operational 7 days from a single site Integrated discharge to assess pilot operational	Evaluation of progress against KPIs and repeat baseline assessment of 7-day services Working group set up to further 7-day services in Adult Social Care Review compliance against clinical standards with Trust.	7-day services gap analysis Review against patient outcomes framework

The local acute provider Hull & East Yorkshire Hospitals have undertaken a baseline assessment of 7 day working which outlined compliance with the 7 day clinical standards:

Clinical standard 2- Time to first consultant review

Clinical standard 5- Diagnostics

Clinical standard 6- Interventions/Key services

Clinical standard 8- Ongoing review

In 2016/17 work will be undertaken to develop the 2 following clinical standards further and ensure full compliance. The main areas of work will include:

Clinical Standard 3 – Multi Disciplinary Review

All emergency patients reviewed within 14 hours over 7 days including health, social care and the voluntary sector. – this follows introduction of the British Red Cross into A&E and a new transfer to assess model for social work in the hospital.

Clinical Standard 7 – Mental Health

Developing a 7 day Psychiatric Liaison within 1 hour for emergency needs. This will include evaluation of the recent addition of 24/7 mental health input into A&E.

A workforce summary has been produced as **appendix 8** – to support the development of 7 day services across public services

5.4 Better data sharing

Progressing data sharing and pursuing developing interfaces between application programmes has been challenging in Hull. We have established the NHS number as the primary identifier for all new social care referrals and data cleansed existing records. This will be an area of focus in 2016-17 and a new post will be recruited to in 2016 to take this work further forward.

The following outcomes are set out within the local the digital roadmap:

- NHS number across all care settings including independent social care providers
- An agreed, consent based, sharing model in place
- 10% of patients actively accessing primary care services online; appointment booking and ordering repeat prescriptions
- 95% of practices offering access to detailed record
- 10% of patients actively accessing their detailed coded GP record
- GPs using the Electronic Referral Services for 80% of first outpatient referrals
- GPs having secure access to their GP clinical system at the point of care
- 100% electronic prescriptions in place across general practice and community pharmacy
- GP summary information being utilised across urgent and emergency care settings.
- GP summary information being utilised across wider primary care and other care settings

- An agreed data-set for Additional Summary Care Information in place, and will have started to share this across agreed pathways
- GPs will receive timely electronic discharge summaries from secondary care

5.5 Data Sharing Milestones

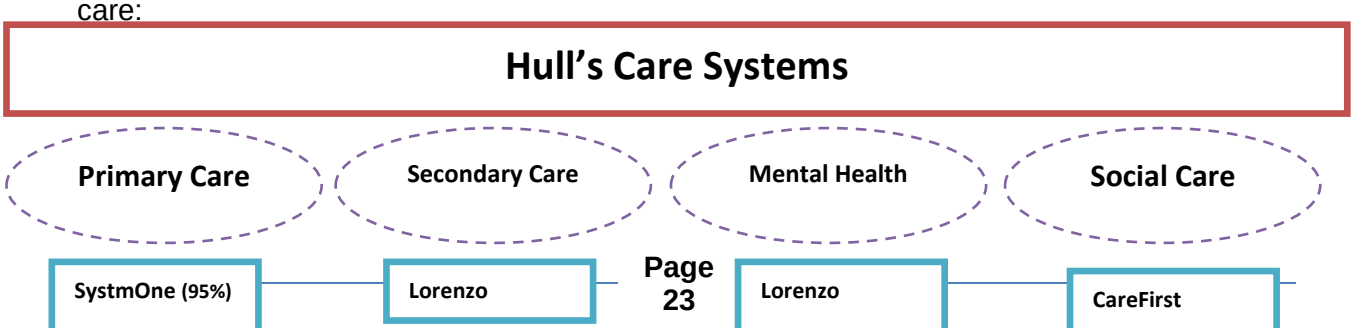
Q1	Q2	Q3	Q4
Digital roadmap to support delivery of integration Put in place a clear governance structure to support development and delivery Review providers' digital maturity index to inform local milestone development Agree a strategy and framework for a shared record solution (SCR) Agree a data sharing consent/opt-out model by end June 2016	Develop a plan to expand use of electronic referrals across other care services; community, social care Develop and implement consistent sharing agreements across all stakeholders Develop and agree a consent based sharing model across all stakeholders	Implement information sharing Agreements across the Hull footprint. Implementation of data sharing consent/opt-out model across services Opportunities for sharing additional information through SCR and begin deployment, i.e. end-of-life preference information	Service users are confident about sharing their data to improve care and health outcomes All members of the health, care and social care workforce will have the knowledge and skills to embrace the opportunities of information

Hull City Council has procured a new system in 15/16 called Liquidlogic to provide Adults, Children and Family services care records. The roll-out of the new system across the social care services will include automatic NHS number population from utilising PDS look-up services and allow a single view, and share with systems in primary and secondary care.

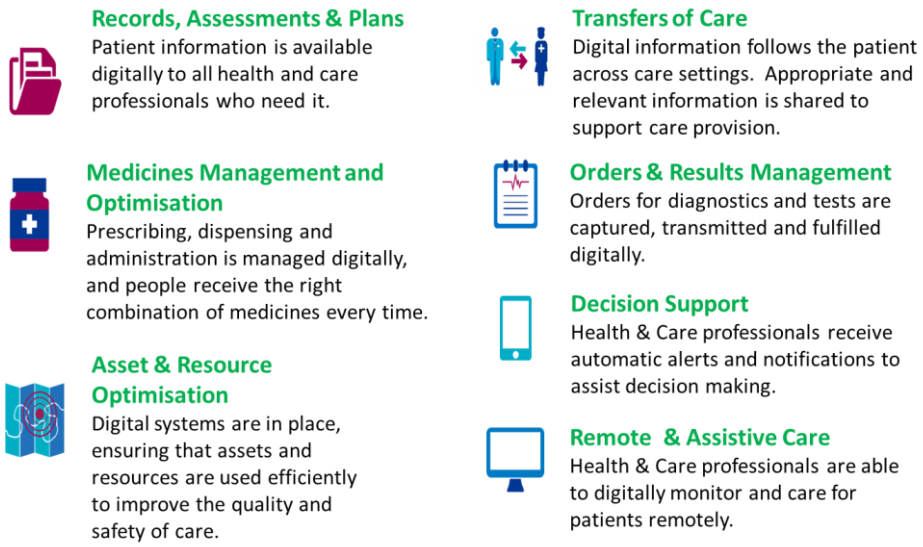
The local authority is progressing work with the Health and Social Care Information Centre to establish connectivity to the NHS N3 network to enable access to NHS systems from social care and establish record sharing. The priority for 2016/17 is to establish the Summary Care Record use within social care.

As part of Hull 2020, an information sharing group will be established to continue to develop the information governance arrangements between organisations using the established Humber Information Sharing protocol, and consultation and engagement will be undertaken with the public about how they perceive, agree what should be shared.

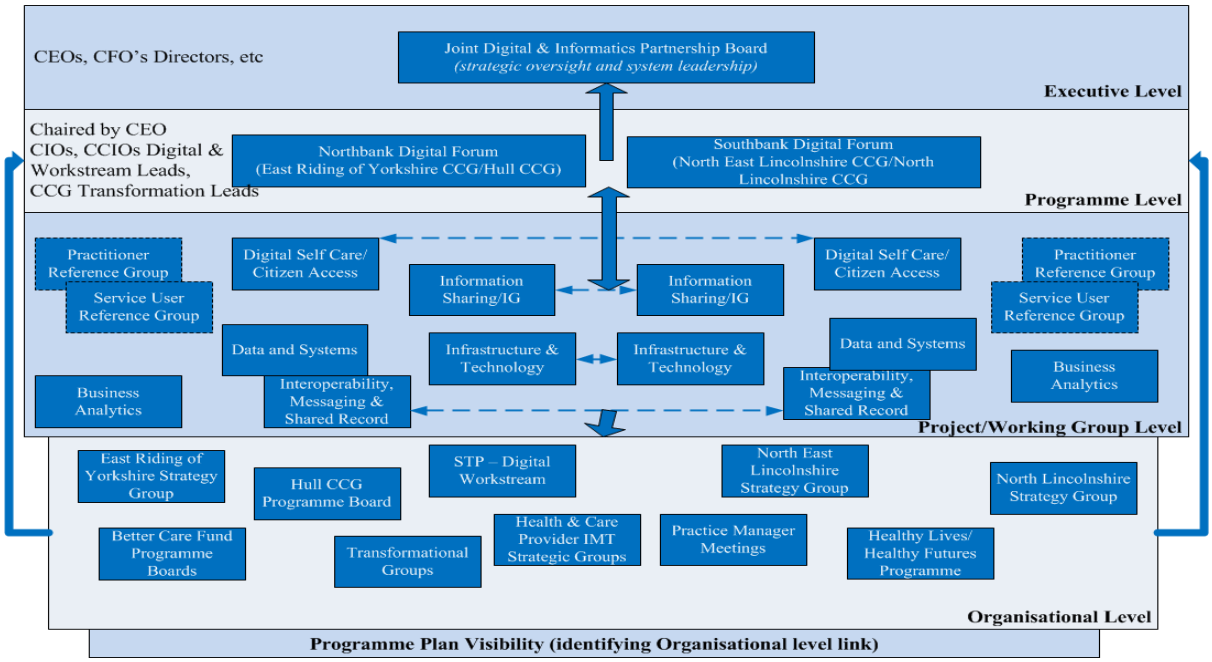
The following diagram outlines Hull's care/information systems landscape to provide direct care:



The Hull2020 IM&T work stream will lead this work to deliver information sharing across systems to support direct care and secondary uses to transform information sharing across care settings.



As part of the development of information sharing a Northbank Digital Forum has been established lead by Hull CCG and East Riding of Yorkshire CCG to programme manage sharing of information between health and social care and other public services. The lead for Information Governance and Sharing controls within Data and Systems and Interoperatibility and Shared records is employed as Information Governance Manager at Hull City Council. The following diagram depicts the governance structure across the Humber footprint.



The information sharing and governance work stream will work with providers to develop information sharing protocols and governance.

The emerging work streams as part of this work will be cross cutting with data sharing/information sharing requirements within Health and Social Care. These programmes of work are as follows with individual organisations taking the lead:

Work Stream	Lead Organisation
Digital Self Care / Citizen Access	Hull City Council
Infrastructure & Technology	East Riding of Yorkshire Council
Data & Systems	Humber NHS Foundation Trust
Interoperability/Shared Records	Yorkshire Ambulance Service/Embed
Business Analytics	eMBED
Information Sharing & Information Governance	Hull City Council
Reference Group: Practitioner	TBC
Reference Group: Service Users	TBC

These work streams will enable and progress a system wide approach across the organisations to develop shared care records and allow people access to their own records and support.

5.4 A joint approach to assessments and care planning

As previously noted, the new Hull community contract specifies a care coordination function to identify an accountable professional. Hull City Council has agreed to adopt the term Care Coordinator to ensure people in receipt of care coordination are experiencing a consistent approach.

The local health care provider, CHCP, have been undertaking a communications exercise with people who use services, primary care and other stakeholders ready for the launch of the new integrated model in April 2016.

See appendix 1 for the care coordination information that has been produced.

All adults in receipt of care will be offered this service from a single point of contact. Provider plans have been aligned to deliver this new contact with CHCP working as lead provider and integrating with services from Hull & East Yorkshire Hospitals, Humber FT, the local authority and voluntary sector partners including the Red Cross.

5.5 Out of hospital care

The requirement to fund NHS commissioned out of hospital services will be picked up within the service improvement plans within the new community contract.

The following table shows the current Better Care allocation and agreed performance target on emergency admission reduction targets 2015-16

Current allocation and contribution

Better Care Programme 2016/17	Hull
Total Fund	**£27.3m**
Minimum – Y/N	No
Additional contribution	£7.6m

The local risk sharing agreement will be varied to note any changes; appendix 2 is included in this submission which provides information on 2015-16 risk share.

Our plans for 2016-17 include expanding on current out-of-hospital initiatives and, wherever possible, operating “an assess-to-admit model” by providing a rapid community response.

This work is interdependent with the programme set out within the System Resilience Group and, in particular, the unplanned care programme for Hull that will concentrate in 2016-17 on delivery of alternatives to admission to hospital.

The following goals and priorities were identified at a recent strategy event for delivery in 2016-17:

Goals

- Raise thresholds for acute hospital admission
- Build clinical and professional trust and collaboration
- Manage risk more effectively
- Reduce duplication of effort and unnecessary delays
- Reduce inconsistency and inequality in the provision of care
- Strengthen service profiles and build public confidence

Priorities

- Trusted single assessment system across health and social care
- Fully integrated community based services – lead contracted provider model linking in with the local authority and voluntary sector
- Shared electronic records between health and social care
- Integrated workforce and training plan
- Develop a system wide pathway for dementia care (and other service areas)

The Hull operational plan describes the CCG ambitions to move towards place based commissioning, organised with social care input around primary care practice groupings, will also work to provide, wherever possible, out-of-hospital care at the point of need. See also appendix 3.

Hull CCG has also developed a plan for an integrated care centre. This scheme is currently at outline business case stage for the capital development and 2016 will see the majority of the work take place to reconfigure services to provide the new services model that will be operational from March 2018. More information can be found on the link below:

http://www.hullccg.nhs.uk/articles/plans-for-fully-integrated-out-of-hospital-care-in-hull-move-forwards

5.6 Agreement on a local action plan to reduce delayed transfers of care (DTOC) and improve patient flow

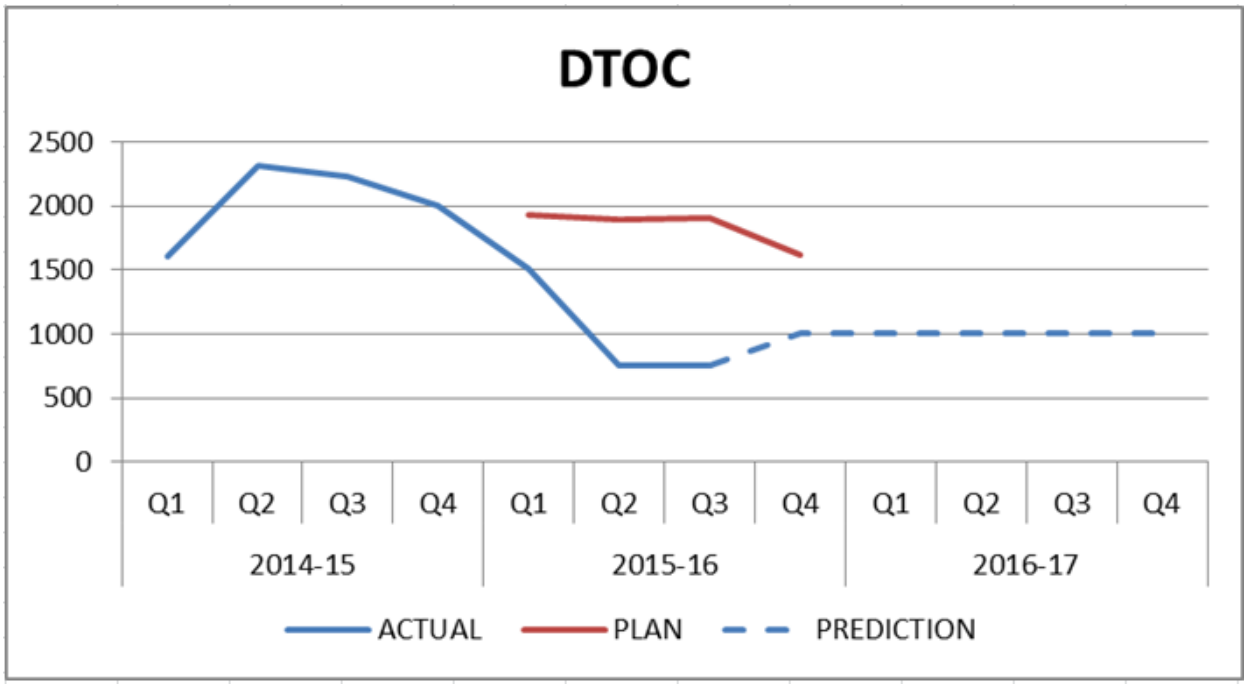
The local Discharge Board that reports into Hull and East Riding SRG provides the programme plan and monitoring arrangements for DTOC.

Hull CCG and Hull City Council are members of this board and have signed up to delivery of this plan for DTOCs from Hull and East Yorkshire Hospitals Trust.

The graph below shows Hull's performance in 2015-16 and our predictions for 2016-17. Investment in reablement options and resources has enabled Hull to meet and sustain its targets.

A weekly system-wide senior meeting also takes place to identify and address any barriers to discharge.

Appendix 4 outlines our Delayed Transfer of Care Action plan for 2016/17 which has been produced locally as part of the Discharge Programme Board.



6. Risks, risk sharing and contingency

Identified risks to Better Care are regularly reviewed at each steering group, with mitigation planned, managed and shared through each organisation's governance structure. The following table shows the open risks to our better care plan.

Risk Number	Risk Description	Action Treatment Description	Review Date	Impact (I) (1- 5)	Likelihood (L) (1-5)	Risk Score (1-25) (IxL)
BCF20	NHS Number population will be more time consuming than anticipated. A consequence of batch processing is that a significant amount of data issues will be highlighted	A work plan has been developed to obtain the NHS N3 connection within ASC. This will enable new people entering ASC a look up feature to populate the NHS number onto records to prepapre for systems integration.	Apr-16	5	4	20

BCF23	Change in the DFG resource allocation could impact on reablement	New Budget allocation for 16/17. A review of fast track and means testing approaches by the LA to be undertaken with the CCG.	Apr-16	5	4	20
BCF8	Sustainable medical workforce in primary care, low number of Gp's (WTE) per head of population	The CCG primary care workforce development plan	Apr-16	3	3	9
BCF15	The shift of activity from acute to community would result in council overspend on social care, as greater number of care packages are required.	Allocation of BCF resource to ensure sufficient care packages. Adult Social Care Review and complex care review being jointly with council and CCG to develop home care and complex care provider market.	Apr-16	3	3	9
BCF16	Failure to agree draw down and use of finance dependant upon multi agency funding	Governance and Risk Sharing agreement for arbitration built into Section 75 agreement.	Apr-16	3	3	9
BCF17	Failure to develop appropriate contract delivery model	Joint working through Joint Commissioning Forum. Contract development process and monitoring defined in Section 75.	Apr-16	3	3	9
BCF18	Not getting information governance right, including informed consent to share information would undermine potential IT solutions	Support from Organisational Caldecott advisors. Use of technical experts to advise on information governance plan and requirements	Apr-16	3	3	9
BCF24	Organisational Governance across the LA and CCG could cause lack of alignment and could cause delay in progress of the schemes	Governance Structure set up to work across organisations through a Joint Adult Commissioning Board reporting into the H&WB	Apr-16	3	3	9
BCF4	Implementation of the Better Care Plan is reliant on cultural change and shared accountability across organisational boundaries.	Development of a culture change programme within ASC is currently underway. Stakeholder events to developed including the BCF annual conference	Apr-16	3	2	6
BCF7	Finance risks including risks associated with over achieving against the target which may require the adjustment of resource allocation	Contingency arrangements are as part of the risk sharing agreement.	Apr-16	3	2	6
BCF9	Slow or non achievement of the BCF outcome metrics	BCF metrics aligned to CCG QIPP plans and LA performance trajectories. Monthly tracking of performance against the metric and national conditions at BCF steering group. The metrics are reviewed as part of the BCF plan refresh for 2016/17	Apr-16	3	2	6

BCF10	Workforce recruitment and development	Workforce development to be picked up as key work stream of provider forum and linked to 2020. Newsletter/updates on progression progress and next steps. Clear and simple messages at staff briefings - the message is that BCF runs through all adult health and social care provision "its what you do and how we can do it better". Staff will be trained on detail and change of practice resulting from BCF programme and Care Bill. Policy and procedural updates to support practice. Online training and use of all media to keep staff informed; encourage feedback and ensure this can be given in all services at all levels. Skills analysis - training needs identified and met.	Apr-16	3	2	6
BCF21	Implementation of 7 day working	Following the Community Procurement excercise undertaken by the CCG in 15/16. Another Gap analysis will be undertaken in Q4 of 16/17 to review the mobilisation of the new contracts and provision in Hull	Apr-16	3	2	6
BCF25	Achieving national timescales working across multi-agent multi sector environments	Better Care Plan recognised as a vehicle for delivery of the 3 major local strategic plans for Hull and work streams embedded within the Hull 2020 programme approach	Apr-16	3	2	6
BCF5	Sharing information between multiple systems and service providers to faciliate and enable new and improve patient pathways.	A BCF information technology working group which will drag on the resources of the national ADASS Information Management Group and link into the Hull 2020 IM&T enabling workstream	Apr-16	2	2	4
BCF6	Introduction of the Care Act	Programme Management and actions to support emerging details as they are released. Information systems will need to be able to transfer between LA's. Assume NHS no, as unique national identifier and progress local use. Keep informed through regional networks. Confirm lead and resources for project support from partners to ensure whole system information is in place.	Apr-16	3	1	3
BCF12	Working agreements amongst all partners is key to monitor whole systems impacts, together with individual partners' plans and their separate governance agreements	Strategic direction provided by Hull 2020 Board. Memorandum of understanding in place across all partners	Apr-16	2	1	2

Our 2016/17 section 75 risk sharing agreement can be seen **Appendix 7**.

7. Schemes and spending plan

The CCG and Hull City Council held a stakeholder conference in November 2015 to inform stakeholders of the progress of the plan so far and gather information for the refreshing of the plan for 2016/17.

The following tables show the refreshed four schemes' summaries and outlines and our intended outcomes and milestones for 2016/17.

Scheme	Prevention	**Scheme Agreed Spend**	£3,589m	**Ref**	BCF - 1
Objective	Build community resilience by applying a coordinated approach to preventative actions through the organisation of care offering early help and support including the use of community assets.				

Summary/Progress	**Stakeholders/Providers**	**Performance Metrics**		**Links to 2014-16 Schemes**
	• NHS Hull CCG • Hull City Council • Age UK • CHCPCIC • Humber NHSFT	Reduction in Non Elective Admission Reduction in Injuries due to falls Reduction in Residential Homes Admissions	-3.5% -4.0% -10%	• BCF1 - Prevention • BCF3 - Falls • BCF6 – Residential & HomeCare

2016/17 Key Deliverables					**Impact / Outcomes**
Milestone	**Due**	**Lead**	**Description**	**RAG**	
See & Solve Team Operational	June 2016	HCC	Development of the see & solve model across adult social care – offering single point of contact to ASC and solution focused outcomes.		People are aware of the services and confident they can access them.
Integrated Ageing Well Physical Activity programme re-procured	Sept 16	HCC	Building on the physical activity offer by the third sector within the community.		People can access more wellbeing and active lifestyle services in their local community.
Loneliness Strategy and Action Plan implemented	Sept 16	Age UK	Developing a network and process for those who are identified as socially isolated and/or lonely.		People will receive person centred coordinated care and support.
First site for Extra Care Housing opens	Jan 17	HCC	Provision of 100 homes for those with an assessed care need within the community.		Maintaining Health and independence.
N3 connectivity in the local	Aug 16	HCC	Access to the summary care record to support		Information shared across public services to reduce

authority			NHS number population and data quality.		duplication.
Falls Prevention awareness campaign	Dec 16	CCG/ Age UK	A campaign led by Age UK on raising the awareness of risk of falls. To build on the work within primary schools, primary care and opticians.		Public awareness of the risks of falling.
Falls Prevention programme for Care Homes	Jan 17	Humber	To develop training programme for staff within care homes, and offer assessments and interventions to those at risk of falls.		Reduce the number of falls 65+.
Pathway for Lifeline to community urgent care piloted	Aug 16	HCC/ CHCP	To provide an alternative from 999 for those who have fallen in their own home. To build on offering further non urgent alternatives to 999 and provide community response *(links to BCF4).*		Reducing number of fallers conveyed to hospital.

Scheme	**Intervention**	**Scheme Agreed Spend**	£10,028m	**Ref**	**BCF - 2**
Objective	Reduce demand on statutory health and social care services, through early identification (risk profiling) and allocation the most suitable care coordinator				

Summary/Progress	**Stakeholders/Providers**	**Performance Metrics**		**Links to 2014-16 Schemes**
	• NHS Hull CCG • Hull City Council • CHCP CIC • Humber NHSFT • Hull & East Yorkshire Hospitals NHS Trust • Primary Care Practices	Reduced number of non elective hospital admissions Reduced number of residential admissions Improved person's experience of care provision	-3.5% -10% +5%	• BCF2 – Primary Care • BCF7 – Long Term Conditions • BCF8 – Mental Health

2016/17 Key Deliverables					**Impact / Outcomes**
Milestone	**Due**	**Lead**	**Description**	**RAG**	
Mobilisation of Care Coordination in community health	Apr 16	CHCP	Developing a proactive care management and coordination through risk profiling within Primary care.		• Early identification of people most at risk of hospital admission • Number of people managed by a named care coordinator • Reduction of readmission to hospital

Social Prescribing procurement	Sept 16	CCG	Development of the social prescribing mechanisms for professionals.		• People use social prescribing and befriending schemes Reduce social isolation
MDT's established with Health & Social Care teams	Oct 16	CCG/ HCC/ CHCP	The development of an MDT model for health and social care professionals to develop joint and trusted assessments for care delivery.		• Increase in the number of people with jointly developed care plans with a named lead professional
Single Point of Contact established between health and social care	Oct 16	CCG/ HCC/ CHCP	Alignment of the two SPoC's between Health and Social Care to provide seamless information, advice and support depending on care need.		• Person centred and coordinated care • Increase in access to services by people and professionals
Dementia Pathway pilot in primary care	Jun 16	CCG/ Humber/ HEYT	Integrated Dementia pathway implementation for pre-diagnosis and post diagnosis support and care across health, social care and the 3rd sector.		• Increase number of carers who feel supported • Increase number of people on diagnosed GP registers • More people living independently in their own home
End of Life strategy and Pathway reviewed	Nov 16	CCG/ HCC	Review of the current end of life pathways and alignment to the EoL strategy to provide seamless care.		• People die in their preferred place of care • Number of people managed by a named care coordinator
Social Workers within Primary Care	Dec 16	HCC	Building on the work of the MDT, dedicated social work will be undertaken within GP Practices offering Early Help and Active Recovery services and being a named care coordinator.		• Early identification of people most at risk of hospital admission • Number of people managed by a named care coordinator • Reduction of readmission to hospital

Scheme Objective	Rehabilitation	Scheme Agreed Spend	£12,103m	Ref	BCF - 3
	Build on existing service models and good practice to enable people to live independent lives				

Summary/Progress	Stakeholders	Performance Metrics		Links to 2014-16 Schemes
	• NHS Hull CCG • Hull City Council • CHCP CIC • Humber NHSFT	Number of people still at home 91days following hospital attendance/admission	91.9%	• BCF3 - Falls • BCF4 – Reablement & Rehabilitation
		Reduced number of residential admissions	-10%	
		Reduced number of injuries due to falls	-4.0%	

2016/17 Key Deliverables					Impact / Outcomes
Milestone	Due	Lead	Description	RAG	
D2A model in social care implemented	Jun 16	HCC	Develop the D2A service within social care to pilot, before phase 2 of integration.		• Improved supported discharge from hospital • Decrease of delayed transfers of care
Refreshed minor adaptations pathway	Dec 16	HCC/ CHCP	Review and refresh the minor adaptations pathway across the LA and providers to streamline and reduce and duplication.		• People receive timely minor adaptations to support independence
Refreshed Active Recovery (reablement) pathway	Oct 16	CCG	Review and refresh the active recovery pathway to ensure people are supported to live independently.		• Increased number of people offered reablement • Increase the effectiveness of reablement
Refreshed Falls pathway	Mar 17	CCG/ Humber	Develop the pathway to reduce duplication across the different levels of support and to increase referrals.		• Reduce the number of falls 65+ • Reduce hospital stay following a fall
Re-procurement of Social Care Reablement provision	Mar 17	HCC/ CCG	Through integrated commissioning tender the reablement health provision to integrate further with social care.		• Increased number of people offered reablement • Increase the effectiveness of reablement

Scheme	Rapid Community Response	Scheme Agreed Spend	£1,604m	Ref	BCF - 4
Objective	Embed integrated care pathways to provide a responsive service across public services that reduces demand on secondary care.				

Summary/Progress	Stakeholders	Performance Metrics		Links to 2014-16 Schemes
	• NHS Hull CCG • Hull City Council • Humberside Fire and Rescue Service • CHCP CIC • Humber NHSFT	Reduced non elective hospital admissions	-3.5%	• BCF3 – Falls • BCF5 – Ambulatory Care • BCF7 – Long Term Conditions

2016/17 Key Deliverables					Impact / Outcomes
Milestone	Due	Lead	Description	RAG	
Pathway from YAS to the Hull FIRST (falls pickup) service	July 16	CCG	Development of the pathway from 999 and 111 to mobilise the falls pick up service.		• Reduction in the number of people conveyed to hospital following a fall
Pathway from LifeLine to the community urgent care service for clinical triage and appropriate response (including Hull First)	Sept 16	HCC	Development of pathway for non urgent “non blue light” response from community alarm providers.		• Reduction in the number of people conveyed to hospital following a fall • Reduction in A&E attendances
Evaluation of the Hull FIRST service and effectiveness against outcomes	Mar 17	HFRS	Continue to Hull FIRST pilot and monitor outcomes.		• Reduce in the number of A&E attendances • Reduce number of people conveyed to hospital

7. Appendices

The following appendices are attached as part of our plans submission

Appendix	Title
1	Care Coordination Information
2	Adult Social Care Business Plan
3	CCG Operational Plan
4	DTOC Action Plan
5	Hull Better Care Scheme and Outcome Summary
6	Hull Better Care Dashboard
7	Section 75 Risk Sharing Agreement
8	Hull 2020 Workforce Summary & Gap Analysis