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	**Stockton-on-Tees Borough Council**
Clinical Commissioning Groups	**NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group**
Boundary Differences	**The CCG boundary includes two local authorities, Stockton Borough Council and Hartlepool Borough Council.**
Date agreed at Health and Well-Being Board:	**12th February 2014**
Date submitted:	**14th February 2014**
Minimum required value of ITF pooled budget: 2014/15	**£.848m**
2015/16	**£14.065m**
Total agreed value of pooled budget: 2014/15	**£.848m**
2015/16	**£14.265m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Alison Wilson
Position	Chief Officer
Date	3rd February 2014

Signed on behalf of the Council	
By	Neil Schneider

Position	Chief Executive
Date	<date>

Signed on behalf of the Health and Wellbeing Board	
Health and Well-being Board	Stockton-on-Tees Health and Well-being Board
By Chair of Health and Wellbeing Board	Cllr Beall
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

Our plans build on existing schemes which are currently in place across both Health and Social Care. The design and delivery of these schemes has been in consultation with service providers, patients and carers and our partners over a number of years.

The ideas for each of the schemes in relation to the Better Care Fund were developed following the establishment of the unit of planning Oversight Group. Each statutory body is represented on this group; membership includes the Clinical Commissioning Group (CCG), both local authorities (Stockton Borough Council and Hartlepool Borough Council) and both Foundation Trusts (North Tees and Hartlepool NHS Foundation Trust and Tees Esk and Wear Valley NHS Foundation Trust).

The Unit of Planning Oversight Group;

- Agreed areas of focus
- Agreed principles for approval of plans
- Provided oversight across the CCG boundaries in development of the plans
- Agreed outcomes required and Key Performance indicators
- Ensured alignment of plans in order to achieve equitable services

The initial ideas were then further developed through a series of workshops and meetings:

- Fortnightly meetings of the Oversight Group – to ensure the project is on schedule and meets the aims and objectives and deals with the concerns and issues raised by all partners
- Fortnightly meetings between the CCG and LA supplemented by separate meetings to discuss issues and matters arising throughout the development of the submission
- Several workshops within the LA to begin to develop the ideas, the data and the evidence from as social care perspective – mindful of the need to integrate with health
- Joint workshops and meetings with stakeholders from the LA, community service, acute service, primary care and mental health service providers to align the schemes and projects to the existing Momentum programme and to ensure that the schemes and projects support both health and local authorities to meet their objectives

As the Unit of Planning Oversight Group includes representatives from both local authorities within the CCG boundary there has been multi agency work undertaken to ensure that plans are aligned where appropriate. Issues identified in relation to the development of the plans are discussed and worked through with Operational Leads and then brought back to the Oversight Group for agreement, as per the agreed governance arrangements.

The CCG actively engages with providers across health and social care and the voluntary sector. Stakeholders are active participants and members of the CCG clinical workstreams and project groups, these groups are responsible to develop and shape future services with a responsibility to deliver the transformation agenda and have been instrumental in shaping a number of the schemes. To ensure parity of esteem between physical and mental health across the health economy whilst creating the new models of care we have actively engaged and included our main mental health provider in within appropriate clinical workstreams and as a key member of the Oversight Group.

The CCG has worked with Providers in relation to joint engagement events, internal and external facing where system or services change is required and we continue to work with our Providers in delivering the Momentum programme which is the blueprint used to develop the BCF plans.

The voluntary sector is represented on the Health & Wellbeing Partnership Group. This group reports to the Health & Wellbeing Board and brings together a range of partners (commissioners, providers, third sector, education and patient/public representation) to develop a shared understanding of the needs the population in Stockton and ensure a joined-up approach to the planning and delivery of services to improve the health and wellbeing of the population and to address inequalities where they exist. This group will be engaged in developments as we take these plans forward.

Stockton Health and Wellbeing Board, as a partnership of the CCG and LA, have engaged and consulted on the development of the Better Care Fund plan either in the main Board or within its sub groups. This has included involvement from Healthwatch, Third Sector, and key health service providers (including the main Acute Trust provider (Mental Health and Community Provider).

The LA and CCG see the Better Care Fund as a vehicle to accelerate the positive changes initiated already within the borough based on service design and provision, building upon the last 12 months of closer partnership ties.

The Health and Wellbeing Board considered the draft version of the plan in February 2014 before approving the final version of the Plan in advance of the April deadline, by which time the CCG must submit to NHSE (National Health Service England) as part of its Strategic and Operational plans. A wider range of providers will also have the opportunity to consider the plan and be able to comment on it.

In addition, formal contract meetings with all Acute, Community and Mental Health providers held by the CCG will be utilised to raise the profile of the Plan and seek feedback on it. It will be included in commissioning intentions and contracting principles for 2014-15 and beyond to ensure that providers are engaged in and understand the planned impact.

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

Our vision and plan is based on what people have told us is most important to them. Over the past year, with the establishment of the CCG and Health and Wellbeing Board both the LA and CCG have engaged 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.

It is our intention to design local services by putting patients and service users at the centre of everything we do and there is a commitment from all partners to continue to engage with patients, service users and providers throughout this process.

There is a strong legacy of local service user, patient, carer, family and public involvement in the design of local services. Some examples of recent engagement activities that have directly shaped and informed this plan include:

- **"Intermediate Care - Client Feedback" –** in place since May 2012. Exploring user satisfaction with and experience of Adult Intermediate Care.

- **"Reablement Client Feedback" -** in place since May 2012. Exploring user satisfaction with and experience of Adult Reablement Services.

- **"Adult / Older People Day Care Feedback" – in place** since June 2012. Exploring user satisfaction with and experience of Adult / Older People Day Care Services.

- **Loneliness in Stockton-on-Tees: Over 50s Survey Report (2012) –** Identifying those who are most vulnerable to the effects of loneliness; providing evidence of associations between loneliness, self reported health status and social circumstances.

- **Consultation and engagement work with service users and carers as part of the refurbishment/upgrade of the Halcyon Centre.**

- "**Adults / Older People Assessment & Rehabilitation Client Feedback"** – in place since July 2012. Exploring user satisfaction with and experience of Adult / Older People Assessment & Rehabilitation Services.

- **Adult and Children's Carers' Strategy** consultation with service users, carers and providers.

- Consultation and engagement activities relating to the development of the **Joint Strategic Needs Assessment and Joint Health and Well-being strategy**.

- Healthwatch have been commissioned by the LA to engage with service users and providers and undertake customer satisfaction surveys around a range of Adult Social Care issues.

- CCG Stakeholder Engagement Exercises – led by the CCG and focussed on CCG priorities. Including two “Call to Action” engagement events which were clinically led and supported by CCG staff and wider team members from the Commissioning Support Unit. The CCG has also engaged with the Voluntary sector and Healthwatch to undertake further conversations with those community groups that are often deemed as hard to hear/reach.

Key themes and comments from patients/people were;

- Services close to home
- Improved communication
- Self-management for Long Term Conditions
- Improved access
- Improved Urgent Care
- Education and support for carers

We believe that the work undertaken to engage and the themes identified have enabled the development of the plans to ensure service user views are driving the development of the schemes.

This work and further engagement activities that are planned throughout the development and implementation of the BCF will help to ensure that there is thorough engagement in our plans and ensure that patients, carers and service users are included as we implement our plans and develop future services/pathways.

The excellent relationships that are already in place with a wide range of partners have supported us to develop a strong shared vision for integrated care and we believe that this will help us to co-design and implement a sustainable model for health and social care delivery in the future.

All partners are committed to supporting a robust programme of engagement and communication to ensure that we continue to build on this momentum.

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
JSNA	Joint local authority and CCG assessment of the needs of the 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 to address the needs identified in the JSNA.
Carers Strategy	Multi agency strategy that identifies the needs of carers locally and priorities to deliver improvements over a three to five year period.
A strategy for Adult Health and Care Services in Stockton-on-Tees	Stockton's vision for Health and Care 2009 / 2014.
2012/13 Local Account	Summary of the priorities, progress and future direction of adult social care in Stockton.
Stockton Council Corporate Plan	Sets out the direction of travel, ambition and service improvements for the next five years. Relevant elements of the plan are: - Promoting equality of opportunity (including Health) - Protecting the vulnerable (including early intervention and prevention) - Developing strong and healthy communities
Stockton's Vision for the Transformation of Adult Social Care	- Implementing service improvements - Transforming Adult Social Care (including the Care Bill and the Better Care Fund) - Future planning to ensure the right services are in the right place at the right time
Clear and Credible Plan	Description of the main health issues and how the CCG will tackle these http://www.hartlepoolandstocktonccg.nhs.uk/publications/
CCG Prospectus	http://www.hartlepoolandstocktonccg.nhs.uk/publications/

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?

The system vision is: ***'To develop outstanding, innovative and equitable health and social care services, ensuring excellence and value in delivery of person centred care working across both Health and Social Care'.***

We will do this by;

- Commissioning for quality outcomes and services deliver the required standards;
- Putting people at the heart of what we do and creating a system that is flexible and responsive enough to recognise the different needs of individuals;
- Actively seeking out unmet need as well as responding to expressed need;
- Establishing systems and processes that are sustainable and affordable to deliver continuity of care, ensuring that people are involved in decision making and planning of their own care and support, including referrals, and being helped to navigate services and systems;
- Striving to improve on what we do through change and innovation;
- Learning from successes and setbacks; and
- Ensuring we include 'Care, Compassion, Competence, Communication, Courage, Commitment' in all we do.

Residents of Stockton deserve the best possible, "joined up" health and social care and should get the right care, in the right place, at the right time, which will help them have longer, healthier lives ensuring they can say *"I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me" (Integrated Care and Support: Our Shared Commitment).* This is why all partners in the public, independent and voluntary sector are working together to improve the local health and social care system.

There is already a strong focus on partnership working within Stockton-on-Tees, The Momentum: Pathways to Healthcare has been the blueprint for the last 5 years and is the means by which the Trust and local health community partners will reconfigure services to deliver safe, high quality, efficient and effective health services for the local population, reflecting both the expectations of the patients, and local and national initiatives which define the expectations on NHS provider organisations. This continues to provide the philosophy for the health and social care economy as closer integration is brought about.

Working in close partnership within the Momentum programme this has helped us to achieve many changes in clinical services which improved quality, safety and patient experience in the services that are commissioned. We now need to ensure that we

continue this and ensure a joined up approach with our social care partners. The Better Care Fund is therefore seen as a significant step forward in developing integrated health and social care services, providing a framework for change. Ensuring we work together to provide better support at home and earlier treatment in the community, through this joint planning we will be able to reduce pressures on urgent care and prevent people needing emergency care in hospital or a permanent care home admission.

Our vision of service delivery as we move forward is to have a sustained focus on integration, meaning *organisations working together to create services that maximise health and wellbeing and address individual needs, improving outcomes and experiences for individuals and communities (Integrated Care and Support: Our Shared Commitment).*

Our vision is that by 2018/19 everyone is able to live at home longer, be healthier and get the right support services where required, whether this be provided by health and / or social care. We will have a healthcare system with integrated health and social care, a focus on primary prevention, early diagnosis and intervention, and supported self-management. Where a person requires hospital treatment if this cannot be provided in a community setting, we expect this will be carried out as a day case treatment or in an outpatient setting.

Care will be provided to the highest standards of quality and safety, with the person remaining at the centre of all decisions. Our focus will be to ensure that people can remain in their own homes or when this is not possible and they have to be treated in hospital we will ensure that their discharge is appropriately planned to ensure that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

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 and objectives of our integrated system are to:

- To ensure that the population of Hartlepool and Stockton-on-Tees have access to a wide range of primary prevention interventions including but not limited to smoking cessation services, exercise, weight management, IAPT, problem drinking support, cancer screening programs, immunisation, social prescribing, carer's support and good nutrition.

- To identify the 'missing thousands' of people who have undiagnosed and unmanaged long term conditions such as cardiovascular disease (including atrial fibrillation and hypertension), diabetes, COPD, liver disease dementia and early cancer.

- To maximise independence and quality of life and help people to stay healthy and well through the development of integrated community health and social care services with a focus on long term conditions, frail elderly (including end of life) and dementia. This will be delivered through the roll out of an integrated care model building on existing care planning, care co-ordination, risk stratification and multi-disciplinary working.

- To streamline care and reduce activities that are carried out by multiple organisations ensuring the right services are available in the right place, at the right time through an integrated community approach providing rapid response to support individuals to remain at home and avoid admission.

- To improve people's experience of services through the introduction of a single point of access across health and social care, utilising the NHS number. We want to work towards improving systems and connectivity across the whole health and social care system that will share people's information to enhance the quality of care and ensuring continuity of delivery.

- To improve outcomes for service users and carers through clearer and simpler care pathways and; proactive management of people with long term conditions. We will do this through co-designing models of care that will meet need. These pathways will be simple to understand, simple to follow and will be available for all staff, service users and carers to see.

- To have a skilled workforce that understands both the health and social care system and works across organisational boundaries, making every contact count.

- To ensure that each person has a package of care that improves their physical, social and emotional wellbeing, acknowledging that all three elements are necessary to enjoy good health.

- To support personalisation and choice by being able to develop a range of coordinated alternatives to hospital and residential care, this will be delivered through investment in personalised health and care budgets ensuring individuals are able to make informed decisions.

- To ensure that digital technology is utilised innovatively to deliver the greatest possible benefit to people using services and carers across health and social care services.

- To improve access to community health and social care services 7 days a week to improve user experience and provide responsive services in and out of hours, reduce delayed discharges and improve support to empower people to live independently.

Our vision for integration is ambitious, it is about establishing a landscape in which different public bodies are able to work together, and with their partners in the third and independent sectors, removing unhelpful boundaries and using their combined resources, to achieve maximum benefit for service users, carers and families.

The expected outcomes are both qualitative and quantitative. We are determined that any changes we implement will have the person at the heart of them and specifically will increase the quality and timeliness of service provision.

The specific quantitative aims of our the schemes are:

- A reduction in the number of residents being admitted to nursing and residential care homes, from both acute and community settings.
- The effectiveness of the Reablement service in keeping people in their own homes after discharge from hospital.
- A decrease in the number of delayed discharges and lost bed days from acute settings for those patients medically fit for discharge.
- A decrease in emergency avoidable admissions.
- Increase in the estimated diagnosis rate of dementia.

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

- People only having to tell their story once.
- 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 programme team who will be responsible for the planning, and mobilisation of the schemes. There will be development of a performance framework to ensure granular analysis of the impact of the schemes at all levels.

We need to ensure that we understand:

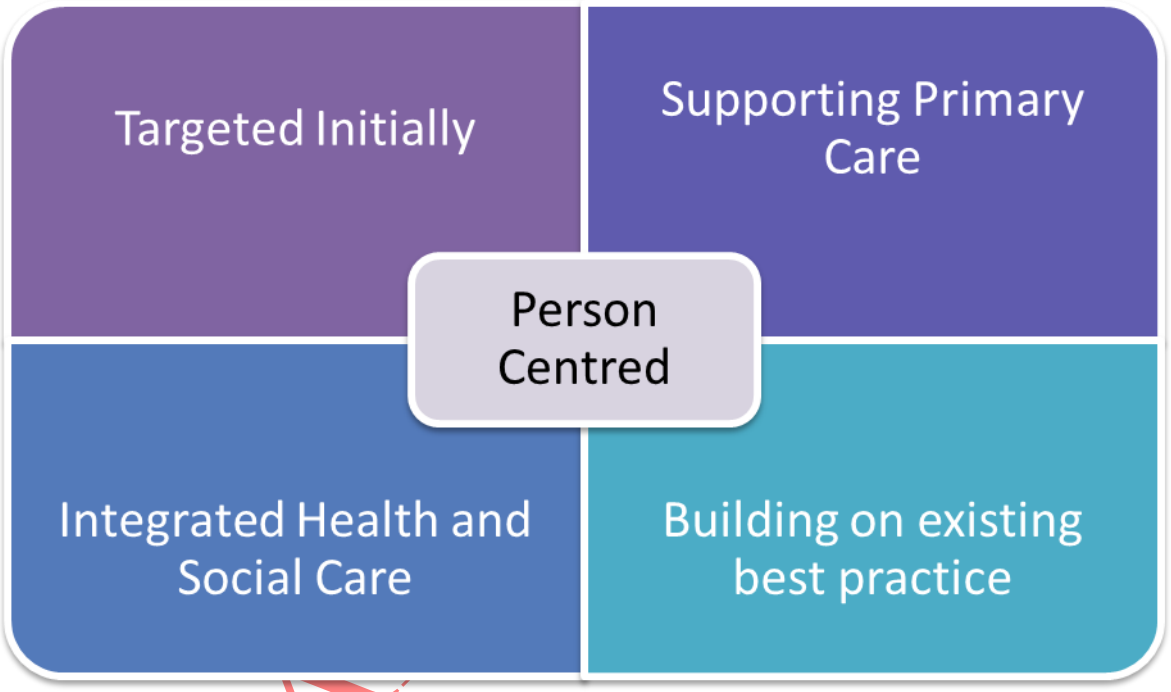
- The impact on our local acute provider on a scheme basis.
- The impact on the local authority.
- How activity has moved through the system in order to help future proof the schemes and identify new opportunities.
- The level of satisfaction service users experience from the change.

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

OVERVIEW AND AMBITION

The joint work programme described in this plan are underpinned by 5 key principles that run throughout the individual schemes:



Person Centred – all about the patient / service user who would be a heart of any new service delivery.
Targeted Initially – Initially targeted in areas where the demand for Health and Social Care and health inequalities are the greatest, helping to deliver improved outcomes and savings more quickly.
Supporting Primary Care – working with GP practices and other practitioners to understand the needs of their patients and acknowledge the importance of effective primary care in the delivery of integrated care. Helping to achieve the best possible outcomes for patients.
Building on Best Practice – not reinventing the wheel or undoing what is already in place, the new model will build on Momentum: Pathways to Healthcare and the existing community renaissance programme.
Integrated Health and Social Care – means that there is a single plan and a single assessment and simplified pathways to care.

Our ambition includes a focus on a number of outcomes including:

SCHEME 1 – MULTI-DISCIPLINARY TEAMS

The principle of this scheme is to move towards a multi-disciplinary team approach building on the existing Momentum: Pathways to Healthcare programme. The first year would entail a multi-agency design of the proposal, underpinned with some key principles and required outcomes, to ensure buy-in from all stakeholders and ensure deliverability.

The multi-disciplinary teams would build on the existing community renaissance programme:

- Community Integrated Assessment Team (CIAT) supports patient discharge from hospital and provides preventative interventions to keep people safely at home.
- Teams around the Practices (TAPS) community nursing teams which support GP practices.
- Single Point of Access (SPA) a centralised seven day contact centre for GPs to access health-based community services.
- Enhanced care teams for the management of complex, long term conditions.

The missing link is the integration of these services with Social Care. There are elements currently in place, for example the CIAT team currently works with, and is co-located with, the Council's complementary Intermediate Care service. But we could go much further.

This scheme would be at the heart of the transformation needed to meet the aspiration and ambition which the Better Care Fund has been established to achieve. The multi-

disciplinary team will have two key aims:

1. Delivering targeted early intervention and preventative approaches to reduce the individuals need for health and social care services and;
2. Effective crisis management to ensure the individual can maintain their levels of independence and maximise their health and well-being.

So what do we mean by 'go much further'? We would look at all of the current initiatives and identify the best way to ensure there is the appropriate level of integration with Social Care. It would include a suite of interventions e.g. OT, community nursing, social care, aids and adaptations, digital care (such as Telecare). It would also facilitate community and voluntary sector support and services in the community from a Social Care perspective. In additional to working with the community and voluntary sector it is important to work with private sector providers for example nursing and care homes to ensure that the care provided is consistent with the outcomes and ambitions of the Better Care Fund.

It should be noted that from a Social Care perspective these solutions are over and above what is currently delivered, because some services users will receive services free at the point of delivery and therefore not subjected to the Fair Access to Care Services (FACS) criteria. This is a deliberate strategy, which is why it is necessary to target this intervention, because if implemented successfully, the new pathway will reduce the impact on social care in the medium to longer term.

Assessments and interventions would be multi-disciplinary with a lead professional who would have the ability to assess and co-ordinate support/care. The clinical lead would be an appropriate health care professional and this scheme would link to the new requirement for all over 75s to have a named GP (CCG have an £5 per head for all people over 75 for this purpose).

The early intervention and prevention will initially be targeted at the over 65s which would include people with dementia and those with longer term conditions. Interventions would also be targeted to reduce in-equalities in health and well-being. This is where there would be the greatest impact for health and social care. However, in the longer term, with the correct evidence base, the service would be rolled out across the whole adult population.

But just putting teams together will not create the transformation which is required from a social care perspective or necessarily from the perspective of the GPs or the patient / service user. So the project would have multiple elements:

1. Maximise the current integrated working arrangements with the CIAT team and the co-location of Intermediate Care. This is a quick win aimed at improving performance and maximising savings as quickly as possible.

2. From 2015/16 Falls prevention would become part of the multi-disciplinary approach.

3. Invest in the 'Integrated Care Home Programme' that provides care homes with professional advice, training and support on agreed issues that can contribute to avoidable admissions to hospital for patients provided there is

sufficient evidence to demonstrate health and social care benefits.

4. Targeting some health and social care resources initially at GP practices where there is evidence of greater referrals to hospital and greater take up of social care packages. By undertaking joint assessments and providing patients / service users with a holistic assessment of need aimed at keeping people safe and independent in their own homes for as long as possible. This will also be linked to our ambition of tackling health inequalities and will therefore include public health interventions which are appropriate to the person.

5. Look at how social care would support Teams Around the Practice ensuring any solution takes account of the number and spread of GP practices across the Borough and the concentration of practices in Central Stockton.

6. Redesign the pathways for Health and Social Care. Some pathways are already being reviewed as part of the Momentum programme and we need to understand which pathways need to be reviewed to meet the objectives of the Better Care Fund, delivering shared benefits.

7. In the longer term referrals to social care would be based on risk and not social care eligibility (FACS). The interventions are intended to be time limited / responsive / pro-active (but not long term) similar to the current intermediate care and Reablement models i.e. working with community matrons, these would be short term interventions to achieve specific outcomes. This should be linked to risk stratification / predictive modelling statistical approach which would help to identify those most likely to benefit from preventive care.

8. Supporting the scheme will be a strand of communications and raising awareness so that all GPs have a clear understanding of the services available (including service levels for services such as the Rapid Response Team) and the revised pathways to health and social care services.

9. And there will also be an on-going requirement for training of professionals to enable generic working and support joint assessments. In addition, we will work with health and social care practitioners to increase their knowledge and skills relating to long term conditions. We will do this in partnership with the specialists (e.g. Foundation Trusts, Community Services and others).

10. Root cause analysis (RCA) – one off project – to look at all admissions to both acute health and social care services. The purpose would be to identify the package of interventions that would have been required to avoid the acute admission to health or social care. This approach would be used to redesign services and develop appropriate interventions in the future. This would link with other RCA work that is currently being undertaken with Care Homes and within GP practices.

Milestones	Timescales
Establish implementation team	April 14
Review existing services – health and social care	September 14

Review pathways and Root Cause Analysis	December 14
Design and consult on new proposals	December 14
Risk stratification and targeted intervention programme complete	April 15
New service in place	April 15

SCHEME 2 – IMPROVING PATHWAYS AND CARE FOR DEMENTIA

These services are focussed specifically on people with Dementia. There is a recognised under-diagnosis of dementia in Stockton and it is expected that there will be an increase in the number of people with early on-set dementia and late on-set dementia when diagnosis rates improve. The aim is to enable people to live in their own homes as long as possible. The early introduction of digital health in a familiar environment will support this.

We will deliver appropriate services in place across the Borough to support across the life-span of a dementia clientand build in open access to services for carers, in other words remove the existing barriers completely, such as through 24/7 help line and/or sign-posting service.

Building on the principles of scheme 1, this scheme builds on the current pathways and the existing work of dementia collaborative of which the CCG, North Tees and Hartlepoo NHS Foundation Trust, TEWV and the local authority are all members. The aim would be to continue the work of the collaborative:

1. To do this, it will be necessary to employ a Collaborative Manager (currently only a temporary project management post) to ensure sustainability of the collaborative:

    - Investing in monitoring and quality checks to ensure good practice is embedded
    - Continue to invest in the training of staff in care homes, including care homes with nursing andother community services, such as home care
    - Ensure social care puts packages of care in place as quickly as possible (to reduce the length of stay in hospital or prevent and admission)
    - Provide support to people earlier in their diagnosis

2. This scheme is also linked to the enabler in scheme 5 – which is the support of appropriate digital care (such as telecare) which would support people to remain safe and living in their own homes for as long as possible.

3. There is also a proposal to use some of the funding to provide Respite for all carers – such as 6 days without charge. This support to carers is aimed at keeping families together. The target for this initially would be for carers supporting people with dementia. Also, to provide crisis support for carers aimed at preventing admissions to hospital or long term care.

4. Following a Kaizen 3P event on the use and purpose of the LiveWell Hub at the

Halcyon Centre for people with Dementia their Carers and professionals, it will be necessary to employ a LiveWell Hub co-ordinator and invest in additional technology such as PC's and Tablets to deliver the on-going service.

Reablement in the Hartlepool area has established a Community Liaison Team. In addition to the dementia liaison services commissioned across the CCG area from TEWV, this may be an approach that can also be adopted in the Stockton area, subject to evidence that the intervention is appropriate and meets its overall aims and objectives.

The first phase of this scheme is to map all the current dementia services to ensure there are no duplications and that the additional funding is aimed at delivering an enhanced and sustainable service.

Milestones	Timescales
Appointments to new posts	June 14
Business cases for respite and digital care interventions	November 14
Enhanced service in place	April 15

ENABLING SCHEME 3 – 7 DAY WORKING

Currently Reablement / Intermediate Care and assessments are all available 7 days per week. These are universal adult services. There is a need to review all services in line with the new multi-disciplinary teams and also the link to Care Call response. The range of services already in place means that there are very few delayed discharges relating to social care – but further work will be undertaken to understand what more can be done to prevent admissions to hospital.

There is a social care Emergency Duty Team (EDT) out of hours service covering the Tees Valley but this will only deal with crisis cases and is not included specifically in this proposal – however, the team will need to be aware of the development of the new services for appropriate referrals and the revised pathways of care.

Further work is planned to ensure that the pathway to Reablement / intermediate care is clear and in-line with the new integrated model.

Currently the Intermediate Care response is within 2 hours – The response time will be reviewed in-line with any new pathways of care and work may need to be undertaken to reduce this to a 1 hour response.

1. Work will be undertaken to raise awareness with GPs about the service and any new pathways of care. This will also include specific engagement activities to build confidence in the service and result in GP referrals.

2. Clear pathways of care will be designed in conjunction with the out of hours providers to ensure a reduction in avoidable admissions to hospital. This is likely to include the commissioning of some emergency beds which could be used for a limited time (2/3 days) to address particular issues / needs.

3. A Root Cause Analysis will be undertaken on delayed discharges from hospital. The results of this will be used to identify any blockages/barriers to discharge including the identification of any services that are required 7 days a week. This intelligence will be used to inform the new integrated pathways of care.

4. Work will be undertaken to ensure that new integrated care pathways are supported by timely access to appropriate aids and adaptations.

5. Service demand will continue to be reviewed and it may be necessary to put additional social care support into the service to maintain the 2 hour response.

6. Clinicians within the hospital will be supported with information to enable them to discharge people with complex needs into the community.

Milestones	Timescales
Engagement with GP and other key stakeholders	September 14
Review pathways and Root Cause analysis	December 14
Business case for any changes to the Multi-disciplinary teams	December 14
Enhanced 7 day arrangements in place	April 15

ENABLING SCHEME 4 – JOINT ASSESSMENTS

There is local agreement that there needs to be a more co-ordinated approach to complex cases, where people have a range of health and care needs and particularly those with long term conditions. This scheme would build on existing services providing 6 week post discharge patient advocate support. This professional would manage the case work for the patient and make sure there is follow-up.

There will be a person-centred approach 'I tell my story once – everyone knows my plan'.

1. A single health and social care plan will be agreed with the patient / service user. A holistic approach with a single assessment and care plan which is clearly articulated to the GP and other people involved in the provision of care. This has the potential efficiency of avoiding duplications in the assessment process. Assessment will include Carers assessments.

2. Assessments and care plans will build up-on the good work that is already in place locally such as the existing pathway for COPD.

3. Systems and processes will be improved – Rapid Improvement Workshops (RPIW) will be held, including a focus on reviewing post discharge service timescales (currently 6 weeks).

4. A support package in the home will be trialled (pilot of just a few people) – to introduce technology as an early intervention (digital health / care package).

5. The use of Telecare will be reviewed, exploring the model in place in Wakefield, where telecare is the default pathway. This will help to inform decisions on the local model.

6. Pilot joint assessments as part of the stroke pathway with the overall aim of improving health and wellbeing, reducing admissions to hospital and reducing admissions to long term nursing or care homes. These joint assessments will then be rolled out to all patients with a health and social care need.

Milestones	Timescales
Risk stratification and identification of target group(s)	August 14
Review of systems and processes	December 14
Trial and business case complete	April 15
New arrangements in place	June 15

ENABLING SCHEME 5 – DIGITAL HEALTH CARE

There is an agreement in principle that Digital Health Care is part of the overall solution, but there is a need for more evidence on the benefits of different solutions before deciding how best to use / target the resource. It is important that the right solution is used in the right place at the right time to deliver the greatest benefits. Any solution will be linked to the overall multi-disciplinary offer.

One proposal is to make Telecare free to all over 75s – expanding the existing client base which is limited those who are FACS eligible. Provided there is evidence to support the impact on health and social care.

Any additional digital services will build upon the current infrastructure and be part of the agreed pathway of care. Ensuring that clients do not have multiple solutions.

Tees Valley Health and Social Care Strategic Partnership Forum has agreed to progress with the support of Teesside University a piece of work that would look at developing a 'digital hub' to improve the support, care and treatment of people accessing technology across the Tees Valley. A small working group has been established to progress an application for funding from the Academic Health Science Network to prepare the groundwork in collaboration with our partners to provide digital care at scale in the future.

Milestones	Timescales
Review of evidence and best practice	December 14
Business Case	February 15

Trial of target group	June 15
Roll out depending on results	December 15

ENABLING SCHEME 6 – NARROWING HEALTH INEQUALITIES

The overarching approach within the schemes is underpinned by the Stockton-on-Tees Joint Strategic Needs Assessment to ensure that all of the local interventions are appropriately targeted and in-line with the best available evidence. The approach is also in line with the Joint Health & Wellbeing Strategy.

The integrated multidisciplinary teams in scheme 1 & 2 will target their early interventions to help reduce inequalities in health and wellbeing through the use of local area profiles and risk stratification tools.

A range of services will be available to the multidisciplinary teams to ensure that support is provided to individuals to help them adopt healthier lifestyles and address the wider determinants of health. This will include access to a range of services including:

- Healthy Lifestyle interventions such as Stop Smoking, weight management, health checks and screening programmes. The Stockton Borough Council Public Health Team have identified further funding to add to the BCF to ensure that they commission healthy lifestyle services that are targeted at the identified population to address inequalities in health within this group.
- Ensuring that the multi-disciplinary teams have the appropriate skills and training to ensure that they can address healthy life-style issues 'Making Every Contact Count'.
- Stockton Warmer Homes Healthy People Project to address issues relating to winter warmth and excess winter deaths. Helping individuals in the target groups to remain healthy and independent throughout the winter months.
- Signposting and self-care to ensure that patients/service users are empowered to manage their own conditions and access appropriate support services to take steps to improve their own health and wellbeing.
- It is recognised that a range of voluntary community sector organisations are commissioned within the Borough of Stockton to address the health and wellbeing needs of the target population and there is a commitment to build upon existing joint arrangements to commission and monitor these services, ensuring integration and alignment to the BCF vision. Future developments within these organisations related to the target groups set out in the BCF schemes will provide opportunities for organisations to address wider social circumstances that may be impacting on an individual's health and wellbeing and will enhance the schemes set out in the plan.

Milestones	Timescales
Various schemes to be developed and implemented	Throughout the year

ENABLING SCHEME 7 – ICT SYSTEMS AND DATA SHARING

Based on the need to use the NHS Number.

1. Review all existing systems
2. Ensure that all systems are using the NHS number
3. Put in place data sharing arrangements based on using the NHS number
4. Put in place the appropriate levels of technical security
5. Put in place data sharing protocols
6. Training of staff in information security
7. Identify the best way of ensuring GPs and other practitioners have access to single assessment data i.e. Health and Social Care records – this may be through a shared portal
8. Ensure that co-located teams are collecting the right data and updating the right systems
9. Put in place an additional level of performance management to ensure the data supports the benefits of all the schemes – local performance information and evidence
10. Develop a combined risk stratification tool to identify individual where a package of early intervention would be most beneficial, support business planning and ensure resources are targeted appropriately.

Milestones	Timescales
Review systems	September 14
Revised processes to use NHS number	December 14
Data Sharing Portal to be developed and implemented	April 16

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 implications for the acute sector are significant given 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. The impact on acute providers has not been underestimated and plans have been shaped accordingly with input from NHS providers.

The main purpose of the proposed developments is to ensure 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 to deliver the BCF plan and to achieve longer term sustainability, the overall spend in the acute sector must reduce significantly in order to properly resource the integrated out of hospital model. Through our joint workshop with the main acute provider locally, it has been agreed the proposed BCF model along with the Momentum pathways to healthcare programme will help us achieve this. Momentum: Pathways to healthcare is based on delivery of a reduced hospital footprint, deliverable through scalable change in the way services are provided outside of hospital. The planned BCF developments will support this change and be a driver for transformation across health and social care. Therefore, the key to success will be in turning this high level plan into real action that allows all partners to reshape their model of service provision accordingly.

We will aim to target our efficiency savings specifically around a reduction in avoidable emergency admissions and A&E attendances, using the available data to target conditions and causes of admission which are deemed to be potentially avoidable. As schemes are developed during 2014/15 acute providers will be involved through ongoing engagement to ensure that providers and commissioning partners are aligned and that these organisations own the system vision for delivery of the BCF.

Net impact on acute providers is not as significant as BCF plans suggest. The CCG 2 and 5 year plans will reflect the BCF implications for delivery of services and has been included in contract negotiations with acute providers which also includes recurring growth investment aligned to demographic uplift.

We will work with our providers to identify through the continual assessment of cost improvement plans using the Star Chamber approach to support and sustain services within the financial envelope including BCF schemes.

e) Governance

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

Governance arrangement that oversees the progress and the outcomes for the work in relation to the plans is the North of Tees Partnership Board. This group brings together key partners and will strategically lead the direction and performance of the schemes as they are further developed and move to the implementation phase.

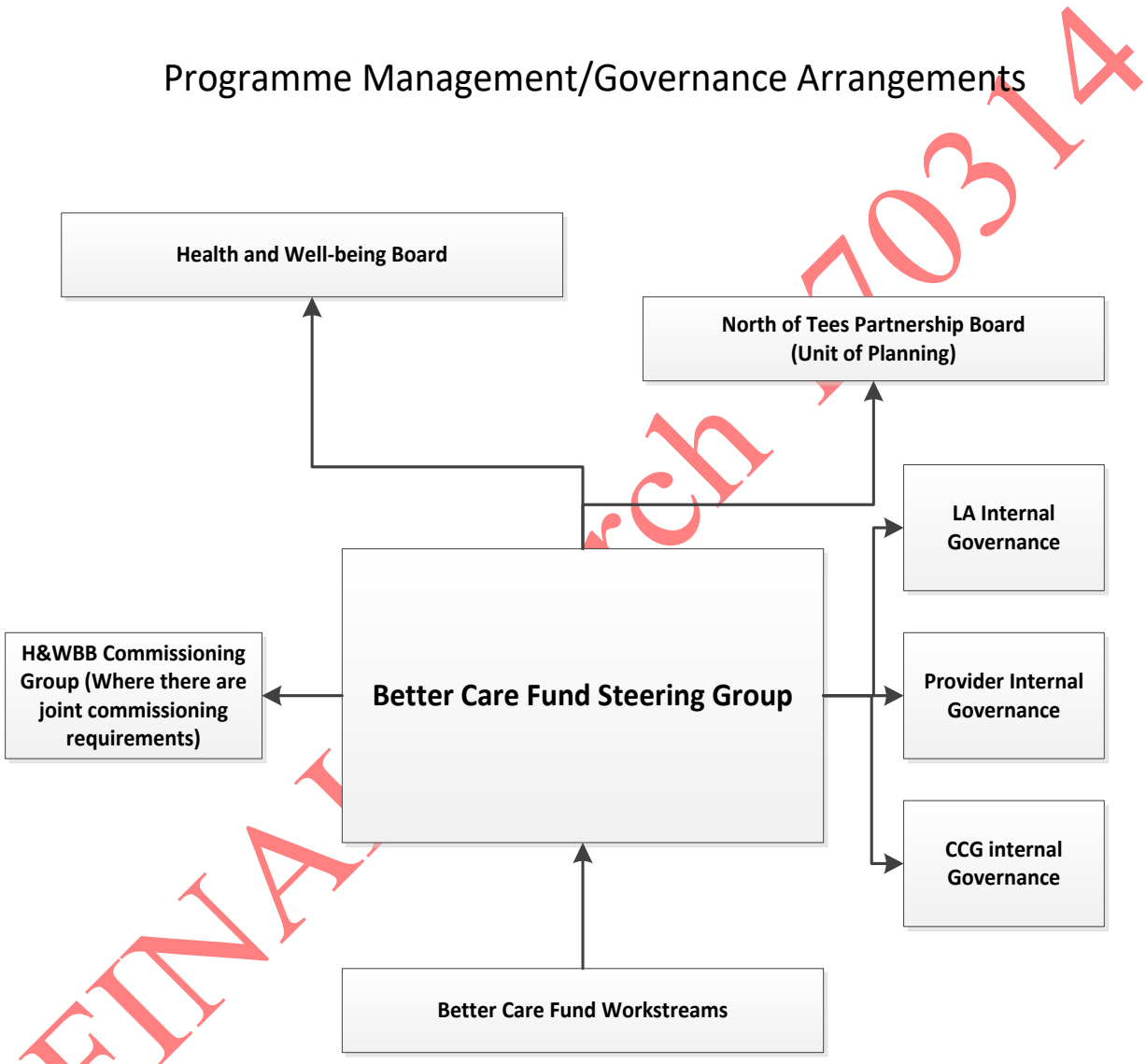
The Partnership Board will provide regular progress and outcome reports to ensure all partners are able to meet their respective reporting requirements in line with their own governance arrangements. This includes but is not limited to; ensuring that the Health and Wellbeing Board remains central to the development and oversight of the proposed schemes making up our Better Care Fund, and will provide regular updates via the Adults Commissioning Group and Adults Board.

The CCG Delivery Team and Governing Body will be kept appraised of the developments and kept informed of the progress of all plans; this is intended to be through development

sessions and/or Governing Body meetings. Member Practices of the CCG will also be kept appraised through Clinical time out events, Clinical Reference Groups and Council of Member meetings.

Diagram 1 sets out the governance arrangementsfor the Stockton Better Care Fund (BCF) programme

Diagram 1.



3) NATIONAL CONDITIONS

a) Protecting social care services
Please outline your agreed local definition of protecting adult social care services.

'Protecting social care services means ensuring that people in Stockton with eligible social care needs continue to be supported in a time of increasing demand (with significant increases in the population aged over 85 years projected) and reducing local government resources.'

We have already started a programme of reviews and transformation aimed at ensuring this objective is met and the Better Care Fund allows us to build on this programme of change by developing opportunities for further integration with Health.

We already have in place a number of services which are jointly funded local authority and NHS however we are not complacent and want to ensure that, where appropriate, these services continue to deliver the outcomes and benefits in line with the Better Care Fund.

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

The current funding would need to be sustained in order to maintain the social care offer to Stockton and increased in order to deliver the schemes outlined in the BCF plan and address the implications of the Care Bill.

The BCF will focus on an early intervention approach providing an integrated package of interventions to people (at a stage where they may have needs below the statutory thresholds and would not have traditionally been eligible for support) in order to reduce or delay the number of people requiring social care services in the future. Helping to maximise an individual's health and wellbeing and ensure the best use of resources across the health and social care system and ensuring the long-term protection of social care services he BCF will ensure the continuation and ongoing development of programmes currently funded through the NHS transfer of funds to social care and is vital to enable the local authority to sustain the current level of eligibility and to support people to maximise independence, choice and control.

These programmes include:

1. Community Bridge Building – Supporting people with learning disabilities and mental health needs to gain the skills and confidence they need to move into employment.
2. Reablement – helping to protect social care outcomes for those at risk of admission or admitted to hospital by providing access to a range of evidence based reablement interventions and pathways of care.
3. Increasing capacity for care planning and reviews within existing services where there has been an increase in demand, such as people with dementia and those with complex needs.

4. Support of 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.
5. Support for Carers – Ensuring a joined up approach to commissioning services for carers.
6. Ongoing service reviews and the transformation and development of services to future proof social care services and support integration.
7. Effective use of capital funding associated with the Disabled Facilities Grant (DFG) and Community Capacity Grant.

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.

See Enabling Scheme 3

Delivery of the integrated care vision described in this BCF plan will require a range of 7 day health and social care services. This has been recognised by all partners involved in the development of this vision and is the reason why '7 Day Working' is identified as one of the enabling schemes.

Seven day social care support services are already in place to support health services in ensuring timely discharge from hospital. Both Stockton's Intermediate Care and Reablement services provide support to clients recently discharged from hospital between 7am and 10pm, 7-days per week including accepting new referrals. In addition The Rosedale Centre provides access to a 7-day per week residential rehabilitation and assessment service. We will be building on these current arrangements under the BCF plans to make sure that effective pathways for discharge continue to be developed including the assessment support required of social workers; speeding up access to direct support to within an hour of referral (currently 2 hours) and supporting people to remain at home without the need for hospital admission.

c) Data sharing

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

All health services use the NHS Number as the primary identifier in correspondence.

Stockton Adult Social Care services currently do not use the NHS number but are in the process of adopting it universally across all Adults Services as the primary identifier.

All NHS providers are commissioned utilising the NHS Standard Contract. This contract requires completion of a valid NHS Number field and in mental health and acute commissioning data sets this is submitted via SUS, this is a national quality requirements on the contract with a financial penalty applied to breaches in threshold tolerance.

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

NHS Number to be the primary identifier across all Adult Services by April 2015. Where individual organisations are non-compliant with the NHS Standard Contract terms a Data Quality Improvement Plan (DQIP) would be agreed to ensure that this requirement is delivered through provider contract meetings.

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))

Stockton Council is committed to adopting systems that are based on Open APIs and Open Standards and this is included as a standard requirement for all systems procurements. CareDirector v3.2, a full case management solution used to provide a range of services and content to Adult social care, while allowing the involvement of health care partners. To enable cross-boundary working, we will improve interfaces between systems. Further, we are creating a data warehouse that will aggregate data from different sources into a consistent format. This will provide one view over the whole systems of health and social care, and allow queries and analyses to take place across multiple, separate systems. Also, it will improve data quality by identifying gaps or inconsistent records. We currently have a high percentage of our member GP practices actively updating the Summary Care Record, and we are committed to adopting Open API functionality as it becomes available in the clinical systems we have deployed through the GPSoC2 framework (SystmOne, EMIS and InPS). We will also look to include appropriate weighting in future tenders and system replacements which favour those with Accessible/Open API functionality. We are currently implementing the Electronic Prescription Service in all of our member practices, which will allow prescriptions issued by our clinicians to meet the ISB0052 dm+d interoperability standards for transmission to other care partners. We are in the early stages of a CCG wide deployment of SharePoint which utilises OpenXML document standards and will facilitate greater information availability and sharing. All clinicians and CCG staff are using NHSMail which complies with Government 'RESTRICTED' standards and can be used to communicate Personal Identifiable Information securely with other clinicians and LA colleagues using GSX Mailboxes

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 Caldicott 2.

Stockton already has an N3 connection, PSN certification and ICT Services are certified to ISO27001 Information Security Management standard. Stockton-on-Tees Borough Council have an information governance programme based on ISO27001 and IG Toolkit level 3 compliance.

Stockton Council will, through appropriate management, strict application of criteria and controls:

i. Observe fully, conditions regarding the fair collection and use of information;
ii. Meets its legal obligations to specify the purposes for which information is used.
iii. Collect and process appropriate information, and only to the extent that it is needed to fulfil operational needs or comply with any legal requirements;
iv. Ensure the quality of information used;
v. Apply strict checks to determine the length of time information is held;
vi. Ensure that the rights of people, about whom information is held, are able to be fully exercised under the Act. (These include: right to be informed that processing is being undertaken, the right of access to one's personal information, the right to prevent processing in certain circumstances and the right to rectify, block or erase information which is regarded as wrong information);
vii. Take appropriate technical and organisational security measures to safeguard personal information;
viii. Ensure that any third party processors contracted by the Authority adhere to appropriate controls.

In addition Stockton Council will ensure that:

i. There are persons with specific responsibility for data protection in the organisation.
ii. All subject access requests will, in the first instance, be referred to an appropriate Officer, who will normally be the Council's Monitoring Officer, who will take reasonable steps to ensure that the request is processed by the appropriate Officer or Officers, unless the requested information is held exclusively by Health and Social Care or Council Tax. These latter requests are to be directed to the relevant Corporate Director of Service, who will take reasonable steps to ensure that they are processed appropriately.
iii. Everyone managing and handling personal information understands that they are contractually responsible for following good data protection practice;
iv. Everyone managing and handling personal information is appropriately trained to do so;
v. Everyone managing and handling personal information is appropriately supervised;
vi. Methods of handling personal information are clearly described;
vii. A regular review and audit will be made of the way personal information is managed;
viii. Documents and any storage media containing input to and output from systems (paper or electronic) detailing personal information will be held, transported and disposed of with due regard to its sensitivity. Confidential paper output no longer required will be shredded before it is included in the recycling process. The disposal of confidential waste may be arranged with firms who provide a certificated secure disposal service. Individual service areas will be responsible for ensuring appropriate arrangements are made. Where arrangements are made with external companies for paper data disposal, or other media holding personal data then checks must be made to ensure that the arrangements are secure and

that disposal certificates are provided and recorded.

All Providers are required to comply with the terms and conditions of the NHS Standard Contract which requires confirmation from Providers they are compliant with the IG toolkit level 2. All Providers are required to provide the relevant IG policies relating to confidentiality, data protection and information disclosure (GC21.10.1); handling and disclosing personal data (GC21.10.2 and 21.10.4); and obligations under NHS Care Records Guarantee (GC 21.10.3)

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.

See Enabling Scheme 4

The integrated approach within this BCF plan will ensure that people who are at high risk of hospital admission will be jointly assessed, will have in place a care plan and will have assigned an appropriate lead professional.

The predictive risk stratification model that is currently commissioned from a health perspective is delivered in partnership across GPs and community matrons and the current predictive risk tool identifies individuals most likely to be at risk of an emergency admission in the next twelve months. This tool is to be further developed to incorporate both social and health risk to enable a targeted multi-disciplinary approach to support people to better self-manage their long term condition, having an appropriate identified accountable lead. This information will also be used in conjunction with other sources of public health intelligence to ensure that resources are targeted at reducing health inequalities.

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 believe focusing on high intensive current users of health and social care within our area will provide us with the maximum impact and benefit in our joint work creating and maintaining a positive environment within which we can transform and integrate local health and social care services.

4) 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

There is a risk that…	**Risk rating**	**Mitigating Actions**
There is insufficient information and data at the correct level and quality to effectively monitor outcomes of all the interlinking projects and schemes and ensure overall delivery of the BCF plan.	High	Working across health and social care information teams to make sure that information and data is collected and presented meaningfully to inform planning and service development. Gaining assurance through the work streams that the schemes and projects outlined in the BCF plan will deliver the required outcomes. Regular reviews will be undertaken to reconsider need, refine plans and flex spending plans or potentially disinvest in schemes that fail to deliver the best outcomes National performance measures will be used where appropriate and where these are not available a locally agreed indicator set will be developed.
The schemes are not in line with existing NHS or LA delivery plans undoing existing good practice.	Med	Partners are and will continue to be involved in the development of the BCF plans to avoid a lack of connectivity with individual organisational plans. The agreed governance arrangements ensure that the impact of decisions relating to the implementation of the BCF are considered by all partners involved in the North of Tees Partnership Board. . Impact assessments and business cases will be developed as appropriate to support service change/redesign decisions. Plans build on the good practice already in place.
There is insufficient time to implement the schemes to have the impact in the short term on performance and savings.	High	Plans build on existing good practice and identify, wherever possible, some quick wins Existing services that will contribute to delivery on the BCF plan will review data collection and performance metrics to

		enable measurement against the BCF outcomes. Any available funding during 14/15 will be utilised to progress the schemes further and faster, where it is appropriate to do so. Contractual mechanisms will be used where appropriate to ensure that all parties are contractually bound to deliver their changes within agreed timescales.
The schemes identified in the BCF fail to deliver the required reduction in acute and care home activity by 2015/16, impacting on the funding available to support core services and future schemes.	High	Assumptions have been modelled using a range of available data. 2014/15 will be used to refine the assumptions, with a focus on developing detailed business cases and service specifications.
The focus is on performance and savings rather than being person-centred and designed to ensure that the individual receives the best possible care.	Low	All the schemes have been / are being designed with the individual at the centre of the changes / improvements. Need to ensure right quality performance measures deliver and sustain high quality care with the person at the centre of services. Ongoing consultation and engagement throughout the implementation of the BCF plan to ensure service users are involved in the design of new care pathways.
Partners can't agree the best model of service delivery and / or the implementation of the model.	Med	Partners will continue to be involved in the development of the evidence based (where the evidence is available) services The agreed governance arrangements ensure that there are mechanisms in place to reach agreement on decisions and resolve any issues via the North of Tees Partnership Board
Processes and ways of working within health and social care services are not changed quickly enough to enable single	Med	Rollout of single assessments, plans and coordinated care approaches will be phased.

assessments and care planning.		Where possible PDSA will be used to ensure that changes can be refined and carefully managed.
Commissioning processes are not able to identify providers to deliver the agreed pathways and services.	High	Need to ensure effective commissioning of all services in line with procurement regulations. Market testing will be undertaken where appropriate to determine whether this is a significant risk (eg Skill set)
ICT providers are unable to meet requirements for the use of the NHS number and the integration of systems needed to support integrated working	High	Nationally there needs to be discussions on the best way of negotiating with suppliers to deliver some of these solutions. Local partners to work closely to understand the implications of an integrated system including costs
If current funding to Social Care is removed / reduced there will be an immediate detrimental impact on the delivery of savings and BCF outcomes.	Low	Funding has been agreed and secured for 14/15 and 15/16 subject to the implementation of the schemes. North of Tees Partnership Board will continue to monitor the impact of changes to social care funding and risks posed to the BCF
Introduction of the Care Bill results in significant pressures for social care services with resulting impacts on the delivery of the BCF plan as well as the wider Health and Social Care system.	Med	Work undertaken to understand the possible impact of the Care Bill; this will be refined as the detail is confirmed. The Care Bill and the Better Care Fund are fully integrated into the Adult Transformation Programme
Organisational pressures and wider health and social care reform restrict the capacity of all partners to deliver the BCF plan.	Med	Dedicated project management resources are being identified to support delivery of the BCF and capacity to deliver on the BCF will be regularly reviewed.
Workforce skill mix and availability to deliver the new pathways of care is not adequate.	Med	Workforce planning and development with Health Education North East and NHS England Local Area Team.

The non-coterminous boundaries for health and social care result in differing priorities and levels of investment that need to be managed by a single CG and acute provider	High	North of Tees Partnership Board enables plans to be shared and implications understood with clear service specifications in place to assure equity across both localities for people accessing services. Opportunities for joint working across the two Las have been explored.