Annex A
Better Care Fund planning template – Part 1

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**City of York Council**
Clinical Commissioning Groups	**NHS Vale of York**
Boundary Differences	**City of York Council sits entirely within the footprint of NHS Vale of York CCG. However the CCG also sits within the boundaries of both North Yorkshire County Council and East Riding of Yorkshire and the CCG is working across organisational boundaries to ensure all plans align**
Date agreed at Health and Well-Being Board:	**29/01/2014**
Date submitted:	**<dd/mm/yyyy>**

Minimum required value of BCF pooled budget: 2014/15	**£3,354K** Which comprises: Health Gain Transfer £2,744K Better Care Funding 14/15 £610K
2015/16	**£11,281,000**
Total agreed value of potential pooled budget: 2014/15	**£4.665K** Which comprises: As above £3,354K Reablement Funding £915K Carers Funding £396K
2015/16	**£11,281,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS Vale of York
By	Dr Mark Hayes
Position	Chief Clinical Officer
Date	<date>

Signed on behalf of the Council	City of York Council
By	Dr Paul Edmondson-Jones MBE
Position	Deputy Chief Executive
Date	<date>

Signed on behalf of the Health and Wellbeing Board	York Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Tracey Simpson-Laing
Date	date

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

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

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

We have a number of existing programmes which have included a range of health and social care providers as active participants and our voluntary and community sector as a whole, providers are now also being engaged to help us co design future plans.

On 16th December 2013, CYC and VoY co-hosted a Health and Social Care Integration Workshop, attended by many of the representatives above. The event was used as a platform for communication, engagement and co-design, drawing on local experiences to help prioritise and develop support options for whole-systems integration. The workshop also gave attendees the opportunity to share learning about different ways that they had managed to overcome barriers to integrated care already.

The outputs from the workshop will be used to develop our model for the pilots to enable us to bring health and social care services together and help make person-centred, coordinated care a reality, improve outcomes for residents and provide better value for money, helping to ensure a sustainable, health and social care service that can work together to meet an individuals' needs.

The model we are proposing will:

- Help to address ways of jointly managing budgets / shared resources.
- Support effective risk stratification.
- Provide a rich stream of learning to help in the development and delivery of integrated care that will be shared between all organisations.

- Assist us with modelling the financial implications of integrated care.
- Provide relevant examples of internal and external models and comparators.
- Ensure that patients and service users are at the centre of future models of care.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

By focusing on our vision for whole system integrated care we have been able to engage with all partners, including patients / users. We believe this will help us to achieve true co-design of the future sustainable model for health and social care delivery.

Our vision is based on what people have told us is most important to them. Over the past 2 years, with the establishment of the CCG, the Health and Wellbeing Board and our first Joint Health and Wellbeing Strategy, both City of York Council and VoY have engaged extensively with patients and carers, residents, and the workforce across the public, private and voluntary sectors about the vision and priorities for health and social care. York's Health and Wellbeing remains committed to this level of engagement and hosts at least two stakeholder events per year. The next stakeholder event in March is focused on integrating health and social care, transforming adult social care and the Joint Strategic Needs Assessment.

The CCG also has a robust programme of engagement and communications across the Vale of York population to ensure we continue to build on this momentum. VoY host the Patient and Public Engagement steering group which includes Health Watch and lay membership to ensure we can capture the real experiences of our patients and residents in our strategic and operational planning. A number of our General Practices host patient participation groups and as a CCG we are committed to at least two wider open forums per year and a number of engagement events focused on specific projects, i.e. long term conditions.

The CCG have held a series of 'world café' events to work with residents to identify their priorities and their key messages. We have focussed our approach to our joint strategy on the outcomes of these events and we have a process of continuous feedback and 'sense checking' through our ongoing engagement programme.

We have also hosted a joint Public and Patient Engagement (PPE) event to focus solely on integration and what this means to individuals, their support networks and the wider community. This event re-iterated the key themes of 'tell my story once' and 'seamless movement through the system' and we will continue to build on these themes as we take our joint plan forward. All the partner agencies have committed to joint communications and engagement events to maintain the focus on collaborative working.

Within the Vale of York area, there is an active voluntary and community sector with partner organisations such as University of York, St John's University and Joseph Rowntree Foundation based here. Such organisations can offer research and depth that is immensely valuable to developing our plans for integration, allowing increased choice and control in our local health and wellbeing system, living longer and living well.

The National Voices research provides an informative and positive framework for continuing to develop our patient, service user and public engagement. Both the CCG and our partners are committed to this approach to progress our vision towards integrated, person centred care and support.

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Terms of Reference for York Health and Wellbeing Board	This sets the strategic environment in which our plans are being delivered
Joint Strategic Needs Assessment (JSNA)	Joint local authority and CCG assessments of the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities.
Joint Health & Wellbeing Strategy.	The Joint Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out in the period 2013 to 2016.
Health Gain Plan	Joint agreement to invest health gains money in areas that deliver both ASC capacity and improved health benefits

Winter Pressures Plan	Additional funding from NHS England to assist the flow of patients through the health and social care system during what was anticipated to be an extremely busy period. Plans jointly agreed.

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Our joint vision is for a health and social care system where residents sit at the centre and the system moves in a joined up manner around them. We want to ensure that the system changes we are proposing result in a more responsive approach, through increased cross organisational working and a greater use of reconfigured financial flows and budget setting which challenge existing financial models, leading to true personal wellness budgets.

In order to achieve our vision, we need to enable change to the way individuals access services, both in and out of hospital, and we are determined to deliver the ethos of Right Care, Right Place, and Right Time, and “making every contact count”. If we are successful in achieving this we will see a reduction in the requirement for hospital based activity and a much greater use of community and home based interventions and packages of support.

In order to achieve our vision we recognise that significant system and process changes will need to happen and we intend to address these through a continued focus on partnership working and innovative financial gain share models.

We are also mindful that to achieve true transformation for all of our residents we will need to address the difficult issues of more collaborative Local Authority work and the challenges this will bring.

Specifically the key changes we will see in our integrated health and social care system will be:

Intensive Support Team – We intend to introduce "Intensive Support Teams" whose key responsibility will be to rapidly assess, diagnose solutions and activate solutions to enable individuals to remain at home, or return there at the earliest opportunity, following a period of exacerbation or crisis. This multi-disciplinary, multi-agency team will act as the enablers to ensure care and support packages are put in place as quickly as possible and in the best interests of the individual and their carers. New funding models to incentivise this new approach to care provision will ensure that service providers maximise opportunities for alternatives to admissions to hospital or care homes.

Shared Care Records – through our joint engagement exercises the clear message we have received is that people "only want to tell their story once". We fully support this and as part of our vision for more joined up service provision we see this not only as one of the greatest impacts our new service model will have, it is also one of the greatest challenges we will have to address. This will require new ways of working across organisations and we are committed to using this approach to facilitate the use of the NHS number as the prime identifier for users of health and social care services

Single Access Point - to make sure the shared care record is used most effectively, we also intend to progress to a single access point for residents who interface with either health or social care. This single access point could be a GP, a care manager, a district nurse, a community matron, an OT or specialist MH worker or any other health and social care practitioner with whom the resident has regular contact. This single contact point will retain accountability for their client and will act as their interface and facilitator to all other services and interventions. Clearly when an individual is admitted to a hospital setting, clinical responsibility will transfer to the relevant hospital clinician but the single access point will still have an accountable role for in reach and discharge planning.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

The aims of our new approach to health and social care provision are both qualitative and quantative. We are determined that any changes we implement will have the resident at the heart of them and specifically will increase the quality and timeliness of service provision.

The specific quantative aims of our new service model are:

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

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

- A reduction in the requirement for emergency placements.

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

To support these aims, we will also expect to see significant qualitative improvements through a more integrated and resident centric model of delivery. Initial aims we expect to deliver are:

- Residents only having to tell their story once. This supports the principle of the shared care record and is one of the key messages from our public engagement processes.

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

- Positive feedback and customer satisfaction reports

Measuring success

We aim to put in place a multi-agency programme team who will be responsible for the planning, implementation and normalisation of our model across the health economy.
This team will also be tasked with developing a suite of monitoring and reporting mechanisms that will allow granular analysis of the impact of the model at all levels. Specifically, these reports will need to identify:

- The impact on our local acute provider on a case by case basis. This level of detail will be crucial in order to help build the potential funding model of pooled budgets we hope to be able to achieve

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

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

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

Our approach to success is outcomes based. We recognise that by working together we will achieve greater levels of quality and best value than we have ever been able to achieve through less integrated approaches and by combining our resources appropriately and where necessary we will succeed in this approach.

We recognise that having a robust evidence base on which to build service change is crucial and we want to investigate further partnership opportunities across the region to maximise this requirement.

The truest measure of success will be a financially balanced system where the shift of spending from the acute sector to community settings has supported transformation and allowed acute providers to re-configure under their terms to ensure their ongoing financial viability.

We will also measure the reduction in, or more appropriate allocation of, care packages to identify how our model has enabled a greater level of appropriate independence.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

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

The major change to the model is the development and eventual mainstreaming of Intensive Support Teams (IST) (this title is not set in stone and further work needs to be carried out with partners and the public to finalise). These teams, based on Extensivist models which have been running very successfully in United States, will be multi-disciplinary and multi-agency and will be the enablers that ensure rapid, appropriate and resident centric solutions are put in place to maximise place of choice for

care and support.

In order to ensure we gain maximum learning and innovation from this approach, we do not intend to be too proscriptive on what the IST will look like. We intend to pilot the approach across 2 or 3 localities, with a range of different providers and will work with them to agree outcomes upon which they can then build their teams. By using this 'action learning centric' approach we believe we can capture the best, and identify and dismiss the worst, elements which we will then use to build a final agreed model of service delivery.

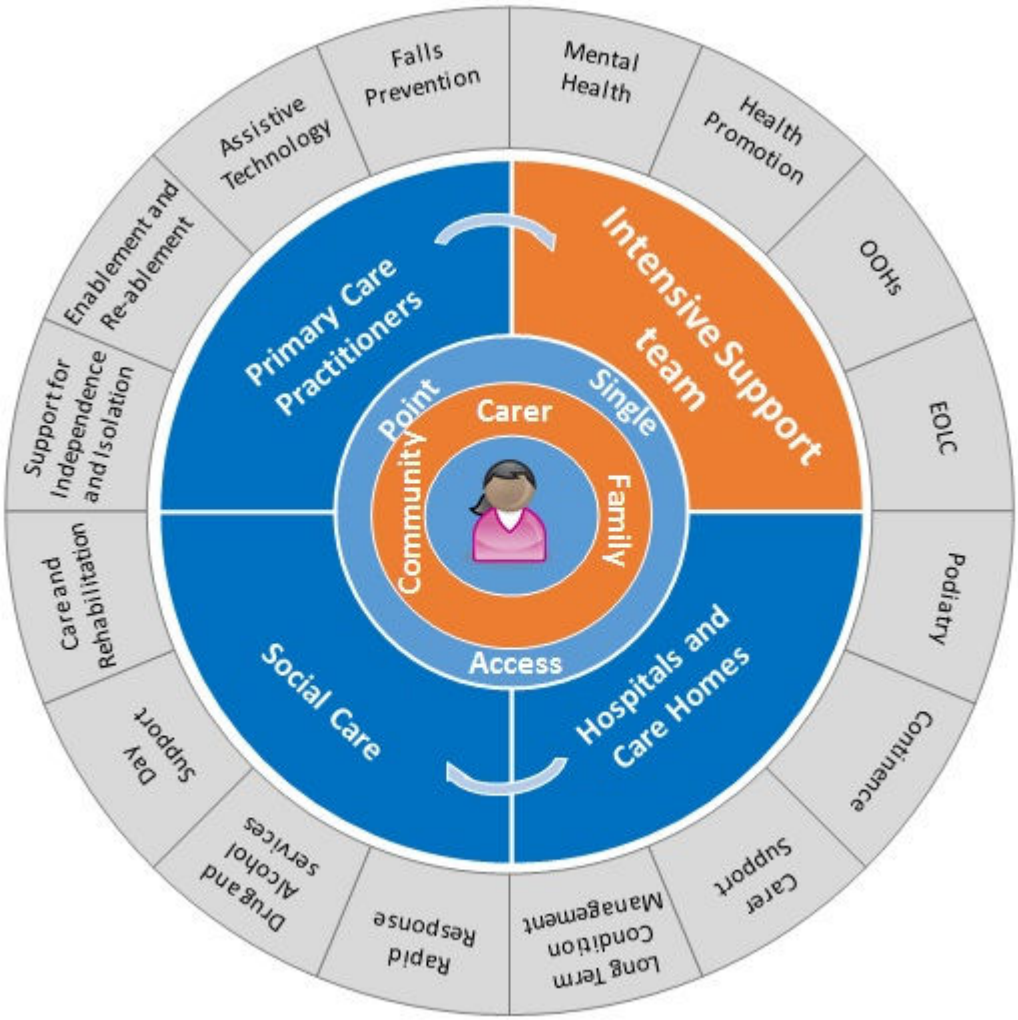
The ISTs will work within a framework of 'wrap-around' interventions. Many of these interventions already exist, in both the health and social care arenas, and some will be the subject of community services procurement and refresh. A key work stream during the implementation of the proposed model will be working with partners to ensure existing and future interventions are fit for purpose and capable of reacting to the pace and accessibility we require the new service to deliver. To achieve this will require a shift to 7 day working and we will develop a specific work stream to identify which services this paradigm shift will be most appropriate for. The workforce and human resource issues associated with this change have also been identified as a key risk to the overall programme. Allied to this, and a key enabler across the whole transformational model, will be ensuring all services have access to and use the individuals NHS number as the prime means of identification.

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

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

The diagram below shows how we envisage the model working and the notes below help explain how the various elements of the model interact.

Resident Centred Health and Care Model



- In this model, the resident sits at the heart of all we do and the various services and interventions revolve around them.
- We recognise the vital importance individuals own support networks play in the health and social care environment and we intend to continue to focus on carer support and liaison to minimise the requirement for emergency placements.

- As previously highlighted, the role and impact of the single access point will be crucial in making the whole system work

<u>Alignment with existing plans and strategies</u>

The York Health and Wellbeing Board provides leadership for continued partnership working between VoY, local authorities, providers and commissioners to ensure our strategic plans for health and social care remain consistent in their aims and objectives.

The JSNA was the basis from which our Joint Health and Wellbeing Strategy was developed and subsequently this has influenced the operational and commissioning plans of the CCG and local authority social care. We now need to join up our systems, funds and teams to ensure that our strategic ambitions for integration can be achieved practically. The Health and Wellbeing Board have a major role here. They will approve our plans for integration and through this governance they will inherit increased decision making powers to move towards this joint approach, i.e. agreements to share risk and reward and to pool budgets. We intend to work more closely with members of the Health and Wellbeing Board as our integration plans develop to ensure they are aware of the impact and consequences, equipped to make timely decisions and can confidently fulfil their core purpose of leading the local health and social care system towards integration. We also recognise that we need to replicate this partnership working at every level. Below the Health and Wellbeing there are a number of partnerships to facilitate and deliver our joint approach, we are working hard to ensure that this becomes the norm, rather than the exception.

We have also worked closely with colleagues across our unit of planning as part of our Winter Planning process which highlighted what we can achieve through collaboration and cooperation. We have developed a number of schemes which impact on the urgent care system (both health and social care), and where appropriate, these schemes may be considered for mainstreaming through our proposed model. Large scale schemes include the establishment of a Multi-Disciplinary Team into Care Homes, additional Emergency Care Practitioner support, support for Emergency Department (ED) staffing, purchase of equipment needed for patient discharge, a trial of a Single Point of Access for health professionals, and an extension to the Hospice at Home programme.

Smaller programmes include additional patient transport, extension of social care teams into the evening and a trial of a new Homeless Support Worker working alongside ED staff.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The key driver for understanding the implications on the acute sector is that the funding to support BCF is already committed and the necessary shift of funding is most likely to come from spend with acute providers.

We have not underestimated the impact this will have and have shaped our joint plans accordingly.

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

Specifically we will aim to target our efficiency savings around:

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

Admissions avoidance

The proposed Intensive Support Teams will play a pivotal role in admissions avoidance. The key areas where they will impact will be through advance care planning – making sure those at most risk of accessing acute services have the necessary support packages in place – and through rapid intervention when individuals do require acute interventions to return the individual to their normal place of residence a soon as possible.

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

Length of Stay/Delayed Discharge

For those patients who are admitted, we want to ensure there is a clear discharge plan and the necessary support packages in place to speed rapid discharge. Whilst much of this is already in place, we believe our new model will allow a much greater synergy between organisations and will ensure any blocks to discharge are identified and removed as soon as practicably possible. The single contact point will have a key role to play in this scenario and the introduction of 7 day a week working across organisations will also facilitate this. We are under no doubt about the challenges this system change will bring but our joint commitment to making the necessary changes will help us to deliver the change we need.

We recognise that what we are proposing carries an element of risk should the necessary reductions in admissions and length of stay not be achieved but we are confident that because we have built such a strong partnership across all elements of the health and social care environment, and we share a common vision for what the future should be as we are focusing on what success will look like.

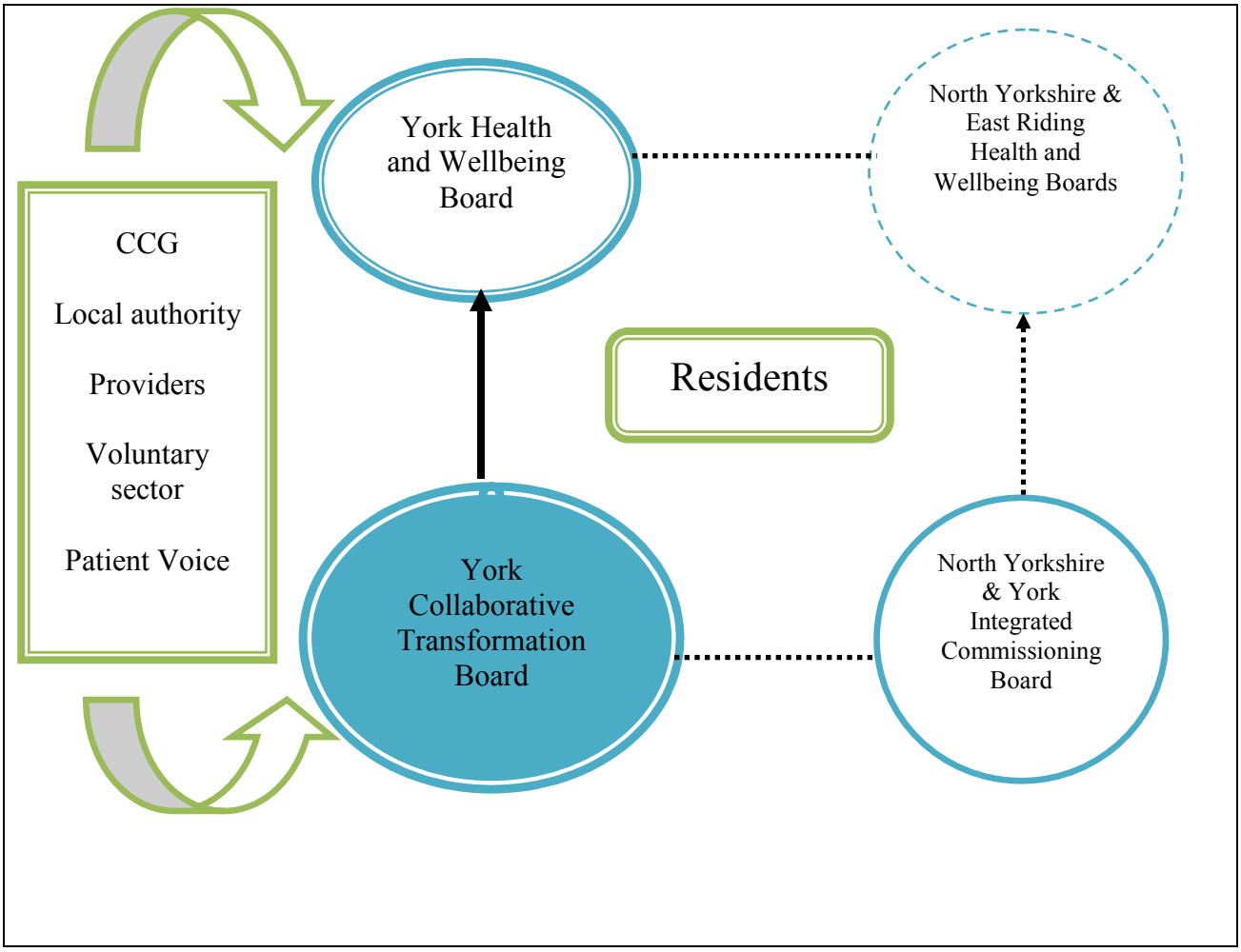
e) Governance

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

The York Collaborative Transformation Board has been established to progress and govern our integration plan. The Collaborative Transformation Board reports directly to York's Health and Wellbeing Board, who hold ultimate responsibility and governance for integrating health and social care locally.

We are actively exploring opportunities to work across geographical boundaries, particularly with North Yorkshire and East Riding local authorities, ensuring our plans are aligned across the whole CCG footprint.

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



NATIONAL CONDITIONS

a) Protecting social care services

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

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

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

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

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

Our preventative agenda aims to support people at the earliest opportunity by providing relevant information and advice in a timely and accessible way, signposting people to the most appropriate resource for their particular needs. Encouraging self-help options and only engaging when required. Supporting people to remain well, and facilitating the self-management of their own wellbeing and wherever possible enabling them to stay within their own homes. Our focus will be on shifting to protect and enhance quality of life by tackling the causes of ill-health and poor quality of life, rather than simply focusing on service options.

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

As local organisations we recognise the need to take urgent action to make integrated care happen. We believe person centred coordinated care and support is key to improving outcomes for individuals. Too often services have not been ‘joined up’ and we haven’t communicated well with each other. We have innovated in some areas and are working hard to develop a person focused approach for all service areas. This approach was used to establish more capacity within our Reablement services that promote independence and self-help.

Funding currently allocated under the Social Care to Benefit Health grant has been used to enable the local authority to sustain the current level of eligibility criteria and to provide increased assessment capacity within hospital and locality care management teams and review and commissioned services to clients who have substantial or critical needs and information and

signposting to those who are not FACS eligible. This will need to be sustained, if not increased, within the funding allocations for 2014/15 and beyond if this level of offer is to be maintained, both in order to deliver 7 day services and in particular to meet the increased demands arising from the new Social Care Bill requiring additional needs and financial assessments to be undertaken for carers and self-funders.

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

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

b)7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

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

A work stream will be established to identify current commissioning, operational and service delivery patterns, establishment and budget for health and social care. This will help evaluate the "as is" position and inform the "to be" development.

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

c) Data sharing

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

Whilst we are not currently using the NHS number as the prime identifier, our systems have the capability to do this and we will rapidly develop a work stream to facilitate this national condition by April 2015.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

As above

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We confirm our commitment to work towards this by April 15.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practise and in particular requirements set out in Caldecott 2.

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

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

The methodology and integrated model proposed in this submission will enable us to identify a single access point for every person with whom we engage within the programme.

“Telling my story only once” is what our residents tell us they want us to achieve through integrated working. We will work towards a single assessment process and data share where it is appropriate.

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

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

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

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

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

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

This is an exciting opportunity and has clear synergies and links with the developments of the Transformation programme now underway within the City York Council. We anticipate the learning from this initiative will also inform the future delivery models for the programme. We believe focusing on high intensive current users of health and social care within our area addresses this question and will provide us with the maximum impact and benefit from the fund in our joint work towards sector improvement and resident satisfaction. Creating and maintaining a positive environment within which we can transform and integrate local health and social care services

3) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	**Risk rating**	**Mitigating Actions**
The proposed model does not reduce emergency admissions		
Agreed system changes between partners are not realised		
Impacts of the model do not have sufficient benefits for the Adult Social Care agenda		
The model becomes politicised which hampers true innovation and risk taking		
HR element of 7 day working		