Updated November 2014

Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

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	**Hull City Council**
Clinical Commissioning Groups	**Hull Clinical Commissioning Group**
Boundary Differences	**Hull City Council and Hull CCG are coterminous**
Date agreed at Health and Well-Being Board:	**08/09/2014**
Date submitted:	**19/9/2014**
Minimum required value of BCF pooled budget: 2014/15	**£10582**
2015/16	**£21709**
Total agreed value of pooled budget: 2014/15	**£11382**
2015/16	**£29057**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Hull Clinical Commissioning Group
By	Emma Latimer
Position	Chief Officer
Date	19.9.2014

Signed on behalf of the Council	Hull City Council
By	Julia Weldon
Position	Director of Public Health And Adult Social Care
Date	19.9. 2014

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	Hull Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Colin Inglis
Date	19.9.2014

<Insert extra rows for additional Health and Wellbeing Boards as required>

c) 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**
Hull 2020 Strategic Plan	http://www.hullccg.nhs.uk/uploads/chronicler/document/document/101/Hull_2020_Commssioning_-_27-08-14.pdf
JSNA	www.hullpublichealth.org.
Hulls Joint Health and Wellbeing Strategy	http://www.hullcc.gov.uk/portal/page?_pageid=221,689965&_dad=portal&_schema=PORTAL
The City Plan	http://www.hullcc.gov.uk/cityplan

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Hull City Council (Hull CC) and Hull Clinical Commissioning Group (Hull CCG) are key strategic partners working together and leading on the delivery of a transformation programme for improvements to health and social care across the city. They serve a population of approximately 290,000 people and are committed to a collaborative approach to improving lives by optimising health and wellbeing within communities.

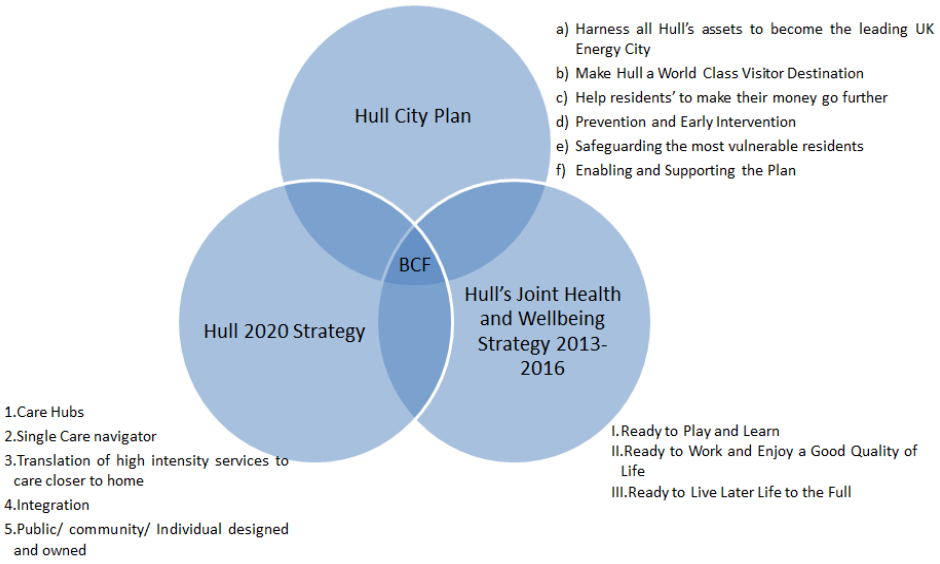
The local vision described within this plan represents our shared aspirations for Hull and provides us with the future state objectives and evaluation criteria to take the integration agenda forward. Individual case examples are presented to illustrate how this plan will look, feel and impact on both the people living in the City and the people working together to provide integrated health and social care.

Hull CC and Hull CCG, along with other public service providers in the City, acknowledge their collective accountability to ensure the best health and social care outcomes for the people of Hull.

Our vision is for whole system integrated care and to achieve this ambition we have taken care to ensure our planned Better Care Fund (BCF) outcomes have been aligned to the 3 interdependent strategies for the City;

- Hull 2020
- Hull's Joint Health and Wellbeing Strategy (2013-16)
- The City plan.

The following diagram shows the interdependency between the City of Hulls 3 major strategic plans and how our BCF plans sits within the centre to deliver some of the required changes through integration.



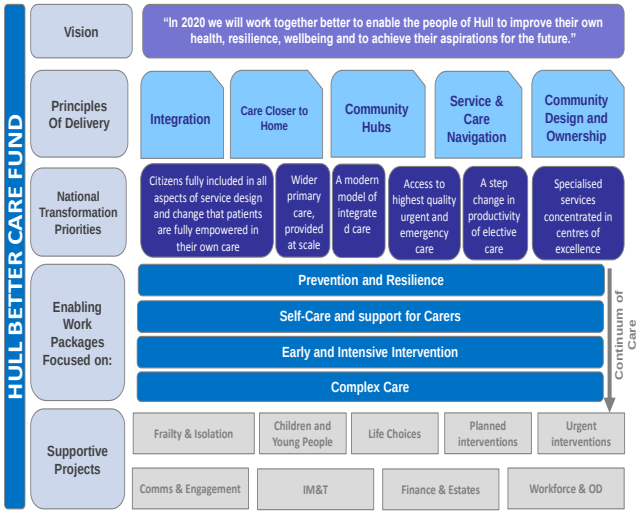
These 3 strategic plans bring together key partners from across the City who are signed up to an improvement programme that will influence the wider determinants of health such as housing and jobs. These local documents provide the blueprint for whole system transformation and reinforce a shared commitment to improve care, quality and access to resources.

The overarching transformational strategy within which our Better Care Plan sits is Hull 2020. The BCF is the delivery vehicle for the adult health and social elements of this large scale programme of work.

The Hull 2020 programme builds on the extensive health and social care commissioning activity that is already in place in Hull and broadens scope to include work with other public sector organisations such as the Police, Fire, Ambulances and local community service providers.

The Hull 2020 programme sets out the wider transformational agenda of all Hulls public sector partners who have committed to work together and lead on the delivery of healthcare commissioning and greater integration with social care. Hull BCF plan sits within the governance structure of Hull 2020.

The Hull 2020 programme of work and the local partner organisations committed to this approach is presented in the diagram below



The Hull 2020 vision is:

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

The defined outcomes of the Hull 2020 programme are:

- Clearly defined, equitable and quality 7 day services available on the basis of need
- People are aware of the services available to them, and confident that they can access what they need when they need it.
- Information is shared across public services to speed up and coordinate care and support and reduce duplication
- A single system that removes traditional organisational boundaries – enabled by integrated governance and partnership
- Making the best use of the available money in Hull public services, to meet the needs of local people.
- A workforce that is fit for the future to meet the needs of the population

Working toward this vision the Better Care Fund provides us with the opportunity to focus and progress our intentions to deliver a joint commissioning strategy for adults that will improve access to advice and information for local people, improve the quality of the care they receive and increase the choice and control they have over their lives through agreed objectives and pooled resources.

The Better Care vision and future state is described below;

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

It is our intention that local health and social care services will not look the same in the next 5 years. Health and Social Care organisational boundaries will be broken down to ensure that care is co-ordinated across different care settings.

There will be easier access to care at the point of need delivered in local communities. People will have more choice and control to enable them to stay in their home.

They will have the resources to self-care and the information to access coordinated care when required. People will understand their local services because they will be instrumental in the development and monitoring of how resources are utilised in Hull

Our Current State

Hull has a population of approx 257,000 people. Between 2010 and 2030, ONS estimate that Hull's population will increase from 266,100 to 311,900 residents, an increase of 17%.
It is a City with high levels of deprivation, associated poor health outcomes and a sharply rising population of older people. The NHS Hull CCG boundary is coterminous with Hull City Council – the Council being the 10th most deprived in the UK.
www.jsnaonline.org
Comparing Hull in terms of commissioning for value against the best 5 CCGs among a peer group of 10 we are ranked 7th with opportunity to improve quality, outcomes and spend in the areas of improved diagnosis, disease prevention and secondary care use.
www.rightcare.nhs.uk/commissioningforvalue

The development of our Better Care Plan has been informed by application of the following questions to inform our planning approach

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

The following table gives a summary of the BCF schemes that are presented in detail in Annex 1. The rest of this section explains the **problems** our City faces, the rationale for the areas of need that we have **prioritised**, the **progress** we will sustain and our **plans** for further improvement through **integration**.

BCF Scheme summary table

BCF1 Prevention- Community Hubs	Build community resilience by applying a coordinated approach to preventative actions through organisation of care in community hubs
BCF2 Primary Care and Self Care	Ensure a more proactive approach to disease management in primary care with introduction of the care coordination model and support for self care.
BCF3 Falls prevention	Embed an integrated falls pathways and network of prevention across the whole system
BCF 4 Reablement and Rehabilitation	Provide an integrated model of reablement and rehabilitation delivered from a single point of contact
BCF5 Ambulatory Care	Provide alternatives to admission for ambulatory conditions and the frail elderly
BCF6 Residential & Home Care	Provide more alternatives to residential care building on the extra care community hubs model
BCF7 Long term Conditions inc Dementia	Design a whole system of integrated care and network of support for people and their carers from self-care to secondary care
BCF8 Mental Health	Develop a fully integrated model including the transfer of staff and assets to provide a comprehensive range of services for people with functional mental illness

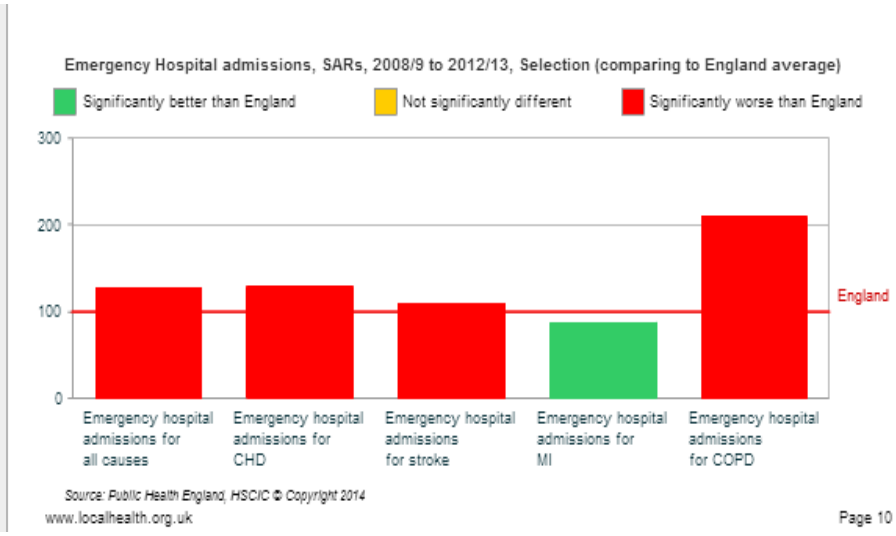
The Problems

There is a need to work with our communities to raise the expectations and aspirations of the people living in the city for better health and support and to capitalise on their own resources to self-care. This has informed the predominate scheme within our plan **Prevention and Community Hubs (BCF 1)**

The JSNA describes how the characteristics of Hull make it quite unique. No other geographical area is similar to Hull and although other areas may have characteristics that are comparable there is no area that shares a number of similar characteristics to Hull in terms of the City's population structure, ethnicity, deprivation, tight geographical boundaries, type of industry, type of housing and workforce.

The health of people in Hull is generally worse than the England average. Deprivation is higher than average and life expectancy for both men and women is lower than the England average. The local Health and Lifestyle Survey 2011-12 reports that 28% of adults in Hull have long-term illness or disability which limits daily activities.

Locally there is a heavy reliance on acute hospital based care. Hull is a national outlier in respect of emergency admissions the graph below shows the particular disease pressure areas of COPD and CHC admissions. We know that this reflects the heath needs of our population and this has informed our BCF initiatives specifically those aimed to improve the management of management of **ambulatory care (BCF5)** and **Long Term Conditions (BCF6)**



Examination of spend and outcomes information confirms that in Hull our areas of highest spend and worst outcomes relate to circulatory disease and mental health.

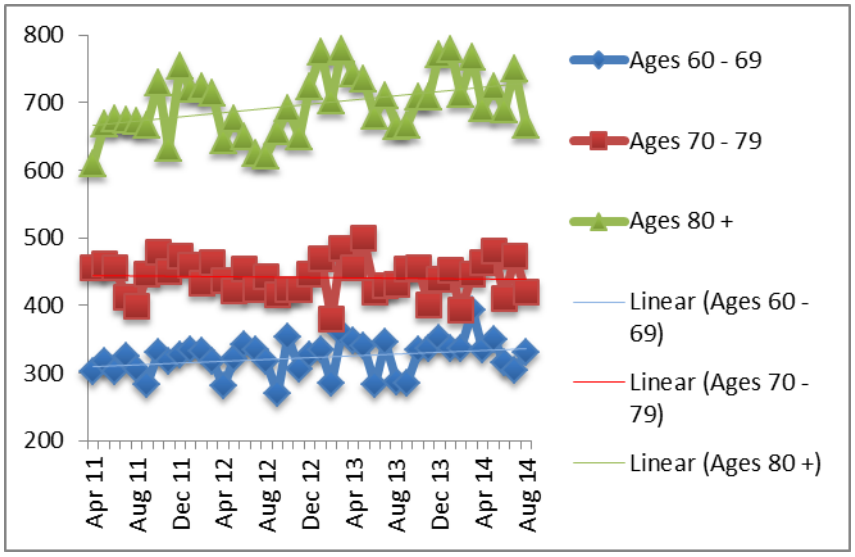
Work with our acute Trust, Hull and East Yorkshire Hospitals presents the full picture of a high volume case mix of elderly people presenting with heart failure and respiratory problems.

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 current pathway this group will present our greatest challenge in managing demand for hospital services. 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.

This demographic growth, low health expectations and disease linked to high levels of deprivation is the rational and local evidence base for our BCF plan having an initial focus on the needs of the elderly with schemes designed to improve **primary care intervention (BCF2) falls prevention (BCF 3) rehabilitation and reablement services (BCF 4) and long term conditions including dementia (BCF6)**

The following graph shows the growth to date in 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 compared with the previous year and on average there were 82 emergency admissions per month due to falls which has informed one of local metrics of reducing falls related admissions by 12% by 2015/16.

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

Analysis indicates that Hull CCG's estimated dementia diagnosis rate is 52.4% and the estimated prevalence for people with dementia is 3097. This identifies an estimated gap of 443 people who have not yet received a diagnosis.

The CCG has set a target to increase the numbers of people on Dementia regisers by 67%. The impact of the increasing recorded prevalence will require provision of more services for people and their carers but in turn it will result in people getting the right kind of support early.

In mental health services, it is widely recognised that people's health and social care needs are entwined and thus service provision is most effective when it is integrated.

Therefore In addition to concentrating our plan on the current reliance on acute secondary care our final scheme **Mental Health (BCF 8)** is designed to address the needs of our adult population of people who have a functional mental illness.

The next table consolidates our thinking in including all adult mental health services as a BCF priority. It shows how Hull CCG compares to the best 5 CCGs amongst a peer group of 10 for mental health care and demonstrates the opportunities to improve quality outcomes and spend in commissioning of mental health services.

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Indicator Name	Hull CCG Rank (11="worst")
Total bed-days in hospital per population for patients >74 years with a secondary diagnosis of dementia	9
Rate of admissions to hospital for patients >74 years with a secondary diagnosis of dementia	10
Mental Health - Improving access to psychological therapies - recovery rate per 1,000 2011/12 NB PER 100	10
Reported numbers of dementia on GP registers as a percentage of estimated prevalence	10

www.rightcare.nhs.uk/commissioningforvalue

The Priorities

The health and social care needs of the City have therefore determined the following priorities for our BCF plan

- Prevention/Community Hubs
- Primary Care and Self-care
- Falls
- Reablement and rehabilitation
- Ambulatory Care
- Residential care and home care
- LTC and Dementia diagnosis and management
- Mental health care

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 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

The Progress

The City does have a wide range of multi-disciplinary provision that is aligned but there is still much to be done to take these developments to the next phase; that for Hull is to

increase the scope and scale of services working together and finally progress to full integration.

We have designed the BCF plan to ensure that it will maintain and enhance what currently works well and continues to enhance the progress that has been made in managing the growth in emergency admissions to hospital and the reduction in permanent residential care placements.

We have enhanced mental health services in Hull and provide more alternatives to hospital admission including effective pathways for End of Life care. We have also through the use of reablement and social care funding improved the delivery of more integrated care designed around individual need.

Work to date has included commissioning integrated services to build capacity and develop the intermediate tier of care in the community with a multidisciplinary approach to reablement and end of life provision.

These services have focused on improving transfer of care from hospital and for many older and disabled people there is improved access to rehabilitation to increase or regain their independence. As a result we have sustained the number of emergency admissions against our population growth but need to take the scope of this work further to continue to do this and achieve the required reductions.

The Plan

As strategic partners Hull CC and Hull CCG realise it will not be enough to simply make incremental adjustments to existing services if we are to meet increasing demand and realise the full potential of integrated commissioning for our most vulnerable groups.

To ensure success we will integrate the commissioning of health and care services to realise the shared vision and commitment to provide seamless and sustainable health and social care services that local people want and need to lead healthier lives.

Without the Better Care Plan the risk is that we continue to be reliant on secondary acute based care as the default in a crisis and create more high intensity demand by not addressing needs sooner. With Better Care we have the opportunity to raise expectations and resilience from within our communities. Redefine our health and social care priorities and jointly commission services which provide pathways away from a crisis demand led response down a proactive outcomes based route to a system of delivery designed around need.

b) What difference will this make to patient and service user outcomes?

Patients and services users will receive the right care in the right place first time. They will be actively engaged in the co design of services that promote community resilience and will have care needs met and coordinated around community hubs. This will allow individuals access to a range of interventions that assess risk and support personal resilience to meet their aspirations and expectations.

Services will be easier to navigate and access 7 days a week. Professionals will share information and trust each other's assessments to transfer care. People will know who and how to contact a named professional who will work with them to coordinate care.

To date the needs of the community have developed with little co-ordination, which has led to a lack of clarity of what is available our plans will ensure care is organised in community hubs providing greater integration of services and early intervention.

Over the course of the Better Care Plan prevention and self-care will become the norm, integrated community teams will be empowered to deliver whole system care which result in acute episodes of care being effectively managed and people being supported to return to independent living.

These changes to the way services are delivered will be recognised and realised by mutli agency teams working to deliver a transformational strategy that focuses on organising a local system of care into 4 delivery models based on need

- **Prevention and resilience**
- **Self-care and carer support**
- **Early intensive intervention**
- **Complex multi care need**

The changes patients and services will see and experience are
:

- **Shift care from hospital to community, residential care to home care**
- **Care organised around Hubs**
- **Lead care professionals and care coordination**
- **7 day working**
- **Information sharing across organisational boundaries**
- **Whole system integration including commissioning**
- **Community owned, designed and delivered services**

The National Voices narrative of integrated care and support describes the understanding of an individual's experience of person-centred coordinated care and support.

Within our plan we have used "I" statements to illustrate what people will experience from the health and care system in Hull. By describing these experiences in a personal way we hope that people are more empowered to challenge the system if it falls short of what people describe as the outcomes they expect. We also aim to raise people's expectation of services by working with them to define their personal objectives.

We have designed all our BCF schemes to be measurable by service users based on outcomes that they can identify and measure their experience against.

Overall our subsequent services will be required to fit will the following outcome for individuals that our service users will measure their experience against;

> ***"I can plan my care with people who work together to understand me and my carer(s), allow me control and bring together services to achieve the outcomes important to me"***

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

The Better Care Fund will be used to invest significantly in an improved, integrated health and social care system, changing the way that health and social care services are funded to drive improvements. It will concentrate initially on services for older and disabled people and mental health care in response to those being our greatest areas of demographic and health and social care related need.

It will resource jointly commissioned health and social care services, shifting care away from hospital to home or community facilities, and promoting self-care and independent living.

It is expected that the secondary care sector will reduce as a result, and that staff in all acute and community services will work differently as we progress our plans.

There are 2 local strategic changes taking place over the next 12- 18mths that will deliver some of the reconfiguration and concrete change required to transform the current structure of health and social care for adults and create a range of services designed and specified around our joint strategic and commissioning intentions;

- Hull City Councils Adult Social Care Review – Redesign of the future delivery of adult social care in the City

- NHS Hull CCGs Community Services Procurement – Re procurement of the CCG current community services contracts across the City

Hull City Councils Adult Social Care Review

Hull City Council have initiated a review of adult social care services in order to deliver on a number of requirements:

- Quality and the modernisation of services, and the delivery of choice/personalisation
- Efficiency and effectiveness for those who are vulnerable and in need of support in the context of the financial landscape
- The Care Act 2014
- The drive for service integration formalised through the Better Care Fund
- Forecast demographic change and demand

Within the scope of the review is all the current in-house council provision for adult social care. This includes mental health community teams, older adult mental health, reablement services, day care, adult social work, case management and adult learning disability services. The review is currently in the targeted engagement and option development stage. The options will describe potential future delivery models for adult social care which could range from a new social enterprise, a jointly owned social enterprise, a wholly Council owned company, reengineered in house provision or a mixture of the above.

The outcome of the review and the eventual delivery model will have to move toward services that promote independence; choice and control to ensure value for money and align with the integration agenda.

NHS Hull CCGs Community Services Procurement

In June 2014, the NHS Hull CCG Board approved a proposal for the re-procurement of a range of community based services, currently contracted for on behalf of the population of Hull from a number of providers. The resource allocation for these services is within our Better Care Fund. The services have a combined annual value of around £30 million per year.

The re-procurement of our community services will need to meet the objectives of our commissioning strategy, particularly the key deliverables of our joint transformation programme, Hull 2020 and delivery of the Better Care Fund plan in partnership with Hull City Council.

This restructure and where applicable contractual change will be the initial enabler for changing the way services are organised and delivered over the next 5 years.

Our focus will be on contracting for integration and innovation, 24/7 provision, care closer to home and value for money services.

Our joint commissioning approach will specify

- Shift of care and resources from hospital to community, residential care to home care
- Care organised around Community Hubs
- Lead care professionals and care coordination
- 7 day working
- Information sharing across organisational boundaries
- Whole system integration including commissioning
- Community owned, designed and delivered services

The reconfiguration and joint commissioning of services will be within the following key principles for change

- A single system of integrated governance and partnership
- Empowered and skilled health and social care workforce who are positive about their role and supported to improve the care and treatment they provide
- The best use is made of the whole public service £, and funds that are community earned/community owned
- People will be living safely and independently in the community and have control over their care and support
- Informed, educated and consequently engaged public who are empowered to drive their own outcomes
- Informal carers are supported to maintain their own health and wellbeing
- People choose what, where and when they access services

Unplanned care services will be transformed to ensure that services are able to respond rapidly to unplanned care needs, across a range of environments, patients will be supported by a new more cost effective model rather than the traditional system based around hospital care.

The majority of care for the elderly will take place within their own home and in community settings with hospital interventions planned when more specialised acute care is clinically appropriate.

Planned / elective care services will be streamlined to bring about efficiencies and improvements to clinical pathways, to deliver more productive elective care, which will improve services and free up the resources to be used for the Better Care Fund.

Key Deliverables

Community Hubs
Services will be reconfigured and delivered from community hubs. This model of care and support will provide a single function for individuals in a geographic location to access services being provided in their community. This will build on existing services in place currently being provided by the local public sector agencies (Council, Health, Police and Fire) as well as voluntary and third sector organisations. Together these partner agencies will work to reduce duplication and combine resources whilst generating resilience within communities to co design and develop services around need.

Extra Care Housing

Extra Care is a subsidiary of the Housing Strategy and sets out how Hull CC aims to provide increased personal choice for adults who need support through development of Extra Care housing delivered by new build and conversion.

Currently, for those with high level support needs who cannot continue to live independently the only alternative is residential care, on which the City is over-reliant. The other main option for older people is sheltered housing but the local stock is variable in quality, with some schemes of poor design. Even the better quality stock is only suitable for older residents with low to medium levels of support needs and is, in any case oversubscribed.

Increasing provision of extra care is expected to reduce reliance on residential care by providing a viable alternative for all adults with support needs. 300 Extra Care apartments on 3 sites are planned for delivery in 2016 as an alternative to sheltered housing and increasing personal choice. Extra Care will be instrumental in providing the range of accommodation needed to support delivery of the BCF plan and community hubs.

Care Coordination

One of the main changes and a model that will be specified in newly commissioned services is care coordination.

Care co-ordination will be allocated from within the 4 groups of the delivery model;

- Prevention and resilience
- Self care and carer support
- Early intensive intervention
- Complex multi care need

Hull has introduced the use of a risk profiling tool in primary care **RAIDAR** to identify people at risk and in need of care coordination. Its implementation and development in primary care will signal access to self-care programmes appropriate services and allocation of the care coordinator role

Care provision may flow up or down the continuum of the delivery model dependent on need

Multi-disciplinary teams will be aligned to provide rapid intervention, transfer care and offer alternatives to admission

Well established expert patient programmes will be in place and a focus will be to engage more people in the most deprived communities giving them the confidence to make small changes, see benefits and feel better, become healthier or reduce risks and raise their expectations of better health outcomes.

The following case studies describe how the delivery model will be applied to individual care.

Case Example – Prevention and Resilience

Marianne *is a frail 80 year old with dementia. She lives with her 85 year old partner, Bert who is her main carer and wants to continue caring for his wife without people 'interfering'. No family members live nearby except for Bert's younger sister. Bert and Marianne's son who lives in another City wants to ensure that his parents stay together; in their own home if possible, as this is what they have always said they wanted.*

Bert doesn't want his son to contact the GP; he doesn't want people in his home or for them to see how much Marianne has changed. Bert has been fearful about what might happen if other people were to get involved, he refused help when Marianne was first told she had dementia and back then they could cope.

One day after she was very restless and tried to leave the house in the early hours of the morning. Bert's feels he is losing patience with Marianne's changed behaviour she is more restless and no longer recognises him. After a very difficult day Bert decides he can no longer cope and calls his GP at 4pm on Friday

Outcomes for Marianne and Bert	Better Care Services
To be able to stay at home where she feels safe	A **Care Coordinator** acts for the family – someone who knows the situation so they don't have to repeat their story and can arrange care around them. There's a 7 day hospital at home service accessible via the local community hub (Geriatrician and Community Psychiatric Nurse) available out of hours through a single access point to assess for delirium and provide any treatment within the home.
To feel calm and well again	Dementia cafe and care groups are accessible in the Community Hub. Bert and Marianne feel part of their community since the city has developed dementia friendly communities. Access to pharmacy supplies is available out of hours, to ensure medication can be provided as soon as possible. Access to psychological support services will also be available, to ensure longer term psychological needs are assessed and addressed
Bert and his son feel able to cope	Overnight care is provided by suitably experienced home care staff to provide extra support for the family carers. The family is also directed to the local carer's information and support service at the community hub for extra help and support over the longer term.

The family have a plan for the future and confidence that if there is a crisis, they will get the help they need	A Lead Care Professional keeps in contact with Marianne and Bert and a care coordinator ensures their personal outcomes are met. The Lead Care Professional will also complete an advance care plan, recording all decisions on the care and support provided and any longer term care needs, such as psychological support. Their GP also works as part of the MDT supporting the family and they are well informed and involved in decision making.

Case Example Self-Care and Support

Dorothy *is now 68 years old and lives alone in sheltered housing and has family who live nearby and a number of friends who support her.*
Dorothy is getting a bit unsteady on her feet and has had a few falls at home, her family have noticed, and Dorothy agrees, she is a bit forgetful at times but she is very much in control and wishes to retain this independence
Dorothy has a history of urinary tract infections. Recently she had a fall resulting in a head injury but did not lose consciousness and used her lifeline to raise the alarm. The wardens called for an ambulance. Dorothy was taken to A&E.

Outcomes for Dorothy	Better Care Services
To get out of hospital as soon as possible return to her own home To receive regular therapy to continue recovery and be fully independent again.	**Assessment & Discharge Planning on an ambulatory care basis.** An outcomes based assessment is begun on arrival in the frailty area of the ambulatory care service. She is clinically assessed by a geriatrician and her medical needs met. A Multi-Disciplinary Team in reaching into the ambulatory area are involved from the early stages to ensure relevant information about Dorothy is available to support her recovery. Dorothy is confident that health and social care professionals have the latest information about her condition and that if she feels unwell she knows she has a plan in place to go home with and will be followed up the next day by the a care coordinator. **Housing and aids** Rapid assessment by the community team is carried out to establish whether she can go home with rehabilitation, her Housing Scheme Warden and Occupational Therapy are fully involved from the outset to ensure any equipment or adaptations required are in place in liaison with the falls service.
To be in control of her future	**Voluntary Sector contribution** Links are made with local voluntary organisations that can provide support and companionship for her when she returns home. Her GP recommends a social prescription and Dorothy is given a 6 week programme of activity based on her

	interests. It includes joining physical activity, singing groups and a lunch club. Dorothy is beginning to feel more confident and that she can manage now and in the future as if she needs help or advice she knows who to ask and that it will be readily at hand

Case Example Early and Intensive Intervention

Catherine *is 58 and has been living with multiple sclerosis for many years. Catherine has home care staff visiting 3 times daily to help her with personal care and housework. She manages shopping and bill payments on line. Her support plan also includes a visit to a day centre once a week. Catherine is starting to show signs of clinical depression. Family and friends call in when they can but she often feels quite alone and anxious about her future and how long she will cope as her physical health is deteriorating.*
Catherine was provided with equipment to help her around the home, a further OT referral was made some time ago but things are getting more difficult – she cannot easily get upstairs and is finding she can't get to the toilet in time. Last week her carers noticed a significant change; Catherine was increasingly tired and listless and her sight is deteriorating. Her GP visited her and changed some of her medication but Catherine made a mistake with her tablets and took too many, her home care worker called the pharmacist who gave her advice.

Outcomes for Catherine	Better Care Services
To stay in her own home with the carers who understand her daily routines	Provision of a full medical assessment in the community with care plan and follow up treatment and support. Integrated Community rehabilitation service review her needs and work alongside adult mental health services to address her physical and mental health as an MDT. Catherine is offered the option to stay in her home with a more intensive package of support and have major adaptation of her home or move to an extra care tenancy.
Have contact with family, ensuring they are involved in care.	She chooses to move to extra care tenancy and the Care Coordinator works with the family to ensure transfer of care and house move takes place.
Not feel so isolated and have more things to do at and away from home	This helps the family to support Catherine and services and a programme of activities is available on the extra care site
To feel well, and have more energy	The accessible facilities in extra care provide Catherine with the ideal built environment. Her health and mental wellbeing improves and she feels more independent and in control. Catherine is risk profiled as being at risk of hospital admission and contributes to her care plan with by her GP and understands the key contacts and services that are in place if she feels unwell.

To be more in control and independent	Telecare is in place to keep her feeling safe and independent, the IT available ensures Catherine can contact her daughter and her friends as often as she likes
To have a Care Coordinator - one person who knows her well and will coordinate care making sure personal outcomes are met.	**Advance Care Plan** A Lead Care Professional is allocated permanently to ensure that a relationship is built, and she carries out a full personal outcomes based assessment. This assessment, along with the initial medical assessment and plan is included in the advance care plan to ensure future care needs are addressed quickly and effectively.

The following diagram depicts how the full complement of Better Care Services will respond and wrap around the service user across the whole system.

An agreed plan of care is in place to manage disease progression. People have a choice of local services accessible form a community hub, their coordinator supports and accesses additional support e.g. respite whilst the Lead Care Professional monitors health and changing needs

A single care plan is in place equipment has been provided with support that allows care and health conditions to be managed on a daily basis. Information and advice is clearer and professional support is available as and when needed. People and carers feel in control.

7 day working , care is more consistent and if a crisis or unplanned care is required it is easy to access, people receive help in their community and avoid admission to hospital and care homes with the help of staff who are well informed, clear about their roles and work together

When circumstances change people are reassessed. They each have a care coordinator whose role is ensuring that support is available to people in their communities. People have access to the Lead Care Professional particularly in difficult times.

Communities provide more practical help in Community Hubs e.g. volunteer drivers to get people to community out patient's appointments. Social prescriptions are issued for a good range of activities, reducing isolation, improving health and well being Dementia friendly communities are developing, so people with dementia and carers can participate and contribute, Bert and Marianne feel well served in local shops and services.

GP and surgery staff work well with community services; one worker is nominated to coordinate our care which is set out in a single care plan. Single patient and care records, as they become available can be accessed by the individual and used by their clinicians and care staff to ensure we only have to tell their story once. We know we will have continuity of care and support, seven days a week, even if hospital admission is needed

Homes are adapted with various simple aids around the home much more quickly with less risk of falls. Waits for major adaptations to homes are reduced; with extra care housing offering choice and more options for disabled. Care hubs contribute to improving specialist care

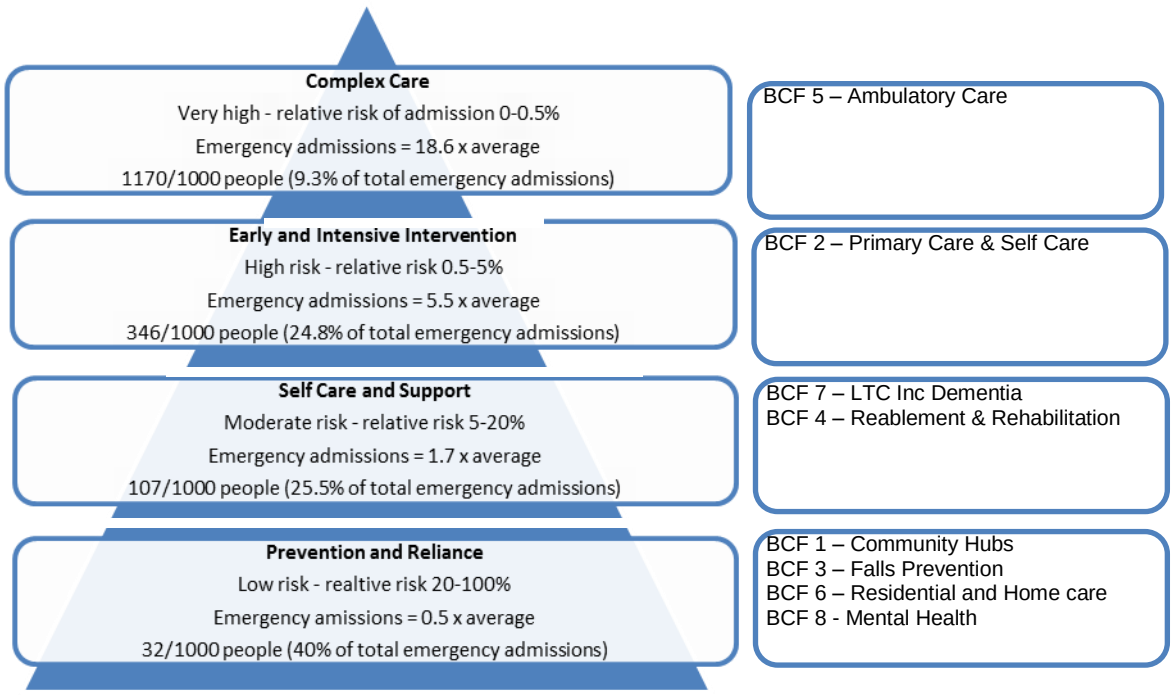
The Therapy services team (with social work, nursing, geriatricians and pharmacy support) provide both early, focused and intensive care and support. Advanced care planning is enacted by coordinators when needs dictate more support is needed. GPs remain involved when a patient is in hospital to add support and assist discharge

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

As our integrated models of care become increasingly centred on prevention, self-care, early intervention and complex care the systems that finance care will have to shift accordingly. Incentives will be needed to promote early detection, diagnosis, rehabilitation and integration, which will in turn need to be balanced by a reduction in the incentives promoting hospital based activity.

To inform and understand our population needs and focus our initiatives in the right areas the Wennberg Model below has been applied to Hulls population and the BCF Schemes



Rates of emergency admissions by different risk patients (based on Wennberg et al 1996). Percentage of all emergency admissions is equal to the relative rate multiplied by the size of the population group.

The local interpretation of the Wennberg model (Table 1 below) demonstrates that in Hull there are **13,601** non elective admissions that could be saved by focusing on supporting prevention, self-care and early intervention. This is a comparison of 2012/13 Non-Elective admissions of **31,828** to the Wennberg modelled activity **18,227** based on population size.

The model provides a useful baseline for assessing the impact of any change on hospital services and the potential to shift the cost of admissions with associated integrated schemes.

The Kings Fund highlights evidence to support a focus on reducing the rates of hospital admissions through active management. Within the recommended evidence (Tian et al 2012) note that the rate of hospital admissions in the most deprived areas like Hull is more than twice the rate of the least deprived areas in England. The Wennberg Model demonstrates that opportunities to transform the system do not always rest with the high risk patients or the 5% of people at high risk of admission. Focusing on supported self-care, wellness and prevention can realise more benefits in terms of shifting the reliance on hospital care and achieving better health outcomes.

Its application demonstrates the benefits of focusing effort on particular populations of a local health and social care economy rather than concentrating services on patients at high risk of admission. The Wennberg model assumes a population average of 63/1000 and breaks this down into tiers of care and the numbers of people admitted from those cohorts.

In Hull the majority of previous work has concentrated on the patient at high risk of admission and those already well known across our systems. However there is evidence that continuing to sustain this demand will not be sufficient to cope with a growth in demand and no growth in resources. The Wennberg model shown below has been applied to the population of Hull (Table 1) to inform the initiatives within of our Better Care Fund.

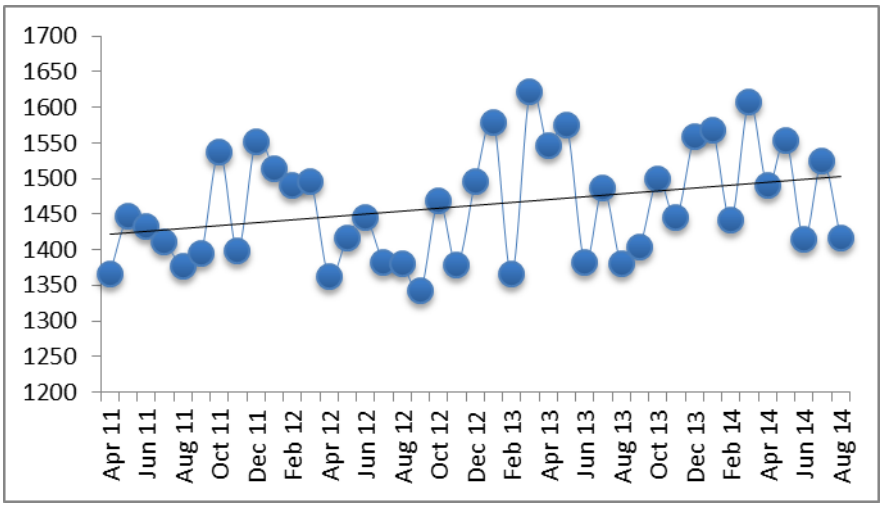
Table 1

Hull Population 289,000					
Relative Risk		No. in Hull (all ages)	Rate of emerg. adms per 1,000 *	Predicted adms (all ages)	% of total emerg. adms
Very high	0.50%	1,445	1,170	1,691	9.3%
High	5%	13,005	346	4,500	24.7%
Moderate	20%	43,350	107	4,638	25.4%
Low	100%	231,200	32	7,398	40.6%
TOTAL		289,000		18,227	100.0%

*Proportions based on the Wennberg Model. (Wennberg D 2006) Kingfund

The Combined Model was developed on a total population of 560,000 patients from two PCTs using three years of hospital data (April 2002 – March 2005), including inpatient (IP), outpatient (OP), and accident and emergency (A&E) attendance data.

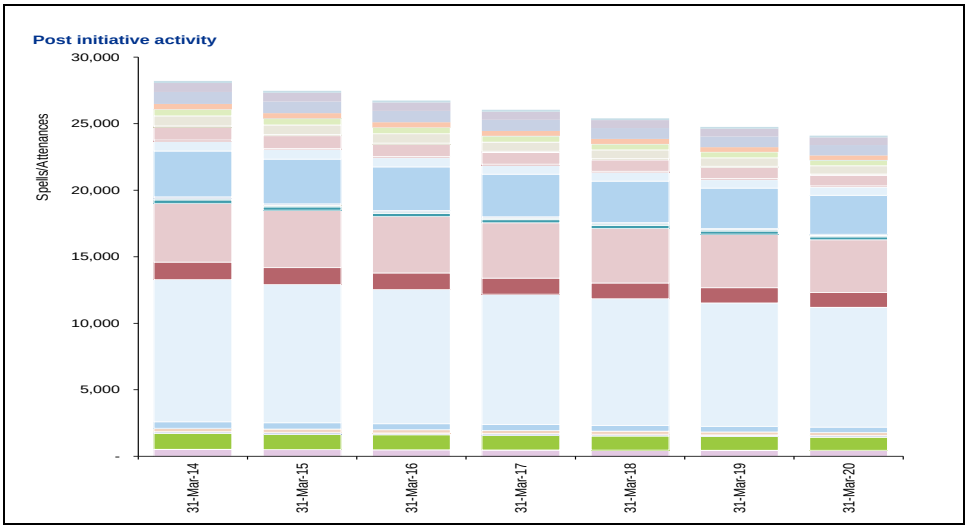
The following graph shows that despite managing admissions against our population growth the recent trend for all emergency admissions is steadily increasing.



The BCF initiatives described in more detail in Annex 1 have been designed to achieve a sustained trajectory of reduced emergency admissions over the course of the BCF by focusing on the broader outcomes that can be achieved by supporting self-care, resilience and prevention for our growing older population. This is the rationale **for BCF1 (prevention and community hubs)** being the overarching initiative and the one that all the other schemes contribute to and have an interdependency with.

With this analysis in mind our plan will continue the work underway to concentrate on our high volume high risk people in the first phase of our **primary care ,ambulatory care initiative and falls schemes (BCF 2, 3 & 5)** and initiate the longer term work to achieve sustainable change by ensuring an equal focus on the populations in the moderate to high cohorts to reduce those admissions **(BCF 1,4,6,7,8)**

This graph below shows the potential impact of the BCF on all adult emergency admissions for all specialties over the course of our plan.



4) PLAN OF ACTION

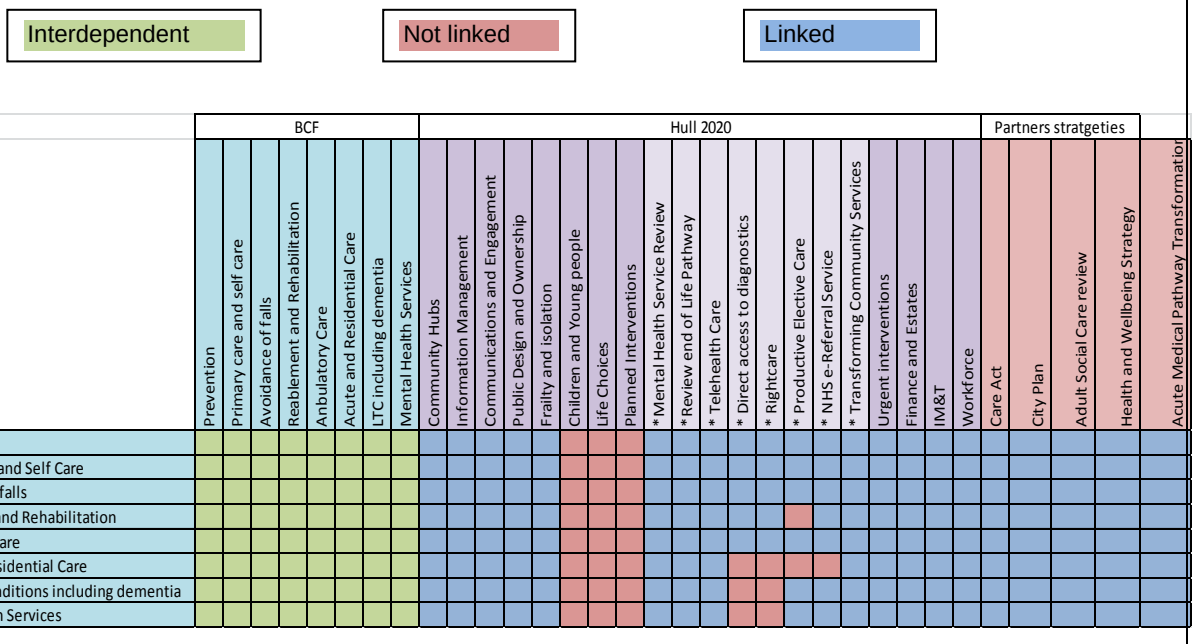
a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

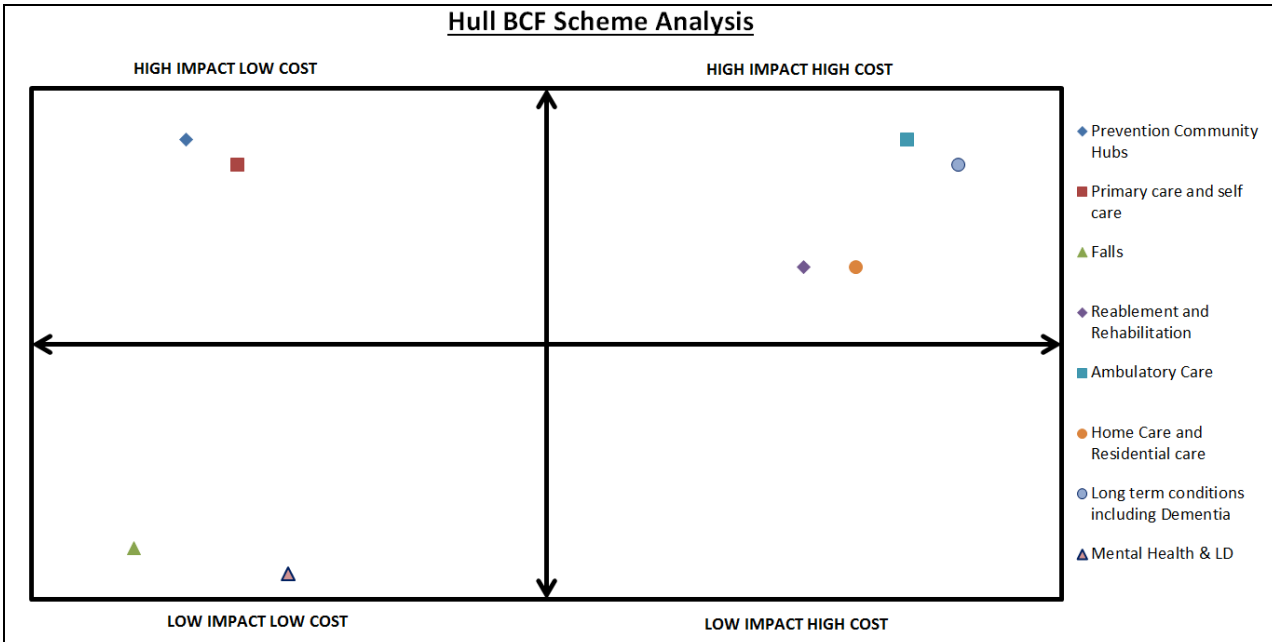
The BCF programme plan is attached for reference and contains the key milestones for the overall plan and each of the schemes.

As previously noted Hulls Better Care Plan captures the transformational work underway across the City as part of the Hull 2020 programme and ensures that initiatives that are starting to have an impact are sustained and that other relevant public sector initiatives to meet the needs of the population are coordinated and aligned to maximise effect and optimise impact.

There are also strong interdependencies with the agenda of the local acute Trust provider and their transformational plans for the acute medical pathway. The work in this area is reflected within **(BCF5) our scheme on ambulatory care** and has informed our decision to align this work in order to address the activity associated with the current cohort of patient's presenting to hospital whose needs might have otherwise been met on an ambulatory or frailty pathway.

The BCF is also interdependent with and purposely aligned with the Hull and East Riding System Resilience Group (SRG) and its objectives. This is a multi agency group of health and social care stakeholders who steer work on the planned and unplanned interventions in Hull to ensure the operational capacity of Hull and East Yorkshire Hospitals. This hospital is our main acute provider and where the majority of acute care takes places for Hull CCG and Hull City Council. It is the SRG that will steer and performance manage the work to achieve a reduction in A&E attendances, emergency admissions and optimise patient flow by working with the CCGs and Councils to reduce delayed transfer of care. The following chart shows the BCF schemes and their relationship to other key work streams





The overall impact of the eight schemes for 2014/15 only has been plotted above and detailed by scheme below.

The Hull BCF schemes detailed in our programme plan are described in Annex 1 a high level summary of each scheme with key milestones is presented in the following tables.

BCF 1 Prevention – Community Hubs

Build community resilience by applying a coordinated approach to preventative actions through organisation of care in community hubs.

BCF Actions	Milestone	Interdependency
Work with people in their communities to design, develop and produce improved community, health and social care services that promote wellbeing and more active lifestyles	Community hub prototype planned for October 2014	Hull 2020 Community Hub pilot Frailty & Isolation Adult Social Care Review Community Re procurement BCF 2 & 5
Evaluation of care coordination pilot in Community Hub with participating GPs	April 2015	
Progress work to achieve Dementia friendly communities and 'Making Hull a place to remember' contributing to the work for City of Culture 2017	Progress rollout work of Dementia Academy 2014/15	
Reduce loneliness and improve well being for older and disabled people, with use of social prescribing and befriending schemes as part of our actions to reduce social isolation and low mood in vulnerable people	Workshop arranged and delivered in October with local stakeholders. Development of strategy included within BCF 1	
Active lifestyles and a healthier Hull be more active and play a greater part in their communities – volunteering, taking part in activities that maintain health and wellbeing	Working with the Older People Partnership Board 2014/15 a series of events and consultation took place in October to inform active lifestyles objectives.	
Falls prevention pilot initiated in Community Hub Pilot	October 2014 Evaluation April 2015	

BCF 2 Primary care and Self Care

Risk profile at risk populations, allocation of care co coordinator role. Reducing demands on statutory health and social care services

BCF Actions	Milestone	Interdependency
Implement proactive risk stratification in primary care to identify people at risk of disease progression and management of people with a diagnosis more proactively.	Risk tool in place reviewed October 2014	Hull 2020 Community Hub pilot Frailty & Isolation Adult Social Care Review Primary Care Co - Commissioning
Building on current risk profiling work and incorporating the requirements of the new proactive care programme in primary care	All GP practices signed up in August 2014 Assessment of number of care plans in place by October 2014	
Promoting and extending self care for people with long term conditions.	Capacity building on existing schemes in place by April	
Telecare and telehealth provision – promote its use and rollout	900 people being monitored by March 2015	
Developing the care coordinator roles and improving access and quality of information available about services available specification written and to describe lead professional role	Specification written Pilot and evaluation complete by April 2015	

BCF 3 Avoidance of Falls

Embed an integrated pathway and network of support across the whole system from self-care to post episodes of secondary care.

BCF Actions	Milestone	Interdependency
Pilot the new Falls prevention proposal within the first community Hub	Jan 2015	BCF1 Hull 2020 Frailty and Isolation SRG plan
Review current service, redesign current pathways in line with NICE guidance	March 2015	
Increase use of community medicines reviews	December 2014	
Include visual review as part of level one falls service	April 2015	
Develop cross sector Intervention programmes	April 2015	

BCF 4 Reablement and rehabilitation

Build on current service model and associated performance framework and reduce waiting times

BCF Actions	Milestone	Interdependency
Develop and deliver a single point of contact across health and social care, review current entry points, triage assessment and internal referrals over 7 days	Integrated model in discharge hub incorporating discharge to assess by April 2015.	Adult Social Care review BCF1 Hull 2020 Frailty and Isolation SRG plan BCF2 BCF3 BCF 5 BCF6
Review current therapy and rehabilitation services to inform plans for integrated teams	Complete By April 2015	

BCF 5 Ambulatory care

Reducing reliance on acute care

BCF Actions	Milestone	Interdependency
Evaluate current ACS pathway development with Hull and East Yorkshire Hospitals	April 2015	HEYT medicine transformation plan Hull 2020 Frailty & Isolation SRG plan BCF1 BCF2 BCF3 BCF7
Commence the new Ambulatory care and Frailty pathways at Hull hospitals	December 2014	
Progress the current pathway work on COPD, Frailty and Heart Failure to a wider disciplinary model. Extend to Falls and Syncope.	April 2014	
Introduce a community model, modelling activity to inform development of a community ambulatory care facility and the plans for a community ambulatory facility in the east of Hull	April 2015	

BCF 6 Acute and residential care

Developing home care in the community hubs

BCF Actions	Milestones	Interdependencies
Progressing the extra care models of delivery	300+ units by 2016	Adult Social Care review Hull 2020 Frailty and Isolation SRG plan
Developing home care hubs into sheltered housing schemes	March 2015	

Consult on existing services and trail new approaches to support people in their own homes to support developing ambulatory care in community settings	April 2015	
Review and develop specification and jointly commission home help services by	September 2015	
Developing / review existing policies to facilitate integrated working including • Moving and handling • Medicines management • Promoting continence and management of incontinence	by April 2015	
Review current End of Life pathways	by October 2014	

BCF 7 Long term conditions including Dementia

Design a whole system of integrated care and network of support for people and their carers from self-care to secondary care

BCF Actions	Milestones	Interdependencies
Care navigator role for Dementia locally define and agree option for a pilot	By January 2015	Adult Social Care review BCF1 BCF2 BCF3 BCF4 BCF 5 BCF6 BCF8 Hull 2020 Frailty and Isolation SRG plan
CANTAB dementia screening IPAD in all practices	end of December 2014	
Develop the operational model for the multi disciplinary support to care hubs	by April 2015	
Developing the use of health and personal budgets and explore efficiencies/ effectiveness of joint processes	June – September 2015	
Jointly commissioned outcome based contracts to ensure lead provider / collaborative work is developed between public and third sector	September 2015 – March 2016	

BCF 8 Mental Health Services

BCF Actions	Milestones	Interdependencies
Develop a fully integrated model including the transfer of staff and assets to provide a comprehensive range of services for people with functional mental illness.	Process concluded September 2015	Adult Social Care review Hull 2020 Frailty and Isolation SRG plan BCF1 BCF2 BCF5 BCF6
Draw up a joint health and social care service specification under a section 75	January 2015	
Select a model that future proofs services and jobs by building in adaptability and flexibility The review will commence in the autumn (September/October 2014	March 2015	
The mental health work is focused on functional mental health for the 18+ age group with no upper age limit Redesign of service pathways and service specifications Reducing some of the reliance on adult mental health beds in the service Identification and development of community services. Make appropriate contract changes	Complete September 2015	

b) Please articulate the overarching governance arrangements for integrated care locally

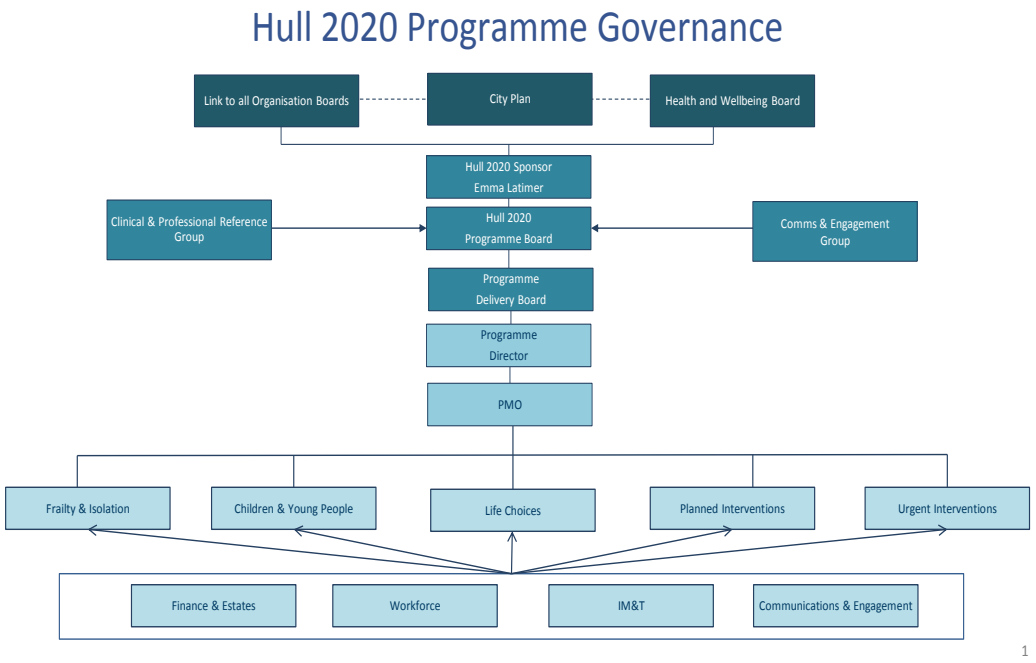
Delivery of the BCF for Hull requires a robust governance structure that transcends organisational boundaries. Hull has begun to operate in this way through The Health and Wellbeing Board which will provide assurance against the plan. The objectives of the Health and Wellbeing Board reflect the joint commissioning intentions of the CCGs and the local authority.

In addition to this the CCG and LA have established the Hull 2020 Programme Board. The Boards main objective is to establish cooperation between city wide partners in order to bring together individual strategies, drive forward purposeful development and the implementation of a single vision. This Board will provide the overarching governance and accountability structures to support integrated care. This is the level at which the strategic issues will be dealt with.

The Hull 2020 Programme Board will provide the strategic oversight of the Better Care Fund initiatives to ensure alignment of the plan with wider transformation ambitions for the City.

The Joint Commissioning Executive Forum will provide the joint accountability for the BCF Steering Group and seek assurance from the group on delivery of the programme.

The following diagram depicts the Boards Governance Structure



A memorandum of understanding between all the partners working as part of Hull 2020 has been developed to ensure joint accountability for delivery of the City's overall plan.

Principles of Partnership working;

- Partnership organisations will work collaboratively and support each other over the period of transformation.
- Individual members will ensure the Hull 2020 strategy is aligned with their own organisations strategies and business development plans.
- Partners will be open, transparent and act in good faith to each other.
- Partners will work in the interests of the population of Hull rather than current organisations and look to make all decisions on a 'best for Hull 2020' basis.
- Open, straight and honest communication, understanding and respecting other people's perspectives within the Participants and with all key stakeholders. As

far as possible commit to try and resolve all issues within the Participants.

- Partners will commit their resources appropriately to support a timely delivery of the agreed programme objectives.
- Recognition that this is an iterative programme.
- Partners will use their influence to support the Hull 2020 programme

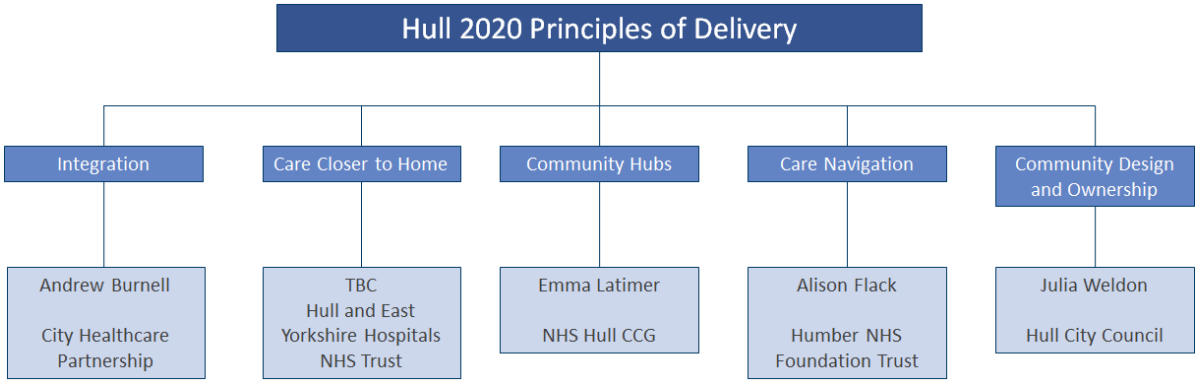
The Boards terms of reference are to;

- Provide strategic leadership and direction to the transformation agenda, with focus on advocacy for an integration model
- Ensure alignment of major strategic plans (e.g. Better Care Fund, East Hull Community Facility, City Plan)
- Consider the potential impacts of the strategy on the wider population of Hull and ensure that wellbeing is at the forefront of all planned developments
- Consider reports on proposed models and strategies with regard to: sustainability, affordability, effective use of existing estate, risks, patient access, compliance with national guidance, achieving good patient outcomes, impact upon workforce
- Ensure all partnership organisations work collaboratively and support each other over the period of transformation
- To ratify the Programme structure and to approve the resources required to deliver the Programme
- Ensure the strategy is aligned with, and optimises the benefits of, Hull 2017: City of Culture initiatives
- Work strategically to navigate change through the political environment and be advocates for the vision within partner organisations
- Maintain pace of delivery and development through strategic guidance and intervention where required
- Offer constructive challenge where proposed approaches lack sufficient innovation
- Operate within legal and statutory requirements for all partnership organisations

The Hull 2020 Board is the place that strategic issues relating to transformational change are addressed with the Hull joint commissioning forum supporting joint commissioning

decisions that are ultimately signed off at the Hull Health and Wellbeing Board.

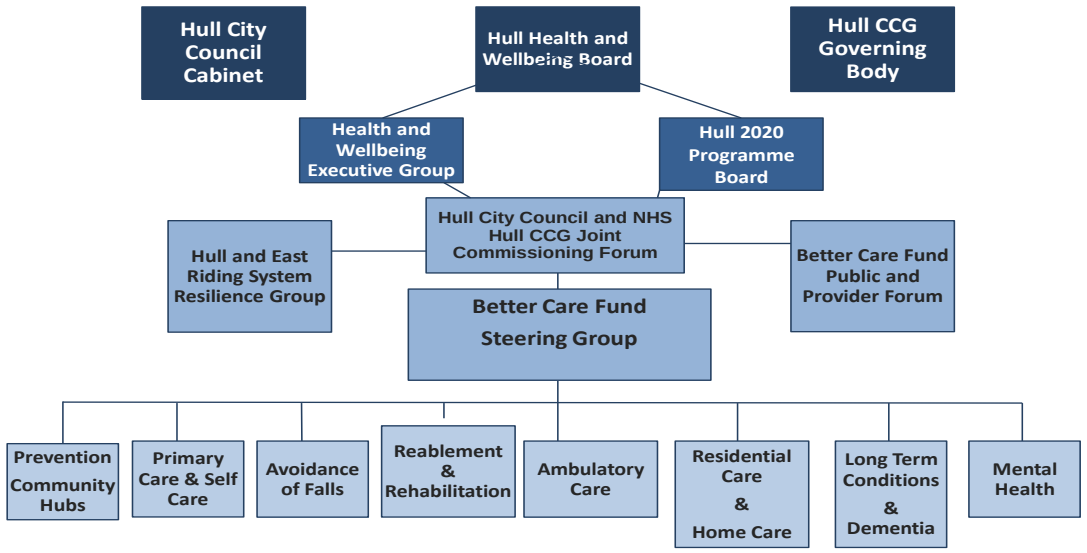
The Hull 2020 principles of delivery are set out below with named local executive officers as the accountable leads



The Hull 2020 work streams provide the operational and implementation groups responsible for the delivery of the required changes the BCF initiatives report into the Frailty and Isolation work stream and the required infrastructure changes are being driven and supported by the Hull 2020 enabling work streams of IM&T, Estates and Finance, Workforce and Communications and Engagement.

Joint Commissioning Executive Forum

The decision making and forum for developing joint commissioning proposals will take place with the Hull City Council and Hull CCG Joint Commissioning Executive Forum. Recommendations and decisions that need ratification will be taken from here through each organisations governing bodies and ultimately to the Hull Health and Wellbeing Board for reporting for Better Care sits below the Hull 2020 programme structure and is shown below



c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

Hull 2020 programme Board provide the strategic oversight of the Better Care Fund initiatives to ensure alignment of the plan with wider transformation ambitions for the City the Board track progress through a programme management approach with a dedicated programme office. Any slippage or barriers to delivery of associated work streams will be escalated here.

The statutory responsibilities of the BCF and governance of the financial elements of the plan are overseen by the HWBB Executive Group with the Joint commissioning forum and BCF steering group reporting in for sign off on the use of resources and performance reporting against BCF metrics. Financial and performance issues will be escalated here.

The operational management oversight is provided jointly by the Assistant City Manager for Hull CC and the Strategic Lead for Planning and Integration in Hull CCG.

4 BCF project officer posts have been jointly funded and will sit within the council and report into the BCF steering group on project delivery and the progress of the programme plan. Any slippage and exceptions will be escalated to the Joint Commissioning Forum.

A Better Care Provider Forum that will include public representation is being established as part of the local consultation and engagement arrangements. This will be a forum information sharing and for providers to raise concerns.

Health watch are acting as our strategic partners on public engagement and accountability.

The Hull BCF steering group take full advantage of the regional group learning and pioneer sites to ensure external review and critical friend support.

Our assurance processes comply with the expectations of the LGA and NHS England.

A programme management methodology to delivery will ensure a robust approach to scheme delivery. Risks and exceptions to programme delivery will be taken to the BCF steering group and any change of controls or mitigation will be escalated to the Joint Commissioning Forum. Issues that cannot be resolved in that forum will be taken to the joint executive of the HWBB for ultimate decision making and adjustments to programme milestones will have to be agreed by the Hull 2020 Board.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Our programme plan and performance dash board are attached for reference

Ref no.	Scheme
BCF 1	**Prevention – Community Hubs**
BCF 2	**Primary care and Self Care**
BCF 3	**Avoidance of Falls**
BCF 4	**Reablement and rehabilitation**
BCF 5	**Ambulatory care**
BCF 6	**Residential and Home Care**
BCF 7	**Long term conditions including Dementia**
BCF 8	**Mental Health Services**

5) RISKS AND CONTINGENCY

a) Risk log –
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 and any financial risks for both the NHS and local government.

The BCF Risk Log is RAG rated in terms of the severity of the risk. Reference to the level of risk sharing and discussion with key stakeholders is described in mitigating actions.

The Hull BCF high level programme risk are presented below the project/scheme levels risk are presented in the programme plan.

The risk log and risk plan will be owned and monitored monthly by the BCF steering Group with issues escalated to the joint commissioning forum.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions & Stakeholder Discussion**
1. Managing the transition of shift of care across care settings whilst the schemes are in development	4	4	16	Programme management methodology to scheme development Performance monitoring; exception reporting and adjusting actions to maintain care quality and capacity Develop cross sectors communication plans with stakeholders and feedback mechanisms Embed shift of care into provider business planning and strategic direction.

2. Implementation of the Better Care plan is reliant on cultural change and shared accountability across organisational boundaries	4	4	16	Empowerment of the workforce to innovate and deliver differently through creative thinking and agile implementation as a critical enabler for change. Specification of expectations in community procurement
3. Sharing information between multiple systems and service providers to facilitate and enable new and improve patient pathways	4	4	16	A BCF information technology working group which will draw on the resources of the national ADASS Information Management Group and link into the Hull 2020 IM&T enabling work stream
4. The impact of the Care Act on the delivery of health and social care responsibilities	4	4	16	Programme management and actions to support emerging details as they are released. Information systems, will need to be able to transfers between LAs Assume NHS no. as unique national identifier and progress local use Keep informed through regional networks
5. Financial risks including the risks associated with over achieving against the target which may require the adjustment of resource allocation	4	4	16	Contingency arrangements are being developed as part of the risk sharing agreement.
6. The acute hospital reductions do not envisage, primarily because emergency admissions continue to rise due to demography and acuity of patient need.	4	4	16	Monitoring of admissions and case mix via BCF 5 (Ambulatory Care) Use of predictive modelling and anticipatory schemes in primary care targeted at GP practices identified via risk profiling.

7. The acute provider will not be able to take out sufficient capacity and cost with the planned change in patients flow and in line with the associated income reductions	4	4	16	Alignment of strategic and business plans. Working closely with Acute provider to predict and assess impact.
8. There is a risk that the shift of activity from the acute to community would result in Council over-spending on social care as a greater number of care packages are required.	4	4	16	Allocation of BCF resource to ensure sufficient care packages. Adult social care review and complex care review being undertaken jointly with council & CCG to develop home care and complex care provider market.
9. Failure to agree draw down and use of finance dependent upon multi-agency funding	4	4	16	Governance and risk sharing. Agreements and process for arbitration built into section 75
10. Failure to develop appropriate contract delivery model	4	4	16	Joint working through joint commissioning forum. Contract development process and contract monitering defined in section 75
11. Sustainable medical workforce in primary care , low number of GPs (WTE) per head of population	3	3	9	The CCG primary care workforce development plan
12. Recruiting/retaining the right workforce: difficult to find the right skill-mix for the care navigators	3	3	9	

13. Achieving national timescales working across multi agency multi sector environments	3	3	9	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. Peer support and sharing best practice across Y& H
14. The requirement to release expenditure from existing commitments without de-stabilising the system in the short term	3	3	9	Financial risk sharing agreement based on section 75; monitor use of programme funds and consider use of under spending to be set aside for contingency fund / special projects which will focus on improving performance failures. Escalation of negative financial impact or slippage within governance structure and risk sharing agreement.
15. Not getting Information Governance right, including informed consent to share information would undermine potential IT solutions	3	3	9	Support from organisational Caldicott advisors. Use of technical experts to advise on information governance plan and requirements
16. Destabilising current providers during process of commissioning for outcomes and transferring resources across care settings.	3	3	9	Robust planning and engagement, phased introduction of new contracts and procurement. Consultation and engagement through Provider Forum.
17. Slow or non achievement of the BCF outcome metrics	3	3	9	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. Buddy system to progress performance across Y&H

18. Workforce recruitment and development	3	3	9	Workforce development to be picked up as key work stream of provider forum and linked to Hull 2020. Newsletters/updates on progress and next steps. Clear and simple messages at staff briefings – the message is that BCF runs through all of 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. On line 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
19. Data inaccuracies such as duplicate records in bulk upload of batch processing/population of NHS number to service users records	3	3	9	Staff training and awareness will be undertaken to ensure staff are aware of the importance of collecting, validating and using the NHS number as the primary identifier in all aspects of their work and communications
20. There is a risk that the project to populate the NHS number into service user records will be a lot more time consuming than anticipated. A consequence of going through the batch processing is that a significant amount of data issues will be highlighted.	3	3	9	Scope the resource requirements and match capacity to demand. Monitor through BCF steering group.

21. Implementation of 7 day working	3	3	9	Gap analysis of current 7D cover and contracting for 7DW as part of community procurement and adult social care review.
22. Working agreements amongst all partners is key to monitor whole system impacts, together with individual partners' plans and their separate governance arrangements	2	2	4	Strategic direction provided by Hull 2020 Board. Memorandum of Understanding in place across all partners
23. There is a risk that other service redesigns and integration initiatives create confusion for the integration.	2	2	4	The Governance Framework of Hull 2020 will ensure alignment of strategic change and transformation initiatives
24. There is a risk that if communications are not managed carefully stakeholders will not know what is happening, when it is happening and how the service will work. Hostile relationships may develop and undermine the implementation and reputation of the service.	2	2	4	BCF Communications plan Provider forum Regular BCF News letters Plans published on HullCC & HullCCG websites Social Media Older Peoples Partnership Board

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

Hull BCF Risk Sharing Agreement

The financial risk sharing agreement between Hull CC and Hull CCG sits within the overall governance arrangements and management of Hull 2020 and the Better Care Fund.
The amount included in our pooled funding and covered by our agreement for 2015/16 is £30.8 million

Partners to the BCF have agreed a single Programme Management Arrangement through the Hull 2020 Board to ensure consistent understanding of the programme delivery and risks. These arrangements include a Chief Finance Officer group with the responsibility for
The BCF steering group will make recommendations on financial allocations that will be presented to the Hull Joint Commissioning Forum (JCF) who will in turn make recommendation to the CFO group. This group is made up all the CFO for each of the Hull 2020 partners.
The Finance group has a critical role supporting the programme arrangements for the Hull 2020 Transformation Programme and the BCF by providing financial assurance on proposals with reference to a number of actions including the following:

- Setting overall expectations on the level of financial change required at a programme level and individual work stream group level
- Producing a system financial framework to support the programme including risk management, short term investment (transitional support) and investment to achieve planned savings
- Providing critical overview of the programme ensuring that the work streams are focussed in achieving system wide and organisational productivity and financial efficiency
- Providing assurance to the Programme Board that work stream proposals are financially viable, any financial changes are achievable, have considered the impact on individual organisational sustainability and do not lead to unintended consequences elsewhere in the health, social care and public service system
- Acting as the main group overseeing the patch wide achievement of the QIPP savings target ensuring alignment with the Hull2020 programme and mitigating the risk of double counting
- Providing performance reporting and challenge in the programme
- Ensure that appropriate and timely commissioning processes are in place to change services that have been identified for transformation
- Ensure Service Development work streams have access to appropriate procurement analysis and understand and adhere to appropriate procurement processes and the current procurement schedule for all participating partners
- Ensure the legal context for transformation of services is known and adhered to by all work streams within the Hull 2020 Programme
- Review all ‘Backroom’ functions and services, and hard and soft facilities

management provision to ensure the system has secured the greatest efficiency in the use of the 'Hull £' for the programmes' constituent members

The Chief Finance Officers meeting will ultimately advise on - and sanction - joint decisions about the best use of the BCF fund to support integration and maximise reduction of shift of activity to community settings.

The BCF steering group will be responsible for the final detail behind this agreement which will eventually form part of the full s 75 agreement for 15/16.
The financial modelling for this and the associated calculations are presented in part 2 of our BCF plan

The principles of our agreement will be as follows

1. The Hull BCF operates on the principles of affordability and equity to ensure a sustainable and resilient care economy and best use of the BCF
2. Partner organisations will act in the best interest of the overall health and social care economy. This will include gain sharing where necessary, and avoidance of changes in one part of the system exerting a detrimental financial impact in another
3. Any changes to services, including investment and decommissioning, will be based on robust evidence demonstrating net impact across organisations
4. The partners will have representation and be involved in the development of organisational plans including and beyond the elements contained within the BCF to ensure alignment of plans and cross referencing of interdependencies
5. Plans and budgetary provisions/contingencies in each area will be agreed by all partners at the beginning of financial year
6. Overall financial management at scheme level will continue to be the responsibility of individual organisations (i.e the relevant statutory body) and in the first instance risk will be managed on this basis.
7. Decisions will be based on medium to long term impact not on short term "wins".

Operationally for 2015/16 this translates into

- each party to the BCF remaining responsible for its historic areas of expenditure and contribution to the pooled budget

- financial risks, mitigation plans and contingencies being developed by the responsible organisation in conjunction with BCF partners and reflected in the BCF risk register

The CFO group will determine the financial monitoring and budgetary control arrangements, and any in year changes to the allocations to the BCF combined financial resources will be sanctioned by the HWBB.

Contract and procurement decisions will be jointly agreed, but will be taken according to the rules of the organisation carrying out the work.

Contingency arrangements are being developed to address a range of financial risks including the risks associated with over achieving against the target which may require

the adjustment of resource allocation within the fund and review of the BCF schemes. This relates specifically to balancing risks of both achievement and non-achievement of the targets against the impact on providers. **(Ref risk 5)**

There is an expectation that the £13.2 million investment provided in 14/15 will be used to set up and support overall schemes and delivery in 15/16 to give the maximum opportunities to deliver the performance element.

As a general principle, any underspends will need to be reprovided the following year. Any overspend on jointly agreed activities will be deducted from the following years investment within the bounds of the financial regimes of the two organisations.

Any underspends not caused by slippage will be for the Joint Commissioning Forum to make recommendations to the CFO group on how this will be spent. Any activities undertaken, which are not jointly agreed, will be undertaken at the risk of the individual organisation(s).

A schedule of identified financial and performance risks and potential mitigations will be produced for the final S75 agreement. (**Ref risk plan – risks 1&7)**

There will be a regular evaluation and review process of schemes each year which will help mitigate the risks for future years and ensure effectiveness and value for money.

Performance metrics are separately shown in the BCF template. Third party providers of services commissioned by the partner authorities will be held responsible for the achievement of performance targets where appropriate through the relevant contractual arrangements

The BCF resources and this agreement will be subject to the usual audit and annual reporting requirements. Differences in accounting treatment will be recognised with advice from the relevant auditors where necessary.

Initial work has taken place to look at how the risks of failure to spend, overspends, and failure to achieve target outcomes might be mitigated through governance and monitoring arrangements and this will be detailed within the section 75 agreement.

The following table details the risk assessment that forms part of our risk sharing agreement.

Risk event	Impact / potential impact	Mitigations / possible mitigations	Residual risk share arrangements
1. Funding not allocated to pooled budget by partners	1. Insufficient funds in pooled budget to meet agreed programme of activity - potentially leading to either (i) failure to achieve target outcomes (see risk event 6) or (ii) overspend for partner(s)	Funding from NHS England has to be transferred to a s75 pooled budget by the CCG	Risk mitigated.
		HCC contribution to BCF from own resources confirmed in Better Care Plan approved by HWB	Risk mitigated.
		CCG contribution to BCF from own resources confirmed in Better Care Plan approved by HWB	Risk mitigated.
2. No agreement between partners on allocation of funding from pooled budget	2. Agreed programme not delivered leading to failure to achieve agreed outcomes (see risk event 6)	Governance arrangements - programme agreed by HWB as part of BCF Plan submission	Risk mitigated.
3. Funds not spent in year	3(i) Possible failure to achieve agreed outcomes (see risk event 6)	Governance arrangements - in-year budget monitoring reports to HWB on a regular basis to enable corrective action / re-alignment of spend programme to take place	Partially mitigated - but see risk event 6.
	3(ii) Possible failure of partners to return underspends to pooled budget	Governance arrangements - treatment of underspends to be determined as part of s75 agreement	Partially mitigated - but see risk event 6.
4. Funds not spent on agreed activities / actions	4. Possible failure to achieve agreed outcomes (see risk event 6)	Governance arrangements - in-year monitoring reports on both spend and performance to be considered by HWB on a regular basis to prevent mis-application of funds	Partially mitigated - but see risk event 6.
5. Overspend of funds in year	5. Potential pressure on partner(s) budgets	Governance arrangements - in-year budget monitoring reports to HWB on a regular basis to enable corrective action / re-alignment of spend programme to take place	Partially mitigated - but treatment of any remaining overspend to be in line with terms of s75 agreement - see also risk event 6.

6. Actual outcomes < Target outcomes	6(a) Potential loss of PR payments leading to potential pressures on partner(s) budgets	Governance - in-year monitoring of performance against agreed targets to be considered by HWB on a regular basis to enable re-alignment of resources to address any emerging shortfalls	Partially mitigated - but treatment of any remaining overspend to be in line with terms of s75 agreement.
		Use of outcome-based contracts for external providers - ie seek to partially offset any loss of funding through reduced payments to providers for (demonstrable) under-performance	
	6(b) Potential failure to reduce costs elsewhere in partner(s) / third parties budgets leading to budget pressures	As for 6(a)	Partially mitigated - but treatment of any remaining overspend to be in line with terms of s75 agreement.

Work is also underway to consider whether linkage of partner inputs to target outcomes might be used as a basis for risk share in some instances. No contingency sum has been built in to the Fund for 2015/16 at this point, but that may be subject to review at 14/15 outturn.

The Council and CCG have begun work with Bevan Brittan and following a workshop on the 24th November 2014 are developing an explanatory memorandum as a guide to the sort of principles the CCGs and Local Authority will take into account when drawing up their Section 75 Agreement as required under the BCF Pooled Fund arrangements. The draft explanatory memorandum is included for reference.

The timeline for completion of the explanatory memorandum is January 2015 with sign off of the section 75 by the end of March 2015.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

Hulls BCF plan a delivery vehicle for improved outcomes and savings across all sectors and has been written in collaboration with partners to ensure the following priorities for Hull are aligned

- Supports preparation for the introduction of the Care Act
- Central to addressing the Dementia Challenge
- Supports the review of Adult Social Care
- Informs the capital and service configuration for the East Hull Integrated Facility
- Supports HEYTS medicine transformation programme of Ambulatory Care and revision of older people's acute care pathways
- Delivers plans for integrated discharge hub and reforming transfers from acute care – introduction of a discharge to assess model
- Links into the Extra care housing developments as care hubs where health and care services can easily be accessed by the local communities

Reference has been made within this plan to the overarching transformational strategy of Hull 2020. The following section present the elements of this strategy that are aligned to and complement the delivery of the BCF plans

The model for Hull 2020 is based on several key outcomes:

A. Public focused services that recognise the needs of the individual (access to service, experience of service, safety, quality)

B. Driven by the people of Hull as well as professionals, expert staff, and partners in recognition of the need for local answers for local issues

C. Addressing the process and system issues - reducing waste, inefficiency and frustration

D. Maintaining a sustainable skilled workforce to meet wider public need

E. Making best use of partnerships across all sectors, particularly through the voluntary sector and exploration of options regarding community owned initiatives

F. Co-ordinating initiatives and building on existing infrastructure to develop a consistent approach to working across Health & Social Care.

These outcomes link directly the Better Care Fund Plan metrics to be delivered across Hull. **The BCF dash board is attached for reference.**

1. Permanent admission of older people (aged 65 and over) to residential and nursing care homes - Reducing inappropriate admissions of older people (65+) in to residential care
2. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services - Increase in effectiveness of these services whilst ensuring that those offered service does not decrease
3. Delayed transfers of care (delayed days) from hospital - Effective joint working of hospital services (acute, mental health and non-acute) and community based care in facilitating timely and appropriate transfer from all hospitals for all adults
4. Emergency admissions - Reduce emergency admissions which can be influenced by effective collaboration across the health and care system
5. Patient/service user experience - To demonstrate local population/health data, patient/service user and carer feedback has been collated and used to improve patient experience. To provide assurance that there is a co-service design, delivery and monitoring putting patients in control and ensuring parity of esteem
6. Injuries due to falls in people aged 65 and over

The table below sets out how the key interventions that will be delivered in 2014-15 by the Hull2020 programme will support both the Hull 2020 and the BCF outcome frameworks.

Hull2020 Interventions in 2014/15	Relevance to Hull2020 Outcomes	Alignment to BCF Metric
Development and roll out of Community Hubs across Hull	A,B,C,D,E,F,	M1, M2, M3, M4, M5, M6.
Establishment of Wi-Fi connectivity for all staff across all public sector offices in Hull	A,B,C,D,E,F,	M5.
Use of cold alarm technology to support cross sector winter planning and specifically to increase the level of prevention	A,B,C,D,E,F,	M1, M2, M3, M4, M5, M6.
Creation of a single portal for people in Hull to access information about the services available to them	A,B,C,D,E,F,	M5.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

The BCF plan is a delivery vehicle for Hull 2020. The NHS Hull CCG strategy and the Hull 2020 programme are aligned and as such form the NHS Hull CCGs strategic plan 2014/15 to 2019/20.

All the BCF schemes are integral to the strategic operating plan and sit within the programme of work throughout the programme work streams that are focused on taking forward the transformation of adult care services. This alignment is demonstrated in the table below.

Hull 2020 principles of delivery	BCF Scheme	Hull 2020 Work stream
• Integration • Community Hubs • Care closer to Home • Single care Navigator • Public design and Ownership	BCF1 Prevention-Community Hubs	Frailty and Isolation Unplanned Interventions Life Choices Planned interventions
	BCF2 Primary Care and Self Care	Frailty and Isolation Unplanned Interventions
	BCF3 Falls prevention	Unplanned Interventions Frailty and Isolation
	BCF 4 Reablement and Rehabilitation	Frailty and Isolation Unplanned Interventions
	BCF5 Ambulatory Care	Frailty and Isolation Unplanned Interventions
	BCF6 Residential Care & Home Care	Frailty and Isolation Life Choices
	BCF6 Long term Conditions inc Dementia	Frailty and Isolation Unplanned Interventions
	BCF7 Mental Health	Unplanned Interventions Life Choices Planned Interventions

The BCF has also been aligned to the national strategic objectives of The NHS planning guidance 'Everyone Counts' which sets out an expectation that every CCG should identify £5 per patient from its allocation for 2014/15 and use this to support practice plans for improving services for older people. CCGs are expected to commission such services on behalf of practices. This funding is intended for additional services over and above those provided for by the Avoiding Unplanned Admissions enhanced service and that complement its objectives. In Hull, this equates to approximately £1.4m. and is being used to pilot more proactive management of over 75s using a care co- ordination

approach to inform development of **(BCF2)**

The Ambition for Improving Outcomes detailed in the BCF Plan are also aligned to the outcomes expected to be delivered by the Hull 2020 CCG strategic plan and transformational programme.

These are contained in the table below:

Ambition for Improving Outcomes	Baseline	2014/15	2015/16	2016/17	2017/18	2018/19	Notes
Ambition for additional years of life from conditions considered ameanable to healthcare	2276.6	2203.7	2181.7	2159.9	2138.3	2116.9	PYLL (Rate per 100,000 population)
Ambition for improving the health-related quality of life for people with long-term conditions	70.40	71.10	73.24	74.70	75.82	76.58	Average EQ-5D score for people reporting having one or more long-term condition
Ambition for reducing emergency admissions?	2900.7	2749.2	2655.4	2538.4	2399.2	2241.5	Emergency admissions composite indicator
Ambition for increasing the proportion of people having a positive experience of hospital care	139.7	136.9	135.4	134.0	132.5	131.0	The proportion of people reporting poor patient experience of inpatient care
Ambition for increasing the proportion of people having a positive experience of care outside hospital, in general practice and the community	5.10	5.00	4.95	4.90	4.85	4.80	The proportion of people reporting poor experience of General Practice and Out-of-Ours Services

The NHS Hull CCG element of the Hull 2020 programme is contributing to the following QIPP plan for 2014/15, which has been approved by the NHS Hull CCG Board:

Description	£m's
QIPP – Demand Management; better management of pathways through early support and intervention, right care first time	**(3.5)**
QIPP – Reduced Outpatient 1st to follow up ratio	**(1.1)**
QIPP – End of Life	**(0.7)**
QIPP – Improving Access to Psychological Therapies re-procurement	**(0.5)**
QIPP – Day Case to Outpatient Conversion	**(0.3)**
QIPP – Medicines Management (prescription costs)	**(0.4)**
QIPP – Better Care Fund/Shared Care Monitoring/Dementia Assessments	**(0.4)**
Total Saving	**(6.8)**

The highest rated risks at the current time relate to the ability of organisations to work together financially and share resources. Whilst partner organisations are fully supportive of Hull 2020 financial implications for organisations are untested.

Principal Risk	Consequences	Owner	Probability Score	Impact Score	Risk Score	Key Controls	Action
Failure to agree draw down and use of finance dependent upon multi-agency funding	Failure to deliver to agreed programme/ scheme/s aborted.	Finance Work Stream	3	4	**12**	Detailed assumptions for service inclusion and development and finance availability to be addressed in business cases.	Review at Programme Board
Failure to manage and support providers through transition/ management of provider market and sustainability	Failure to develop and implement a transitional strategy in regard to financing service change including where justifiable dual running or pump priming projects.	Finance Work Stream	4	3	**12**	Detailed assumptions for service inclusion and development and finance availability to be addressed in business cases.	Review at Programme Board
Failure to develop appropraite contract delivery model	Failure to agree mechanism for pooling resources where appropriate.	All	3	4	**12**	Transition plan required for any agreed service changes.	Review at Programme Board
Risk of insufficient revenue to operate preferred service models	The scheme ends up not being revenue saving or neutral and/or under utilisation of building	Hull CCG/Providers	3	4	**12**		Review at Programme Board

d) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

In response to the NHS England invitation for expressions of interest in co-commissioning, NHS Hull CCG has submitted a proposal to work with the Area Team to jointly commission and ultimately take delegated responsibility for the commissioning of GP primary care services and approved ready now to progress with delegated commissioning responsibility for certain aspects of primary care.

This is seen as vital to enabling the CCG to realise its ambitions for the development of new models of primary care and the future sustainability of primary care services in Hull in the context of rising demand and needs.

The benefits of co-commissioning are expected in the following areas:

- Integration of health and care services
- Raising standards of quality and reducing unwarranted variation
- Enhanced patient and public involvement in the development of services
- Addressing health inequalities

Hull CCG expect co commissioning to;

- achieve greater integration of health and care services, in particular more cohesive systems of out-of-hospital care that bring together general practice, community health services, mental health services and social care to provide more joined-up services and improve outcomes;
- raise standards of quality (clinical effectiveness, patient experience and patient safety) within general practice services, reduce unwarranted variations in quality, and, where appropriate, provide targeted improvement support for practices;
- enhance patient and public involvement in developing services, for instance through asset-based community development;
- tackle health inequalities, in particular by improving quality of primary care in more

deprived areas and for groups such as people with mental health problems or learning disabilities

The following responses were received from our GP practices in response to the consultation on co commissioning to help inform early-stage planning; future communications and engagement.

- This would enable primary care and community services to be linked in a meaningful way to improve patient care and make the process more cohesive. The previous model where GPs, PNs, District Nurses, HVs worked together in an integrated team enabled effective patient communications, maximisation of resources, and better patient care.
- In the current model there are too many inefficiencies and a complete lack of co-ordination of service.
- Layers of service are being added on, but no-one is linking these overall.
- We Believe that health and social care need to work closer together and co-commission services, especially in cases of the over 75s, vulnerable adults and children. More provisions in social care are needed for the over 75s.
- Buy in from Primary Care providers
- Local additions to Primary Care Contracts (this will meet strong opposition from LMC and GMSC nationally)
- Sharing of information and joint meetings with are team
- Shared decision making with other primary care providers without short term political influence local or national (within limits)
- More local decision taking into account wider/better on patch knowledge
- Better cohesive planning to cover wider primary care community medical, psychological and social
- Raise expectations of delivery of care to level playing field, reward good practice, penalise poor practice
- Organisation to be seen to be keeping own house in order and working for community

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Hull City Council will protect community services in order to support eligible adults to remain independent in their own home, promoting choice and control Adult social care will support people to live full and active lifestyles.

Hull City Council will maintain eligibility at critical and substantial (Fair Access to Care Services).
The BCF schemes will identify people sooner and assessments will be timelier thereby ensuring targeted interventions promote self care and achieve continued independence.

We will do this by :

- Targeting resources to keep people at home
- Aligned existing CCG resources to avoid duplication
- The Care Act, which will promote a new model of social work , recognising that the duties for prevention and 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
- Tackle lifelong care needs with more really intervention and by reducing health inequalities

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

We will ensure local social care services are protected by aligning resources to the BCF but changing the focus and type of provision to promote self care and resilience.

The Council have reviewed their advice and information provision and as a result are developing a ‘see and solve’ strategy (BCF1) the purpose of which will be to provide an integrated response with an early offer of preventative support by the right service first time to divert needs from acute and crisis resources (BCF3)

- Provision of non recurrent funding

- Reducing the costs of care with shift of resources to preventative and early intervention models

- We recognise the needs of the aging population and have reflected this within some of the protection of local services:

- The Dementia Academy will promote to the wider public and to service providers the awareness of Dementia and share best practice to improve the services people will experience (BCF 7)
- Dementia Peers will support people at the point of diagnosis to understand and recognise the help and support that is available to them. (BCF 7)
- Aging well will support older people at home to remain active and encourage a healthy lifestyle.(BCF1)
- Thornton Court a supported housing complex with 24hr care and integrated therapies to offer an alternative to hospital and reablement after an episode of acute care funded through section 256 monies will be maintained and the model enhanced**. (BCF4)**
- Hull CC and Hull CCG already jointly commission a City wide carers service that includes advice information and practical support for carers including the offer of direct payments.
- One of the local initiatives to ensure people are assessed by the right person first time is our local Discharge Hub model. The Discharge Hub is the colocation of multidisciplinary health and social care teams from acute and community care who lead on transfer of care from hospital to home and are working to develop the discharge assess model **(BCF4)**
- Our provision of Home Care services has been increased through the BCF to ensure capacity to take the shift of reliance from acute and residential care to more home based support. **(BCF6)**

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The amount relating to the protection of adult social care services is based on the level of funding allocated in the expenditure plan to Social Care, in both 2014/15 and 2015/16 this is £12.7m. The LGA Ready Reckoner tool has been used to determine the indicative amount of funding for the area in support of the implementation of the Care Act as £779k in 2015/16 and at least this value of service is included in the expenditure plan.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

The new duties will be met by

- Improving access to advice and early help to maximise choice and control in accessing care and support services, especially for self funders. (BCF1)
- Proactive approach to support people to access early help and preventative services (BCF1 , 2, 3)
- Development of self assessment, self care and connecting to appropriate support, developing the digital offer.
- Implementation of the national eligibility criteria along with policy development to support portability of assessments.

- Extension of the Personal Budget and Direct Payment offer for ALL eligible clients regardless of the care they receive.
- Increasing availability of advocacy. (BCF1,2, 4,6,7,8)
- Development of the workforce to understand the new Care act duties and how they are applied in practiced.
- Provision of carer's assessments and support. (BCF 1,2,3,4,5,6,7,8)
- Development of deferred payments to ensure people will no longer need to sell their homes to fund their care and support.
- Development of the framework to provide customers accounts which detail the funding contribution from the individual in meeting the care cap.
- Developing in-reach into prisons to provide assessment and support for disabled prisoners

v) Please specify the level of resource that will be dedicated to carer-specific support

Section 7 a v)
The expenditure plan incorporates £445k in both 2014/15 and 2015/16 for carer specific support across Adult Social Care and Children & Young Peoples' services.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

No effect on local authority budget in total, but scheme content of BCF has been revisited to ensure that the revised emergency admissions target can be met, and that adequate funding has been allocated to cover new duties under the Care Act

b) 7 day services to support discharge

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

7 day services (7DS) currently operate in Hull. Services locally have moved to 7 day working by deployment of 5 day provision working over 7. Moving towards a single point of access to align to discharge teams (Integrated discharge hub)

However we will improve on this position by increasing to ensuring service provision is the same any day of week.

The delivery of 7DS will be specified within the re procurement of our community services across Hull with the NHS contract. Services not currently subject to the community procurement will be reviewed and 7DS added to the improvement and development plan sections.
The CCG and Local Authority will work with local providers to meet the required milestones for inclusion of the clinical standards for 7DS by undertaking the following actions with associated milestones.

Actions and Milestones for 7DS

Milestone	Action
2014/15 Year 1	• Review all current services operational cover under as part of the adult social care review and community procurement by April 2015 including; Identify gaps in 7DS cover, Identify any resource gaps • Extend this review wider than current intermediate care services to include social care OTs, pharmacy (meds management, therapies and creating the multi-agency worker role that can implement an agreed plan on behalf of a qualified health or social care practitioner). • Systems review of the pathway for frail elderly people and of processes for hospital discharge to identify where 7-day services will be best targeted to get the best outcomes. • Prioritise services for delivery of 7DS provision within BCF schemes • Identify opportunities to redesign operational arrangements within existing resources through integration of care teams • Production of a costed plan for 7-day services across the whole system.
2015/16 Year 2	• New contracts will be procured with 7DS specified as integral to the provision • Ensure clinical standards for 7DS are reflected in national quality requirements of NHS standard contract. • Produce working protocol for operating a ‘trusted assessor’

	model across organisational boundaries in line with development of data and care plan sharing • The creation of care hubs will create effective deployment of staff and reduce the overheads of 7 day working. • The local Integrated discharge hub model will be developed with community and hospital teams working together to facilitate safe transfer of care across the week • Ambulatory care in place and A&E liaison across 7 days with a single point of referral.
2016/17 Year 3	• 7DS operational across health and social care • 7DS embedded in clinical standards of NHS contract. • 7 day single point of contact for integrated services and care coordination • 24/7 telecare response service and provide with an urgent domiciliary care response.

Because we will be extending current 7D working and contracting for 7DS we have not identified any risks to achieving 7D working

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c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

The NHS number will be used as the primary identifier and will be detailed in a prominent position on all paperwork. The NHS number will be collected as part of the minimum data set at the earliest opportunity.

The use of the NHS number as the primary identifier is a contractual requirement of current commissioned services (with the exception of bespoke services such as sexual health) and will be for future contracts.

We aim to create the infrastructure to ensure our care providers can all use the same patient record; the BCF will help ensure this happens by joining up Health and Social Care data across provider systems linked via the NHS number, and guaranteeing that the required governance is in place to ensure individual information is shared in an appropriate and timely way.

Systems already in use

- Systm One, a clinical computer system that allows service users and clinicians to view information and add data to their records
- Emis Web, a clinical computer system that allows service users and clinicians to view information and add data to their records
- Vision, a clinical computer system that allows service users and clinicians to view information and add data to their records
- CareFirst is the Council's social care system which facilitates the recording of social care data including the processing of financial payments

Data Scripts to allow the bulk population of the NHS number into service user records in Hull City Council's Social Care System (CareFirst) have been purchased and tested.

The work required to run the scripts against CareFirst (to produce the outputs) for submission to the NHS MAC service commenced w/c 10th September. Once a sample batch file has been received by the MAC Service this will allow them to 'batch process' the data in order to supply the relevant NHS numbers (for that set of service user records) for population into CareFirst. The batch processes will be thoroughly tested before applying them to the live system.

Any records that already have an NHS number recorded will be validated for accuracy.

This batch processing, validation and any data correcting will continue to be undertaken over a number of months

Hull social care has plans to collect the NHS number as early on in the clinical/care pathway process as possible, the number will then be recorded manually in CareFirst. The number will be clearly denoted in a prominent position on all the social care paperwork when it is printed from CareFirst.

The option of using temporary NHS numbers will be investigated for use on records for example; for people visiting from overseas.

Populating social care records with the NHS Number and using this as a primary identifier will be hugely beneficial in assisting the process of identifying records for the same person held in different systems this will further help facilitate the integration of services and sharing of information and the matching of services.

Using the NHS Number will help to reduce duplicate records in source systems as this will be a unique number, attached to one record only.

Any other records with similar characteristics (same names, dates of births etc) will be highlighted a potential duplicate records. This will help to increase data accuracy and reduce the risk of information being recorded on the wrong person's record.

The whole process of sending matching requests and receiving the MACS response file will help drive overall better data quality.

As part of any integration work - protocols and processes will be put in place to enable information about which records have been accessed in which systems to be audited to ensure that records are only accessed by those with a legitimate reason on a need and a right to know basis. It will improve data quality by identifying gaps or inconsistent records.

We currently have over 70% of Hull GP practices on Systm One IT system in addition to our main community provider. By April 2015 we aim to provide the opportunity for our care providers to use the same patient record; the BCF will help ensure this happens by joining up Health and Social Care data across the borough linked as above via the NHS number

To date we have established

- All health services use the NHS number as the primary identifier in correspondence.
- Hull Social Services are in the process of adopting this and have a plan in place to use the NHS number as the primary identifier
- Commitment to collecting the NHS Number as a primary identifier
- Project work to match user records with the numbers has commenced.

The main bulk batch processing/population of the NHS Number to service user records in the social care system will be carried out over the next 7+ months via the MAC Service.

To facilitate the ongoing population of this data, new service user records will either be automatically populated with their NHS number via the batch service or these will be manually input by the social worker.

Processes for checking the accuracy of manually recorded numbers will be put in place.

As part of an agreed process, social care staff will be instructed to check the NHS number has been recorded correctly. This will be done with the service user themselves (if they have access to it) and/or with their NHS colleagues at the earliest opportunity in the care process.

There is a risk that the project to populate the NHS number into service user records will be a lot more time consuming than anticipated. A consequence of going through the

batch processing is that a significant amount of data issues will be highlighted i.e. duplicate records, wrongly or different name spellings on CareFirst to those on the NHS Spine. (BCF risk 12)

We are currently undertaking a mapping exercise of the clinical and information systems which are utilised at different stages of a person's life from cradle to grave. This exercise will identify the points at which data is required to be shared.

The data sharing arrangements will be complaint with the standard contract IG requirements, IG toolkit requirements and professional clinical practice Caldicott 2.

Full compliance is expected to be in place by March 2015

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Hull's social care system, CareFirst has fully developed Open APIs with published xml schemas to enable integration. The CareConnect services allow data to be extracted and updated from the CareFirst system, by any external system. Both web service and message based interfaces are available, in addition to some business processes, events to automatically push data out from the system under certain defined triggers. CareConnect has published API schemas with documented dataset and xml guides. CareConnect supports all significant business functionality.

The above gives the necessary assurance that CareFirst has Open APIs and these are available now.

All national clinical systems in health are based upon Open APIs and all future contracts for clinical systems will include this requirement.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practice and in particular requirements set out in Caldicott 2.

Hull City Council is committed to ensuring that the appropriate IG Controls will be in place. Hull is IG Toolkit compliant.

Work is taking place within the information governance framework and we are committed to maintaining five rules in health and social care to ensure that patient and service user confidentiality is maintained. The rules are:

1. Confidential information about service users or patients should be treated confidentially and respectfully.
2. Members of care team should share confidential information when it is needed for the safe and effective care of an individual.
3. Information that is shared for the benefit of the community should be anonymised
4. An individual's right to object to the sharing of confidential information about them should be respected.

Decisions around the integration with relevant systems, which data will be shared on what occasions have yet to be discussed in detail. Once agreement on what needs to be achieved to facilitate the provision of better care has been decided, information on key milestones can then be provided.

The main risk will be around each organisation defining who will have access to the data and maintaining the correct access. Strict user access protocols and processes will be agreed upon, embedded and monitored.

Information Sharing Protocols will be established to allow the legal sharing of data.

The actual mechanisms by which the data is viewed/transferred and on how regular a basis the updates will happen will also need to be decided upon as a priority action.

Health partner organisations who do not sign up to PSN are able to send information via secure email using .gsn address.

Hull City Council has achieved full PSN accreditation and is working towards 'V12 LA IG Toolkit / Information Governance Statement of Compliance (IGSoC)' accreditation.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

Under the terms of the Proactive Care Programme a minimum of 2% of patients aged over 17 are being placed on practice risk registers (along with any children with complex needs).

54/57 GP practices in Hull are working to risk profile their patients using **RAIDR**

"RAIDR is a suite of dashboards that has been developed by NECS http://www.raidr.co.uk/ (hosted by North of England CSU). It is Gcloud and interacts with practice clinical systems and SUS/HES data via **DISCRO.**

RAIDR has an accessible and user-friendly 'front end'; it runs one of the industry-standard Risk Profiling algorithms (Combined Predictive Model). In addition NECS sort out Data Sharing Agreements with Practices and providing IG and confidentiality guidance, and provide MiQuest queries that will extract the minimum required data from Clinical Systems, which enables production of Risk Profiled lists."

"RAIDR provides access to patient level information that has a risk score attributed to each patient sourced from primary and secondary care data to identify the 2% of patients that are most at risk of a hospital admission that can be placed on the risk register and a care plan completed where clinically appropriate.

This risk tool is deemed to meet the requirements as set out in the NHS England guidance and is supplied to the CCG by NYH CSU who are an approved risk stratification supplier and their tool and specification have been verified by the confidentiality advisory group and given legal (section 251) cover.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

54 out of 57 practices have signed up to the (productive primary programme) Avoiding Unplanned Admissions Enhanced Service for 2014/15 and arrangements have been put in place for the patients of the practices not covered.

Currently there is some variation in the degree to which health and social care teams work in a multi-agency approach to care planning. In terms of transfer of a patient's care from hospital to the community, there is no single assessment and care planning tool.

However, there is a collaborative process in place: where the majority of a patient's needs are for social care social work teams will lead the care assessment with input from a range of health professionals; where a patient's needs are mainly health-related, a health professional is responsible for assessment of care (through use of decision support tool), with input from social care teams. Social care reablement and intermediate health care teams are co-located at the hospital, and take a multi-disciplinary approach to assessment and care planning.

A 'Discharge Hub' has been established to facilitate collaborative working between health and social care agencies to manage the safe and effective transfer of patient care from hospital to the community and allocate a lead professional to undertake the transfer.

Hub members include local authority social care staff, intermediate health care teams and hospital staff. The use of a joint/shared care planning tool to support transfer of care will be explored through the Discharge Hub in 2014/15.

Hull has an established Multi-Disciplinary Team meeting programme to support the joint review and assessment of patients considered as high risk of hospital admission. These meetings are attended by a range of health and social care professionals including GPs, Long Term Conditions team, social care, district nursing, consultant geriatrician, and addictions services.

The city-wide care coordination service will support the management of older people in the community by establishing a named care coordinator for older, frail and complex patients who are identified by practices; it will also directly support GPs to fulfil their named accountable GP role (for patients aged 75 and over) and complement the work of general practices to achieve the aim of the Avoiding Unplanned Admissions Enhanced Service (Productive Primary Care)for 2014/15 which is to improve services for vulnerable people and those with complex physical or mental health needs who are at high risk of hospital admission or readmission.

The named accountable GP is responsible for ensuring the creation of a
Personalised care plan and maintains overall accountability for ensuring that the personalised care plan is being delivered and that patient care is being reviewed as necessary. The proposed care coordination service model will support the accountable GP by acting as the main point of liaison for the patient and by undertaking the following functions:

- Work in partnership with named GP for over 75s
- Part of a multi-disciplinary team approach to patient care and will collaborate with GPs, practice nurses, community nursing services, therapies, the acute trust, social care and the voluntary sector.
- Ensures joint care planning and coordinated assessment of care needs are undertaken
- Coordinates and navigates the patient's journey through the health and social care system
- Ensures that the needs of carers/families are addressed
- Engage with local services for the elderly to identify availability of and gaps in provision/care for this cohort of patients

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

NHS England (HSCIC) will carry out a data extraction from GP practices clinical systems at the end of October which will also include a self-certification template submission from GP practices which will demonstrate compliance and will provide the CCG with the number of patients allocated a care plan; the minimum cohort will be the top 2% of patients deemed at risk of a hospital admission.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

Hull CC and Hull CCG share a people's panel and actively engage with the 8,500 members. A quarterly survey provides regular feedback on service views and provides the opportunity to design questions to gain views on service developments and proposals. Existing information on public views from recent surveys and CCG focus groups has informed this plan.

In addition the CCG has a group of Ambassadors who have volunteered to get involved in supporting the CCG's engagement and public involvement work and provide a mechanism for feeding information into the CCG and out to the local population.

The locally recruited Ambassador team is currently 25 strong, representing people from all walks of life; many are active community leaders, and others provide a vital link with other voluntary and community groups with which they are involved.

Ambassadors along with and other members of the People Panel are regularly surveyed on their views about local service developments and public expectations. The most recent People's Panel survey included a question relating to statements about health and social care. A sample of responses is detailed below;

Question: How much do you agree or disagree with the following statements about health and social care

Response Rate 1692 Out Of 2000 Surveys Sent		%
Care or treatment should be available at all times (including evenings and weekends)	Strongly disagree	1.5%
	Tend to disagree	2.8%
	Neither	3.6%
	Tend to agree	39.2%
	Strongly agree	52.8%
I would like all of my care or treatment to be managed through a single point of contact	Strongly disagree	2.9%
	Tend to disagree	9.1%
	Neither	23.5%
	Tend to agree	41.1%
	Strongly agree	23.4%

The people's panel will form a significant role in supporting the communications and engagement process but our broader baseline data collection on experience will be undertaken at City wide level using the social care survey.

Work to date tells us that people want services that maintain their independence and provide more choice and control over care being delivered in their community and in their own home. In our most recent personal social services (PSS) Social Care survey 1,264 questionnaires were sent out with 405 responses, results shown below:

How much do you agree with the following statement? The people, who provide my care, including health care, work together well.

Please circle your response answering on a scale from 0 to 10 with 0 = strongly disagree to 10 = strongly agree.

Strongly disagree — Strongly agree

0 1 2 3 4 5 6 7 8 9 10

The people who provide my care work together well.		
Count of The people who provide my care work together well.		
The people who provide my care work together well.	Total	Percentage
0	5	1.23%
2	2	0.49%
3	8	1.98%
4	15	3.70%
5	18	4.44%
6	21	5.19%
7	32	7.90%
8	74	18.27%
9	62	15.31%
10	128	31.60%
-9 No response	40	9.88%
Grand Total	405	100.00%

The patient experience metric within the plan template part 2 is a threefold indicator with the aim of increasing positive responses, number of surveys distributed and positive responses to the question. This survey was introduced in 2014 and therefore only one year baseline is available but will be used to monitor the effectiveness of integrated care models and on-going development and improvement. The results of the survey are currently being analysed locally.

The positive response rate will be calculated using scores of 6 – 10 (0 = strongly disagree, 10 = strongly agree). The latest data indicates that of the 405 returned surveys 365 patients/service users responded to the question and, 317 responded positively to the question indicating a satisfaction score of 87%.

A public event was held on the 12th March 2014 led by The Hull Older Peoples Partnership group to launch the wider public engagement plan for BCF and we are following this up across the first 2 weeks in October to coincide with Older Peoples day on the 1st October 2014 with a series of engagement and consultation events on our plans. The Hull Older Peoples Partnership Board have led on this work and act as our local partner to link into the wider third sector for the coordination of engagements an events

Healthwatch have also undertaken a baseline assessment of what Integration means to people and we will use this to inform our service user experience metrics.

The Council and CCG websites and associated social media will also be utilised to inform and gather views.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Provider Overview

Hull & East Yorkshire Hospitals NHS Trust (HEYHT) is the main acute hospital provider for Hull. It provides a comprehensive range of acute hospital, specialist and major trauma services for approximately 1.25 million people. Services delivered relating to a large acute general hospital are used by people predominantly living in the Hull, the East Riding and Northern Lincolnshire; with the wider population of Yorkshire accessing specialised services.

HEYHT provides networked services with other providers in the area, including; major trauma, major vascular, neurosciences, cardiology, oral surgery urology, cancer services, and a range of screening services. The only major services not provided locally are transplant surgery, major burns and some specialist paediatric services. The Trust employs approximately 8,664 staff working across the hospitals and community, with an annual turnover of £495m.

Hull Royal Infirmary	Hull Royal Infirmary is based in the centre of Hull. With 709 beds, it is the emergency centre for the Trust. The A & E department sees 120,000 people each year, and is currently being upgraded with support from NHS Hull CCG. The site also consists of a dedicated Renal Dialysis unit, an Eye Hospital and the Women's and Children's Hospital; there is a clinical skills facility that supports training and education across all healthcare sectors.
Castle Hill Hospital	Castle Hill Hospital, Cottingham is located 6 miles outside of Hull in the NHS East Riding CCG. It provides predominantly elective care, with 610 beds. This site includes the award-winning Queen's Centre for Oncology and Haematology, the Centre for Cardiology and Cardiothoracic Surgery (bringing diagnostic and treatment facilities in one state-of-the-art building on the site), and the Centenary Building (Breast Surgery and ENT).

City Healthcare Partnership

Provides community services across Hull, such as children and young people's services, adult nursing care, out of hours GP services, minor injuries and some primary and dental care

Humber FT

Provides a comprehensive range of mental health, community services, learning disability and addictions services to people living in Hull and the East Riding of Yorkshire

Yorkshire Ambulance Service

Provides 24-hour emergency and healthcare services to a population of more than five million across the county of Yorkshire

All local providers including Health Watch have been copied into all the Hull Better Care papers that have been taken to the Hull HWBB. The Hull Health and Wellbeing Overview and Scrutiny Commission are regularly briefed and these papers are publically available on the council website. The CCG Council of Members and Senior Leadership team are briefed monthly and presentations to the Hull CCG Board on the submission process are made as required.

Private Sector

Information about the development of the Better Care Plan has been circulated to all city residential and home care providers.

Third sector

The Hull Older Peoples Partnership group which is made up of third sector providers including those supporting our older resident's black and ethnic minority groups in Hull has been briefed. This partnership and their representatives have been informed and are now with assisting us with ongoing engagement.

ii) Primary care providers

Local GPs have been informed of the Hull 2020 and BCF schemes through the Hull Council of Members meeting and will continued to be informed through this forum and local GP peer groups. All practices are working within the plan on delivery of **BCF2** primary care and self-care. Some GP representative sit on key working groups e.g. frailty and isolation, ambulatory care, LTC and falls.

iii) Social care and providers from the voluntary and community sector

A local BCF provider forum is being established to take this work forward and ensure ongoing engagement in the development and delivery of the BCF plan.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The Hull Better Care Fund plan seeks to deliver transformational change in both health and social care in order to maintain services in the face of growing demand. The demand impact is twofold – ability to meet the needs through medical advances and technological solutions and the impact of the forecast demographic changes. The value of the Hull Better Care Fund requires the system to transform the care and avoid 7,500 unplanned admissions to acute care.

The emphasis of this plan in on a shift of care – by the right person, in the right setting; the most notable impact of which will be a reduction in unplanned admissions to acute care. Hull has one main acute hospital provider, Hull and East Yorkshire Hospitals NHS Trust (HEYHT) which provides a comprehensive range of acute hospital, specialist and major trauma services for approximately 1.25 million people living in the Hull, the East Riding of Yorkshire and the Northern Lincolnshire area.

Through the Better Care Fund plans, both health and social care services will be transformed to deliver on prevention, self-care, early intensive intervention and complex care – this requires whole system transformation, which means that there will be an impact on acute providers, community and mental health providers, adult social care provision, the voluntary, community and social enterprise organisations and care home providers.

The most significant area in terms of provider impact will be to address the workforce issues – having the right staff, with the right clinical and partnership skills and creating the right culture will be key to the delivery of successful integrated care.

The Hull 2020 Programme Board includes a wide range of public sector partners, co-commissioners and most crucially a senior representative from Hull and East Yorkshire Hospitals NHS Trust, Humber NHS FT, City Healthcare Partnership CIC and the Yorkshire Ambulance Service. That board is underpinned by a range of work-streams and sub-groups that specifically include support for organisational change, the changing workforce requirements and the financial stability of the whole system of health and social care.

A memorandum of understanding has been developed between members of the Hull 2020 Programme Board that underpins the contribution required from each part of the system – this includes the agreed risk management arrangements.

Mechanisms must be created that allow funding to flow to the point of need, in order that the shift of care is mirrored by a shift in resource. This will be supported by formal risk management arrangements that mitigate the impact of financial flows within the system and the impact on any individual organisation in any one financial year.

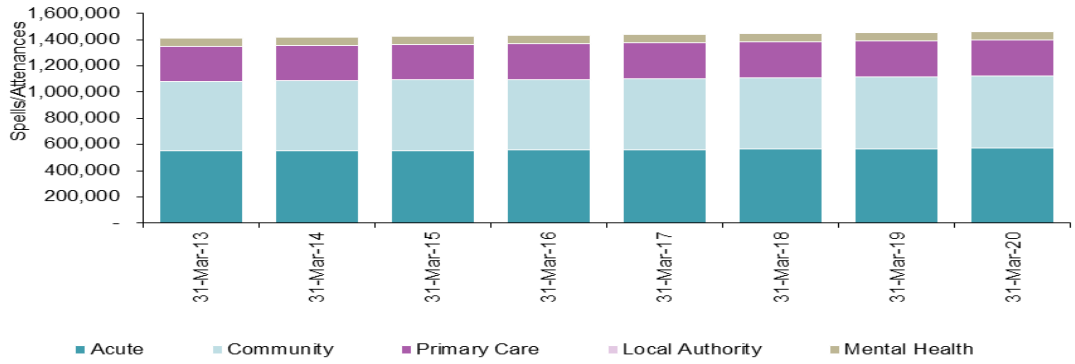
Existing commissioning forums with each of the main providers will continue to support the detailed working of the required system changes.

We expect to maintain performance on all the NHS service delivery targets; this will be closely monitored through the Hull 2020 programme management arrangements and the management of projects that support the Better Care Fund. Proxy indicators will be used to support progress against the broad outcome measures.

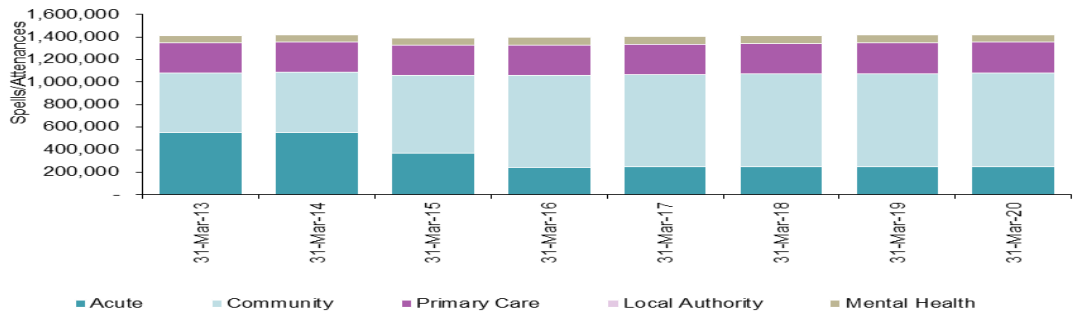
A process of consultation, engagement *and agreement* with providers is underway and still in development at the time of this draft submission.

The following graphs show a high level representation of the potential activity shift over the next six years as a result of transformational initiatives across the City of Hull, from base case activity to activity following the implementation of initiatives.

Base case activity



Post initiative activity



Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.