Revised July 2014

Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Stockton-on-Tees Borough Council**
Clinical Commissioning Groups	**NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group**
Boundary Differences	**Not applicable**
Date agreed at Health and Well-Being Board:	**28/08/2014**
Date submitted:	**dd/mm/yyyy**
Minimum required value of BCF pooled budget: 2014/15	**£704,000**
2015/16	**£12,882,000**
Total agreed value of pooled budget: 2014/15	**£843,00**
2015/16	**£14,265,00**

b) Authorisation and signoff

Signed on behalf of the NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group	Signature needed
By	Ali Wilson
Position	Chief Officer
Date	<date>

Signed on behalf of Stockton-on-Tees Borough Council	Forward to Jas Lang for signature when approved
By	Neil Schneider
Position	Chief Executive
Date	<date>

Signed on behalf of the Stockton-on-Tees Health and Wellbeing Board	Forward to Jas Lang for signature when approved
By Chair of Health and Wellbeing Board	Cllr Beall
Date	<date>

c) Related documentation

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

Document or information title	**Synopsis and links**
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. http://www.teesjsna.org.uk/stockton/
Joint Health & Wellbeing Strategy 2012-18	The Joint Health and Wellbeing Strategy sets out the Health and Wellbeing Board priorities and actions to address the needs identified in the JSNA. http://www.stockton.gov.uk/documents/839159/jointhealthandwellb.pdf
2012/13 Local Account	Summary of the priorities, progress and future direction of adult social care in Stockton. http://www.stockton.gov.uk/adultservices/supportforpeople/areyoubeingservedwell/
Clear and Credible Plan	Description of the main health issues and how the CCG will tackle these. http://www.hartlepoolandstocktonccg.nhs.uk/wp-content/uploads/2013/11/HAST_CCG_5_YEAR_PLAN_FINAL_INTERNAL_WEB-15-August.pdf
5 year Strategic Plan	http://www.hartlepoolandstocktonccg.nhs.uk/wp-content/uploads/2013/11/HAST-5-Yr-Plan-on-a-Page-FINAL.pptx
2 Year Operational Plan	http://www.hartlepoolandstocktonccg.nhs.uk/wp-content/uploads/2013/11/HAST-2-Yr-Plan-on-a-Page.pptx
CCG Prospectus	Description of the main health issues and how the CCG will tackle these. http://www.hartlepoolandstocktonccg.nhs.uk/publications/

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 http://www.stockton.gov.uk/stocktoncouncil/ourperformance/stocktoncouncilplanandreports/
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 xma0036 CESC Trans Image.pdf
A strategy for Adult Health and Care Services in Stockton-on-Tees	Stockton's vision for Health and Care 2009 / 2014 http://www.stockton.gov.uk/documents/adultservices/AdultVision.pdf
Carers Strategy	Multi agency strategy that identifies the needs of carers locally and priorities to deliver improvements over a three to five year period. http://www.stockton.gov.uk/documents/adultservices/CARERS_STRATEGY_2013-2017...pdf
Integrated Digital Care Fund Bid	The Integrated Digital Care Fund bid is a bid for funding to support the ICT elements of the Better Care Fund. HAST Bid v6.docx

2) VISION FOR HEALTH AND CARE SERVICES

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

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.

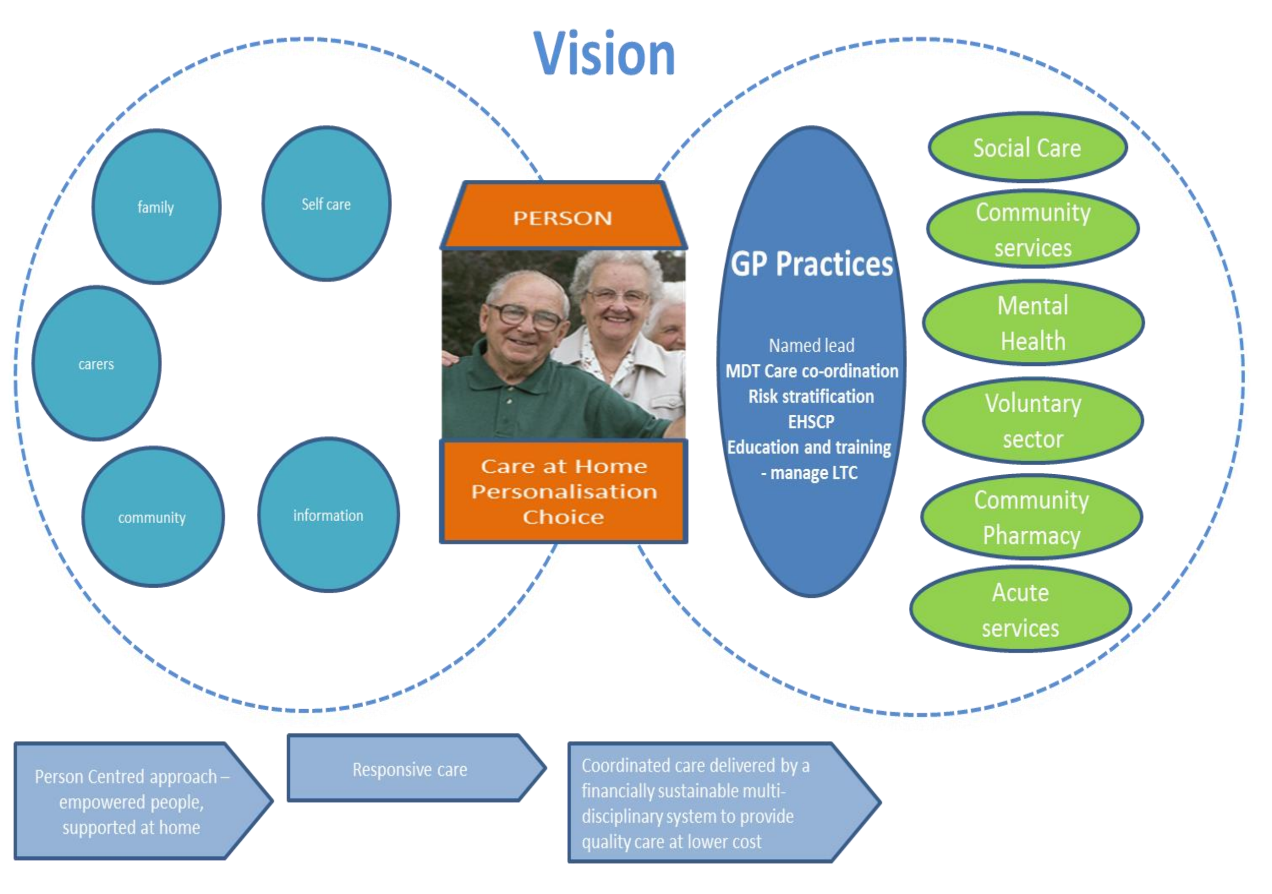
Our vision of service delivery as we move forward is to have a sustained focus on

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.

Our Vision for Integration:



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

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.

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

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.

Key Changes Integration will bring:

Key Changes

"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; pg7)

Greater use of voluntary and third sector organisations

Proactive management of Long Term Conditions

7 day services

Integrated Care Packages

Joint Assessments

Integrated community health and social care

Greater use of digital technology

Improved access to reablement services to support people to remain at home

People only having to tell their story once

Clearer simple pathways (Momentum)

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 hospital admissions.
- Increase in the estimated diagnosis rate of dementia.

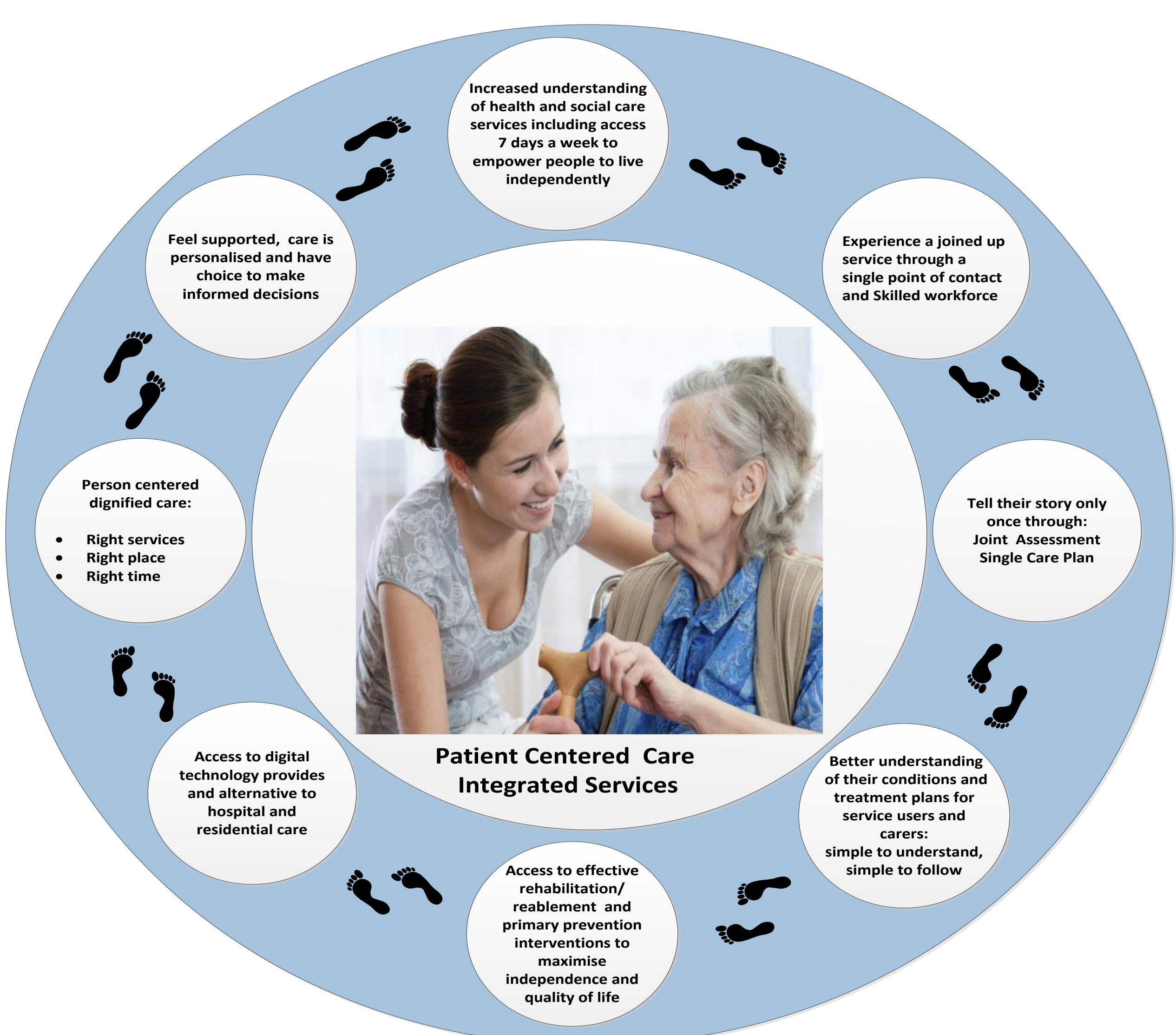
To support these aims, we will also expect to see significant qualitative improvements through a more integrated and person centric model of delivery.

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.

People will experience an integrated service which flexible and responsive enough to recognise the different needs of individuals shifting from reactive (unplanned) care to prevention and proactive care. Success will mean that people receiving care and support from our integrated multidisciplinary services will experience the following:



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 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.

3) CASE FOR CHANGE

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

Demographic Changes & Increasing Demand for Services
Stockton-on-Tees has an estimated population of over 33,000 people aged 65 and projections from the JSNA suggest that between 2014 and 2021 the numbers of people living in Stockton-on-Tees aged 65-79 and 80 and over are projected to increase dramatically with an additional 5,203 people over 65 in 2021.

Research shows that older age is associated with an increased incidence of multiple long term conditions and a growing number of functional and cognitive impairments. It is estimated that 58% of those aged 60 and over report having a Long Term Condition (LTC) with 25% of over 60s having two or more LTCs[1]. For Stockton this would mean that by 2021 there will be approximately 9600 over 65's with two or more LTCs.

The number of older people who are living alone is also increasing and it is estimated that 11,000 older people in Stockton-on-Tees are currently living alone. This is at a time when the availability of informal care by family members is also declining.

- Cardiovascular Disease: over 2,000 older people in Stockton are predicted to have a longstanding health condition caused by CVD which will need long-term care and rehabilitation
- Chronic Obstructive Pulmonary Disease (COPD): over 500 older people in Stockton are predicted to have a longstanding health condition caused by COPD which will need long-term care and rehabilitation.
- Diabetes: the number of people aged 65 and over in Stockton with diabetes is forecast to increase from 3,900 in 2012 to 4,700 in 2020
- Dementia: In 2014 2,180 people (65+ years) are predicted to have dementia. This is predicted to rise to 2,659 people by 2020 and 3.646 people by 2030. (Source: www.poppi.org.uk)
- Falls: The number of older people in Stockton predicted to have a fall each year is 8,000, nearly 700 of which will result in hospital admission.
- Obesity: Being obese increases the likelihood of someone developing type 2 diabetes and can bring reduced mobility and independence as well as adversely affecting many medical conditions. It is estimated that 8,000 older people in Stockton are obese.

These trends have resulted in a growing demand for health services to treat multiple long term conditions as well as care services to help individuals cope with everyday activities such as dressing, bathing, shopping, or preparing food.

The Stockton-on-Tees Better Care Fund Plan recognises these trends and focuses on older people, particularly focusing on people with long term conditions. The BCF Plan aims to help manage the growing demand for health and social care services through:

- a more integrated approach to the delivery of care and support;
- population level risk stratification to identify those individuals who are at greatest risk of emergency hospital admission, admission to long term care and poor outcomes; and

[1] Source: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf (page 7)

- a focus on earlier intervention and preventative pathways.

Health inequalities
There is also a unique social and economic mix across Stockton-on-Tees, with areas of acute disadvantage situated alongside areas of affluence. Whilst 29% of the population live within the top 20% of least deprived areas of England, 27% live in the 20% most deprived areas. This results in large inequalities in health and wellbeing and significant challenges for the planning and targeting of health and social care services. As the Marmot Review on health inequalities made clear, a person's health and wellbeing in later life is affected by a wide range of determinants such as poverty, housing, employment and education, as well as healthy lifestyles and health care.

The Stockton-on-Tees Better Care Fund Plan recognises these wider determinants of health and aims to adopt an earlier intervention approach which includes a more holistic approach to care planning, which will incorporate housing issues, social isolation, healthy lifestyle issues, as well as the promotion of screening and vaccination programmes.

Joining-up care across Health and Social Care
There are already strong relationships between health and social care services within Stockton-on-Tees, however there is a recognition that a more integrated approach would result in significant improvements in care for individuals. Evidence also suggests that more effective ways of targeting services are required to ensure services target those people who are in greatest need. The Stockton-on-Tees Better Care Fund aims to address this through a more systematic risk stratification approach which helps to identify those people most at risk of poor outcomes including those most at risk of hospital admission and admission to long term care. Through this approach the BCF plan aims to identify those at risk at an earlier stage and begin to shift the focus of care towards a more pro-active, preventative approach.

The integrated approach described in the Stockton-on-Tees Better Care Fund Plan will help to address these issues and deliver the vision through:

- Effective population based risk stratification to ensure that services and support are targeted at the right people helping to maximise benefits and address inequalities
- Focusing on a more planned approach based on the principals of early intervention and prevention
- Multi-disciplinary teamwork and Inter-professional networks
- Single holistic assessments
- Joint care planning
- Care coordination and case management
- Effective management of long-term conditions
- Effective integrated crisis management responses in times of crisis
- A focus on self-management, involving and empowering individuals, choice and control
- Effective use of digital technologies
- Shared clinical records.

In order to develop the Stockton-on-Tees BCF Plan a review of the available evidence base on health and social care integration and transformational change was undertaken. This has informed the local approach and is helping to shape the individual schemes within the Stockton-on-Tees BCF Plan.

4) PLAN OF ACTION

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

Better Care Fund

Scheme 1
Multi-disciplinary Teams

- SCH1-1:Initial design for MDT to support Early intervention and Prevention approach
- SCH1-2:Developing Pathways & designing MDT approach Early Intervention & Prevention
- SCH1-3:Developing Pathways & designing MDT approach Crisis Management
- SCH1-4: Training and Workforce development
- SCH1-5: Training and Development Care Homes
- SCH1-6: Identification of at risk population

Scheme 2
Pathways and Care Dementia

- SCH2-1: Roll out dementia collaborative work
- SCH2-2: Review benefits of using digital care
- SCH2-3: Review respite provision
- SCH2-4: Further development of the Living-well hub
- SCH2-5: Community dementia liaison service

Enablers
Schemes 3 - 8

- EN3: 7 day working
- EN4: Joint Assessments
- EN5: Digital Health Care
- EN6: Narrowing Health Inequalities
- EN7: ICT systems and Data Sharing
- EN8: Communications and Engagement

SCHEME 1 – MULTI-DISCIPLINARY TEAM

	Milestones	Timescales	
	Establish implementation team	April 14	Complete
SCH1-1	BCF Stakeholder Event – understanding the issues	June 14	Complete
	3P Design Event for MDT for Early intervention and prevention and crisis management	Oct 14	Event organised
	Develop action plan from 3P event	Nov 14	
	Develop pilot MDT	December 14	
	Develop pilot to increase access to Reablement	December 14	

	Implementation of pilots	Jan - April 15	
	Develop directory of services to support joint working across all partners	April 15	
SCH1-2	Use pilot to develop pathways for Early intervention and prevention	Sept 15	
SCH1-3	Use pilot to develop pathways for Crisis Management	Sept 15	
1&2&3	Evaluation of pilot	Sept 15	
	Develop proposal for full solution	Dec 15	
	New service in place	April 16	
SCH1-4	Training and development of workforce	Ongoing	
SCH1-5	Evaluation of all Care Home training and development	December 14	
	Develop Care Home training and development programme – embed and mainstream service proposal	April 15	
	Roll Out Care Home programme	Ongoing	
SCH1-6	Risk stratification and targeted intervention programme complete	April 15	

SCHEME 2 – IMPROVING PATHWAYS AND CARE FOR DEMENTIA

	Milestones	Timescales	
SCH2-1	Evaluation of dementia collaborative with proposals to mainstream activity	October 14	
	Appointments to new posts	December 14	Funding secured for temporary appts to ensure continuity
	Develop proposals for new dementia programme and embedding best practice for initial programme	Jan 15	
	Enhanced service in place	April 15	
SCH2-2	Review benefits of using digital care	Jan 15	Currently underway University of Teesside
	Pilot & wider roll out of Digital Health Care	See Enabler Scheme 5	
SCH2-3	Pilot of respite approach & process review	April 15	
	Business cases for respite care	September 16	
	Implement respite proposals	April 16	
SCH2-	Proposals for further development of the	December 14	

4	Living-well hub		
	Roll out enhanced service	April 15	
SCH2-5	Community dementia liaison service business case	Sept 14	
	Roll out of programme	Jan 15	

ENABLING SCHEME 3 – 7 DAY WORKING

Notes:

- 7 day working scheme is linked to the delivery of the Multi-disciplinary Team to support the Crisis Management pathway
- 7 day working is also supported by Enabling Scheme 7 – ICT and Data Sharing, the system will be needed to ensure maximum efficiencies in 7 day working and in particular the impact on reducing unnecessary admissions to care

Milestones	Timescales	
Engagement with GP and other key stakeholders	April 15	
Review pathways and Root Cause analysis	June 15	
Business case for any changes to the Multi-disciplinary teams	December 15	
Enhanced 7 day arrangements in place	April 16	

ENABLING SCHEME 4 – JOINT ASSESSMENTS

Notes:

- Joint Assessments will be part of the approach for both the Multi-disciplinary Team and the Dementia Collaborative
- Joint assessments is supported by Enabling Scheme 7 – ICT and Data Sharing, the system will be needed to ensure that the practitioners undertaking joint assessments have access to the relevant information about the patient / service user to inform decisions on patient / service user need

Milestones	Timescales	
3P event MDT	See scheme 1	
Risk stratification and identification of target group(s)	March 15	
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

Milestones	Timescales	
Review of evidence and best practice	January 15	University Teesside report plus evaluation of successful local authority schemes
Pilot 1 - use of digital technologies to support people diagnosed with dementia	March 15	Project Team in place
Pilot 2 - use of digital technologies in a cohort of clients that would not be eligible under our existing FACS criteria	March 15	Project Team in place
Evaluation of pilot	April 15	
Roll out depending on results	December 15	

ENABLING SCHEME 6 – NARROWING HEALTH INEQUALITIES

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

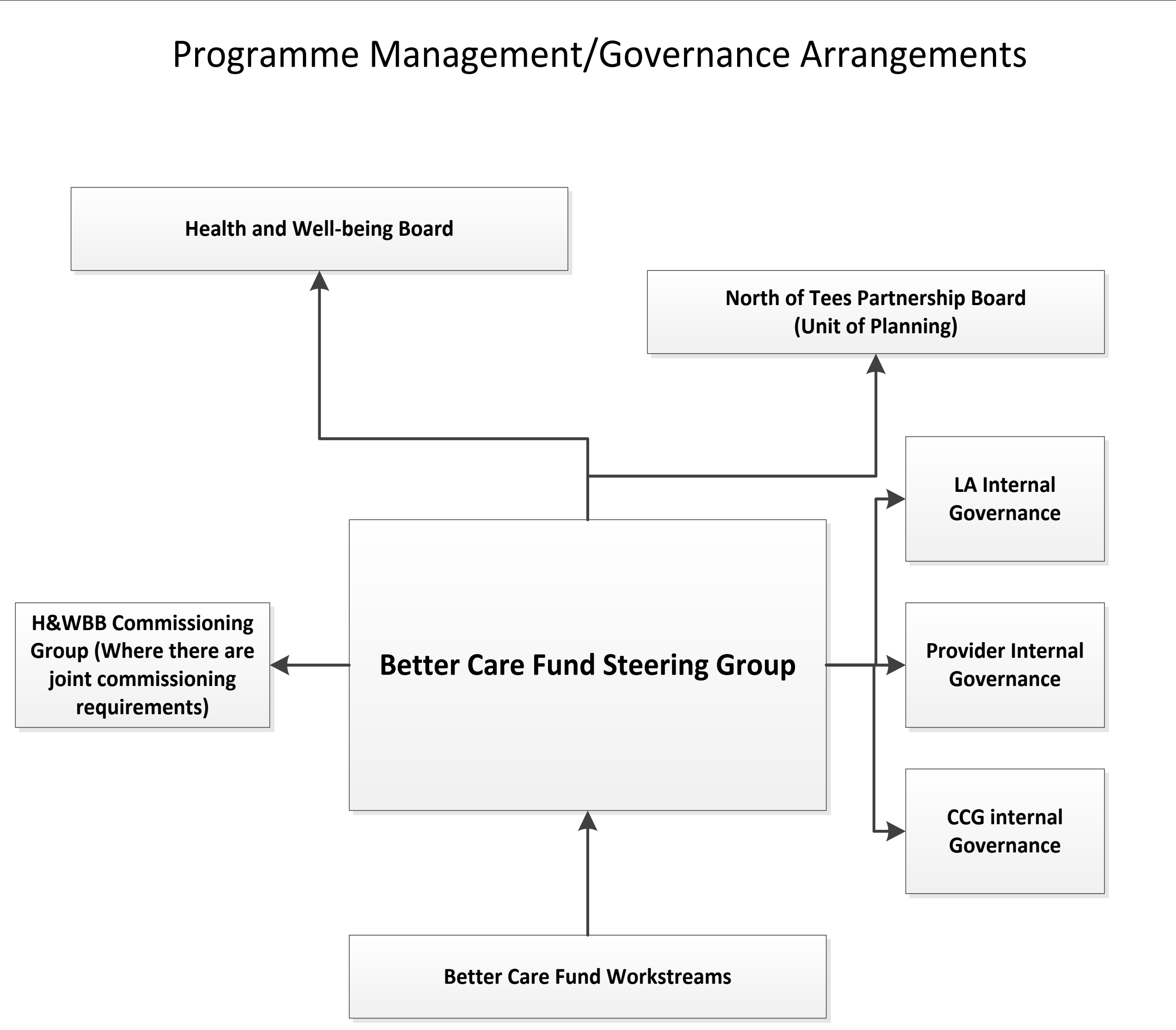
ENABLING SCHEME 7 – ICT SYSTEMS AND DATA SHARING

Milestones	Timescales	
Funding Bid	September 14	Submitted – through to stage 2 – interviews 11th September
NHS number – local authority	April 15	
Information and joint working protocols	Ongoing	
Data Sharing Portal to be developed and implemented	April 16	

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

Robust governance arrangements for the Stockton-on-Tees Better Care Fund Plan were agreed by the Stockton-on-Tees Health and Wellbeing Board in April 2014. These governance arrangements reflect the partnership approach that is required to effectively deliver the integrated approach described in our Better Care Fund Plan but also acknowledges the needs of individual partner organisations to ensure that decisions are taken through their own internal governance arrangements. The agreed governance arrangements ensure that a system wide perspective and approach is taken through the North of Tees Partnership Board which covers the Hartlepool & Stockton-on-Tees CCG Unit of Planning.

The diagram below sets out the governance arrangements for the Stockton Better Care Fund (BCF) programme.



The **North of Tees Partnership Board** brings together key partners across the Unit of Planning to provide strategic leadership and oversight to the development and delivery of the Hartlepool and Stockton-on-Tees Better Care Fund Plans. Ensuring alignment with wider strategic plans across health and social care; co-ordinating and aligning all cross-organisational activities across the health and social care economy aimed at delivering service change; addressing risks and issues that might impact on the delivery of the Better Care Fund; agreeing contingency and risk management arrangements in the event that planned schemes do not deliver to projections; coordinating and sharing how decisions will be taken within partner organisations; and supporting assurance processes.

The **Stockton-on-Tees Health & Wellbeing Board** is responsible for; signing off and ensuring delivery on the Stockton-on-Tees Better Care Fund Plan; ensuring that the BCF plan responds to local needs, is aligned with the Health & Wellbeing Strategy and supports system integration across health and social care; agreeing the use of funding under the Better Care Fund pooled budget arrangements; addressing any risks and issues arising that relate to the wider Stockton health and social care system; and progressing (through the Stockton Adults Health & Wellbeing Commissioning Group) any joint commissioning implications and requirements arising from the Better Care Fund.

The **Better Care Fund Steering Group** is responsible for; ensuring delivery on the Hartlepool & Stockton-on-Tees BCF plans; developing new pathways and models of care; ensuring that partner organisations have taken decisions through their internal governance processes in order

for decisions to be made; ensuring each organisation provides sufficient resources to the work streams to ensure successful implementation of the programme; developing a joint communications strategy; resolving and appropriately escalating issues and risks associated with the Better Care Fund; ensuring other groups are updated and assured of progress.

The **Stockton BCF Work Streams** are responsible for developing the pathways and models of care under each of the BCF schemes; resolving issues and risks which are within the remit of the project; developing the detailed implementation plans and taking day-to-day responsibility for implementation once the new pathways and models of care have been agreed.

Each of the partner organisations will ensure that decisions and information is taken through their own internal governance structures. For example 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.

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

The arrangements for management and oversight of the delivery of the Better Care Fund Plan is described in 4b above. A clear process for managing risks and issues and monitoring and managing performance has been agreed as part of the BCF governance arrangements.

In addition, dedicated project management resources have been identified within the partner organisations to support delivery on the Better Care Fund Plan.

d) **List of planned BCF schemes**

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

Ref no.	Scheme
1	Multidisciplinary Integrated Service
2	Improving Pathways of Care for Dementia
3	Enabling Scheme 1: 7 Day Working
4	Enabling Scheme 2: Joint Assessments
5	Enabling Scheme 3: Digital Technologies
6	Enabling Scheme 4: Narrowing Health Inequalities
7	Enabling Scheme 5: ICT Systems and Data Sharing

5) RISKS AND CONTINGENCY
a) Risk log

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

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
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.	1	4	4	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. Local performance framework and performance management process under development.
The schemes are not in line with existing NHS or LA delivery plans.	2	4	8	Partners are and will continue to be involved in the development

This may be exacerbated by the non-coterminous boundaries for health and social care resulting in differing priorities and levels of investment that need to be managed by a single CCG and acute provider.				of the BCF plans to ensure connectivity with individual organisational plans. The agreed governance arrangements ensure the impact of decisions relating to BCF implementation 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. Opportunities for joint working across the two LAs have been explored.
There is insufficient time to implement the schemes to have the impact in the short term on performance and savings.	4	4	16	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. BCF 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 possible to ensure that all parties are contractually bound to deliver within agreed timescales.
The schemes identified fail to deliver the required reduction in emergency hospital admissions and admissions to long term care by 2015/16, impacting on the funding available to support core services and future schemes.	3	4	12	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 BCF implementation plan will be phased to prioritise those schemes likely to have the biggest impact on reducing emergency hospital admissions.
Partners can't agree the best model of service delivery and / or	1	2	2	The agreed governance arrangements ensure that there

the implementation of the model.				are mechanisms in place to reach agreement on decisions and resolve any issues. Partners will continue to ensure that service models are informed by the evidence base and best practice examples. Methodologies such as Lean '3P' will be utilised to support design and agreement on the model. Ongoing consultation and engagement throughout the implementation of the BCF plan to ensure service users are involved in the design of new care pathways.
Processes and ways of working within health and social care services are not changed quickly enough to enable single assessments and care planning.	2	4	8	Rollout of single assessments, plans and coordinated care approaches will be phased. 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.	1	5	5	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 (e.g. 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.	2	3	6	Local partners to work closely to understand the implications of an integrated system including costs.
Introduction of the Care Act 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.	3	4	12	Work undertaken to understand the possible impact of the Care Act; this will be refined as the detail is confirmed. The Care Act 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.	2	3	6	Dedicated project management resources have been 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.	2	3	6	Workforce planning and development with Health Education North East and NHS England Local Area Team.

b) Contingency plan and risk sharing

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

Stockton Borough Council and NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group have agreed to operate the main schemes on a pilot basis thereby minimising risk of non-delivery and adding flexibility. Each individual scheme will need to be evaluated and reviewed throughout the year to identify if they are adding value, this is also the case of existing services with possible disinvestment if necessary. Both CCG's and Local Authorities already have set contingencies within their financial plans which may be required should schemes not achieve agreed outcomes.

6) ALIGNMENT

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

These plans have been designed to benefit from, align to and enhance work already underway within the CCG and wider health environment. The CCG is committed to reducing health inequalities and improving the quality of services and therefore the experience of patients. This responsibility is met through the CCG workstream process which involves partners from the wider health environment to ensure that work is not undertaken in isolation and we can mutually maximise on our efforts.

The CCG works with and has commissioned a number of local services and initiatives within the local voluntary and community sector. These services and projects are intended to support various patients to engage with health, social care and other community services. These include

1. Commissioning self-management and support programmes for patients with long-term respiratory disease from the local hospice
2. Providing additional support programmes for patients with early-disease respiratory disease
3. Commissioning of voluntary and community services to help reduce health inequalities and support the local health priorities.

Within the Council there are a number of strategic initiatives which are aligned and support the Better Care Fund:

1. Efficiency reviews – these reviews identified new ways of working across the whole of the delivery of Council services the models align to the principles and pathways outlined in the Better Care Fund plan.
2. Care Act 2014 implementation
3. Health and Well-being strategy which supports integration across the Health and Social Care economy to improve the health and well-being of the population – the Better Care Fund is fully aligned to this strategy
4. Carers strategy has recently been reviewed and new Carers contracts in place. These have been developed in line with recent best practice.
5. Housing Strategy ensures that the housing provision supports the need to

maximise independence and provide independent living.

6. Health Sciences network – the plans for digital technologies is aligned to a wider strategy across health and social care which is informed by the health sciences network research and evaluation project.

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

In order to develop our plan we worked collaboratively with partners from the Health and Well Being Boards to ensure that we established a set of aims that while specific to our organisation also reflected the delivery of broader system wide goals and ambitions.

In further developing our strategic plan, in line with our vision, we have revisited these aims to ensure they are fully inclusive of the integration process as part of the Better Care Fund (BCF) the Clear and Credible Plan, and in light of national guidance (i.e. Everyone Counts 2014/15-2018/19 strategic and operational plans.

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

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

The CCG submitted an expression of interest for co-commissioning in June and are currently awaiting to hear the outcome of the application from NHS England.

We intend to work with member practices, stakeholders, voluntary organisations, public health and social care partners and local communities to identify and shape key health improvements. We will target parts of our community where we can have the greatest impact, following the principles of proportionate universalism, to attempt to reduce inequality of outcomes. We believe working with partners shaping improvement will enable us to create a culture across organisational boundaries of peer-based challenge and support, which in turn will develop a system with a focus on continuous learning and improvement of patient and person-centred care with birth to death delivery.

A key aim will be to develop a way of working that motivates the primary care workforce, providing a better work/life balance and thus sustainable primary care provision for the longer term. We expect to promote professional autonomy and responsibility and ensure staff are engaged developing their ability to drive decisions and make improvements within services to help improve patient care with a focus on improving quality outcomes.

7) NATIONAL CONDITIONS

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

a) Protecting social care services

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

‘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.

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

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.

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

The total amount from the BCF that has been allocated for the protection of adult social care services is £5.107m including the capital funding for disabled facilities grant and the community capacity grant.

In addition, at least the local proportion of the £135m has been identified from the additional £1.9bn national funding from the NHS in 2015/16 for the implementation of the new Care Act duties. For Stockton, £691k his has been identified as a separate transparent Care Act scheme within the plan

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

There is a complete transformational change programme in place within Adult Social Care at the local authority. It covers five key elements of change:

7. Efficiency reviews – the implementation of efficiency reviews which have been carried out over the last three years. These reviews identified new ways of working across the whole of the delivery of services for Mental Health and Learning Disabilities.
8. Care Act – projects to support the implementation of the Care Act
9. Information Management and Process change – this strand is reviewing supporting functions such as finance, e-marketplace and the commissioning function
10. Pathways to care and prevention – is a review of the pathways and seeks to identify approaches in service delivery to increase enabling activity; maximise independence; and reduce clients coming into care
11. Better Care Fund – implementation of agreed schemes

The whole programme has the oversight of the Adult Programme Board and is sponsored by the Director of Children Education and Social Care. The Better Care Fund is also overseen by the Health and Wellbeing Board and North of Tees Partnership Board, in line with the governance arrangements set out in this document.

The Better Care Fund / Pathways to care and prevention support the successful delivery of a number of the new Care Act requirements:

- Promoting well-being
- Preventing, reducing or delaying needs
- Advice and information (understanding pathways to care and services)
- Person-centred care and support planning
- Integration and partnership working
- Delayed transfers of care from hospitals

The Informatics strand in the Better Care Fund and the Care Act are inextricably linked with the NHS number, Caldicott2, API and open standards, common to both projects.

We are aligning the Care Act and Better Care Fund but we are conscious that the full impact of the Care Act is yet to be determined and is expected to be significant and the impact is unlikely to be fully met through BCF projects / funding.

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

Within the plan there are two schemes that cover carer specific support namely:-

a) The existing carers funding totalling £464,000
b) Improving pathways and care for dementia - respite and services for carers - £400k

How this funding will be used to support improved outcomes for carers

a) Stockton Council and the Hartlepool and Stockton-on-Tees Clinical Commissioning Group developed an updated Carers Strategy following a wide ranging consultation with carers, carer support services, the cared for and general public interested in carer issues, to determine the services they needed to obtain high quality outcomes and improve their well-being and quality of life. The Strategy is very much a "you said – we will do" to developing services.

The Council and CCG developed a service specification, based on the Strategy content, which required a more dynamic approach to supporting carers and meeting their needs. Following development of the specification the service was put out to tender.

Sanctuary, the new carer support provider, is providing a wider range of services to meet the wide range of needs carers have.

b) There will be are services 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 client and 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.

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

Investing in monitoring and quality checks to ensure good practice is embedded

It will be necessary to employ a Dementia Pathways Service Development Manager (currently only a temporary project management post) to ensure sustainability of the work carried out by the collaborative, to work specifically in the Borough to drive forward Stockton's Dementia Action Plan.

Continue to invest in the training of staff in care homes, including care homes with nursing and other 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 and reduce stress on carers). Provide support to people earlier in their diagnosis.

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.

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. This service will also link up to the carer support service provided by Sanctuary where appropriate.

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.

What types of services are being commissioned? How will the experience be different from the perspective of a carer?

Previous carer support service provided low level assessments and did not focus on carers being able to be independent of support services. As a result carers engaged with the support provider indefinitely, very often over long periods of time. Many carers never left the service once registered.

The new carer support service commenced April 2014 and provides a detailed assessment of the carers needs (see attached) on registering followed by an initial intensive support period to address those needs.

Carer support includes a wide range of support services (see attached) with the progress of the carer being re-assessed regularly within the intensive support period to ensure their needs are being met. The aim is for carers to be able to build resilience and with the help of a variety of support mechanisms no longer be dependent on services.

Examples of the services provided are:

- Advice and information
- Carers training to help carers deliver safe, effective care
- Counselling
- Emergency planning
- Respite – traditional and funding for other respite opportunities (e.g. purchase of hobby materials, club membership)
- Health assessments
- Carers card
- Community based drop-ins
- Hospital link worker
- Support groups- general and specialist
- Support to obtain employment / education
- Work experience
- Timebanking

Carers will be involved in decisions about how the service is delivered e.g. surveys, focus groups, including carers interviewing new staff.

Demonstrate an evidence based consideration of how carer support will impact on patient level outcomes.

The carers consultation highlighted the fact that carers and the cared for felt that much improvement was needed in NHS services around awareness of carers' roles, carer's needs and how carers involvement can benefit the patient. The updated Carers Strategy includes specific reference to carers' needs and support within NHS services. The Carers Strategy Implementation Group is currently developing a programme of awareness raising and identification of training needs for NHS staff to enable more effective identification of carers, their needs and how best to support them and involve them in decisions around the care and support of the patient.

Improved carer support and involvement will contribute to improved care and support of the patient by improving:

- delivery of care / treatment,
- understanding of the patient by NHS staff
- understanding of care treatment by carers

Highlight any risks relating to the delivery of carer-specific support and ensure that these are cross referenced in the risk log alongside appropriate mitigating actions.

Risk	Rating	Mitigating actions
Reduction or removal of funding by either funding partner will immediately impact on ability to deliver service.	Low	Three year contract agreed by both funding partners. Funding has been agreed for 2014/15 and it is anticipated funding will be available for the full contract period within the constraints of overall funding.
Provider fails to deliver as required by service specification.	Low	Robust procurement procedure ensured high quality provider. Robust contract monitoring procedures in place.

Supporting documents to carer-specific support.

- Stockton-on-Tees Borough Council & NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group Joint Strategy for carer Support services for Adults, Children and Young People. 2013-2017

- Sanctuary Carer Support Services

- Sanctuary Carer Assessment Record

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

The social care related benefits identified within the BCF plan align with those of the Councils Medium Term Finance Plan (MTFP) and Strategy for the Adults Big Ticket reviews to stem future financial pressures by:-

a. Reducing costs in these areas where possible
b. Stem growth through examining alternative means of service delivery

The revised plan has not affected the Councils Medium Term Financial Plan position. The change to a payment for performance arrangement does expose the Better Care Fund to greater risk but this is covered in the contingency plan and risk sharing section above.

b) 7 day services to support discharge

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

The technical guidance references measures related to the NHS standard contracts – all of which would include an SDIP to ensure that we develop the contract, services and clinical processes. The 7DS identified below will be contracted by the LA and we are unsure whether they will include SDIPs and the required action plans needed to ensure move to 7DS is managed within timescales. We could include a statement to provide assurance that we will ensure that there is an up to date SDIP and action plan with clear quality requirements in place.

See Enabling Scheme 1: 7 Day Working

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

Adopting the use of the NHS number is a priority because without this it would not be possible to

deliver the Integrated Digital Care (IDC) project. We are dependent upon the NHS number to create the single health and social care plan as it is the only unique indicator used by all partners.

The adult social care system, Care Director, already has the capability of using the NHS number. The next step is to determine the best method of collecting, verifying and maintaining the NHS number. Furthermore, it will be necessary to change the processes in adult social care so that the collection and verification of the NHS number is part of standard operating procedures.

In the longer term, the new technology associated with the IDC project will have provision for Spine Mini Services to enable the NHS number to be maintained. NTHFT already capture the NHS number for all patients as routine. The inclusion of the NHS number on correspondence, such as discharge information, is automatically populated directly from the system.

The use of the NHS number has been mandated in TEWV for a number of years. If a patient's NHS number is not provided, all members of staff are responsible for contacting either the referrer to obtain the number or performing a trace on the PDS to ascertain the correct identifier for the patient. This trace must be undertaken in 3 working days. On a monthly basis a batch trace is performed to verify that the correct NHS number is recorded against the correct patient. In this way NHS number in TEWV is currently at 98.3% compliance (Target is 99%).

Milestones

- Batch upload of NHS numbers into Adult Social Care system
- Change processes to collect NHS number where possible (ASC)
- Implement process to check and verify NHS number for all new clients (ASC)
- Specify and procure new Integrated Digital Care system
- Implement IDC

Risks

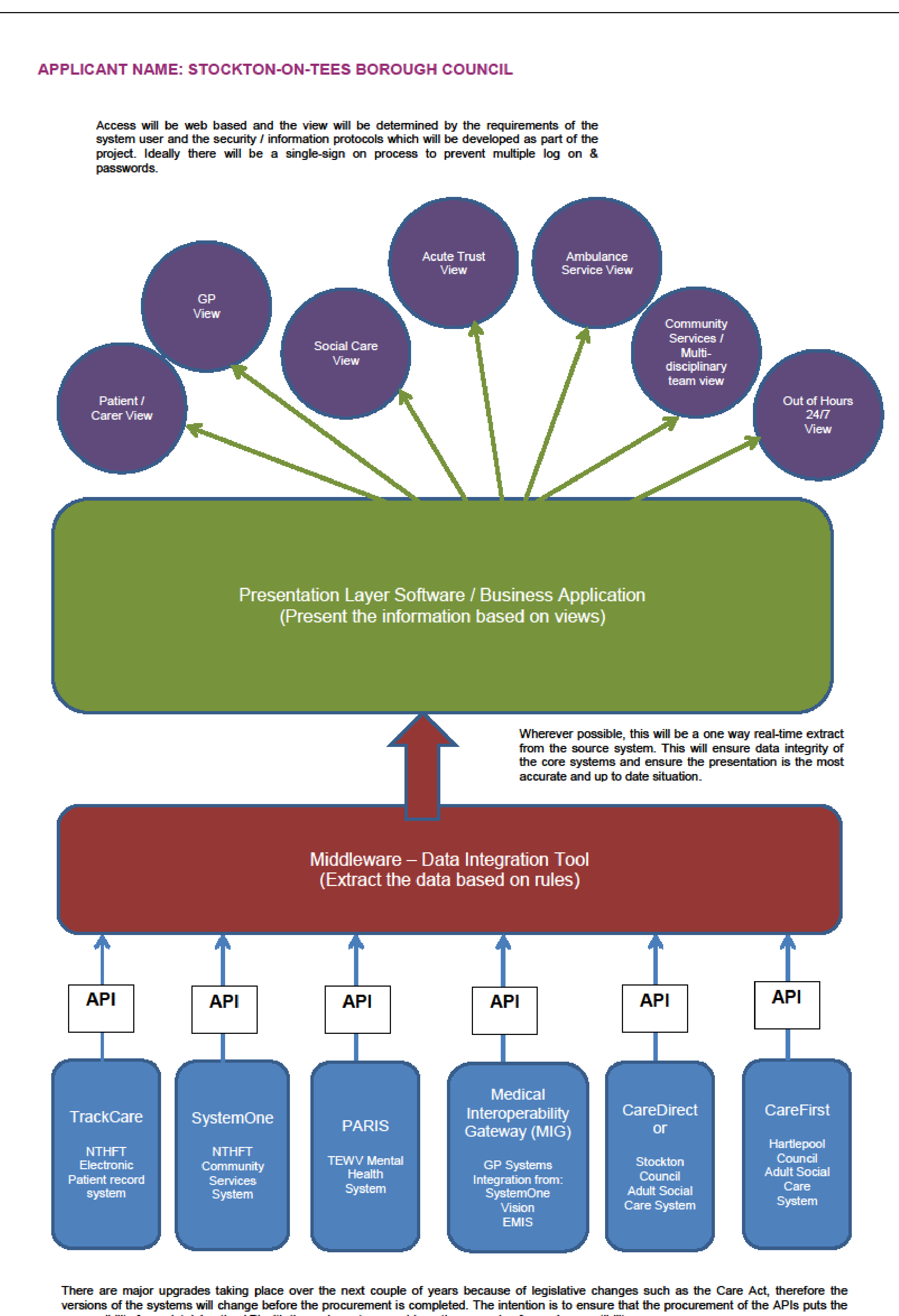
- ICT providers are unable to meet requirements for the use of the NHS number and the integration of systems needed to support integrated working

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

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 procure a system which will extract data from core systems and present the service user / patient data in real time. 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. See diagram below.



There are major upgrades taking place over the next couple of years because of legislative changes such as the Care Act, therefore the versions of the systems will change before the procurement is completed. The intention is to ensure that the procurement of the APIs puts the responsibility for maintaining the API with the main system provider – thus ensuring forward compatibility.

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.

Milestones

- Employ an analyst to fully design system, specification and procure solution
- Employ an information governance officer to review all the IG issues and develop protocol and procedures to support joint working
- Implement solution – alongside business process changes

Risk

- Solution is unaffordable
- Technically too difficult to procure and implement

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice 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.
v. Everyone managing and handling personal information is appropriately supervised.
vi. Methods of handling personal information are clearly described.
vii. 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 for high risk populations

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

See Enabling Scheme 2: Joint Assessments

The integrated approach within this BCF plan will ensure that people who are at high risk of poor outcomes including those most at risk of hospital admission and admission to long term care will be jointly assessed, will have in place a care plan and will have assigned an appropriate lead professional to coordinate their care.

The predictive risk stratification model (RAIDr) 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 hospital admission in the next twelve months. This has been used to identify those patients at highest risk of hospital admission.

Work is underway to develop an approach that can build upon the existing RAIDr system to incorporate social care information and explore the possibility of also incorporating an evidence based frailty score. This will 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.

We believe focusing on high intensive current users of health and social care 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.

However, over time it is hoped that this targeting approach will begin to focus on a more preventative and earlier intervention with those individuals who are in the medium risk categories.

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

Risk stratification
A systematic population based risk stratification process will be in place to enable the Multidisciplinary service to target interventions at those individuals at greatest risk of poor outcomes including those most at risk of hospital admission and admission to long term care, including people with dementia and mental health problems. Work is underway to develop an approach that can build upon the existing RAIDr system to incorporate social care information and explore the possibility of also incorporating an evidence based frailty score.

Joint Assessment & Care Planning
Every person identified as being at risk will have a joint assessment undertaken by the Multidisciplinary Service. Work is underway with all partners to develop a joint assessment tool and agree the assessment and care planning process. The ICT and data sharing enabling strand will support this process. The methodology being used to help overcome the barriers to joint assessment and care planning will include lean '3P'.

Accountable Lead Professional
The new pathways of care will ensure that every individual is assigned an accountable lead professional to coordinate their care. This will be the most appropriate professional dependent upon the individual's primary need. The approach will be aligned with the new primary care requirements for all over 75s to have a named GP.

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

Every individual who receive support from the Multidisciplinary Service will have a joint care plan in place. This is described in Enabling Scheme 2: Joint Assessments.

8) ENGAGEMENT

a) Patient, service user and public engagement

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

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.

b) Service provider engagement

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

i) NHS Foundation Trusts and NHS Trusts

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.

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.

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.

ii) primary care providers

The CCG when developing their 2 & 5 years plans with Better Care Fund plans being an intrinsic component of those plans have undertaken appropriate clinical engagement /consultation with the CCG Council of Members who represent the CCG and Governing Body. Clinical Time Out events have been held with member practices which have been instrumental in the development

of the Better Care Fund plans and commissioning intentions. The CCG Stockton Locality lead is also a member of the North of Tees Partnership Board.

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

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 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 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.

c) Implications for acute providers

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

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

The 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.

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

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no: 1
Scheme name:
Multidisciplinary Integrated Service
What is the strategic objective of this scheme?
To develop a Multidisciplinary Integrated Service to deliver care to older people in Stockton-on-Tees. This scheme is central to the delivery of the integrated vision and responds directly to the issues identified within the case for change (see section 3).
Overview of the scheme

The Multidisciplinary Integrated Service will support two distinct care pathways with the following 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.

The design of the Multidisciplinary Integrated Service will build upon existing service developments such as the Momentum: Pathways to Healthcare Programme, developments within social care and the Community Renaissance Programme, which includes:

- 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.

Key principals in the design of the Multidisciplinary Integrated Service:

- **Form will follow function** - The design will be informed by what is needed to deliver the 2 care pathways. Ensuring that the right mix of professionals are part of the service and that it has the right tools to enable it to be effective e.g. good information systems; good highly trained staff; the ability to make decisions.
- **Risk Stratification** – Using population based risk stratification to identify the target population. Work is underway to develop an approach that can build upon the existing RAIDr system to incorporate social care information and explore the possibility of also incorporating an evidence based frailty score.
- **Joint Assessment, Care Planning & Care Coordination** – every person identified as being at risk will have a joint assessment and a single care plan with a care co-ordinator responsible for ensuring that the plan is carried out.
- **Shifting to a more preventative early intervention approach** – the service will begin to shift care towards a more preventative proactive approach reducing the need for reactive interventions.
- **Information, Intelligence & an evidence-based approach** – will be used to inform the design and implementation of the service to develop a responsive model which maximises benefits and outcomes.
- **Single Point of Access** – Simple referral mechanisms will be established.
- **7 Day Working** – current 7 day working arrangements will be expanded to support hospital discharge and ensure that the pathways and services are available to referrers 24/7.

- **ICT, Information and Performance Management** – the service will be supported by efficient systems and processes that enable care to be delivered seamlessly across organisational boundaries.
- **Workforce Development, Communications and Engagement** – rollout of the service will include an ongoing programme of training and awareness across all partners and the wider public about the new pathways, available services and how they can be accessed. Public, patient and carer input will also be sought in the design and ongoing development of the service.

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.

The Multidisciplinary Integrated Service will initially be targeted at the over 65s which would include people with dementia and particularly focusing on those with long term conditions. Interventions would also be targeted to reduce inequalities in health. It is the ambition that if successful this integrated approach could be rolled out to deliver services to the whole adult population.

The scheme has 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 multidisciplinary service.
3. Rollout and expand 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 that 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. Ensure the approach to identify the lead professional / care-coordinator is aligned with the new primary care requirements for all over 75s to have a named GP.
8. 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 will be linked to risk stratification / predictive modelling statistical approach which would help to identify those most likely to benefit from preventive care.
9. 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.

The delivery chain

This scheme will be jointly commissioned between the CCG and Local Authority. The providers include NHS Community Services, Mental Health Services, Primary Care and Local Authority.

The evidence base

This scheme has been informed by a review of the available evidence base on health and social care integration and transformational change. Particularly focusing on the work undertaken by The King's Fund, Nuffield Trust and others to understand key enablers and facilitators in the development of integrated approaches and acknowledging the overall lessons for the development of more integrated services.

The table below outlines some of the key evidence-based tools that this scheme includes that support professional and service integration including:

Tools to support clinical and professional integration:	Tools to support service integration:
Case finding & risk-stratification	Care co-ordination
Comprehensive joint assessments	Case management
Joint care planning	Centralised information, referral and intake
Shared clinical records	Multi-disciplinary teamwork
Technologies to support continuous & remote patient monitoring	Inter-professional networks
Peer review	Shared accountability for care
	Co-location of services

Investment requirements

Total investment 14/15 = £245k (See Table 3 – HWB Expenditure Plan 2)
Total investment 15/16 = £5,411k(See Table 3 – HWB Expenditure Plan 2)

Impact of scheme

The impact of this scheme on emergency hospital admissions is described in Part 2, Tab 4. HWB Benefits Plan.

Other anticipated outcomes include:

- A reduction in the number of residents being admitted to nursing and residential 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
- Benefits of new ways of working for other teams and the potential to rollout the approach more broadly across health and social care
- Improved patient experience
- Faster response times and more integrated support to both individuals and their carers/families.
- Improved efficiency through streamlined care, reducing activities that are carried out by multiple organisations ensuring the right services are available in the right place.
- Workforce development – development of shared skills and knowledge across health and social care.

Feedback loop
The impact of the Multidisciplinary Integrated Service will be measured through a range of indicators. Including the national BCF measures and a basket of local indicators which are being developed into a local performance framework. In addition, a number of pilots are being established during 2014/15 to provide feedback, test the approach, understand the impact of the different elements of the scheme and further develop a local evidence base for the approach.
What are the key success factors for implementation of this scheme?
• Design - getting the design of the scheme right is critical to the success of the programme and significant time and resource is being invested during 2013/14 to involve all partners in this process. Methodologies including Lean 3P (Production Preparation Process) is being used to support the design process. • Workforce development and supporting cultural change to support new ways of working. This is being developed as part of the design of the Multidisciplinary Service. Initial work is already underway with some existing health and social care teams to undertake process mapping and redesign and begin to support integration and shared working practices. • Strong and sustained system leadership – This is in place through the agreed governance structures and local task and finish groups. • Ownership and involvement of frontline professionals – Front line professionals will be leading and supporting the development of the new pathways.

Scheme ref no: 2
Scheme name:
Improving Pathways of Care for Dementia
What is the strategic objective of this scheme?
To develop improved pathways of care for dementia ensuring individuals and their carers receive evidence-based integrated care and support. This scheme is central to the delivery of the integrated vision and responds directly to the issues identified within the case for change (see section 3).
Overview of the scheme
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 Stockton-on-Tees to support individuals through the progression of the disease and ensuring open access to services for carers. The scheme will work to remove barriers to accessing care through initiatives such as 24/7 help lines and sign-posting services. 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 Hartlepool NHS Foundation Trust, TEWV and the local authority are all members. The aim would be to embed and enhance the work of the collaborative: 1. To do this, it will be necessary to employ a Dementia Pathways Improvement Manager to work with the Collaborative and work across health and social care to improve local dementia pathways. Work will include: • 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 and other 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 • Mapping of the current dementia services to ensure there are no duplications and that the additional funding is aimed at delivering an enhanced and sustainable service • Development of a Dementia action and implementation plan for Stockton-on-Tees, which supports an integrated approach across partner agencies. 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. Provision of respite for all carers – This support to carers is aimed at keeping families together. The focus for this project would initially be for carers supporting people with dementia. 4. Provision of crisis support for carers aimed at preventing admissions to hospital or long term care. 5. Recruitment of a LiveWell Hub co-ordinator to develop and manage the new LiveWell Hub at the Halcyon Centre for people with Dementia their Carers and professionals. 6. Investment in the ongoing development of the new LiveWell Hub at the Halcyon Centre. 7. Evaluation and rollout of the Community Dementia Liaison Service, which is currently in place in a neighbouring LA area.

The delivery chain

This scheme will be jointly commissioned between the CCG and Local Authority. The providers include NHS Community Services, Mental Health Services, Primary Care and Local Authority. Providers also include the Voluntary and Community sector.

The evidence base

Stockton and Hartlepool Councils are already working in a Dementia Collaborative with Tees Esk and Wear Valleys NHS Foundation Trust, which is funded by the CCG. There are also a number of Voluntary and Community organisations who make up the Collaborative.

The reason for establishing the Collaborative was informed by evidence from the 'Living Well with Dementia: A national dementia strategy 2009'. And the Prime Ministers' challenge on dementia: delivering major improvements in dementia care and research by 2015 (published 2012). And more recently regional research, Dementia 2014: A North East Perspective.

This all states that effective dementia care and early identification of dementia is critical to managing the condition in the long term and in understanding and reducing the impact on Carers. The Collaborative has achieved significant measurable results: for example, the lead in time between identifying a person who may need continuing health care to completion of the Decision Support Tool meeting was reduced from a 10 day average to 8.3 days average, a 17% improvement.

Investment requirements

Total investment 14/15 = £205k (See Table 3 – HWB Expenditure Plan 2)
Total investment 15/16 = £2,392k (See Table 3 – HWB Expenditure Plan 2)

Impact of scheme

- Early identification of dementia
- Ensuring the patient is fully involved in the decision making process – focused on outcomes
- Improved information sharing
- Better patient experience
- More supportive impact on Carers
- LiveWell Hub provides co-ordinated response to meeting patient information and advice needs
- LiveWell Hub will provide a resource to support the professional development of the work force to equip them to meet the needs of people with dementia

Feedback loop

Data is collected and reported quarterly through the Dementia Collaborative Steering Group which in turn reports to the North of Tees Partnership Board. This arrangement is in place and has been working for some time.

Recently a regional study was undertaken to assess the impact of the work undertaken by the Collaborative

Locally the Livewell Hub also has its own steering group to ensure effective management of the new service.

What are the key success factors for implementation of this scheme?

- Ensuring the patient is fully involved in the decision making process
- Effective partnership working
- Sharing information
- Well-trained staff

Scheme ref no: 3
Scheme name:
Enabling Scheme 1: 7 Day Working
What is the strategic objective of this scheme?
This is an enabling scheme supporting delivery on the 2 main schemes (Scheme 1: Integrated Multidisciplinary Service and Scheme 2: Improved Pathways of Care for Dementia) within the BCF Plan. This scheme will ensure that services are in place to deliver the identified care pathways 7 days a week (where this is required) and facilitate timely discharge from hospital and effective crisis management.
Overview of the scheme
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 achieve a 1 hour response. 6. Clinicians within the hospital will be supported with information to enable them to discharge people with complex needs into the community.
The delivery chain
This scheme will be jointly commissioned between the CCG and Local Authority. The providers

include NHS Community Services, Mental Health Services, Primary Care and Local Authority.

The evidence base

Peopletoo Ltd have undertaken a regional review of Reablement and Intermediate Care services in 2012 and its findings were:

- Elements of good practice exists across the region
- Given configuration differences, common opportunities exist:
  - Unit cost range is relatively high
  - Utilisation is not maximised uniformly across the group
  - Performance monitoring and reporting is inconsistent
  - Private and independent sectors could form part of the solution
  - Regional collaboration opportunities exist
  - Benefits tracking should be more robust – a regional model
  - Establishing a different delivery entity could cement a regional collaborative model

Peopletoo undertook a further piece of work to review the working practices of the two local authorities, Stockton and Hartlepool and the findings were:

Supported 7 day discharge – whilst anecdotally this takes place, formally the Hospital Discharge Liaison Team only operates 8.30 a.m. to 5p.m. Monday to Friday which can result in people remaining in an acute setting over the weekend. We would recommend that existing service levels are reviewed.

24/7 Credible Alternatives to Admission – CIAT teams which incorporate Rapid Response currently only operate 8a.m. to 8p.m. in Stockton and 8a.m. to 10p.m. in Hartlepool. This means that out of hours there are limited alternatives available to admission. Talking to GPs in other areas where we are developing Integrated Pathways to support care in the community, they state that one of the reasons for admission is the lack of credible alternatives particularly on Friday afternoons and out of hours. Introduction of a 24/7 Single Point of Access which can coordinate access to step up and step down services along with out of hours alternatives such as sitting services, step-up beds with a multi-disciplinary assessment taking place the following day, could help to address this and whilst early days in Durham this will form part of the 'Short Term Intervention Service' which will be evaluated over the next 12 months.

Capacity available within current Rehabilitation and Reablement Teams – from analysing data provided and meetings with key personnel, it is apparent that there are issues with capacity across Stockton and Hartlepool. The reablement function in Stockton currently has 7 FTEs (although soon to increase to 15 FTEs) providing reablement for on average 15 – 25 clients and in Hartlepool 29 FTEs taking on average 23 referrals per month (covering intermediate care, reablment and telecare) [2]. However emergency hospital admissions for over 65's average 88 per week in Hartlepool and 148 per week in Stockton (based on April – September 2013 data) this does not include elective admission discharges and whilst not all require Rehabilitation or Reablement, Rehabilitation type services may well be required following orthopaedic surgery for a proportion of over 65s.

We will use all these findings to ensure that social care services support discharge from hospital in the most effective way.

Investment requirements

Total investment 14/15 = £64k(See Table 3 – HWB Expenditure Plan 2)
Total investment 15/16 = £60k (See Table 3 – HWB Expenditure Plan 2)

Impact of scheme

- Supports 7 day discharge from hospital
- Reduced emergency admissions at weekends
- Improve the capacity within the teams to support 7 day working

[2] Please note referral numbers from 2012 updated, figures to be provided

Feedback loop

See scheme 1:
The impact of the Multidisciplinary Integrated Service will be measured through a range of indicators. Including the national BCF measures and a basket of local indicators which are being developed into a local performance framework.

In addition, a number of pilots are being established during 2014/15 to provide feedback, test the approach, understand the impact of the different elements of the scheme and further develop a local evidence base for the approach

What are the key success factors for implementation of this scheme?

- Ensuring the right levels of staffing and availability of services over the full 7 days
- Consultants available within acute setting to enable timely discharge

Scheme ref no: 4

Scheme name:

Enabling Scheme 2: Joint Assessments

What is the strategic objective of this scheme?

This is an enabling scheme supporting delivery on the 2 main schemes within the BCF Plan. This scheme will ensure that there are effective processes and systems in place across organisations to ensure that holistic joint assessments can be undertaken which facilitate the development of joint care plans.

Overview of the scheme

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.

The delivery chain

As for Scheme 1:
This scheme will be jointly commissioned between the CCG and Local Authority. The providers include NHS Community Services, Mental Health Services, Primary Care and Local Authority.

The evidence base

The main evidence for this is the Kings Fund – Sam’s story. With people living longer with more complex needs it is more important to put the person at the centre of what we do and to ensure that there is a lead accountable professional who is capable of co-ordinating someone’s care bringing together a range of health and social care professionals.

This is further supported by anecdotal evidence provided by feedback from patients and service users who are frustrated by the fact that agencies don't talk to each other and thus leading to a poor experience.

Further evidence from the Kings Fund (Source: Case management: What it is and how it can best be implemented) is that higher levels of satisfaction are achieved from the approach we are advocating.

Critically however, this will be difficult to achieve without having good systems for sharing information.

Investment requirements

Total investment 14/15 = £64k(See Table 3 – HWB Expenditure Plan 2)
Total investment 15/16 = £120k (See Table 3 – HWB Expenditure Plan 2)

Impact of scheme

The main impact will be on patient / service user experience

Feedback loop

The impact of the Multidisciplinary Integrated Service will be measured through a range of indicators. Including the national BCF measures and a basket of local indicators which are being developed into a local performance framework.

In addition, a number of pilots are being established during 2014/15 to provide feedback, test the approach, understand the impact of the different elements of the scheme and further develop a local evidence base for the approach.

What are the key success factors for implementation of this scheme?

- Multi-disciplinary team
- The right professional assigned to the patient / service user
- Single point of access
- Effective information systems (including ICT and information sharing protocols)

Scheme ref no: 5
Scheme name:
Enabling Scheme 3: Digital Technologies
What is the strategic objective of this scheme?
This is an enabling scheme supporting delivery on the 2 main schemes within the BCF Plan. This scheme will ensure that the new pathways of care are supported by access to a range of digital technologies. Recognising the potential of digital technologies to maintain independence and help in the management of long term conditions.
Overview of the scheme
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.
The delivery chain
This scheme will be jointly commissioned between the CCG and Local Authority. The provider will be determined by the final solution and an appropriate procurement exercise to ensure value for money.
The evidence base
Different local authorities have taken different approaches to the provision of digital technologies – some have provided it globally to everyone over the age 75 (Sunderland) and others, such as Stockton, only to those who are FACS eligible. Stockton has evidence that Care Call / Telecare has reduced the number of calls to emergency services and possibly prevented the need for someone to be taken into hospital. This is supported by the study set out below: **The Whole System Demonstrator (WSD) Programme [source: telecare services association]** The Whole System Demonstrator (WSD) programme is the largest randomised control trial of telehealth and telecare in the world. The trial involved 6191 patients, 238 GP practices across three sites, Newham, Kent and Cornwall and was set up to look at cost effectiveness, clinical effectiveness, organisational issues, effect on carers and workforce issues. It focused on three conditions, diabetes, Chronic Obstructive Pulmonary Disease (COPD) and coronary heart

disease.

The headline findings for the telehealth element of the trial were published in January 2012. These findings show that, if delivered properly, telehealth can substantially reduce mortality, reduce the need for admissions to hospital, lower the number of bed days spent in hospital and reduce the time spent in A&E:

- 15% reduction in A&E visits
- 20% reduction in emergency admissions
- 14% reduction in elective admissions
- 14% reduction in bed days
- 8% reduction in tariff costs
- 45% reduction in mortality rates

But it is clear that it isn't a silver bullet in its own right and needs to be supported by other interventions. Also, it needs to be targeted to be cost effective and for this reason we are starting by undertaking two specific pilots which will then be evaluated and a business case built for further investment.

Investment requirements

Total investment 14/15 = £65k(See Table 3 – HWB Expenditure Plan 2)
Total investment 15/16 = £750k(See Table 3 – HWB Expenditure Plan 2)

Impact of scheme

The main impact of this scheme is anticipated to be a reduction in admission to hospital.

Feedback loop

There will be two pilots established during 2014/15 – these will be evaluated and findings presented to the North of Tees Partnership Board.

In addition to the pilots, Teesside University has been commissioned to undertake a study of the impact of TeleHealth and this will also be presented to the Board.

What are the key success factors for implementation of this scheme?

- Good risk stratification to ensure the right people get the right intervention
- Robust evidence from pilots to support further investment

Scheme ref no: 6
Scheme name:
Enabling Scheme 4: Narrowing Health Inequalities
What is the strategic objective of this scheme?
This is an enabling scheme supporting delivery on the 2 main schemes within the BCF Plan. This scheme will help to ensure that resources are effectively targeted to help reduce inequalities and ensure that the Integrated Multidisciplinary Service (Scheme 1) and Improved Pathways of Care for Dementia (Scheme 2) are focused on delivering a preventative approach which addresses the wider determinants of health and wellbeing.
Overview of the scheme
This is an enabling scheme to ensure that a range of services will be available to the Multidisciplinary Integrated Service 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. Including the expansion of the Stockton Service Navigation Project. • It is recognised that a range of voluntary community sector organisations are commissioned in Stockton-on-Tees to address the health and wellbeing needs of the target population. 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 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.
The delivery chain
The commissioners for these activities will be Stockton Public Health Team within Stockton-on-Tees Borough Council. Services will be commissioned form a range of providers depending on the nature of the service. This includes NHS providers and voluntary and community sector providers.
The evidence base
All of the interventions that will be commissioned under this scheme are informed by the available evidence base including guidance from the National Institute for Health and Care Excellence, and a range of topic specific public health evidence bases. This is also supported by local evaluations conducted by local Universities and supported by the Public Health Team, which is enabling more accurate predictions about the projected impact and outcomes.
Investment requirements
Total investment 15/16 = £200k (See Table 3 – HWB Expenditure Plan 2)

Impact of scheme

Impact on reducing emergency hospital admissions/readmissions, maximising independence and reducing/delaying the need for long term care through addressing broader issues affecting health and wellbeing such as poverty, housing, loneliness/social isolation, adoption of healthy lifestyles. Improved patient experience and self reported health and wellbeing.

Feedback loop

Outcomes will be measured through a range of indicators dependent up-on the specific service. The Public Health Outcomes Framework will provide a range of indicators associated with this scheme and some local indicators will also be established. For example improvement in self reported health and wellbeing will be measured using tools such as the Long Term Conditions Outcomes Star and Warwick-Edinburgh Mental Well-being Scale (WEMWBS).

The commissioned services will be evaluated through contract review mechanisms and through external academic research led by local Universities to determine the impacts and outcomes.

In addition, some services are being established during 2014/15 to pilot the impact and further develop a local evidence base for the approach.

What are the key success factors for implementation of this scheme?

Key success factors include:

- Ensuring alignment with the agreed care pathways in Scheme 1 and 2
- Developing simple mechanisms for
- Ensuring holistic assessments and joint care plans consider the wider determinants of health and make onward referrals to these services
- Ensuring simple referral mechanisms are in place to support referral into these services

This scheme builds upon existing schemes within Stockton-on-Tees. There are already clear and simple referral processes in place to ensure people have access to a range of health and wellbeing services and this proposal will strengthen this, helping to ensure that the wider determinants of health are considered and addressed routinely with all people who receive care form the Multidisciplinary service.

Scheme ref no: 7
Scheme name:
Enabling Scheme 5: ICT Systems and Data Sharing
What is the strategic objective of this scheme?
Our vision puts the person at the centre of the decision-making process ensuring that all health and social care professionals have a holistic view of the individual's needs be that health, social care or wider social needs such as housing. The Integrated Digital Care solution will support this vision.
Overview of the scheme
The solution will support: • Joint working between health and social care including joint assessments with a nominated lead professional who will be responsible for the delivery and integrity of the plan. • Out of hours working and weekends where it is more difficult to get access to professionals. The single plan will inform person-centred decision-making, as oppose to system-centred decision-making. Our philosophy is to keep it simple but effective. We will NOT be replacing all our current ICT systems; we will be building on that investment and at the same time finding a more effective way of sharing information. We will retain the integrity of the source systems and there will be no write-back. The solution would be: • To have a single health and social care plan which is sourced, real-time from five core business systems (2 x Foundation Trust, 1 Primary Care, 2 x Local Authority) plus the Medical Interoperability gateway which brings together all the GPs systems • To improve our data quality and have clear guidance regarding the source system for the care plan • To ensure that all professionals have appropriate access to the right systems at the right time dealing with all the information governance issues to ensure the needs of the person drive business decisions about the way we work The impact will be that: • A person's needs drive the solutions which are jointly developed, and inform decision-making. • There will be improved communications and more efficient and effective joined-up working across health and social care. • GPs will have a holistic view of their patients and will make more informed decisions in and out of hours There are four main elements to the project: **Information Governance** We will have a dedicated information governance practitioner who will work closely with all five stakeholder organisations to ensure that all information governance issues are overcome. They will produce the relevant guidance and deliver training as needed. **Business Improvement** Practitioner change agents will be part of the implementation team. They will identify all the business processes which need to be changed to support the new way of working. They will map and 'lean' all the processes to ensure maximum return on investment. They will also produce all

the process manuals needed. This will include setting out all the data quality requirements

Stakeholder Engagement
Success of this project will be reliant upon buy-in from a number of stakeholder groups including GPs, Accident and Emergency and Out of Hours services. They will need to work with the single care plans to ensure that the person's wishes are taken into account when determining how to respond to their needs. As part of the project all stakeholders will be fully consulted and involved in the design of the solution.

Technical Solution
The technical solution will not be straight forward. The intention is to use what is already available or currently under development such as N3 / PSN network protocols; NHS secure email. For each of the five major systems and the Medical Interoperability Gateway, there will need to an API developed. The middleware and presentation layer are likely to be either proprietary or off the shelf, subject to the procurement process.

The delivery chain

The commissioners will be jointly the local authority and the CCG. The host organisation for the project will be the North Tees Foundation Trust. An agreement will be developed for all partners to ensure ownership of assets is clearly established.

North Tees Foundation Trust will procure the solution subject to the Board's approval of the specification. The provider will be an external ICT company. It is important to note that there is a commitment to using Open Source solutions wherever possible and to with the OpenSource team to share best practice.

The evidence base

The design of the ICT solution is based on what is known to work in similar complex environments. It uses the very latest technology providing a real-time view of the patient using web technology. The risk is that the solution is designed to join up systems from several organisations including GPs who also have a range of different solutions. However, we are assured that the technology solution we are seeking to deploy does exist albeit not currently joining up both Health and Social Care systems.

We have tried to design a system which will retain the integrity of the source systems i.e. there will be no write back. This is deliberate but comes with it the need to continue to support several systems across the whole health and social care economy. It will therefore be necessary to have clear decisions on which systems are the primary source for the data and the need to have in place good data quality systems to support them. This will mean that the social care system will continue to maintained separately to the Acute and Community Care systems and may therefore require double entry.

Investment requirements

Total investment 14/15 = £200k (See Table 3 – HWB Expenditure Plan 2)
Total investment 15/16 = £100k (See Table 3 – HWB Expenditure Plan 2)

Impact of scheme

The realisation of the benefits of this project will be phased and are initially identified as follows:

- Patient / Service User – The biggest benefit will be the one that is realised at the end of the project when it is fully implemented. There will be a single care plan for everyone over age 75 and those with long term conditions identified as a priority through the work of the Better Care Fund. This will include joint assessments and ensuring that a person's information is available 24/7 for round the clock care.
- Information Governance - There will be a number of Information Governance benefits. Protocols will be developed, training provided and most importantly, the outcome will be to ensure that joint working across health and social care is fully supported and not hindered

by the need to have good security. These benefits will be phased over the life of the project.

- Working Practices - There will be a change in working practice to support the joint working arrangements across all the teams. These benefits will be phased over the life of the project.
- Data Quality – Part of the project will be to ensure that all the data to be presented in the single care plan will be up to date and accurate. This will include ensuring that processes are in place to support this.
- NHS number and integrated systems – The main deliverable from this project is to join up information across five separate ICT systems using the NHS number as the unique identifier. The NHS number will be used within social care by April 2015 making way for the integration to take place during the implementation of the integration solution during 2015 /16.

Feedback loop

The delivery of the benefits will be phased over the whole project – but the intention is to report all benefits on a quarterly basis to the Steering Group (see governance arrangements). A final implementation benefits report will be produced and reported to the North of Tees Partnership Board (Unit of Planning) and Health and Wellbeing Boards.

Other than tracking successful implementation of the project it will be difficult to put in place direct performance measures of the benefits of implement the system. This is because the improvement in timely access to information is likely to inform GP and other professional's decisions about a service user / patient which could result in an avoidable admission to hospital for example – but the system is the tool by which the decision is made. It is clear that without such a system the decision making processes will be more difficult and cumbersome and certainly not so accessible.

What are the key success factors for implementation of this scheme?

- Taking a holistic approach to change
- Ensure data quality issues are addressed
- Getting buy-in from all stakeholders including Out of Hours GPs
- Working with the Open Source team to share best practice across the country and particularly from partnerships already deploying the technology
- Ensuring that all Information Governance issues are fully addressed and solutions identified
- Continuing to work with all organisations and suppliers involved in the project to make sure that the systems can be integrated as required

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Stockton-on-Tees Health & Wellbeing Board
Name of Provider organisation	North Tees & Hartlepool NHS Foundation Trust
Name of Provider CEO	Alan Foster
Signature (electronic or typed)	Forward to PA for signature when approved

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	17,488
	2014/15 Plan	17,184
	2015/16 Plan	16,301
	14/15 Change compared to 13/14 outturn	-304
	15/16 Change compared to planned 14/15 outturn	-883
	How many non-elective admissions is the BCF planned to prevent in 14-15?	0
	How many non-elective admissions is the BCF planned to prevent in 15-16?	1,222

For Provider to populate:

Judith – when the above has been completed in draft please can you lead on completing the provider response.

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	