No.	Key Actions	Investment required	Outcomes and Success Criteria	Details
1	**Community Bridge Building Project**	£155,000	**Adult Social Care Framework:** To increase the proportion of adults with learning disabilities in paid employment (as per national ASCOF indicator). **NHS Outcomes Framework:** ***2 - Enhancing quality of life for people with long-term conditions***. 2.2 Employment of people with long term conditions. **Public Health Outcome Framework:** 1 - Improving the wider determinants of health**.** 1.8 Employment for those with a long-term health condition including those with a learning difficulty/disability or mental illness.	To support the implementation of this service for clients with learning disabilities as a mainstream service following a successful pilot.
2	**Reablement Team**: Implementation of reablement support through newly developed multi-link	£131,000	**Adult Social Care Framework:** To improve the proportion of people still at home 91 days after discharge from hospital into reablement provision. **NHS Outcomes Framework:** ***3- Helping people to recover from episodes of ill-health or following injury.*** **3b** Emergency readmissions within 30 days of discharge. **3.6 i** Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation service (ASCOF 2B) **ii** Proportion offered rehabilitation following discharge from acute or	Full year costs for 3 Assistant Care Coordinators and 1 Social Worker: to support redevelopment of the reablement pathway and to increase capacity, in line with: - regional review and on-going work stream - dementia collaborative Rapid Response Improvement Workshop recommendations to promote equitable access for people with dementia This is additional to the core team following an increase in demand as a result of the dementia

			community hospital. **Public Health Outcomes Framework:** ***4- Healthcare public health and preventing premature mortality.*** **4.10** Emergency readmissions within 30 days of discharge from hospital (Placeholder) **4.12** Health-related quality of life for older people (Placeholder) **4.14** Excess winter deaths **4.15** Dementia and its impacts (Placeholder)	collaborative pathway review
3	**Supporting existing key services:** To enable sufficient resource for assessments, care planning and reviews to be undertaken in response to increased demand; to support the care costs of the associated increased number of clients. In particular, the following areas of spend have been identified as pressures in the social care budget for 2013-14: - to support the increased number of clients with dementia assessed as	£2,385,000	**Adult Social Care Framework:** To maintain low rates of delayed discharges of care from hospital. To reduce the overall rate of new permanent admissions to residential and nursing care. To increase the proportion of Carers in receipt of information / advice / services. To improve the proportion of service users, in receipt of eligible services, who take up their personal budget as a direct payment. **NHS Outcomes Framework:** ***2 - Enhancing quality of life for people with long-term conditions*. 2.1** Proportion of people feeling supported to manage their condition **2.4** Enhancing the quality of life for carers. ***3- Helping people to recover from episodes of ill-health or following injury***. 3b Emergency readmissions within 30 days of discharge. **3.6 i** Proportion of older people (65 and over) who were still at home 91 days after discharge	Investment will enable current services to be maintained and developed, whilst also meeting the costs of services for increasing numbers of clients This includes supporting existing key services such as:- Supporting increased demand for social care assessment support in discharge planning and reablement Support to independent sector care homes for increasing demand for discharge support not requiring therapy input as a route to independence Investment in the Homecare call monitoring system used for call monitoring and rostering for Homecare and reablement services All of these services are required to maintain the timely discharge of clients from hospital The activity in these areas has increased this financial year and have resulted in budget pressures.

	eligible for 24 hour care (£373,000) - to support the increased number of clients with complex physical needs arranging their support via a Direct Payment (£859,000) - to support the increased number of older people and people with learning disabilities requiring care home services/ complex care packages (£289,000) -to support the increased number of clients requiring home care services (£24,000) -to support proactive client reviews through additional social work resource in the review team (£18,000) -additional transport costs for clients (£45,000) The remainder of the funding will be used to		from hospital into reablement/ rehabilitation service (ASCOF 2B) **ii** Proportion offered rehabilitation following discharge from acute or community hospital. **Public Health Outcomes Framework:** ***4- Healthcare public health and preventing premature mortality*.** **4.14** Health-related quality of life for older people (Placeholder) **4.16** Dementia and its impacts (Placeholder)	

	support core services to ensure that eligible care needs are met and that timely hospital discharge continues e.g. in line with the growing activity in the intermediate care service and Rosedale Care Centre (£777,000).			
4	**Developing and Reviewing services** Additional social work and occupational therapy resource to support client reviews and service redesign Additional service manager resource to enable Head of Service secondment to implement Efficiency,	£286,000 £68,000	**Adult Social Care Framework:** To maintain the current levels of timeliness of assessments. To improve the proportion of reviews completed. **NHS Outcome Framework:** ***2- Enhancing the quality of life for people with long-term conditions. Enhancing quality of life for people with dementia*** **2.6 i** Estimated diagnosis rate for people with dementia(PHOF 4.16) **ii A** measure of the effectiveness of post-diagnosis care in sustaining independence and	'Big Ticket'/Adult Programme Board reviews and implementation: to increase commissioning and care management (social work and occupational therapy) resource to support the review work streams and on-going care management of clients, including Winterbourne View planning.; to support the implementation of the recommendations of the Dementia Collaborative work streams.

	Improvement and Transformation review recommendations (learning disabilities, mental health services, carer support, independent living)		improving quality of life(ASCOF 2F) ***5 - Treating and Caring for people in a safe environment and protect them from avoidable harm*.** 5a Patient safety incidents reported,5b Safety incidents involving severe harm or death, 5c Hospital deaths attributable to problems in care. **Public Health Outcomes Framework:** ***4- Healthcare public health and preventing premature mortality.*** **4.10** Emergency readmissions within 30 days of discharge from hospital (Placeholder) **4.14** Health-related quality of life for older people (Placeholder) **4.15** Excess winter deaths **4.16** Dementia and its impacts (Placeholder)	

	Implement of EIT review recommendations: LD Commissioning post to review and develop services	£39,000	**Adult Social Care Framework:** To increase the proportion of adults with learning disabilities living in their own home or with their family. To increase the proportion of adults with learning disabilities in paid employment. To maintain the proportion of adults in contact with secondary mental health services living independently, with or without support To maintain the proportion of adults in contact with secondary mental health services in paid employment. (As per national ASCOF indicators) **NHS Outcomes Framework:** ***2 - Enhancing quality of life for people with long-term conditions;*** **2** Health-related quality of life for people with long-term conditions (ASCOF 1A) **2.1** Proportion of people feeling supported to manage their condition **2.2** Employment of people with long-term conditions (ASCOF 1E PHOF 1.8) **2.4** Health-related quality of life for carers (ASCOF 1D). ***5 - Treating and Caring for people in a safe environment and protect them from avoidable harm.*** 5a Patient safety incidents reported, 5b Safety incidents involving severe harm or death, 5c Hospital deaths attributable to problems in care.	Additional commissioning manager support to undertake service reviews and procurement activity.

Appendix 2

Supporting information provided by Stockton Council Social Care.

The social care funding plan identifies a number of social care core business areas. The overall aims of discharge support and reablement services are to:

- promote and maintain independence and to delay/reduce/prevent the need for social care services.
- delay/ prevent admission to a care home
- prevent admission/ readmission to hospital and to enable timely hospital discharge.

These outcomes are to the benefit of both health and social care.

The Adult Programme Board ('Big Ticket' Review Board) has been established following the programme of Efficiency, Improvement and Transformation Reviews across adult services to ensure that the review recommendations are implemented and that strategic planning continues, with a view to ensuring that services are fit for purpose and that value for money is achieved. Additional resources are required so that key managers and practitioners are able to address the related work streams without being compromised by busy 'day job' responsibilities. A significant number of clients are jointly funded by health and social care, so the service improvements and efficiencies made will also be to the benefit of the NHS.

The total budget spent on adult services is approximately £52 million.

Community Bridge Building

The Community Bridge Building Scheme has been running as a pilot since April 2012 and is delivered alongside the STEPs service, which helps disabled adults into work or volunteering. The service is designed to prevent people with a Learning Disability from needing social care services or to enable eligible clients to move on from traditional buildings based services, by focusing on their social, educational, vocational and employment aspirations to develop practical community based opportunities for them. The service outcomes are aligned to the personalisation agenda. A pilot is in progress for clients with mental health problems (funded by public health) and the service outcomes are being monitored with a view to this becoming a mainsteam service for all adults.

The pilot has achieved the following outcomes to clients:

- Assessment Programme: which has helped clients to prepare for the move into community activity or employment related opportunities
- Work placements: which have provided unpaid work placements with local employers to assist a pathway to employment
- Employment: in which clients have been supported to find suitable paid work, including job carving (1 to 8 hours) through to full-time employment (16 hours plus)
- Volunteering: by assisting clients to take up volunteering opportunities which has given them an insight to responsibilities and understanding of work

- Sports: with clients actively taking part in sports/exercise to improve health & wellbeing
- Leisure: with clients attending various sessions based around their identified interests, improving socialisation
- Travel training: which has enabled travel to activities of their choice, which has increased independence
- Education/Training: by facilitating and supporting their vocational interests

Reablement service

Stockton has a team of reablement staff working alongside Social Workers, Community Health Teams and the Intermediate Care team to deliver support to help people to do things for themselves, rather than doing things to or doing things for people.

This intervention is time-limited (the maximum time that the user can receive reablement support is up to six weeks) and is free at the point of entry.

Stockton has looked to keep the reablement service outcome-focused. The overall goal is to help people back into their own home or community and living as independently as possible (which is mirrored with the ADASS measures we use to evaluate the effectiveness of the service);

Reablement is a very personalised approach and requires regular evaluation. The reablement team agree and work towards specific goals with the service users. Reablement support is tailored to the individual user's specific goals and needs, but can include support with a range of Activities of Daily Living (ADLs).

Ultimately, the goal of the service is to reduce or minimise the need for on-going support after the period of reablement.

The Stockton and Hartlepool Dementia Collaborative

The collaborative has been established to implement *Living Well With Dementia: a national dementia strategy* (DH, 2009). This strategy has 17 key objectives, broadly-themed into three high-level outcomes:

i. Raising awareness and understanding
ii. Early diagnosis and support
iii. Living well with dementia

The aims of the North of Tees Dementia Collaborative are to deliver large-scale change across organisational boundaries to improve services for people with dementia in Stockton-on-Tees and Hartlepool. It has been endorsed by the Chief Executives of the statutory organisations involved.

Following a number of improvement events (Rapid Improvement Workshops or RPIWs) focusing on a wide range of care pathways, the collaborative will be working to embed the recommendations in practice, which will require additional care management resource.