Health and Wellbeing Board

Stockton Better Care Fund Plan Narrative 2016/17

Date: **21 March 2016**
2nd Submission

Stockton-on-Tees BOROUGH COUNCIL

Health and Wellbeing

APPROVAL – Phase 1	
Name	Stockton-on-Tees Borough Council Hartlepool and Stockton-on-Tees CCG
Date	21st March 2016

APPROVAL – Phase 2	
Name	Health and Well-being Board
Date	27th April 2016

Contents

1. INTRODUCTION

1.1 Overall Objectives and Ambition for Better Care

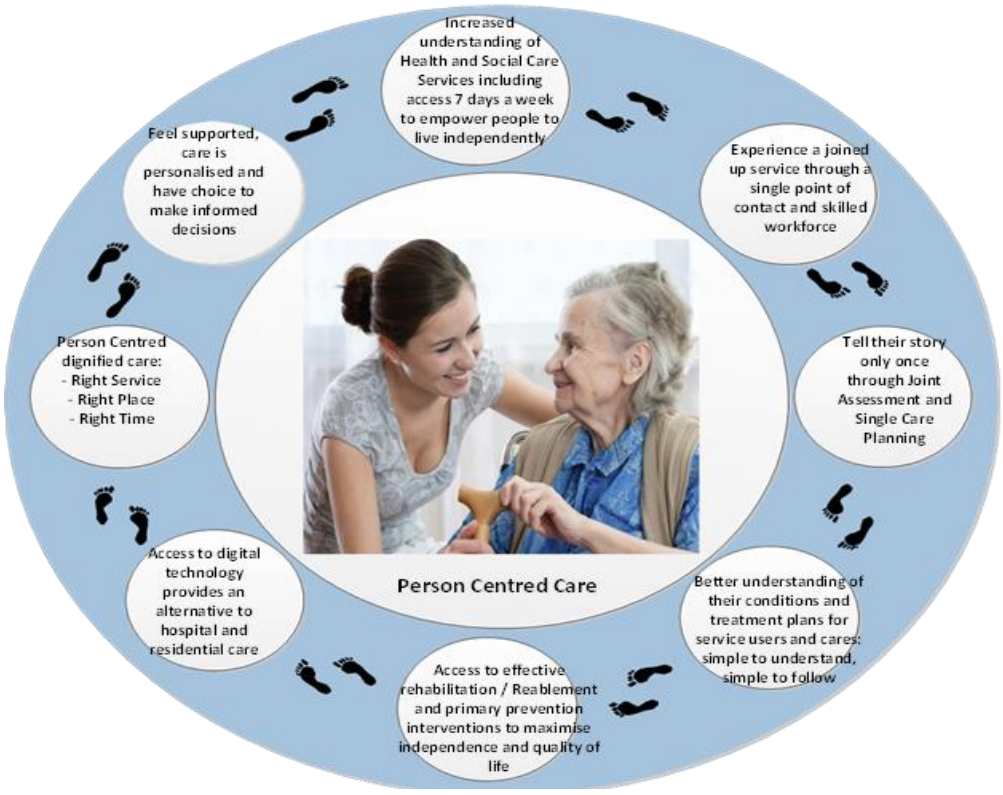
*"Meeting patient needs **now** and **future proofing** for the coming **generation** with **consistently better** health and social care delivered in the **best place**"*

… and within available resources

There is a whole system change taking place across the Health and Social Care economy and the Better Care Fund (BCF) is a small but nonetheless critical part of this ambition for change. The Five Year Forward Plan and the Hartlepool and Stockton-on-Tees CCG Operational Plans and the Sustainability and Transformation Plans clearly set out this vision.

The vision is that by 2020/21 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. Focus will be on integrated health and social care, primary prevention, early diagnosis and intervention, and supported self-management with the aim of closing the health and wellbeing gap and reducing health inequalities as well as driving transformation to close the care and quality gap.

To support this, we have been working together as partners to deliver services differently ensuring we achieve maximum benefits for service users, carers and families. We have put the person at the centre of our plans and we have, and continue to, redesign our pathways to ensure that this is the case.



The plans we have in place for BCF will contribute to the delivery of improvements in

- Reduction in Non-Elective Admissions (General and Acute)
- Reducing inappropriate admissions of older people (65+) in to residential care
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Reduction in Delayed transfers of care from hospital per 100,000 population

1.2 Evidence

Demographic changes mean that there is a high likelihood of an increase in demand on both Health and Social Care in future years. The Better Care Fund can support the reduction in this demand by putting in place a number of strategies around early intervention and prevention, supporting people to stay in their own homes where appropriate, for as long as possible. We also need to ensure those with the greatest need are fully supported and have a co-ordinated response to reduce duplication and ensure the most appropriate services are delivered. Carers are also critical in ensuring people achieve the best outcomes and we need to support carers more.

Stockton-on-Tees has and estimated population of over 32,343 [1]people aged 65; projections from the Market Position Statement 2015 (MPS) suggest that between 2014 and 2020 the numbers of people living in Stockton-on-Tees aged 65 is projected to increase dramatically with an additional 6,000 people over 65 in 2020 (19%) and 1500 people over 85 (41% increase).

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[2]. 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 12,000 [3] 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 550 older people in Stockton are predicted to have a longstanding health condition caused by bronchitis and emphysema which will need long- term care and rehabilitation. This is projected to rise by over 14% by 2020
- Diabetes: the number of people aged 65 and over in Stockton with diabetes is forecast to increase from 4,100 in 2014 to 4,609 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 in 2014 is

[1] ONS population projections analysis too, 2014
[2] https://www.gov.uk/government/uploads/attachement_date/file/216528/dh_134486f (page 7)
[3] Projecting older people population information system

8,627, nearly 679 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 over 8,500 (8,711 in 2014) 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.

Health in-equalities across Stockton-on-Tees are a further challenge which we are addressing partly through the Better Care Fund but also by ensuring that our approach to Better Care is linked very closely to our wider Health and Well-being strategy. Additional money has been made available to the Better Care Fund from the Public Health budget, to acknowledge the need to have a joined-up approach to early intervention and prevention, health in-equalities and issues associated with welfare.

There is 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.

In recognition of this challenge, we established a Health and Well-being team as part of our Multi-Disciplinary Service. This new service which went live in October 2015, undertake holistic assessment which include social care needs, health needs and also looks at the person's wider well-being needs such as welfare and social isolation.

2. OUR STORY

2.1 Underpinning Strategies

None of the partners plans sit in isolation of each other. As we all develop our strategies we are working in partnership to ensure that they all link together to achieve our jointly developed vision and ambitions for Stockton-on-Tees.

The Better Care Fund is not seen as a separate strategy, it is a complementary document which support the wider objectives of the Health and Well-being Strategy.

Our BCF plan for 2016/17 is building on the foundations progressed during 15/16, the 'NHS Five Year Forward View', CCG Operational Plan and the Sustainability and Transformation Plan (STP) clearly sets out this vision.

Vision - *"Meeting patient needs **now** and **future proofing** for the coming **generation** with **consistently better** health and social care delivered in the **best place"***

Local Digital Road Map

The CCG along with partner organisations are developing a Local Digital Roadmap to be paper free at the point of care by 2020 (NHS England Five Year Forward View). The footprint for a local Digital Roadmap includes 38 GP Practices within Hartlepool and Stockton, North Tees & Hartlepool NHS FT, Tees, Esk & Wear Valley NHS FT, Stockton Borough Council, Hartlepool Borough Council and Hartlepool and Stockton-on-Tees CCG. A steering group with attendees from each of the partners has been set up to support the development of the roadmap which has to be produced by June 2016. The key focus areas of the roadmap are to be:

- Identifying the data that is to be shared between systems.
- Creation of a consent model/framework.
- Creation of a Communication and Engagement with the Public Strategy.
- Engage with the workforce with a view to change cultures.
- Coordinate and share how decisions will be taken within each of our organisations

In 2016/17, as part of the BCF ICT Strategy we will be procuring a system that will provide an integrated digital care record, which will share relevant data across Primary Care, Community, Social Care, Acute, Mental Health and Urgent Care Services. The system is to be in place for use from April 2017. This is building upon the implementation of Medical Interoperability Gateway (MIG) in May 2016, which will enable data sharing across GP Practices and Out of Hours Primary Care Providers. This system will support the implementation of the Local Digital Roadmap.
https://www.england.nhs.uk/digitaltechnology/info-revolution/digital-roadmaps/

Further Background Information – recently refreshed documents

Document or information title	Synopsis and links
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. https://www.stockton.gov.uk/media/1384/joint-health-and-wellbeing-strategy.pdf
2014/15 Local Account	A summary of the priorities of Adult Social Care and its progress at implementing its priorities https://www.stockton.gov.uk/media/5616/loac-14-15_4th-proof.pdf
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 https://www.stockton.gov.uk/media/4718/big-plans-bright-future-council-plan-2015-2018.pdf

2.2 Jointly Developed

Our Better Care Fund plan has been jointly developed with all our partners and specifically:

- Hartlepool and Stockton-on-Tees CCG
- North Tees and Hartlepool Foundation Trust
- Tees Esk and Wear Valleys FT
- Catalyst – our VCSE umbrella organisation
- Stockton-on-Tees Borough Council
- Public Health (Stockton)

Delivery Partnership	Commissioning Partnership
• Stockton Borough Council • North Tees Hartlepool FT • Tees Esk Wear Valleys FT • VCSE - various	• Stockton Borough Council • Public Health • Hartlepool and Stockton-on-Tees CCG

The plans have been co-created with all partners involved. There were initially a series of workshops which set out the original vision and plan, these were informed by consultation which had been undertaken by HaST CCG. Subsequently these have been enhanced as follows:

- 3P event to develop ideas for the development of the Multi-Disciplinary Service
- Ongoing development of the MDS through regular workshops at joint meetings
- Dementia development day which included all providers, including the VCSE, service users and their carers – this looked at the gaps in service to determine what new services needed to be developed to support people with and without a diagnosis of dementia
- Service User engagement event which was an opportunity to discuss our ideas with service users and representative groups. They fed in their views to inform future developments.

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- Partner review day – using the 'reflecting on 2015/16, planning for 2016/17, self-assessment tool review' we held a workshop to review our existing plans to inform the next development of the plans
- Carers engagement – we have just commissioned a consultation with carers to understand their needs
- Dementia provider event – a further dementia event has been organised to discuss with all providers the strengths and weaknesses of provision

Because of the collaborative and partnership arrangements we have in place, any new initiatives or reviews which link to our Better Care Fund objectives, are shared across all partners. This means that we are able to collaboratively improve our services and our pathways making the best use of all our resources.

3. LOOKING BACK – OUR ACHIEVEMENTS AGAINST BCF 15/16

3.1 What we did

The focus of our first year plan was:

- Early intervention and prevention
- To create a strong partnership across health, social care and the VCSE
- To protect Adult Social Care, including reablement and intermediate care
- To ensure the successful implementation of the Care Act 2014
- To ensure there was good governance to support the plan

Our BCF 2015/16 plan set out two main schemes and five enablers:

Multi-Disciplinary Service
Improving Pathways and Care for Dementia

1. 7 day working
2. Joint Assessments
3. Digital Health Care
4. Narrowing Health In-equalities
5. ICT Systems and Data Sharing

We have made some good progress in our first year:

Stockton Information Directory

Developed a Stockton Information Directory which is an online system to support people who need advice and information and who want to know about the services available in the Borough. We developed this as a self-service option and we are constantly developing its functionality. We have recently added a Personal Assistant (PA) finder to support our plans for personalisation and the Integrated Personal Commissioning project, and a self-evaluation tool for the Care Act.

First Contact Adults

In response to the Care Act 2014 and the need to ensure that people access the most appropriate services, including our new Multi-Disciplinary Service, we established a new First Contact Adults service. With our new pathways we ensure that people who contact the Council are triaged and sign-posted to the most appropriate services and given advice and guidance where necessary. The new pathways are designed to provide a strong early intervention and prevention service ensuring that people are enabled in the first instance and only being referred to social care for a Care Act 2014 assessment when this is the most appropriate outcome.

Multi-Disciplinary Service

We have established a Multi-Disciplinary Service (MDS), the service went live on 4th October 2015. Included in the MDS is a new team made up of six well-being facilitators who undertake joint health and well-being assessments. The team is a mix of health and social care and employees are currently seconded into the service. They are managed by a MDS Manager who is also responsible for ensuring there are effective pathways from the community, into

and out of the service. A more recent addition to the team is Housing Occupational Therapy, ensuring that there are links to housing needs.

They deliver a free service for up to six weeks, based on the Care Plan which they develop with the person and they continue to support them and co-ordinate their care until the end of this period when there is a final assessment to determine whether or not further services are needed. Many of the services which form the Care Plan are delivered by the VCSE and to support this, we have co-located with the team, a member of the Stockton Welfare Advice Network.

We have been very pragmatic about how we established the MDS. We agreed jointly between the North Tees and Hartlepool Foundation Trust and the Local Authority to second our staff into the service. This reduced the risk to the staff whilst we developed this new service. It means that the employees continue to be employed by their existing employer on existing terms and conditions and the whole service is jointly delivery by the Trust and the Local Authority. This arrangement has worked extremely well and has meant that we were able to recruit excellent staff.

The staff themselves were directly involved in the development of the service and they spent the first month developing the new joint assessment. They cross-trained each other so that individually they are capable of undertaking the whole assessment, but they are equally able to share their expertise if there are any complex requirements. They were not only trained in health and social care, they were introduced to a range of services from the Voluntary Community and Social Enterprise sector so they were aware of different options available to them as part of their care planning process.

In line with our strategy to be Paper Free at point of Delivery 2020, our Well-being team are fully mobile and are able to share their assessments, in accordance with the persons' explicit consent, with their GP's.

This service is set up so that it can work 7 days a week and respond to other developments which are in the pipeline such as a joint health and social care Single Point of Access and Delayed Transfers of Care.

Improving Pathways and Care for Dementia

The LiveWell Dementia Hub (the Hub) was officially opened on the 19th May 2015 by the then Mayor of Stockton-on-Tees Councillor Barbara Inman. The Hub has been established as a central point of contact for dementia specific information and activities. The ethos is based on the integrated community model by co-locating information and support services in one venue.

Support for the Hub is provided by funding from the Better Care Fund:

- Hub Coordinator – Responsible for the Hub's strategic development, collaborating with partner organisations, the management of the building and co-ordinating activities and training sessions with local dementia services to ensure the Hub is a centre of pre and post diagnosis support for people with dementia and their carers.

- Hub Administrator – Responsible for being a first point of contact for queries, dealing with information requests and the day to day running of activities in the Hub. As a trained dementia champion, the Administrator delivers regular dementia friends sessions to increase awareness of dementia.

Following the appointment of a Dementia Strand Manager we ran a workshop for people with dementia, their carers and providers of services including the VCSE. At the workshop we identified the gaps in provision and made recommendations for a number of pilots to be established which are now underway:

The programme focuses on increasing awareness and understanding of dementia; encouraging help-seeking and help-offering; providing appropriate information and support to promote independence; and skilling up the workforce. It consists of five projects which are:

Project 1 - Increase awareness

The project involves a production of a leaflet to promote the benefit of early diagnosis and intervention, Hub and Stockton Information Directory. It also promotes the use of a standardised screening tool across health and social care to increase early diagnosis. It also utilises the GP dementia register by funding the GP practices to send out appropriate information to people with dementia who are on their registers.

Project 2 - Dementia volunteers

This project encourages people with dementia and their carers to become 'expert dementia champions' to promote awareness and reduce stigma of dementia. It also encourages them to take part in local voluntary services to improve their community involvement and promote a positive image of dementia.

Project 3 - Information and early support

This project is to build on the success of the existing dementia advisor service which is provided by the Alzheimer's Society funded by the Catalyst via the Health Initiative Programme (funded by the HAST CCG and Public Health). The service provides information, advice and support for people with diagnosed or undiagnosed dementia and their carers and families. The advisors act as a key point of contact and link workers as they provide on-going support for the service users through the journey of dementia. The service also targets hard to reach communities such as Black, Asian, Minority Ethnic background and Refugee (BAMER), Learning Disabilities, those who are socially isolated and rural areas. This project is to continue funding the dementia advisor service for 12 months.

Project 4 - Live well with dementia and support for carers

This project aims to provide 22 weeks of Maintenance Cognitive Stimulation Therapy group for people with dementia and their carers in 3 localities. The programme delivers activities/education/advice/support and allows carers to have a choice of taking a break. It will cover 48 individuals with dementia and 48 carers. The project also provides a separate carer home support service for 100 people. The service provides activity-based befriending in client's own home to promote independence and short break for carers.

Project 5 - Workforce development

This project delivers a tailored dementia training programme to improve the competence of staff who are working with older people. There will be 10 sessions of tier 1 and 10 sessions of tier 2 training. Domiciliary home care workers, pharmacists,

extra care and housing staff will be targeted initially. Skilling up the workforce will encourage help-offering and make every contact count.

Digital Health Care

Digital health refers to technologies which help address the health and social care problems and challenges faced by service users in the community and in residential settings. Generally, digital health in this context is concerned about the development of assistive technologies and other smart media to support the service user and their carers manage their needs more effectively than with direct care alone. During 2015/16 we have established two pilots which will be monitored and rolled out subject to the evaluation of the schemes:

Project 1: Falls Management in Care Home settings

Based on the successful project piloted in 2013, it is proposed that this is now rolled out to a wider audience (200 residents concurrently). The aim of the project is to prevent avoidable falls for residents in a care home setting and subsequently being admitted to hospital for health and social care support. It will achieve this through educating and training all contracted older people Care Homes within Stockton in Tees of the various different methods currently available that will assist in their safe delivery of care through assistive technology, and through the installation of appropriate equipment to a maximum of 200 residents (at any one time) where they can enhance the safety of residents.

Project 2: Preventative Dementia Care

This project has been based on national good practice and is aimed to identify up to 50 people at risk of a breakdown in their support and utilise early intervention and support to delay deterioration and maximise their health, abilities and informal support structure. It will achieve this by developing expert carers through the early provision of standalone equipment to support their role, by offering telecare to support and targeting and management of risks in the home for people with dementia, and to build on the findings of the Smarter Homes for the future project.

Smarter Homes for the Future was piloted in 2013 and identified that by providing an assessment and advice of minor changes to a service users home (layout, colours, simple equipment, etc.), the property can be made more dementia friendly and reduce the risk for people to live independently.

We are currently developing a business case for providing people over 75 with free Telecare services. The business case will consider whether or not there would be benefits to health and social care.

As part of the work we are doing with Integrated Personal Commissioning, we are also introducing the Florence system. This is system which uses SMS text messaging to support people with COPD. The development of the system will be a collaboration between the people with COPD and the practitioners involved in their care.

Narrowing Health Inequalities

Public Health have identified an additional £200k to be pooled into the budget so that we can further integrate services and make sure that those public health initiatives which are complementary to the Better Care Fund are included in the section 75 agreement.

During 2015/2016 the schemes which formed part of the joint budget were:

- Warm Homes Healthy People
- Stockton Service Navigation Project

In 2016/17 this will also include:

- Falls service, initial assessment, low level intervention and education and awareness. The service will be co-located with the Multi-Disciplinary Service to ensure there is a joint approach to assessments and outcomes for people who access the services.

ICT Systems and Data Sharing

Detail about information sharing and our achievements in 2015/16 is set out in section 5.4.

VCSE Services and Social Prescribing

Following a formal review of three social prescribing services, the Pooled Budget Partnership Board has agreed funding to secure these services for the next two years. These services all have objectives which support the outcomes of the Better Care Fund:

Service	Description of the service
Better Health, Better Wealth	The Better Health, Better Wealth programme provides targeted and sustained interventions for people aged 65 or over who live in the borough of Stockton on Tees. They provide 3 key areas of support to all clients; • Holistic Health and Wellbeing assessment • Home Energy assessment • Welfare rights assessment The service receives referrals from a multitude of sources including the MDS Wellbeing Facilitators, Stockton Welfare Advice Network (SWAN) and self-referrals. The service is community based allowing staff to make contact with individuals who are typically 'hard to reach' by taking referrals in a myriad of ways that may not be traditional pathways into service such as; supermarket promotions, in town centre and café' promotional days, community groups, activity groups such as the bowls group and older people's sheltered housing drop ins. The service captures clients pre early intervention before they come into contact with statutory services.

Service	Description of the service
	The service uses the Warwick Edinburgh Wellbeing Scale (WEWBS) to measure the outcomes for the clients.
Close 2 Home	The Close 2 Home service provides support for people with Long Term Conditions (LTCs) or people who have experienced regular or repeated hospital admissions and often the management of LTCs has an impact upon a person's mental health and wellbeing. Close 2 Home offers 1-1 support to individuals for up to 12 weeks supporting them to develop coping strategies and self-management skills to enable them to independently self-care and maintain their own health and wellbeing. The service receives referrals from a wide range of sources including the wellbeing facilitators, community matrons, adult social care teams, GPs and VCSE organisations. The service is predominantly health outcome focused which utilises a linked data set to evidence the reduction in hospital A&E admissions, non-elective admission and reducing length of stay. However it is evidenced that the impact of social care is also reduced as people are managing their LTCs more effectively and have improved mental health therefore reducing the need for social care interventions. The service uses the Warwick Edinburgh Wellbeing Scale (WEWBS) to measure the outcomes for the clients and has an information sharing agreement with North Tees and Hartlepool Foundation Trust to create a linked data set that depicts the reductions in admissions and the average costings saved.
Staying Out	The Staying Out service is designed to help older people at risk of hospital admission, or recently discharged to stay active and remain independent. The service targets referrals from professions (health, social care and voluntary sector) and focuses on people in the top 2% of the GP 'at risk' register. Staying Out provides 12 free sessions (including hot lunch) for each individual and provides opportunities for the clients to; • Mix with other people, not just their own generation and develop peer networks • Learn new creative skills

Service	Description of the service
	• Gain a sense of achievement • Receive health, wellbeing and welfare advice from professionals and other organisations • Maintain self-confidence and communication skills The service links directly with the MDS and they received 10 referrals in the first month of the MDS service going live. The service also receives referrals from GPs, Community Matrons and adult social care and is currently operating at full capacity. Arc Staying Out demonstrates how all of the VCSE programmes can complement each other, Arc is linking with Age Uk's programme 'Better Health, Better Wealth' to help the clients access support with benefits and welfare advice in order to help them sustain their attendance after the 12 free sessions thus improving their ability to self-manage and remain independent without the need of social care or health services.

By working closely with the VCSE (they are on a number of our implementation groups including the Better Care Fund Steering group) we are able to jointly identify opportunities where the sector can support the Better Care Fund.

Integrated Personal Commissioning

HaST CCG in partnership with the local authority and Catalyst (our umbrella VCSE organisation) are a demonstrator site for IPC. This complements both the local authority and the CCG's ambition to increase the number of people taking personal budgets.

The cohort of people who will initially benefit from IPC are over the age of 65 with non-cancerous COPD.

Discharge Process

A number of Better Care Fund initiatives and linked developments have been implemented that aim to improve the discharge process including:

- Co-location of first contact services and teams that support the discharge process;
- Seven day social work input, focused on hospital discharges; and
- Additional capacity commissioned from home care providers to facilitate weekend discharges.

Further developments are planned that will further improve the discharge process and pathways including:

- An enhanced Early Intervention Service that will facilitate more timely handovers from Rapid Response Nursing to Adult Social Care.

- A review of the Emergency Care Therapy Team discharge process; and

- A review of the Patient Choice Policy associated with hospital discharges.

The Trust has worked in partnership with the LA and CCG colleagues to review and revise the Choice policy and relevant discharge pathways. The Choice policy has been reviewed and approved by Trust board and shared with Local Authority partners ready for implementation.

The local authority has also undertaken two major service reviews to support the discharge process:

- Rosedale is a centre for rehabilitation and assessment with nursing support provided by the district nursing service and is based in the community. The review was to ensure that the pathways and referrals were standardised and the service was appropriately used and maximised wherever possible.

- Intermediate Care and Reablement are critical services supporting early discharge from hospital and ensuring that people can return home as soon as possible. The pathways have been reviewed and also the triage capability of service. Optimum use of technology and sharing information was also a key part of this review.

Outcomes

The plans we have in place for BCF will contribute to the delivery of improvements in:

- Reduction in Non-Elective Admissions (General and Acute)
- Reducing inappropriate admissions of older people (65+) in to residential care
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Reduction in Delayed transfers of care from hospital per 100,000 population

It is too early to fully assess the impact that each of the initiatives have had on our performance. Most of the services that have been put in place are pilots or have only been in place a short length of time. We know from our exit interviews that people highly regard our MDS but we need to demonstrate the benefits it will deliver in the longer term. During 2016/17 we will be developing business cases to mainstream the most successful projects.

We have had some excellent outcomes by co-locating the SWAN within the MDS as set out in the attached report. We have achieved an increase in income for people of £151k between October 2015 and February 2016. Some people have seen their income increased by over £9,000 per year which has nearly doubled their income! The attached document includes a case study from one of the well-being facilitators.

MDS FEBRUARY 2016 - SWAN.docx

3.2 Our Review

In January we held a workshop with all the key people who have been involved in our Better Care Fund. This included representatives from all our stakeholders. The workshop used the Better Care Fund: reflecting on 2015/16, planning for 2016/17, self-assessment tool.

The key findings were that we need to:

- Ensure we communicate messages/awareness to staff within Health and social care to minimise resistance and raise awareness.
- Continue to engage with and receive buy-in from all stakeholders.
- Share risk across all partner organisations.
- Standardise 7 day working across organisations/services.
- Align strategies and overlap these around care objectives.
- Develop and produce meaningful outcomes for the MDS to mainstream the service
- Provide support services for carers that is non-means tested.
- Re-visit and evaluate the effectiveness/duplication of services of the VCSE social prescribing services
- Develop a business case to support free telecare for everyone over the age of 75.
- Develop a business case for the future model of the SPA/First Contact.
- Link Warm Home Healthy People to the MDS.
- Switch our focus from early intervention and prevention to people with complex needs and long term care – especially care co-ordination.

Throughout 2015/16 we have been developing our ideas for the Better Care Fund and have already approved business cases which will see new services come online in April 2016:

- New falls services (early intervention, education and awareness)
- INTENSIVE COMMUNITY LIAISON SERVICE – extended service and co-located with the MDS
- Single Point of Access, health triage capability to complement the triage in Adult Social Care

From the findings of our review, we are developing our ideas for:

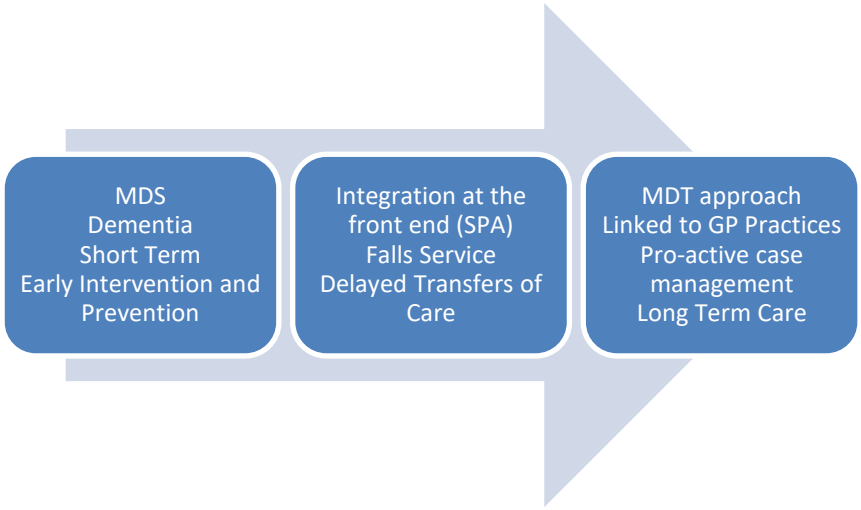
- Long Term care
- Delayed Transfers of Care
- Training in care homes
- A new Single Point of Access with a fully integrated health and social care triage capability, ensuring the most appropriate services are deployed to support a persons needs
- Developing a business case for offering people over the age of 75 a free Care Call service

4. LOOKING FORWARD – OUR AMBITION FOR BCF 2016/17

4.1 What we want to achieve

Our 2015/16 plans were mostly about delivering early intervention and prevention services and joining up health and social care delivering co-located and integrated services.

Towards the end of the year we started to develop our thoughts on where we would like to see greater integration.



The main development priorities for 2016/17 are:

- Delayed transfers of care – services and pathways
- Single Point of Access – shared health and social care service
- Health pathway referrals into the MDS – building on pilot work with GP practices and ECTT
- Digital Integration – MIG to be rolled out initially and then the wider integration project – linking into the Digital 2020 project
- Business cases to mainstream services (from pilots to services)
- Long term care – care co-ordination putting the person at the centre

The challenges we have:

- Performance management – accuracy of data and granularity
- Need to develop robust business cases
- Collecting the evidence of the impact on both Health and Social Care

Delayed Transfers of Care

There have been several reviews of services within the local authority and the Trust. The Trust have also been involved in 'The Perfect Week'. Building on this work we have established a new workstream. Our plans for DTOC are set out in Section 5.8 below.

Single Point of Access

We have significantly strengthened our 'front door' to both health and social care by putting triage capability in to both First Contact Adults and the health Single Point of Access.

However at the moment the two services are operating separately and we believe that the decision-making would be strengthened if we put the two services together.

During 2016/17 we will develop the business case and if appropriate put a new service in place by April 2017.

Health Pathway Referrals

We have good pathways into our MDS from Adult Social Care but we need to strengthen the pathways from health.

We are working closely with community services and the new triage capability in the SPA will also ensure that health referrals are made into the most appropriate MDS services.

The next stage is to work with GP's so that they understand the capabilities of the MDS. We are currently working with two GP practices so that we can determine which patients would benefit the most from our early intervention and prevention offer which can be delivered by our Well-being Facilitators in the MDS, a risk stratification. Once we have completed the pilot we will be able to engage with all the GP practices.

Digital Integration

We have already agreed and are rolling out the implementation of the Medical Interoperability Gateway (MIG) into GP practices and out of hours GPs. This will be our first stage towards greater integration which will achieve during 2016/17. This solution will also provider 'view only' to other partners such as social care, community services and acute trust.

More detail about this is set out below in Section 5.4.

Business Cases to Mainstream Services

Because of the uncertainty around the future of the Better Care Fund we used our 2014/15 initial funds and 2015/16 pooled budget, to establish a number of pilot projects. During 2016/17 we will be developing the evidence based business cases to mainstream the successful pilots.

Long Term Care

This is the 'gap' in our existing plans. Building on the models deployed in some pathfinder / vanguard sites, we now want to start to develop our solutions to meet the needs of people with complex needs including frailty and multiple long term conditions.

In the first instance we will work with all our partners across health, social care, primary care, the VCSE and mental health, to identify what would work best in the local area. This approach is similar to the development of our MDS services. We will then implement the preferred model as a pilot during 2016/17 with the aim of rolling out a solution across the whole borough by April 2017.

4.2 How we will deliver this

We have strong governance arrangements for development of the plan and for the implementation of the plan which involves all the key stakeholders.

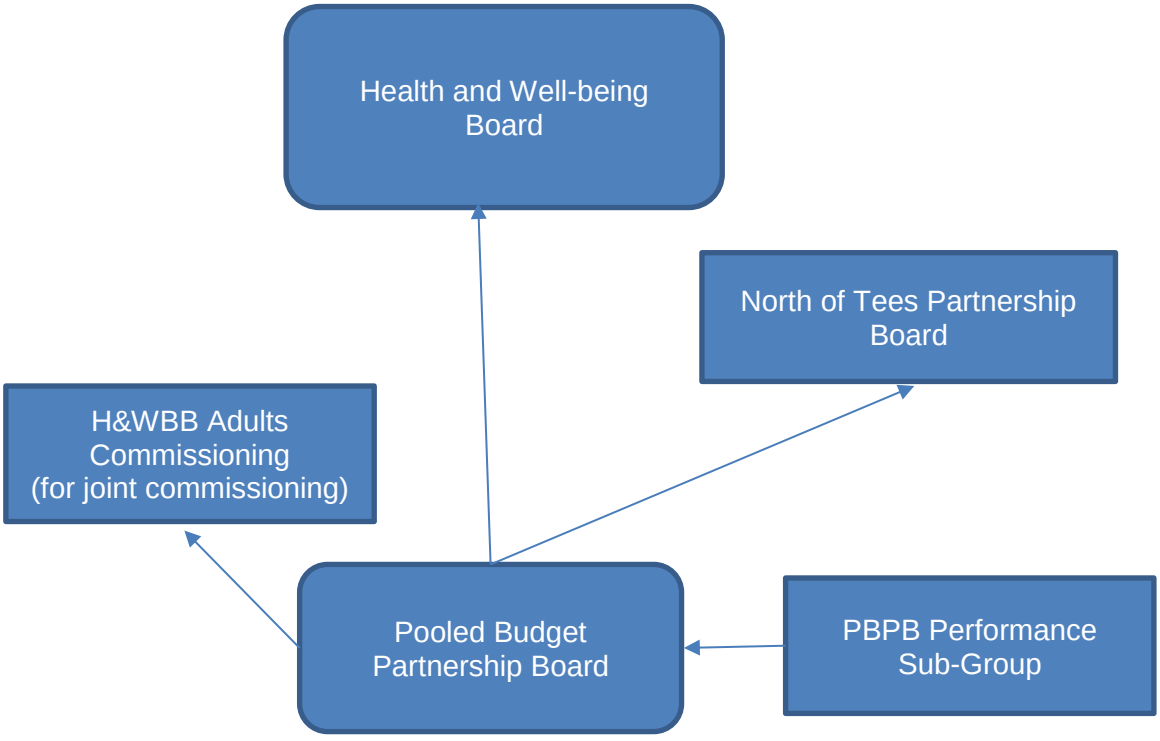
Implementation Workstreams:

- Better Care Fund Implementation Team – Steering Group
- Multi-Disciplinary Service
- Dementia
- Digital Health
- ICT Integration
- Integrated Personal Commissioning
- Communications and Engagement

For our 2016/17 plans there will be a new workstream:

- Delayed Transfers of Care

We have strong governance arrangements for the budget and accountability for the delivery of the Better Care Fund:



Health and Well-being Board – oversees the development and implementation of the Better Care Fund plan. They also sign off the plans and sign off the quarterly performance reports.

North of Tees Partnership Board – is where all the partners meet to discuss the progress against the plan including the performance against the plan. It includes delivery partners as well as commissioners. Issues can be escalated to the Board if they can't be resolved locally.

Pooled Budget Partnership Board – is the board established under the Section 75 agreement to oversee all the budget and performance matters relating to the Better Care Fund. All business cases go to this Board for approval.

H&WBB Adults Commissioning – is a sub-committee of the Health and Well-being Board and oversee all joint health and social care commissioning.

Pooled Budget Partnership Board Performance Sub-Group – meets to discuss all performance matters and all budget matters. Prepares reports for the Pooled Budget Partnership Board and the North of Tees Partnership Board.

The whole programme is monitored using Managing Successful Programmes methodology and there is a detailed implementation plan supporting the programme.

Set out at appendix 1 is a High Level Implementation Plan

We have developed a Stakeholder Management strategy and a detailed communications plan which is attached below:

BCF Communications Pla

There is an overall risk log for the Better Care Fund and this is attached.

BCF Risk Log 160301.xls

4.3 Anticipated Outcomes

The plans we have in place for our 2016/17 plan will contribute to the delivery of improvements in ;

- Reduction in Non-Elective Admissions (General and Acute)
- Reducing inappropriate admissions of older people (65+) in to residential care
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Reduction in Delayed transfers of care from hospital per 100,000 population
- Increase in the estimated diagnosis rate for dementia
- Improved patient experience of services

5. NATIONAL CONDITIONS

5.1 Plan and Minimum Budget Approved by Health and Well-being Board

The BCF Plan including minimum budget and performance measures was signed off by the health & Wellbeing Board as required throughout the submission and assurance process.

All BCF quarterly returns have been approved through the Health & Wellbeing Board following approval by the BCF Pooled Budget Partnership Board. It was recognised that the dates of returns and Boards did not always coincide, so the Board formally delegated authority to sign off returns to the Chair of the Health & Wellbeing Board, Chief Officer of the CCG and Director of Children Education and Social Care (now Director of Adults and Health following a restructure on 1st January 2016) within the LA.

The Health & Wellbeing Board includes representation from the two Foundation Trusts (FTs) that deliver the majority of NHS services locally, and both FTs are also represented on the North of Tees Partnership Board which receives BCF Performance Reports at every meeting.

5.2 Maintain Provision of Social Care Services

In line with our Better Care Fund plan for 2015/16 we continue to maintain the provision of social care in Stockton-on-Tees and can confirm that this follows on from the 2012 guidance on the transfer from health to social care which was implemented in 2013/14.

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 Act.

In 2015/16 the total amount from the BCF that has been allocated for the protection of adult social care services is £7.107m including the capital funding for disabled facilities grant.

The Better Care Fund monies has been used to protect social care and out of hospital services and develop new integrated health and social care services. The main focus has been on early intervention and prevention and ensuring services are targeted at those with the greatest need. By targeting our funds in this way we aim to meet our targets for hospital admissions and permanent admissions to residential and nursing homes.

The increase on 2015/16 original plan takes account of the increasing demand on social care services, the growth in packages (consistent with the increasing frailty and multiple comorbidities), the additional investment in Carers assessments, care plans and personal budgets, and the other increased burdens include those associated with the implementation of the Care Act 2014.

The areas of spend which have been supported with the funding are set out in Section 6.

Care Act 2014 and Better Care Fund

We have implemented a new Care Act Assessment and a new Carers Assessment which have both been integrated into our electronic system. We have devised a new Care and Support Plan which focusses on the outcomes that people which to achieve.

Each person is given a copy of their Care Act Assessment and informed of their indicative budget prior to the Support Planning process commencing. The support planning entails a further visit to the person, allowing the person to reflect on their needs and consider how they may wish to spend their indicative budget.

A carers resource allocation system (RAS) has been developed linked to the outcomes identified in the Carers Assessment. A process has been implemented to ensure that Carers can access an assessment from the local authority even if the person they care for is not known to the local authority.

A new first contact team has been created which identifies the need for preventative services. Assessments are paused while preventative services are explored to ensure that clients are given the opportunity to maximise their independence.

Our Care Act plans and our Better Care Fund plans have be linked from the beginning:

- We needed to have a different customer contact and triage service which would meet the needs of the Care Act and also provide us with a pathway to our new Multi-Disciplinary Service – we create a new First Contact Adults Service.
- Personalisation and the need to increase the take up of personal budgets is important for the Better Care Fund, Integrated Personal Commission and the Care Act – we are developing solutions for increasing the number of Personal Assistants, we have launched a PA finder on our Stockton Information Directory and we are strengthening our team which manages personal budgets.
- Early intervention and prevention are a key part of the Care Act and for 2015/16 our focus has been on delivering services to people who would not necessarily meet the criteria for a Care Act assessment but by providing early support, including Befriending and Welfare services we are keeping people in their own homes and independent for longer.
- Integration of health and social care is another area where the Care Act and Better Care Fund complement each other – we have established joint teams, and co-located services to ensure the person is at the centre of our care and support.

Outcomes for Carers

As set out in our Better Care Fund 2015/16 submission, 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.

We have continued to work with our carer support provider to develop the most appropriate services to meet the needs of carers. We have changed the contract recently to reflect the additional support to carers which is provided by the local authority in response to the implementation of the Care Act. Carers now receive a carers assessment and care plan from the local authority and where appropriate carers receive a personal budget in line with our resource allocation system.

Our Dementia strand has a particular focus on supporting carers. Situated next to the Halcyon Day Care Centre, our LiveWell Dementia Hub provides support, advice, guidance and signposting to people who are concerned about someone who may have memory loss or people with a diagnosis of dementia and their carers.

Within our Digital Health strand we are piloting an approach with 50 people who have an early diagnosis of dementia. We are deploying various aides and adaptations aimed at keeping people in their own homes for as long as possible and this includes the use of Telecare. This will also provide support for carers who will be involved in the implementation of the individual packages of support.

All of the new pilot services we have established will be closely monitored and if successful they will be rolled out to the appropriate target groups.

Examples of other services which are provided to support carers:

- 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

We have recently commissioned a piece of work to consult with carers, especially in relation to our Dementia strand. The aim is to understand what is missing which will inform our plans for the development of further services in 2016/17.

5.3 How Plans Support 7 Day Services

We have established a separate group to look at 7 day services. There are a number of perspectives which we are considering:

- The Clinical Standards for 7DS and the priorities and contracts for the CCG
- Where 7 day working supports early discharge from hospital
- Where 7 day working support our other objectives of keeping people out of hospital as part of our early intervention and prevention strategy

We have established the Multi-Disciplinary Service on the basis of working 7 days a week, but at the moment the pathways don't support this. We are introducing triage into the Single Point of Access, and when we have assessed the demand we will put in place services to support the new arrangements.

We already have 7 days services in place across health and social care and these were set out in our 2015/16 plans. We want to ensure that we complement these services to achieve our objectives rather than putting in place resources which are under-utilised.

NHS IQ 7 Day Standards

Significant work has been undertaken by North Tees and Hartlepool NHS Foundation Trust (NTHFT) and South Tees Hospitals NHS Foundation Trust over recent years in taking forward this agenda. The Trusts have well-established Programme Boards with a named organisational lead responsible for driving forward the Seven Day working framework. THE CCG in collaboration with the Providers and NHSIQ undertaken a gap analysis and commenced the delivery of plans and collectively agreed the clinical standards which were taken forward in year incorporated within the Provider Service Delivery and Improvement Plan (SDIP) as a contractual requirement. During 16/17 we will continue to work

collaboratively with the FT and NHS Improving Quality Team to ensure delivery linking with the wider programmes of work being under taken as part of BCF plans.

Considerable work has also been undertaken with TEWV, to ensure that all service areas include 7 day and urgent access in community settings and not just in patient areas.

NHS IQ 7 day standards have been published. There are 10 clinical standards and there is a requirement to have 5 completed this year and 7 by the end of March 2016. These have been incorporated into the commissioning plans with the Acute Trust.

During 2016/17 we will be working towards the three standards relevant to the Better Care Fund:

Standard 1 – Patient Experience (being actively involved in shared decision making supported by clear information to make fully informed choices)

Standard 3 – Multi-Disciplinary Team Review (An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place)

Standard 9 – Transfers to community, primary and social care (support services must be available 7 days a week to ensure that the next steps in the patient's care pathway can be taken)

Overall approach – action plan

Stage 1 – mapping (activity & outcomes)
Stage 2 – assess services against the clinical standards
Stage 3 – review of pathways & identify what is needed 7 days

5.4 Better Data Sharing between Health and Social Care

We have employed a dedicated experienced information governance manager for two years. This is to ensure information governance is progressed at a good pace and with the right attitude, about ensuring that the correct policies are followed and to ensure data sharing issues are not a barrier to change.

The main areas of work being undertaken by our IG Manager are:

- To ensure compliance with statutory obligations, the common law duty of confidentiality and the Caldicott Principles
- To link in with national initiatives and ensure that any changes to national guidance and legislation is implemented into the local plan
- Ensuring the necessary safeguards to privacy are in place including best practice such as Information Sharing Agreements and Privacy Impact Assessments
- Ensuring we have the right infrastructure in place to support information sharing (systems, networks e.g. N3, E-mail protocols)
- Ensuring we have the right policies and procedures in place to support information sharing and effective decision-making for the person (such as the operations of the Multi-Disciplinary Service)
- To work on the Integrated Personal Commissioning project which has some unique information governance challenges, especially as we engage more with the

voluntary community sector

- To help us promote the value of information sharing with practitioners, such as primary care, and ensuring that the public get the right messages
- To allow us to data for secondary purposes so that we are able to use our information and intelligence to support our decision making and ensuring that our resources are most effectively deployed. We also want to use secondary data for risk stratification and for performance management to demonstrate impact and outcomes. A methodology will need to be developed based on NHS guidance, compliance with the law and common law duty of confidentiality.
- To work with all partners to eradicate all barriers to change and to support our Local Digital Roadmap ambitions

Open Systems / Connectivity / Standards

Much of the infrastructure needed to support information sharing is already in place, including N3 connections, compliance with relevant standards for information security such as ISO27001 and GCSX.

The major hurdle to overcome is systems integration and the use of API's. Some services are already able to share information electronically but this is because the data is all held in the same system. The Medical Interoperability Gateway (see below) will allow us to share information across Primary Care regardless of the system in use by the GP practices, however, wider integration will require the use of API's or similar.

As we develop our integration solution we will negotiate with supplier to provide API's or other gateways which allow access to their information for data sharing purposes. This will happen during the next 12 months.

NHS Number

In line with the Care Act 2014 and the national conditions set out in the Better Care Fund, all partners are now using the NHS number so that we can link data sets to help us better understand the impact of the sector on the individual.

In our 2015/16 plans we set out the progress made by each partner organisations this plan sets out what we have achieved during the year and our ambition for 2016/17.

The NHS number is now part of the data collection process for Adult Social Care and when the person is unable to provide the number it is a priority to find the number by using NHS spine service. The local authority is now 89% compliant on the use of the NHS number with an ongoing plan in place to improve compliance.

The VCSE services are now also collecting the NHS number, where appropriate. This has enabled organisations to demonstrate the impact of their service on meeting targets within the Better Care Fund.

Sharing Data In-practice

The Multi-Disciplinary Service needs to share information with Adult Social Care, GP's, NHS Community Services and other partners. Robust Information Sharing Agreements have been put in place and explicit consent is required before a person's information is

shared. The team are using SystmOne which is the same system used by GP's and NHS Community Services and this allows them to share information electronically. At this stage information is manually loaded into CareDirector (the social care system) and manually passed onto other agencies where appropriate. The service is co-located with other health and social care services and they able to do this because of the N3 connectivity which exists in all our major buildings.

Integrated Digital Care Record

The ambition is to have a fully Integrated Digital Care Record. Over the last 12 months we have been specifying our requirements by talking to all our major stakeholders, including MH services (TEWV), the local authority, GP's, the acute trust (NTHFT), the ambulance service (NEAS) and our out of hours GP service. We needed to find out what information they needed to support their decision-making and what information they were able to share with other organisations.

We have looked at a wide range of solutions:

- Off the shelf data integration products – these are very expensive and have the capability of doing much more than we might need in the short term
- Medical Interoperability Gateway (MIG) – this is a product which has been adopted by a number of GPs and is a proven cost effective solution. We are in the process of implementing this as a first step towards greater integration.
- Summary Care Record / Enhanced Summary Care Record – we thought this would be a really good solution. Unfortunately it doesn't have all the data we need to be fully integrated, for example it doesn't include social care. This has been dismissed as a full solution although some health partners are using it, such as Mental Health.
- Pathfinders – we initially considered the work undertaken in the Leeds Care Record. This was doing much of what we needed but unfortunately it isn't fully integrated and it was built in-house. We understand that there is a new product emerging from this project called Ripple which is open source – this looks very interesting and is something we are following up.

We are in the process of implementing the MIG and working with all GP practices to ensure that they are able to obtain the appropriate permissions with their patients to allow us to get maximum benefits from this first stage of integration.

The next stage is to undertake a full procurement to purchase the system which will allow us to join up both health and social care.

There remain a number of challenges, including:

- Ensuring that we can work with our providers to allow integration into their systems
- Getting patient and service user consent to share
- Data quality
- Putting in place Information Sharing Agreements across all partners

Local Digital 2020 plan

We have submitted our digital footprint which at this stage only includes the partners within the Hartlepool and Stockton-on-Tees CCG boundaries. We have done this because we are building on existing relationships and a buy-in from all partners to pursue and

integration model.

We are in the process of aligning all the partner ICT strategies to ensure we all have a strategy to be Paperless at the point of delivery by 2020.

Summary

Project	Status	Progress / Notes
Raising awareness	Commenced	Staff training to ensure they understand the risks and requirements. Awareness of benefits to Primary Care in advance of implementing MIG Poster campaign to be developed to promote the benefits and myth busting to members of the public
Information Sharing Agreements	In place	These are routinely developed every time a new service comes on line or there is a change to an existing service
APIs	Not started	
Consent models	In place	Sharing is proposed to take place on an implied consent to share explicit consent to view model. Explicit consent is sought at each stage before records are viewed to ensure that data sharing for service delivery is in place Further work needs to be done with GPs as part of the MIG
Use of data for secondary purposes	Considering options	There are a number of options: - The CSU develop the capability (this is being considered) - Use of third party Business Case is being developed before being shared at the Pooled Budget Partnership Board
Systems interoperability	Limited	This is in place where the system is the same across different partners (SystmOne) Manual or separate data entry is used where it is not possible to share information electronically – ISA's are in place to support this.

Risks

- GP's refuse to participate. We will implement wherever we can and continue to promote the benefits to GP's who don't participate. All GP's are now members of a

single federation and we are using this as a conduit for spreading messages of best practice

- Data Quality is poor which means that the data is not in a usable format. We will continue to work with providers and staff to ensure that wherever possible the right coding structures are being implemented and reinforce the message about good data quality and its benefits.

- Suppliers refuse to participate and open up their systems. We will use our procurement and contract negotiation capability to press home the need for systems integration. We will also work with national bodies and representative bodies to get the message across.

- Solution is extremely expensive and unaffordable. Money has been set aside to procure a system but some 'all singing all dancing' systems are very expensive. We also don't know at this stage how much suppliers will require for integration and open API's. We will undertake a robust procurement process and wherever possible use solutions which have been deployed using pathfinder funding. There is also a regional strategy for integration, we will use this if appropriate and timely.

5.5 Joint Assessments and Care Planning

There are five elements to our joint assessment and care planning strategy linked specifically to the Better Care Fund:

1. GP care planning for the top 2% people with multiple long term conditions
2. The Multi-Disciplinary Service which is aimed at everyone over the age of 65 who doesn't have a long term care package (early intervention and prevention)
3. Intensive Community Liaison Service (ICLS) co-located into the MDS and linkages to GP practices
4. Care Co-ordination for people who have complex long term needs over the age of 65
5. Integrated Personal Commissioning for people over the age of 65 who have a diagnosis of non-cancerous COPD

GP Practice

GP practices have been identifying people with frailty and also people in the top 2% of greatest need and they have been co-ordinating the care for these individuals and developing care plans. At the moment these plans are not integrated with social care but there is an ambition to look at this as part of the development of our 2016/17 plans.

Multi-Disciplinary Service

The MDS undertake a holistic assessment of people who are referred to the service. These are people over the age of 65 who require early intervention and prevention. They receive services for up to six weeks and during that time they have joint health, well-being and social care plans which are co-ordinated by the well-being facilitator until they are assessed and then stepped-down or referred onto other services to support their on-going needs.

Intensive Community Liaison Service (ICLS)

A large proportion of acute hospital admission comes from care homes for clients with infection and delirium. We have therefore commissioned an enhanced ICLS service which

will provide specialist mental health input as part of the Multi-Disciplinary Services (MDS) in order to achieve the BCF ambition of providing an integrated health and social care services.

Delirium causes significant mortality and morbidity. Failure to detect and treat delirium increases the risk of poor health outcome and need for hospital and/or care home admission. Educating clients, carers, GPs, health and social care professionals can improve early detection and management in the community.

We have also commissioned the development of a delirium video which will complement the enhanced ICLS, Dementia Awareness Training Programme, Stockton Information Directory and the Adult Social Care Workforce Development Programme.

Care Co-ordination for people with Long Term Care

In our plans for 2015/16 we have developed services mostly to support people with early intervention and prevention. The services are short term but holistic and are aimed at ensuring people remain in their own home with the right support to keep them out of hospital and long term care.

In our plans for 2016/17 we want to switch our focus to people who need care co-ordination of their long term care plans. In the first instance we will hold a workshop of all key professionals and practitioners to understand the gaps in service and how by providing a Team Around the Person, we can ensure that their care if fully joined up, not duplicated, services and packages of care are complementary and that we only have one view of the person. We anticipate that this will include all practitioners from primary care (GP), social care, community services, mental health services and that the lead co-ordinator would be the person who has the most involvement in their care.

Integrated Personal Commissioning

Stockton is a demonstrator site for IPC. Our cohort is people over the age of 65 with a diagnosis of non-cancerous COPD. We are in the process of developing our approach to care planning which will involve expert users, the VCSE as well as professionals from Adult Social Care and the MDS. We need to develop significant capability in this area because we intend to roll this out with ambitious targets over the next 2 years. The targets are set out in Memorandum of Understanding.

The intention is to have joint health and social care budgets with the person determining the best use of the budget to meet their personal needs.

5.6 Consequential Impact on Providers

The reductions on non-elective activity that BCF schemes will support have been included within the CCG Operational Plans. Negotiations are ongoing with acute providers in relation to the impact of the reduction in non-elective activity.

5.7 Local Risk Sharing Agreement

The CCG and Local Authority have agreed that the plans set out for the BCF require the full investment of the Pooled Budget to be able to achieve the impact desired. Both organisations have agreed to manage the risks of both increased emergency admissions into hospital and increased admissions into residential care within contingencies set aside within the respective organisation.

During 15-16, the Payment for Performance pot was released into the BCF Pooled Budget due to the MAR data showing a reduction over the period quarter 4 2014/15 and quarters 1-3 2015/16 in emergency admissions of 4.88% on the same period in the previous year.

The Financial Summary in the planning template shows that there is an investment of £4,751,500 in NHS Commissioned out of hospital services. This is £1,032,291 greater than the minimum requirement set out in the BCF Allocations.

5.8 Delayed Transfers of Care

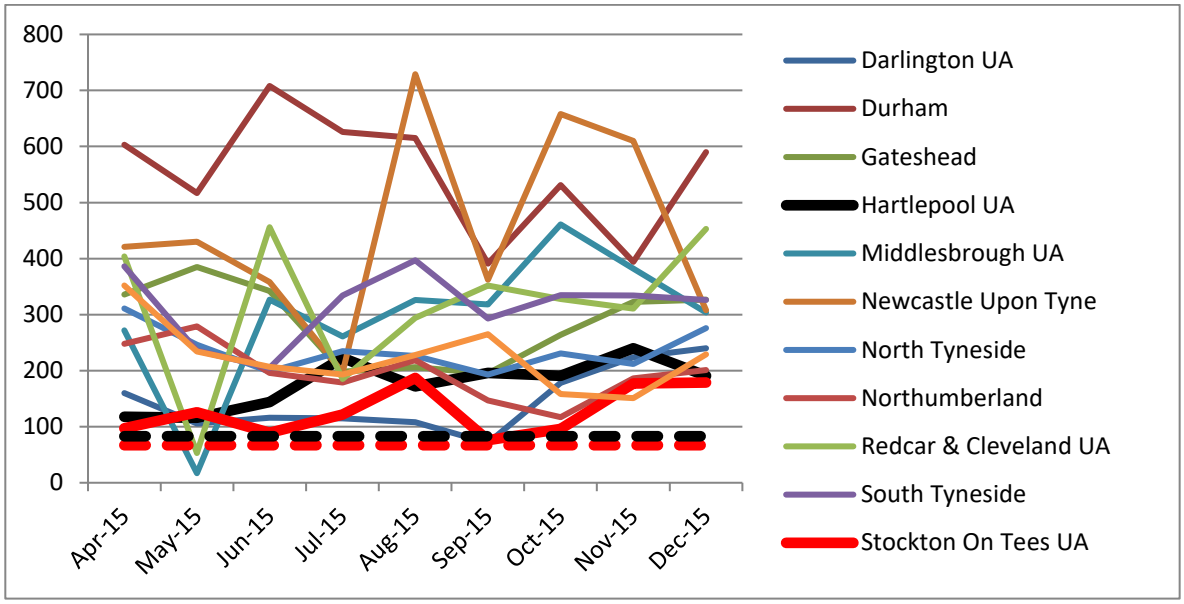
Health and Social Care Staff are committed to the objective of providing high quality responsive care and support to people who have been in hospital and need support for their transfer of care when they are ready for safe discharge. However patients can be delayed waiting for onwards care due to a number of circumstances for example waiting for social care to be arranged at a residential or nursing home or for a care package to be developed or sometimes an individual's assessment aren't completed before they recover. Other factors such as family/patient choice about where the person is to be transferred to; housing and equipment installation can also come into play.

Local Situation:

A delayed transfer of care trends analysis undertaken across the North East suggests that Hartlepool and Stockton on Tees currently have the lowest reported DToC bed days across the region; however, local partners have agreed a 50% reduction in bed days for 16/17 with an overall ambition to reduce by a further 50% in reported DToC days in 17/18.

The chart below shows the DToC rate per 100,000 of adult population and demonstrates the ambition for Stockton On Tees BCF plans in 16/17.

DToC rate per 100,000 per adult population (Stoctkon)



---------- 50% ambition for Stockton on Tees LA in 16/17

Local Reported Reasons for DTOC

Delayed transfers of care are a significant concern expressed by acute trusts however the data reported in relation to delayed transfers of care is often unclear as to whether the reasons for delay could be subject to interpretation leading to misinterpretation of the data. For example (table 1), 63% of the reasons reported for DToC (two thirds) of total bed days) (table 1) relate to nursing home placement/patient or family choice, however what is unclear from the data is how many of the days relate to the same patient and if they are interrelated ie; choice of nursing residential bed availability vs actual nursing residential bed availability in Stockton. We do know from our local intelligence that there is nursing residential bed capacity within Stockton however it is often not the choice of placement for the patient/relative and often remain in an acute bed until their home of choice is available. We also need to better understand the DToC delays for people waiting for NHS non-acute care to better inform our out of hospital services provision.

Table 1. Reported reasons for DToC in Stockton on Tees

By Provider	No of Days	Percentage
North Tees & Hartlepool NHS FT	870	75.72%
South Tees NHS FT	161	14.01%
Tees, Esk and Wear Valleys NHS FT	108	9.40%
Other	10	0.87%
Total	**1,149**	**100.00%**

Reason for Delay	No of Days	Percentage
Completion of Assessment	52	4.53%
Public Funding	7	0.61%
Waiting further NHS non-acute care	113	9.83%

Awaiting residential home placement or availability	171	14.88%
Awaiting nursing home placement or availability	237	20.63%
Awaiting care package in own home	25	2.18%
Awaiting community equipment and adaptations	28	2.44%
Patient or family choice	485	42.21%
Disputes	9	0.78%
Housing - patients not covered by NHS and Community Care Act	22	1.91%
Total	**1,149**	**100.00%**

A number of BCF initiatives and linked developments have already been implemented that aim to improve the discharge process including:

- Co-location of first contact services and teams that support discharge process;
- Seven day social work input, focused on hospital discharges; and
- Additional capacity commissioned from home care providers to facilitate weekend discharges

Further developments are planned that will further improve the discharge process and pathways including:

- A Multidisciplinary Service that will facilitate more timely discharges across health and social care services
- A review of the Acute Trust's Emergency Care Therapy Team and discharge process; and
- Implementation of a revised Patient Choice Policy associated with hospital discharges.

In addition to this to deliver the new BCF DToC ambition, the CCG, social care and acute trust partners have agreed to develop a local action plan for managing delayed transfers of care which includes the locally agreed target.

The plan will assist organisations identified within it in meeting the requirements of the Better Care Fund delayed transfer of care target and metrics set out in the new policy framework (2016).

A high level implementation plan for DToC is set out at appendix 1.

6. FUNDING PLANS

6.1 Funding against Key Schemes and Enablers

Detail about the schemes is set out in sections 3 and 4. The breakdown of actual spend is set out below:

Description	Detail	Total Spend £
Multi-Disciplinary Service	NHS Community Services including Rapid Response	1,198,077
	Rosedale and Reablement	837,996
	Additional protection for Adult Social Care – to support Care Act and increasing demographics and social care services to support integrated services.	2,000,000
	Housing Occupational Therapy	80,000
	First Contact Adults	90,000
	MDS Services – including the Well-being Team and the MDS Manager and IG Officer	675,614
	SPA Triage capability (new)	108,887
	VCSE services (new): - Care Closer 2 home - Better Health Better Wealth - Staying Out	201,810
	Mental Health – spectrum of care	112,000
	MDS funding for new schemes being developed for 2016/17 (new)	492,616
Total		5,797,000

Description	Detail	Total Spend £
Improving Pathways and Care for Dementia	Livewell Dementia Hub	85,000
	Mental Health and Dementia Services	1,481,000
	Dementia projects delivered by the VCSE to support BCF	107,000
	Enhanced ICLS service co-located with MDS and supporting GP practice	162,143
	Dementia funding for new schemes being developed for 2016/17 (new)	556,857
Total		2,392,000

Description	Detail	Total Spend £
Enabling – Digital Care	Digital Care pilot projects	70,000
	Digital Care funding for new schemes being developed for 2016/17 (new)	680,000
Total		750,000

Description	Detail	Total Spend £
ICT and Data Sharing	MIG Implementation (new)	30,600
	Further ICT development for Integrated Digital Care Records (new)	69,400
Total		100,000

Description	Detail	Total Spend £
Care Act Funding	Care Act	691,000
Protecting Social Care (in addition to services which are now part of the MDS)	Additional Capacity to implement major changes	354,000
	Carers Services	464,000
	Support for timely discharge from hospital	738,000
	LD and complex care	1,802,000
Total		4,049,000

Description	Detail	Total Spend £
Public Health	Warm Homes Healthy People	100,000
	Falls prevention and education services co-located with the MDS	100,000
Total		200,000

6.2 Disabled Facilities Grant

The Council's allocation of DFG funding has consistently been 'topped up' year on year by the Council to ensure that we address the needs of the most vulnerable within our local community (for example an additional £288k contribution was made by the Council for the 2015/16 financial year to ensure an initial total budget of £1m.) In addition to Council resources, the Council has historically been successful in securing additional resources from external partners and this has included a £200k allocation for both 2014/15 and 2015/16 by the CCG, resulting in a final 2015/16 DFG budget of £1.2m. Which is vital if we are to address the needs of an ageing population.

The budget management and delivery of DFG lies with the Council's Housing Team, whilst the assessment of need (and identification of appropriate adaptations to address) lies with Occupational Health colleagues (part of the Adults and Public Health Directorate). Both teams work collaboratively to ensure a seamless service delivery, in addition they met quarterly to review best use of resources / discuss potential improvements to service delivery etc. More recently these meetings have been expanded to include colleagues within the Better Care Team.

In terms of addressing housing and needs identified with the Better Care Fund plan, whilst maintaining our statutory requirements in relation to DFG's (specifically supporting independent living) we also operate a fast tract 'DFG' process and an equipment loan scheme (for ramps and stair lifts). Both of these schemes are aimed at ensuring we are able to respond quickly and effectively in instances where the applicant has a life limiting illness and/or an adaptation would support hospital discharge.

We continuingly seek to ensure that our service delivery remains fit for purpose and delivers value for money. In terms of addressing emerging needs we are seeing an increasing number of applicants who are unable (or struggle to meet their financial contribution) on this basis we are currently exploring the use of an loan scheme to support such applicants. In terms of value for money we ensure effective procurement (often cross LA and/or with Registered Housing providers) to ensure that the resources we have available are maximised and waiting times are kept to a minimum.

7. PERFORMANCE METRICS

7.1 Non-elective Admissions

The Better Care Fund Schemes are one of the initiatives that will support the reduction in all non-elective (NEL) admissions. The reduction of NEL has been included in the CCG's operational plans for 16/17; within these plans an activity reduction has been allocated to BCF Schemes (this reduction equates to 255 less non-elective admissions during 2016/17).

7.2 Admissions to Residential and Nursing Care Homes

There continues to be rigorous scrutiny and challenge of all proposed admissions to 24 hour care, via the Mental Health and Learning Disability and Older People's Resource Panels, to ensure all appropriate options for community based care and support have been explored and considered.

7.3 Effectiveness of Reablement

It is forecast that 138 clients will have been discharged from hospital into rehabilitation and reablement services in Q3 2015-16 and it is expected that 123 (89.1%) will have remained at home 91 days after discharge. We also use a local performance indicator based on the proportion of clients who have no ongoing care needs following completion of their social care support. Of the 594 clients provided with support at the end of December 2015, 423 (71.0%) had no ongoing care needs. A higher proportion of clients with no ongoing care needs is an indicator of the success of rehabilitation services in reducing the need for longer term care and support.

7.4 Delayed Transfers of Care

A delayed transfer of care trends analysis undertaken across the North East suggests that Hartlepool and Stockton on Tees currently have the lowest reported DToC bed days across the region; however, local partners have agreed a 50% reduction in bed days for 16/17 with an overall ambition to reduce by a further 50% in reported DToC days in 17/18.

APPENDIX 1 – HIGH LEVEL ACTION PLAN

Multi-Disciplinary Service

Milestone	Owner	Timescales
Business Case for Training in Care Homes to Pooled Budget Partnership Board	CCG	April 2016
Intensive Community Liaison Service – enhanced service co-located with MDS	Dementia Strand Manager	April 2016
Launch MDS service	MDS Manager	April 2016
New early intervention Falls Service up and running	MDS Manager	May 2016
Single Point of Access (SPA) triage capability in place	NTHFT / CCG	May 2016
Business Case for MDS – move into mainstream services	BCF Programme Manager	June 2016
Continue to develop Health pathways into the MDS	MDS Manager	Sept 2016
Commission three VCSE social prescribing services	H&WBB Adults Commissioning Group	Sept 2016
7 day working – continue to develop individual service business cases	BCF Implementation group	Ongoing
Develop business case for joint health and social care Single Point of Access	Transformation Managers	Sept 2016
Implement new joint health and social care SPA (depending upon outcome of business case)	Transformation Managers	April 2017

Long Term Care – Care Co-ordination

Milestone	Owner	Timescales
Event to scope what we mean by Long Term Care - Care Co-ordination – opportunities to developed further joint health and social care working	BCF Programme manager	July 2016
Proposal to Pooled Budget Partnership Board	BCF Programme Manager	Aug 2016
Develop pilot around a couple of GP practices	Transformation managers	Dec 2016
Evaluate pilot and extend, subject to business case	Transformation managers	June 2017

Improving Pathways and Care for Dementia

Milestone	Owner	Timescales
Consultation with Carers regarding gaps in services	Communications Group	June 2016
Business case for support to the Livewell Dementia Hub	Dementia Strand Manager	June 2016
Outcomes of four pilot projects – report to Pooled Budget Partnership Board: - Increase awareness - Dementia volunteers - Information and early support - Live well with dementia and support for carers - Workforce development	Dementia Strand Manager	Dec 2016
Continue to develop services where gaps are identified – proposals to Pooled Budget Partnership Board	MDS Manager	Ongoing

Digital Health

Milestone	Owner	Timescales
Develop business case for Telecare for over 75's	Transformation manager	June 2016
Evaluation of pilot schemes - Falls management in Care Homes - Preventative dementia care	Digital Health strand lead	Dec 2016
Develop further initiatives as gaps and opportunities are identified	Digital Health strand lead	Ongoing

ICT Integration Strand

Milestone	Owner	Timescales
Implementation of the Medical Interoperability Gateway	ICT Strand Lead	June 2016
Business case for wider integration	ICT Strand Lead	August 2016
Procurement of solution	ICT Strand Lead	Dec 2016
Implementation – phased – phase 1	ICT Strand Lead	April 2017
Implementation – phase 2	ICT Strand Lead	Dec 2017
IG issues and data quality	IG Manager	Ongoing

Delayed Transfers of Care

Milestone	Owner	Timescales
Establish Strategic DToC Steering Group including; • TOR, • Governance arrangements • Assurance and monitoring responsibilities	Clinical Lead/Steering Group Members	April 2016
Complete self across organisations against the NHS High Impact Changes guidance	Steering Group Members	April 2016
CCG to develop the scope of the local 16/17 CQUIN for improving patient flow and discharge.	CCG In-hospital workstream/Provider Management	April 2016
Link with relevant System Resilience Group (SRG) leads to ensure any interdependency in relation to SRG schemes align with the DToC programme of work	Identified BCF Project Leads	April 2016
Complete mapping of services/pathways across organisations	Identified BCF Project Leads	May 2016
Review self-assessments and local mapping of services/pathways against best practice.	Identified BCF Project Leads	May 2016
Undertake a 3P event to support a joined up health and care DToC pathway across the local geography to support patient flow, DToC performance including admissions avoidance. Outcome of event: One DToC Pathway and action plan agreed.	CCG/ Identified BCF Project Leads	June/July 2016
Paper presented to the North of Tees Partnership Board outlining DToC pathway and implementation plan for agreement.	Steering Group Clinical Lead	July 2016

Communications and Engagement

Attached is the current communications action plan.

BCF Event Planner v0.4 160317.docx