# Hull Integration & Better Care Fund Plan 2017 – 2019

Hull City Council

NHS Hull Clinical Commissioning Group

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## FOREWORD

Since 2014, Hull City Council and NHS Hull Clinical Commissioning Group have developed a strong partnership to deliver Better Care for the people of Hull.

The Better Care Fund has acted as a catalyst for integration of services and professions across health, social care, public and third sectors. As we move into our third Integration and Better Care Fund plan, we recognise that the Better Care Fund and pooled budgets between the CCG and Local Authority underpins our wider ambitions to integrate commissioning and delivery across all services within our local Place Based Plan for Humber, Coast and Vale Sustainability and Transformation Plan (STP), which is led by the Chief Executive of Hull City Council with the CCGF accountable officer as Vice Chair

A milestone achieved in 2016/2017 was the development of Integrated Commissioning between the CCG and Local Authority and the reconfigured governance structure across both organisations. This will underpin our Better Care plan and further develop section 75 agreements for both Adults and Children's health and social care services.

Our plan for 2017-2019 builds on the successes of service delivery so far, and has a focus on our flagship project for integrated adult services, in the development of an integrated care centre which will act as a hub of integrated services across the city.

In developing our plans we are focusing our work on measuring the success of existing better care fund services through 2017-2018 to inform how we can further integrate services across the city.

## 1. LOCAL VISION FOR HEALTH AND ADULT SOCIAL CARE

Together the adult social care vision of " A Life not a Service" and the clinical commissioning group vision " Creating a Healthier a Hull" will deliver our Integration and Better Care Fund vision **"People in Hull can expect better care and better care will be organised around them"**

In delivering integrated services and meeting our objectives - our core 4 headline schemes and principles are:

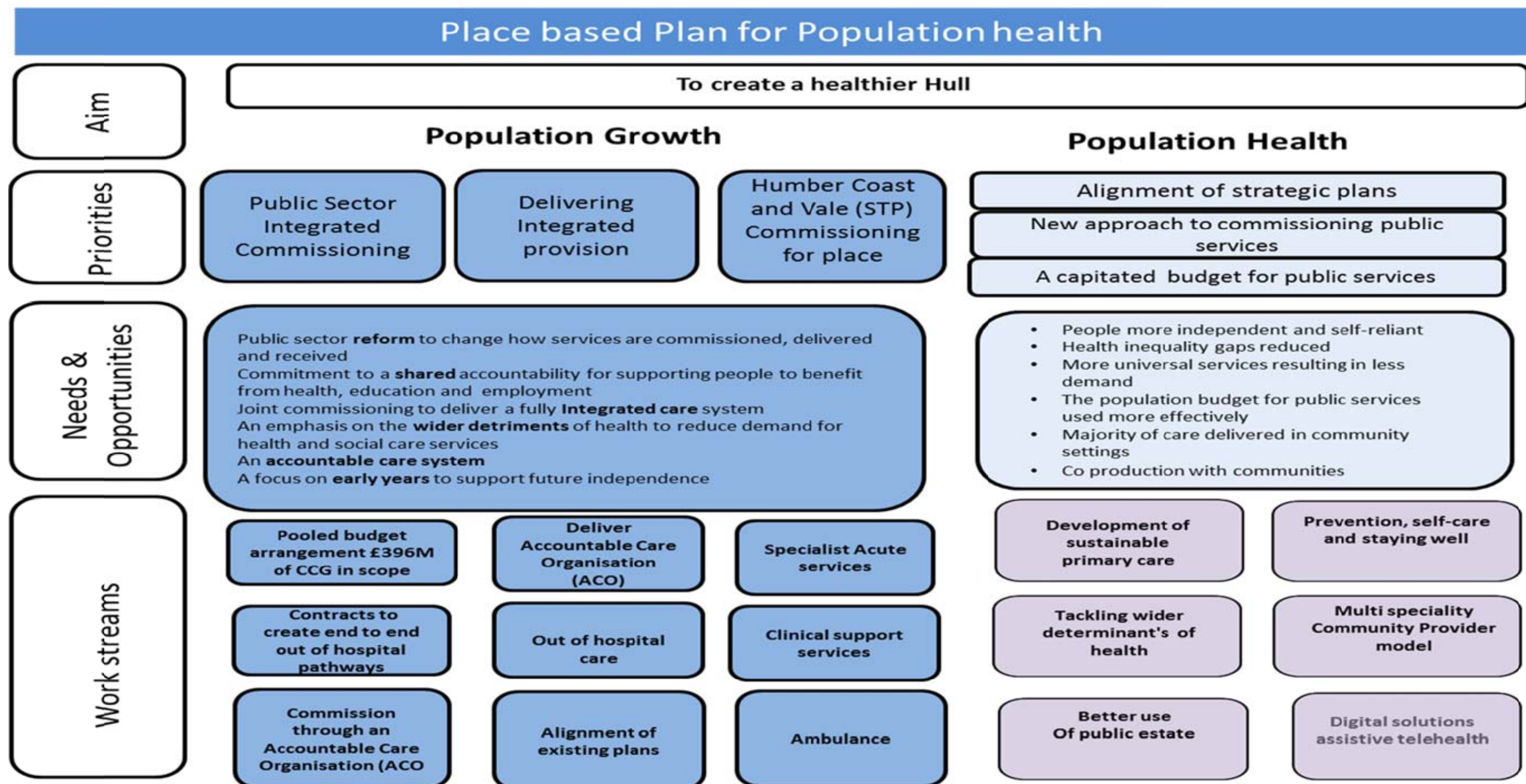
**Prevention, Intervention, Rehabilitation and Rapid Community Response**

## Strategic Planning

The following section describes how the BCF plan now sits within broader strategic planning in Hull.

The city plan for Hull is a strategic plan for economic and inclusive growth and has been updated to include health and care services. This in turn has been aligned to the Humber, Coast and Vale STP Place Based Plan for Hull which is taking a population health approach to planning under the headings of; Integrated Commissioning, Integrated Delivery and alignment to STP.

The diagram below shows the population health approach being taken in the development of the place plan for Hull.



The City Plan and local STP place based plan informs our integration and better care fund objectives with delivery of the following aims.

- **Integrated Commissioning**
  1. An integrated financial plan covering health and social care
  2. An integrated prioritisation process for investment and disinvestment
  3. Joint Commissioning to deliver a fully integrated care system
  4. A joint approach to contracting and procurement
  5. A reduction in duplication and the sharing of skills and resources across Hull City Council and Hull CCG

- **Integrated Delivery**
  1. Sustainable primary care at scale
  2. An integrated delivery model for Hull
  3. A shift from acute to the community
  4. Services aligned to other strategic plans (e.g. STP level plans)

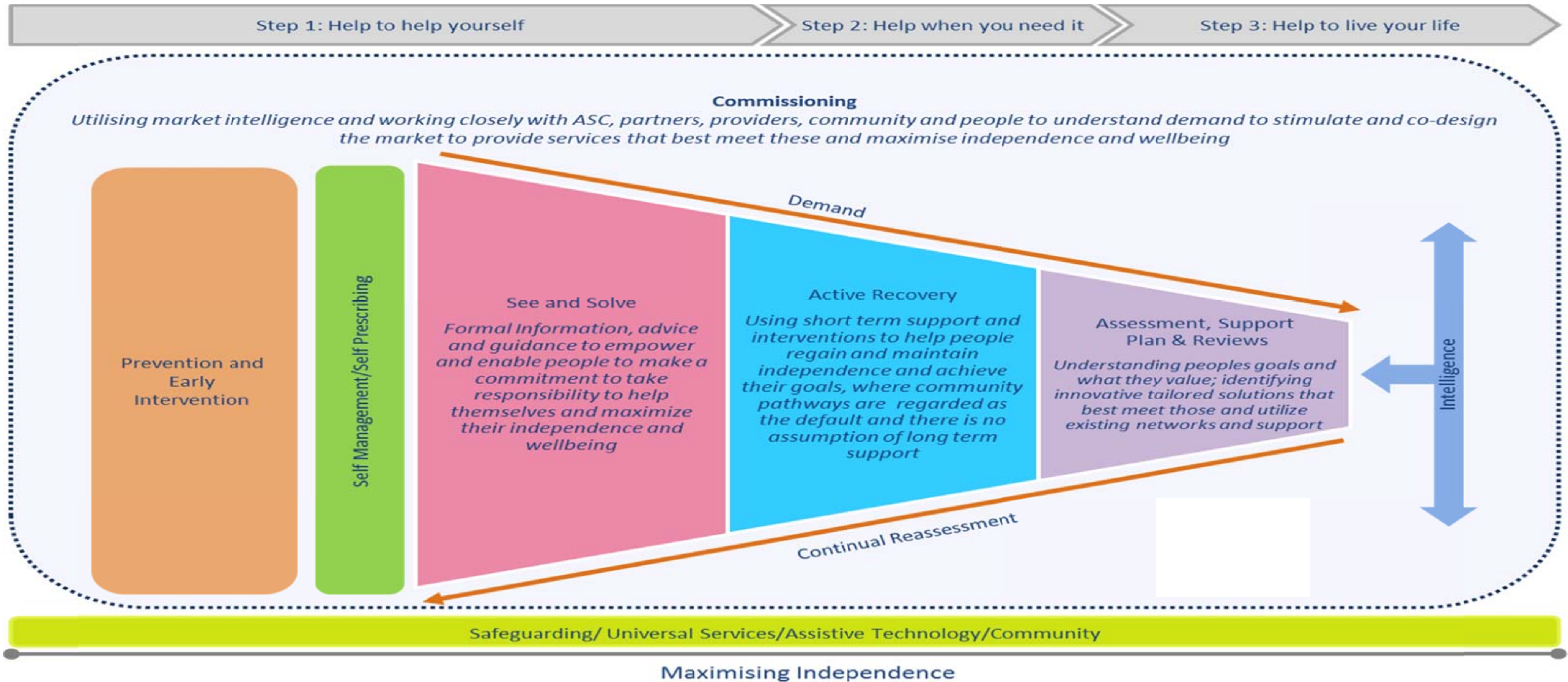
- **Tackle wider determinants of health**
  1. System change through public sector reform
  2. A strategic response to addressing need and managing population health
  3. Community participation, ownership and empowerment
  4. Local ambitions for economic growth, investment and infrastructure combining the broader objectives of the city plan which improves health and wellbeing for the population
  5. An emphasis on the wider determinants of health to reduce demand for health and care services

In addition to the system wide plans, the local adult social transformation programme will see changes in the way services are accessed and delivered from 2017. Underpinning this are key principles to support people that maximises independence and wellbeing.

The new operating model is based on 3 steps:

1. **Help to help yourself**
2. **Help when you need it**
3. **Help to live your life**

The model below shows our ambition for the delivery of adult social care services from 2017:



### A number of guiding principles have been developed which underpin the design of the Adult Social Care Model:

- Maximise independence and help people live the fullest life possible, preventing, reducing or delaying the need for formal services, by focusing on enabling people to do things for themselves with the support of their own networks and the community;
- Provide a prompt and adequate response to everyone, not just those people for which there is a statutory duty, ensuring provision is correctly prioritised;
- Facilitate a whole community approach to improving wellbeing and maximising independence across Hull by building new, and strengthening existing networks and partnerships across the community;
- Prevent social care needs from escalating wherever possible, ensuring a financially sustainable service;
- Provide a greater focus on prevention, early intervention and support for self care through promoting and encouraging self management at the earliest opportunity;
- Provide creative and innovative solutions which draw upon family and community networks  not reliant on ASC
- Provision of services will be equitable of 7 days supporting people in the community and hospital. New commissioning frameworks will be developed to support 7 day services with social care providers aligned to health services already providing 7 day services.

## Integrated Care Centre

**For people who attend the centre, they will receive a single assessment which will be shared across health and social care to provide joined up care across providers.**

Our Integrated Care model focuses on frailty and the pathway supports people to receive the correct support at the right time from the most appropriate practitioner depending on which stage they are on the pathway.

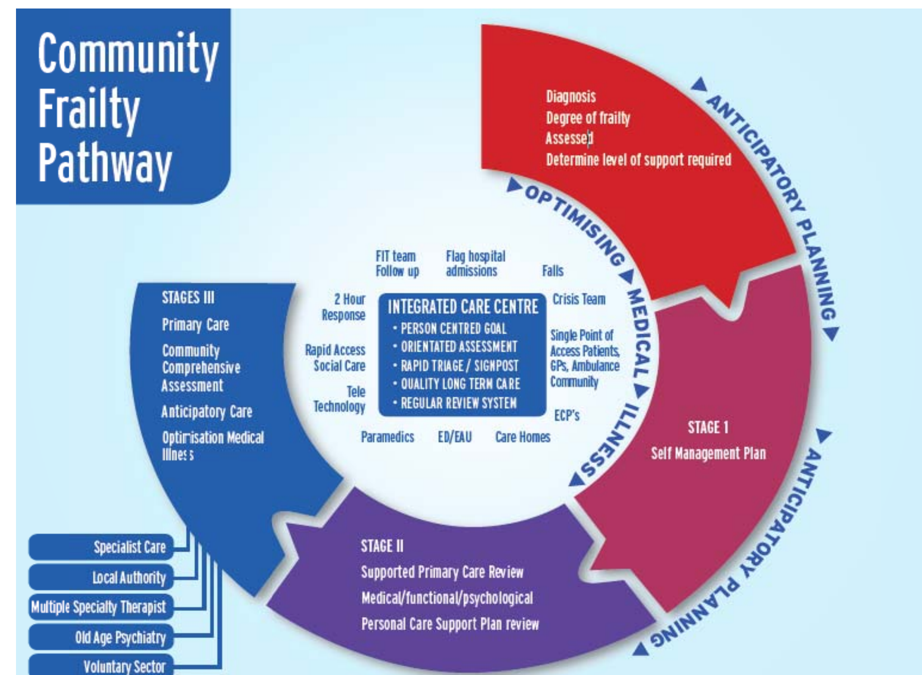
This model is being implemented across the community, and the centre will act as the hub for integrated care.

### Our flagship project for our 2017-2019 plan will be the opening of the Integrated Care Centre in May 2018.

The centre will be the home of health and social care teams to support people within the community. The centre will provide outreach provision to care homes and our extra care facilities.

Proactively managing the 4% of our population in the first instance who are frail or with multiple long term conditions.

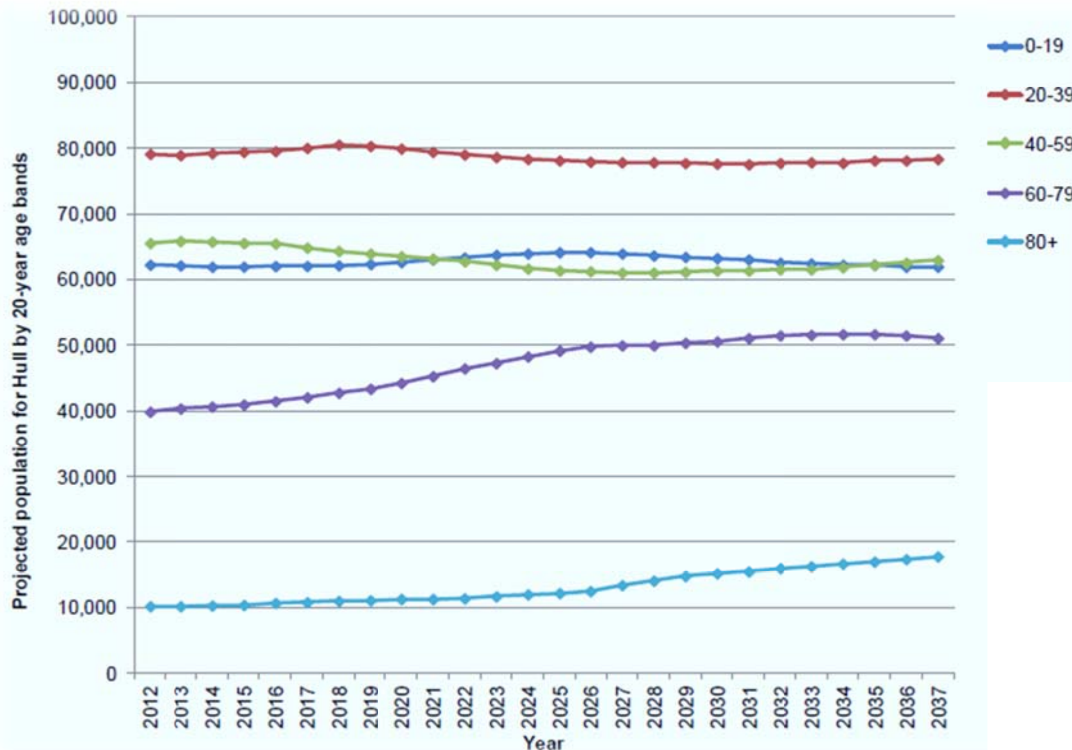
The centre will be open 7 days a week with an aim to prevent non elective admissions and re-admissions to hospital.



## 2 Performances and Progress

### Hull is the third most deprived city in the UK and is predicted to see a 23.8% increase in people aged 65 and over by 2025

Kingston upon Hull has a population of approximately 258,000 people and a GP practice list size of c296,000 from the neighbouring towns and villages on the border with the East Riding of Yorkshire. The Hull CCG and Hull City Council boundary is co-terminus, whilst the GP list size is 30K higher than the population this in itself is not a major issue as ourselves and East Riding of Yorkshire are major users of Hull & East Yorkshire Hospitals NHS Trust highlights why it is important to work closely with our partners in the East Riding and keep sighted on the direction and development on each others plans.



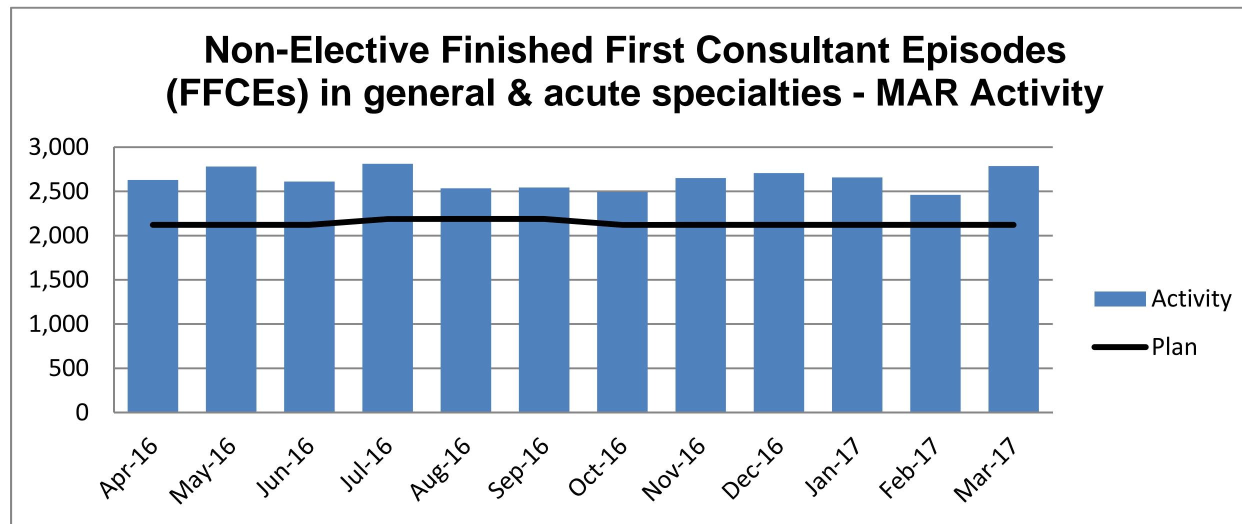

Life expectancy is lower than the UK average (77 years for men, 80 years for women). Long term conditions prevalence is high and people tend to seek support later in their disease progression so that preventative interventions and support are too late, this in turn results in the reliance of secondary care services.

The percentage of people aged 65 and over in Hull out of the total population is currently estimated at 14% but it is expected to increase by 23.8% by 2025; the percentage of people aged 85 and over is currently around 1.8% and is expected to increase to 2.5% by 2025.

In 2016/17, 305 people aged over 75 where placed permanently into residential care. Our plan focuses on integrated assessment and review by health and social care to maximise independence.

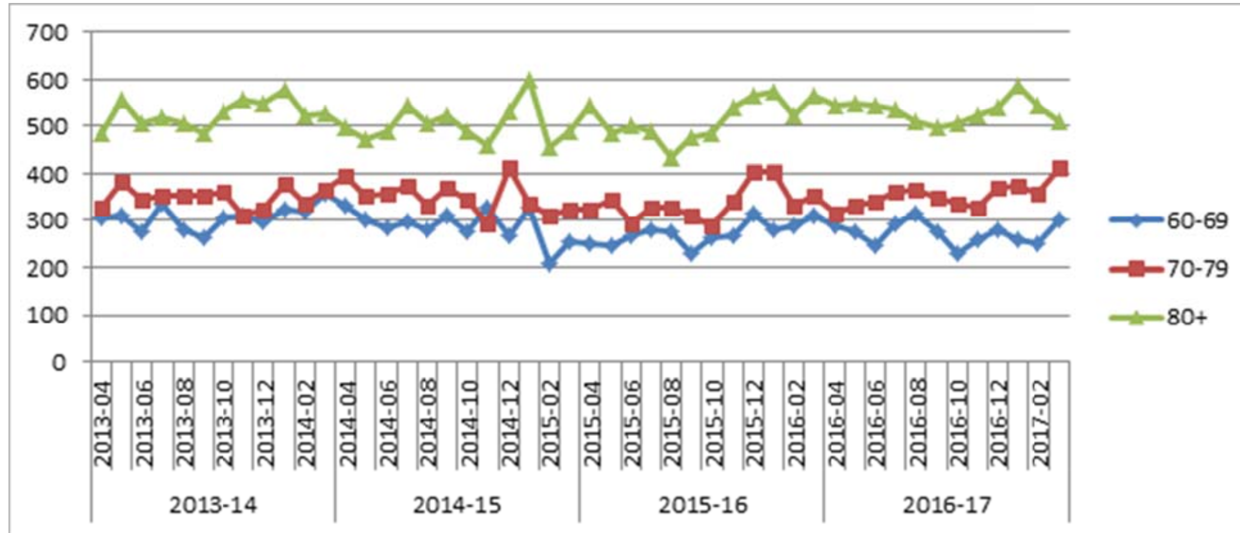
Hull's population is set to increase to 261,000 by 2025. The impact of an ageing population, living with a range of long term conditions places increasing demand on appointments within the whole system, not just primary care. Coupled with this is the impact of social isolation brought about by a less mobile group of people which adds the need for public sector services to be delivered in a coordinated, seamless manner placing individuals at the core of decision making.

The default position for many is still to go to hospital and the emergency department. In 2016 we established an urgent care centre with diagnostics and x-ray facilities to reduce demand on the emergency department and prevent an unnecessary admission. Our work for 2017-2019 will be to work with care homes, enhancing health and social care support within the homes for the most complex residents and the utilisation of both the community urgent care service and an outreach service within the integrated care centre which is currently being built and due to open in May 2018. Both of which will enhance our Health & Social Care - Care Coordination model.




*During 2016/17 our non elective admissions continued to over trade against our trajectory.*

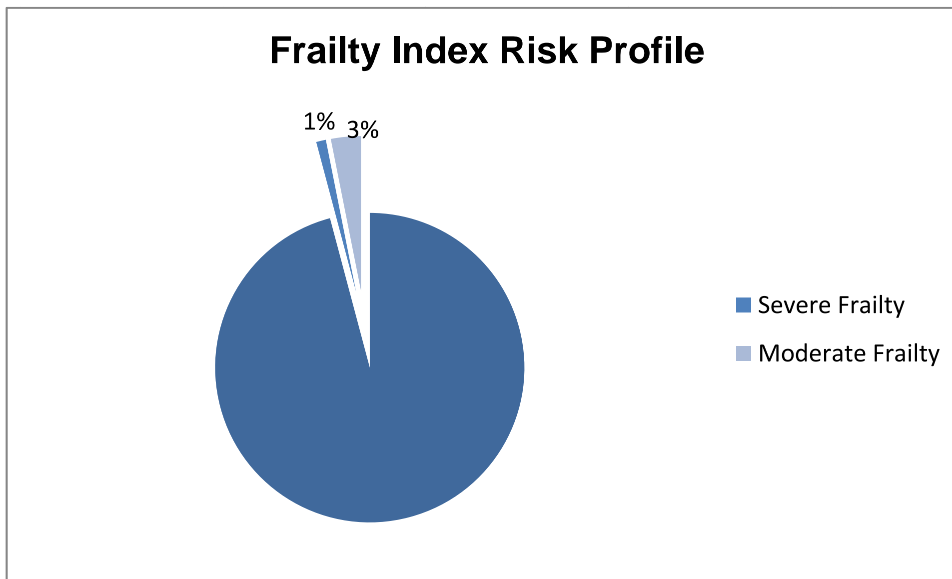
*In partnership with East Riding of Yorkshire CCG a risk and incentivised contract was established with Hull & East Yorkshire Hospitals NHS Trust. This new block contract providing a fixed income to our acute Trust, heralds a fundamentally different approach to working together and improving health outcomes. This has been welcomed by the Trust and commended by NHS England.*




**Hospital Admissions**
A significant number of our elderly population was admitted to hospital. The graph shows the number admissions of people admitted with our population being over the age of 80.

**60%** of people discharged through our Transfer to Assess process are over the age of 80. This approach will be enhanced through phase 2 of the Integrated Care Centre.

To understand the issues and potential demand for the integrated care centre and priority for integrated care. The Frailty Index Tool has been undertaken within primary care.




*With the practice list size at c296K the results show that 1% of people are severely frail and 3% are moderately frail. This information will allow practitioners to proactively case find and manage people at risk of a hospital admission and provide care closer to home.*

Our local population has a mix of health, care, education and social needs within each individual. We cannot separate out these individual needs, which make up that unique person, and many of these needs are co-dependant with changes in one having a direct impact on other aspects.

Yet we currently continue to have organisational structures which manage the individual aspects separately leading to duplication and gaps in services, less optimal outcomes and additional financial impacts.

Through our joint working focussed around Better Care we have successfully started integrated commissioning of health and social care with a greater focus on outcomes as well as joint systems and processes.

The focus for 2017/18 is to move towards integrated commissioning between the CCG and the local authority with alignment between aspects of Adult Social Care and will include Children's & Young People and Public Health.

**NHS and Social Care Interface**

Hull is currently ranked 16th in the country on the NHS and Social Care Interface, our integration and Better Care Fund plans aim to maintain this position whilst building on the good practice through a programme of work measuring the success of our schemes.

## Priorities

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

- There is a continued 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 continue to improve frontline, day-to-day **communication** between professionals in order to deliver a seamless blend between service providers and service sectors.
- In terms of the **resources** available, there is a need to improve efficiency and deliver services for the 21st century. In addition, a major challenge is to recruit and retain a highly skilled workforce, in particular primary care services face major challenges in recruiting and retaining staff. The public sector is the largest employer in Hull and being proactive with schools such as the newly established St Mary's Health & Social Care Academy can encourage local people to train and work in Hull to deliver excellent public services.
- Measures and metrics for performance of services are **cross-sector and jointly owned.** The role of the Integrated Commissioning Officers Board (ICOB) and Strategic Partnership Board will be a critical enabler for these changes, particularly with regards to driving further forward integrated delivery.

## Our Partners

Our plans will be delivered through public sector reform and focus on people, communities and place. Our partners to our Integration and Better Care plan support integrated delivery and our future plans.

A system wide approach is developed and overseen by the City Plan - Health & Care, Strategic Partnership Board. The Board will oversee all strategic plans relating to health and care.

**Appendix 1** – Hull Place Based Plan
**Appendix 2** – Strategic Partnership Board Terms of Reference

**Our partnership with healthwatch and the third sector continues into 2017-2019 to provide consultation and engagement with people and services.**

Both the CCG and Local Authority of Major Partners of Hull 2017. This is playing a part in reducing social isolation and bringing health and wellbeing as a focus of events as part of being the City of Culture.

## Progress

Following a successful year of implementation of the Better Care in Hull plan, Hull City Council and the CCG have been building on the integration between health and social care.

| | |
|---|---|
| **Prevention** | Mobilised Extra Care Housing sites, providing 316 homes for people with support needs, ensuring services provided on site meet the needs of people and the local communities in which they serve |
| | Development of early help and prevention through the establishment of the See & Solve team within the community for people to access to get advice and support when in need. |
| | Progressed with the System Integration and interoperability to develop a Local North Bank Integrated Care Record, reviewing options for single assessment tools |
| | Produced a Falls Prevention Campaign and leaflet for public awareness of risks of falls |
| **Intervention** | Further developed the care coordination model that will support the integrated care centre once opened |
| | Commissioned the social prescribing “Connect Well Hull” service and launched an online support portal for public and professionals to access to find out about what services are available from health, social care and community groups. |
| | Embedded the ‘Carers Service’ integrated within primary and social care to support carers, ensuring joint assessments and needs are met |
| | Established Multi-Disciplinary/Agency Teams pilot within Primary Care |
| | Early support at the point of diagnosis for people with Dementia, ensuring they and their carers receive quality information, advice and support. |
| **Rehabilitation** | Increased the Active Recovery offer within Health and Social Care to support people to be re-abled at home and through our reablement units |
| | Developed the transfer to assess model within the acute trust, and piloted trusted assessments |
| **Rapid Community Response** | Evaluated and commissioned the Hull FIRST Falls Pickup Service, and enhanced referral pathways from community alarms and housing providers/sheltered schemes. |
| | Started the building works on the Integrated Care Centre due to open May 2018. |

# 3. THE PLAN

## Funding Contributions

Our Integration and Better Care Fund financial plan will see £36.9m for 2017/18 and £40.8m in 2018/19 pooled together for health and adult social care under section 75 agreements.

| Contributions | 2017/18 £ | 2018/19 £ |
|---|---|---|
| Improved Better Care Fund | 8.97m | 12.6m |
| CCG Minimum | 20.1m | 20.5m |
| CCG Voluntary | 2.1m | 1.7m |
| Local Authority Voluntary | 3.7m | 3.7m |
| Disabled Facilities Grant | 2.157m | 2.347m |
| **Total** | **36.99m** | **40.75m** |

Our plans for the additional grant funding from the iBCF have been allocated to new programmes of work to meeting the grant conditions. The funding is apportioned to each condition as detailed below:

| Improved Better Care Fund | 2017/18 £ | 2018/19 £ |
|---|---|---|
| Market Stabilisation | 6m | 8.1m |
| Reducing Pressures on the NHS | 1.4m | 2.7m |
| Social Care Need | 1.6m | 1.8m |

## Delivery

The Delivery of our Integration and Better Care Fund Plan is split into 4 core areas:-

- Building the success of Better Care Fund into the local approach to integrated commissioning
- Measuring the success of our schemes and existing plans
- Build up the work already undertaken and further implementing the High Impact Change Model
- Implementing further investment from the Improved Better Care Fund, meeting the grant conditions

## Better Care Fund

Our 2016-2017 Better Care Fund plan set out to spend on services under our 4 headline schemes. These have been delivered and continue into our Better Care plans for 2017-2019. As part of this process we have reviewed three services established under the our plans which are attached as **Appendix A, B and C**.

Our priorities for 2017-2019 remain the same as set out below, whilst we progress the initiatives from the previous plans, we continue to measure the success of priority services.

| | |
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| **Prevention (BCF 1)** | • See and Solve<br>• Befriending<br>• Extra Care housing<br>• Home Care (Supporting Independence)<br>• Falls Prevention<br>• Information Sharing/Systems Integration |
| **Intervention (BCF 2)** | • Care Coordination<br>• Social Prescribing<br>• Multi-Disciplinary Team long-term condition management<br>• Health & Social Care Single Point of Contact(s)<br>• Carers' Service<br>• Dementia Collaborative<br>• End of Life<br>• Mental Health |
| **Rehabilitation (BCF 3)** | • Active Recovery (Reablement)<br>• Falls Recovery<br>• Health & Social Care Transfer to Assess<br>• Intermediate Level of Care: (Thornton Court/Highfield/Early Supported Discharge-Stroke) |

| **Rapid Community Response (BCF 4)** | • Hull First – Falls Response<br>• Integrated Care Centre<br>• Ambulatory Care |
|---|---|

In addition to our existing plan we will be progressing initiatives that support integration and the Better Care Fund for 2017-2019:

| Scheme | What are we delivering | Outcomes | When will this be delivered |
|---|---|---|---|
| **Prevention** | Integrated Health & Social Care Dementia Support for people newly diagnosed with dementia | • A new pathway for dementia services<br>• Early diagnosis and access to treatment and support services<br>• Increased Registered population with practice planning for patients and carers | May 2017 |
| **Intervention** | Proactive Case Management / Frailty Pathway | • Application of the electronic frailty (EFI) index across primary care<br>• All severely and moderately frail identified and care plan in place<br>• Reduction non elective admissions and readmissions | October 2017 |
| **Rehabilitation** | Increasing capacity at our Active Recovery pathway to support people home following a hospital admission to people with therapy interventions and social care needs to maximise independence. | • Reduction in admissions to residential care<br>• Reduction non elective readmissions<br>• Reduction in Delayed Transfers of Care<br>• Reduction in Hospital Length of Stay | December 2017 |
| **Rapid Community Response** | The **Integrated Care Centre** will provide health and social care assessment and intervention to support people closer to home, within the community. The centre will provide an outreach service | • One Single point of access<br>• (*sign post and mobilise* services)<br>• Single Assessment Framework (*will make use of a shared support plan and integrated care record and be compatible with multiple systems.*)<br>• An integrated Care coordination model | May 2018 |

| | | | |
|---|---|---|---|
| | into Care Homes | (*encompasses self-care support, advocacy, monitoring and review across disciplines).*<br>• Rapid access to high quality effective response and decision making in the community including diagnostics<br>• Integration of Mental and physical health increasing psychological input to MDT's supporting patients with long term conditions.<br>• Optimisation of third sector support<br>• Effective on-going review process.<br>• Optimisation of tele- technology/ accessible expert advice in a crisis. | |

Measuring the success of our existing schemes:

| Scheme | What service are we measuring | What are the key measures of success | When will this be undertaken |
|---|---|---|---|
| **Prevention** | Dementia Academy | • Joint Working / Single Assessments<br>• Improved Peoples Outcomes<br>• Positive Service User Feedback<br>• Partner Feedback<br>• Approach to Integration<br>• Service Leadership<br>• Governance & Quality | October 2017 |
| | Falls Prevention | | January 2018 |
| **Intervention** | End of Life | | April 2018 |
| | Single Points of Contact | | December 2018 |
| **Rehabilitation** | Early Supported Discharge (Stroke) | | July 2018 |
| | Active Recovery | | February 2015 |
| **Rapid Community Response** | Ambulatory Care | | October 2018 |
| | Rapid Responder Service | | March 2019 |

## High Impact Change Model

A system wide action plan has been developed to implement the High Impact Change Model – **Appendix 3** shows an overview of the action plan agreed at the Hull & East Yorkshire A&E Delivery Board.

Utilisation of the Improved BCF has been developed in our plans to implement the High Impact Change Model.

## Improved Better Care Fund

Hull's plan for the Improved Better Care Fund has been aligned to the 3 grant conditions and aims to invest in capacity to delivery. the 8 domains of the High Impact Change Model. A focus of implementing the iBCF will be undertaken during 2017/18 and measured through waypoints during 2018/19.

| Scheme | Description | Outcomes |
|---|---|---|
| 1. **Homecare Capacity** | A 5% uplift incentive in actual and planned activity within the home care market to free up additional capacity within the established homecare framework.<br><br>Investment into the CM2000 software for homecare monitoring to enable commissioners to monitor delivery and market capacity across all providers. | • Stabilise the home care market to provide choice and flexible provision<br>• Incentivise weekend discharges from hospital when packages of care are established or restarted.<br>• Increase capacity to meet acute demand on discharge when medically fit, meeting the Estimated Discharge Date (EDD)<br>• Homecare providers will lead on acute planned admissions ensuring that packages can be restarted for people in receipt of their care<br>• A system to see market capacity and manage patient flow |
| 2. **Residential Capacity** | An inflation uplift to residential care providers. The uplift is required to meet the change in demographics and the ageing population and reduce the additional pressured which have not been met by the social care grant and council tax revenue generated for adult social care. | • Residential Market receives increase to support National Minimum wage and inflation increases<br>• Provision of placements for changing demographics<br>• Incentive to support weekend discharges back to residential care 7 days a week<br>• Increase in number of people in receipt of Direct Payments |
| **3. Integrated Commissioning Development** | Commissioning development will focus on establishing an integrated commissioning team, working with health commissioners to enhance health with care homes and social care services. | • Service Directory for public, people and professionals to self help and support people to access services<br>• Re-tender of adult social care frameworks<br>• Implement the High Impact Change Model across providers<br>• Integrated Health & Social Care Commissioning |

| | | |
|---|---|---|
| | Providing best value for money, quality and support to meet peoples outcomes<br><br>Strengthen the Quality and Contract Monitoring function | • Quality Monitoring and Outcomes of contracts<br>• Market Stability through contact monitoring<br>• Commissioned regulated provision of achieving outstanding |
| **4. Support Package Brokerage** | Establish a brokerage service that coordinates all packages of care utilising the trusted support plans and assessments undertaken by the teams. | • Increases capacity of social workers, to concentrate of advice, information and assessments<br>• Central oversight of market capacity and stability, creating a single point of contact<br>• Dedicated Brokerage Officer(s) for hospital discharges<br>• Monitor and manage intelligence of people across the system in services ensuring that peoples outcomes are delivered through monitoring progress in short term placements |

| Scheme | Description | Outcomes |
|---|---|---|
| **5. Active Recovery** | A multi disciplinary service providing social work and support to promote HomeFirst. This will support the discharge from hospital, intermediate care and community placements. | • Increase capacity to support discharge from secondary care and facilities to ensure people go home safely<br>• Promotes Discharge to Assess model across health and social care |
| **6. Rapid Responder Service** | Providing a rapid response service for people with social care needs in the community. The service will be linked to lifeline to provide an alternative to 999 ambulance calls in social crisis | • Supports people to obtain a lifeline when no relatives, carers or friends can be the named contact<br>• Increase in number of people with a lifeline across the city<br>• Integrated to support other lifeline pathways such as the Hull FIRST Falls pathway<br>• Increases capacity with the Out of Hours team |
| **7. Rapid Recovery Short Stay Service** | Integrated within DTOC service, specifically for short term placements and intensive therapy. This will support the existing Thornton Court scheme | • Increases capacity through rapid turn around for appropriate people for active recovery/rehabilitation<br>• Integrates with existing health services including Therapies and Early Supported Stroke Discharge |

| | | |
|---|---|---|
| | within the Better Care programme, with faster turnaround times to get people home with rehabilitation services from Health & Social Care<br><br>Availability of intensive active recovery step down placements in the community | • Creates additional capacity for active recovery placements within the community |
| **8. Crisis Housing Support** | Supporting people with housing needs, will coordinate the discharge of people from hospital and community settings working across all agencies to support a person home – existing or new. | • Coordination of complex cases across agencies and housing sector<br>• Ensures people have the adaptations required to live independently<br>• Housing issues dealt with by a specialist, reducing demand on social care<br>• Supports rapid discharge from hospital and community settings, reducing delays for housing issues |
| **9. Seven Day Services** | To support the NHS, by providing adult social care services 7 days a week and prevent unnecessary admissions and delayed discharges;<br><br>7 day services will include Social work, Active Recovery, Supporting Independence and Brokerage Provision of 7 day services within commissioned HomeCare and Residential Care | • Establishes diversionary pathways for social care needs with ambulance service, community urgent care services, emergency department and assessment units to prevent attendance or admission to hospital<br>• Support people within in the community in crisis to prevent unnecessary attendances<br>• Provision of equitable services 7 days a week, 365 days a year<br>• Sunday to become the new Wednesday where services are optimal across health and social care<br>• Effective safe discharges from hospital on a weekend |
| **10. Homecare Responder Service** | Pilot to work with  homecare providers provide market capacity and support discharge in establishing packages of care through the discharge to assess process. | • Maintain the DTOC target of under 3.5% daily delays when people are not eligible for Active Recovery as have no rehabilitation potential and require care. |

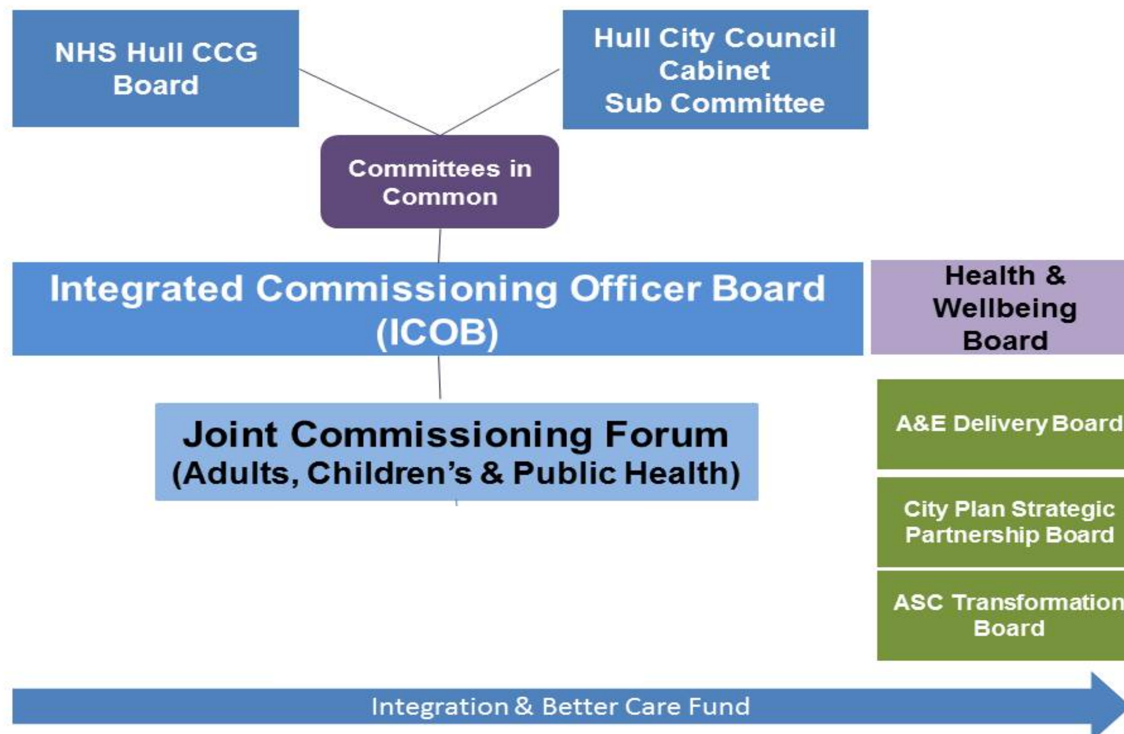
| Scheme | Description | Outcomes |
|---|---|---|
| **11. Community & Early Help Pathway** | Develop the community infrastructure and stimulate the third sector/community groups to provide support for people to maintain independence.<br><br>Identification on gaps in the market and coordination of prevention and early help which will strengthen community response and mapping. | • Supporting people that are socially isolated and feel lonely<br>• Supporting people diagnosed with Dementia offering early help, information, advice and support for people and their carers<br>• Support carers health and wellbeing<br>• Provision of services to support social prescribing<br>• A mature early help pathway within the community<br>• 7 day services across the community |
| **12. Locality MDT Development** | Development of the locality teams to provide a multi-disciplinary approach to people with care needs to support independence and regular reviews to ensure the level of care is appropriate | • Supports working closely with Primary Care and Community Health to effectively manage elective admission<br>• Reduces assessment waiting lists through a one off investment<br>• Investment into patient flow systems (Cayder) to link locality and community teams to hospital discharge pathways |
| **13. Quality & Workforce Development** | Investment into the in house provision and commissioned services to provide quality and a highly skilled workforce that is responsive to the new operating model of adult social care in Hull. | • Recruitment events to generate interest in careers in social care, supporting efforts of St Mary's Health & Social Care Academy and other providers of social care training.<br>• All staff trained on Solution Focused Thinking, moving towards the new operating model to reduce number of assessments and promoting self help<br>• All staff trained as trusted assessors to allow assessment to be accepted across health and social care professions, reducing the number of assessments people receive by different professions<br>• Schemes to offer practice development and apprentices within adult social care that are professionally co-ordinated<br>• Membership of the Care Association to provide best practice and quality standards across social care and a DTOC Coordinator and represent all care homes in Hull<br>• Annual Quality Conference for services in Hull to celebrate outstanding delivery and promote best practice and sector-led improvement across health and social care |

In developing the schemes for the Improved Better Care Fund, the schemes have been mapped against:

- **Grant Conditions**
- **High Impact Change Model**
- **Better Care Fund Headline Schemes for Integration**
- **Adult Social Care New Operating Model**

| Ref | Scheme | Market Stablisation | NHS Pressures | Social Care Need | High Impact Change Model | | | | | | | | BCF Mapping | | | | ASC New Operating Model | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Early Discharge Planning | Systems to Monitor Patient Flow | Multi Disciplinary Teams | HomeFirst / Discharge to Assess | Seven Day Services | Trusted Assessors | Focus on Choice | Enhancing Health in Care Homes | Prevention | Intervention | Rehabilitation | Rapid Community Response | Early Intervention | See & Solve | Active Recovery | Assessment | Health & Hospital | Commissioning | Brokerage |
| 1 | Home Care Capacity | ■ | | | ■ | | | ■ | ■ | | | | | ■ | | | | | | ■ | ■ | ■ | ■ |
| 2 | Residential Care Capacity | ■ | | | | | | | ■ | ■ | | ■ | | ■ | | | | | | ■ | ■ | ■ | ■ |
| 3 | Commissioning Development | ■ | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | | | | ■ | |
| 4 | Support Package Brokerage | ■ | | ■ | ■ | ■ | ■ | | ■ | ■ | ■ | | | ■ | ■ | | | | | | | | ■ |
| 5 | DTOC Service – Active Recovery | | ■ | | ■ | ■ | ■ | ■ | ■ | ■ | | | | ■ | ■ | ■ | | | ■ | ■ | ■ | | |
| 6 | Rapid Responder Service | | ■ | | | ■ | ■ | ■ | ■ | ■ | | | | | | ■ | | | ■ | | | | |
| 7 | Rapid Recovery Short Stay Rehabilitation Pilot & Active Recovery | | ■ | | | ■ | ■ | | ■ | ■ | ■ | ■ | | | ■ | | | | ■ | | | | |
| 8 | Crisis Housing Support Pilot | | ■ | | | | ■ | | | | | | | ■ | | | | | ■ | | ■ | | |
| 9 | 7 Day Services across ASC | | ■ | ■ | ■ | ■ | | | ■ | | | | ■ | ■ | ■ | ■ | | ■ | ■ | ■ | ■ | ■ | ■ |
| 10 | HomeCare Responder Pilot | | ■ | | | ■ | ■ | ■ | ■ | | | | | ■ | | ■ | | | ■ | | ■ | | |
| 11 | Community & Early Help Pathway | | | ■ | | | ■ | | ■ | | | | ■ | ■ | | ■ | ■ | ■ | | | | | |
| 12 | Locality MDT Development | | ■ | ■ | | ■ | ■ | | ■ | ■ | | | ■ | ■ | ■ | | | ■ | ■ | ■ | ■ | | |
| 13 | Quality & Workforce Development | | | ■ | | | ■ | | ■ | ■ | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |

# 4. PROGRAMME DELIVERY & GOVERNANCE




To deliver our vision for integrated commissioning and delivery we have reconfigured our governance structure. Robust governance arrangements are in place, via a Programme Delivery system to ensure delivery of the work programme with project leads reporting into the Integrated Commissioning Officers Board which acts as the overarching programme board, responsible for delivery of CCG and Local Authority work programme.

### Joint Commissioning Forum:

- Reviews high level project plans and makes recommendations to support improving the plans
- Receives progress reports ensuring the delivery of each programme is on track, with risks and issues recorded and addressed
- Ensures alignment of the key milestones across the work programmes, managing interdependences as necessary.
- Makes recommendations and progresses information to the Integrated Commissioning Officers Board, Health & Wellbeing

### Integration & BCF Monitoring Group:

Project plans, benefits realisation and progress reports are reviewed / agreed by Integration & BCF Monitoring Group which also monitors Performance and Financial of the pooled budgets. Results from the process of measuring the schemes under the plan will

be reported to this group. This group is the operational management of the projects which interfaces with system wide boards which have their own role within delivery of the Integration and Better Care Fund plan:

- **Hull & East Yorkshire A&E Delivery Board**
  Responsible for the Implementation of the High Impact Change Model
  (Action Plan – Appendix 3)

- **Adult Social Care Transformation Board**
  Responsible for delivering the vision and new operating model within Adult Social Care
  (Business Case - Appendix 6)

- **City Plan – Health & Care, Strategic Partnership Board**
  Public Services oversight and alignment of strategic plans for integrated commissioning and integrated delivery
  (Terms of Reference – Appendix 2)

## Integrated Commissioning Officers Board (ICOB):

20161207 HullICOB ToR.docx

## Committees in Common:

CIC Cabinet Report.pdf

## Risk

The management of risks of the plan will be undertaken and regularly reviewed at the Monitoring Group and reported by exception to the Programme Delivery Board and through the governance structure. The risks of the Integration and Better Care Fund Plan have been reviewed and will be owned by the Integrated Commissioning Officers Board

Project Level risks will be managed by each individual work stream and reported by exception to the Monitoring Group within the parameters whereby risks will impact on the outcomes and benefits being delivered under the plan.

**Appendix 7 –** Fund and Programme Risk Register

Our plan outlines our intentions in relation to financial spend. By November 2017 a Section 75 agreement will be in place which controls the risk sharing arrangements between Hull City Council and NHS Hull Clinical Commissioning Group.

**Appendix 8 –** Section 75 Risk Sharing Agreement

## 5. NATIONAL CONDITIONS

The following section describes how NHS Hull CCG and Hull City Council Better Care plan 2017-2019 meets the national conditions.

### 1 - Jointly Agreed Plan

The Integration and Better Care Fund plan 2017-2019 has been developed between Hull City Council and NHS Hull CCG. Approval for the BCF and Improved Better Care Fund Schemes and delegated responsibilities has been through the governance process as described in section 4. The following timeline shows the approval process.

| Approval Timeline | Date Approved |
|---|---|
| **Integrated Commissioning Officers Board** | 14 July 2017 |
| **Health & Wellbeing Board** | 18 July 2017 |
| **Committees in Common** | 8 August 2017 |

Local partners have been engaged in the development of this plan:-

- Housing – Members of Integrated Commissioning Board
- Health Providers – A&E Delivery and Strategic Partnership Board
- VCS – Strategic Partnership Board

### 2 – Social Care Maintenance

Adult Social Care will be maintained through the following investments whilst implementing the New Operating Model within Hull for Adult Social Care which will see further integration of teams and more resources to address challenges and reduce demand and pressure on the NHS and social care through Active Recovery models that encompass reablement and transfer to assess.

| Social Care Maintenance | 2017/18 £ | 2018/19 £ |
|---|---|---|
| Better Care Fund Allocation to Social Care | **8.41m** | **8.56m** |
| Improved Better Care Fund | **8.97m** | **12.55m** |
| Disabled Facilities Grant (Housing Authority) | 2.157m | 2.347m |
| Care Act 2014 Implementation | 1.69m | 1.98m |
| Reablement | 0.690m | 0.690m |
| Carers | 0.549m | 0.549m |

## 3 – Out of Hospital Services

The requirement to fund NHS commissioned out of hospital services was delivered through service development and improvement plans with the community provider and adult social care in 2016/17.

Our plans for 2017-2019 focus on services around the Integrated Care Centre, in which a whole system approach to develop integrated care in Hull. All partners including the hospital are on board with this development and will see a shift of resources come across from the acute sites into the community. This will build on our approach to "assess to admit" and provide a rapid community response. The integrated care centre will provide fully integrated out of hospital care 7 days a week.

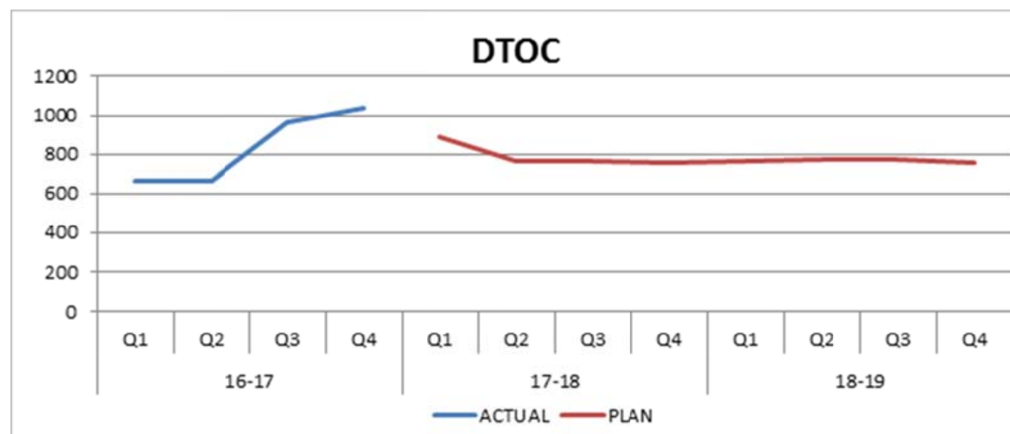
The allocation of fund is as follows and shows the contributions from the minimum CCG contribution and voluntary contributions

| NHS Commissioned Out of Hospital Services | 2017/18 £ | 2018/19 £ |
|---|---|---|
| Ring Fenced for NHS Commissioned Out of Hospital Services | 15.6m | 15.97m |

Hull CCG has entered into an aligned incentive contract with Hull & East Yorkshire Hospitals NHS Trust, this ensures a shared risk approach to the management of demand across the system. Therefore financial risk and the management of activity is shared by all system partners. A new contractual governance structure has been put in place to monitor activity and agreed outcomes.

## 4 – High Impact Change Implementation – Managing Transfers of Care

Our Integration and Better Care Plan focuses on implementation of the High Impact Change Model to establish locally a mature model. Through the use of BCF and Improved Better Care Fund; further work will be undertaken during 2017-2019 to establish system wide processes.




Locally our ambition is maintain our performance for Delayed Transfers of Care.

The NHS and Social Care Interface will be used as tool to review our performance in the 4 metrics for Better Care Fund.

The following matrix outlines the current progress made of implementation since the model was released in 2016, and revised in April 2017. The Monitoring Group will oversee delivery of the implementation from the A&E Delivery Board.

| | Domain | Status | Actions |
|---|---|---|---|
| 1 | Early Discharge Planning | Plans in Place | • Plans in place to utilise providers and single point of contact for people requiring Elective Care with support needs on discharge. |
| 2 | Systems to Monitor Patient Flow | Established | • Development of patient flow systems to cover social care and community virtual wards |
| 3 | Multi-Disciplinary/ Multi-Agency Teams | Established | • Single assessment paperwork to be developed<br>• Increase in capacity to cover 7 days services<br>• Build on services provided by the VCS within the Discharge Hub |
| 4 | Home First/ Discharge to Assess | Established | • Increase capacity for process including nursing, therapy and social care professionals across the pathway<br>• Establish process for Care Homes/Home Care providers to accept people/restart packages |
| 5 | 7 Day Services | Plans in Place/ Established | • Additional resources being recruited to provide consistent health and social care services |
| 6 | Trusted Assessors | Established | • Further development of single assessment tools for health and social care professionals within the hospital and community. |
| 7 | Focus on Choice | Established | • Use of VCS to implement the choice protocol to patients and relatives through existing contracts. Providing early engagement within the Emergancy Department and assessment units.<br>• Integrated VCS within Discharge Hub. |
| 8 | Enhancing Health in Care Homes | Plans in Place | • Review Care Home MDT pilot with Community Health provider to roll out across the city.<br>• Develop Residential Care framework to include requirements on Health. |