Integration and Better Care Fund

Narrative Plan Template 2017/19

Better Care Support Team

Area	Stockton-on-Tees
Constituent Health and Wellbeing Boards	Stockton-on-Tees
Constituent CCGs	Hartlepool and Stockton-on-Tees CCG

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1. Introduction/Foreword

Building on the successes of 2016/17 and previous years, the BCF Plan for 2017-2019 will support further integration and partnership working that delivers improved outcomes for older people.

- New Models of Care
- Integrated Hospital Discharges
- Community Integrated Intermediate Care
- Integrated Single Point of Access
- Care Home Support
- Dementia support
- Digital Technology
- Use of iBCF Grant

Agreed outcomes of the Better Care Fund Plan 2017-19

- More accessible and effective integrated care to support older people and their carers to stay healthy with long term conditions through early invention and prevention avoiding unnecessary complications and acute crisis
- Improved experience for older people who are admitted into hospital, ensuring that they do not remain in an acute hospital bed for longer than is clinically necessary
- Early diagnosis, treatment and ongoing support for people with dementia and their carers through good access to services and information, promoting independence for as long as possible
- Improved health, wellbeing and safety of people living in care homes
- Enabling people to tell their story only once through agreed joint assessment and care planning processes
- Improved partnership and collaborative working
- Reduce duplication of services with people seeing the right person, right place right time

Summary of funding contributions for the Better Care Fund Plan in 2017/18 and 2018/19

Funding	2017/18	2018/19
CCG Minimum Contribution	13,322,169	13,575,291
Local Authority Additional Contribution	200,000	200,000
Disabled Facilities Grant	1,360,283	1,473,959
iBCF Allocation	3,803,989	5,056,249
TOTAL	**18,686,441**	**20,305,499**

Further details relating to the schemes can be found in the planning template and pages 44 onwards of this plan.

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-on-Tees health and social care system; and progressing any joint commissioning implications and requirements arising from the Better Care Fund.

The membership of the Board comprises of:

- Stockton-on-Tees Borough Council (Elected Members and Officers)
- NHS Hartlepool and Stockton-on-Tees CCG
- Public Health
- Healthwatch
- NHS England
- Tees, Esk and Wear Valley NHS Foundation Trust
- North Tees and Hartlepool NHS Foundation Trust
- Hartlepool and Stockton Health - GP Federation
- Police and Crime Commissioner
- Voluntary and Community Sector representatives

2. The Local Vision and Approach for Health and Social Care Integration

There is a whole system change taking place across the health and social care economy in Stockton-on-Tees. This is clear in the overriding philosophy of Stockton-on-Tees new Adult Social Care Strategy (people and communities are at the heart of all we do and evidence based decision making, planning and action) and four of its eight objectives:

- Continue to work closely with the NHS
- Maximise use of scarce financial resources
- Ensure most effective and appropriate use of our own and our providers' workforces
- Work in partnership

The Better Care Fund (BCF) is a small but nonetheless critical part of this ambition for change. There is recognition by system leaders that a more collaborative and system wide approach is required to provide solutions to the challenges faced across current systems. Building on the foundations developed to date, the 'NHS Five Year Forward View' and the Sustainability and Transformation Plan (STP) clearly set out this vision.

There is a whole system change taking place across the health and social care economy in Stockton-on-Tees and the Better Care Fund (BCF) is a small but nonetheless critical part of this ambition for change. There is recognition by system leaders that a more collaborative and system wide approach is required to provide solutions to the challenges faced across current systems. Building on the foundations developed to date, the 'NHS Five Year Forward View' and the Sustainability and Transformation Plan (STP) clearly set out this vision.

Vision - "Meeting people's needs now and future proofing for the coming generation with consistently better integrated health and social care delivered in the best place"

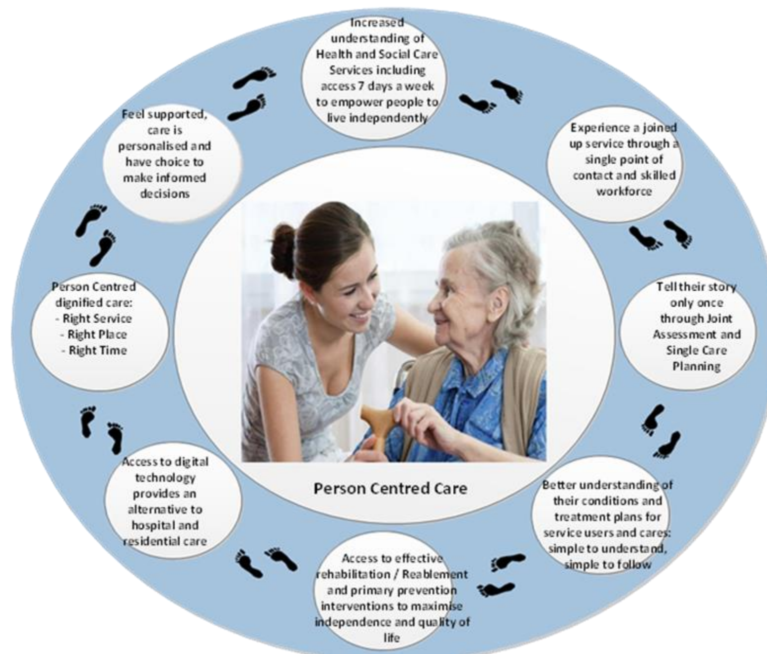
The vision is that by 2020 everyone is able to live at home longer, be healthier and get the right support where required, whether this be provided by health or social care. The focus will be on integrated health and social care, primary prevention, early diagnosis and intervention and supported self-management 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.

Residents of Stockton- on-Tees deserve the best possible 'joined up' health and social care and should get the right care, in the right place, at the right time, supporting them to have longer, healthier lives. People should be able to 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" *(National Collaboration for Integrated Care and Support, (2013), Integrated Care and Support: Our Shared Commitment, National Collaboration for Integrated Care and Support).*

This is why partners across health and care services have been working together to deliver the system vision described in the BCF plan, including a sustained focus on integration to 'create services that maximise health and wellbeing and address individual needs, improving

outcomes and experiences for individuals and communities'. The person is firmly at the centre of our plans, and pathways will continue to be designed to maintain this (Diagram 1.)

Diagram 1.



The CCGs two year operational plan articulates how it is intended to achieve transformation will be achieved at scale and pace in order to deliver the requirements of the 'Five Year Forward View' building on the progress already made during 2016/17 and focusing on the following areas:

- Further strengthening of partnership working with all providers and other CCGs across the Sustainability and Transformation Plan (STP) footprint in order to understand the shared opportunities and wider impact of respective plans;
- Continuing to build on strong history of working in partnership to drive improvements in the health and wellbeing of the local population; and
- Detailing the quarter on quarter benefits of the transformation programmes planned to deliver the expected outcomes

In June 2016 a vision of 'meeting our communities needs now and for future generations, with consistently better health and social care delivered in the best place' was set at STP level. This was supported by a clear articulation of the challenges associated with an overreliance on hospital based services. To do nothing is not an option. The plan is ambitious, and will deliver a transformed system for the local workforce and local population.

The plan intends to see everyone get healthier, but also to ensure that the health of the most vulnerable is as good as that of the most fortunate. The plans are focused on reducing unnecessary demand and reducing waste and inefficiency, whilst maintaining high quality services. These are the challenges that must be faced up to collectively by GP practices, people using services, the community, social care, providers of services and partner organisations; on the basis that good health is everyone's business. This will lead to better outcomes for people with shorter hospital stays, improved access to GPs and a financially sustainable system. The Better Care Fund is one of the ways in which the partnership

approach to dealing with these pressures is being driven forward, ensuring that the health and wellbeing of local residents is at the heart of local plans and aspirations.

Sustainability and Transformation

The Darlington, Durham Dales, Easington and Sedgefield, Hambleton, Richmondshire and Whitby, Hartlepool and Stockton-on-Tees and South Tees Sustainable Transformation Partnership's plan "Working together to improve health and care" identifies four areas for improvement and this Better Care Fund Plan for Stockton-on-Tees takes account of these and applies them for local people:

- Preventing ill health and promoting self-care: Helping to stop people from becoming poorly and helping to manage their health and any medical problems they already have.
- Health and care in communities and neighbourhoods: Supporting people to stay well and independent for as long as possible by improving health and care services within their area. Known as "New Models of Care" in Stockton-on-Tees, this approach will bring primary and intermediate care services together, in the community. This will help people access the services they need, in the area where they live, and help minimise unnecessary hospital visits.
- Quality of care in our hospitals: 'Better Health Programme' improving the quality of care in hospitals and reducing the distance people have to travel for routine appointments e.g. blood tests, but making sure that people get the best treatment and see the right specialist when they need to.
- Better Health Programme: reviewing services provided across Durham and Tees Valley – (which includes Stockton) to make sure that services are meeting the needs of the population, are of a consistently high standard and have the staffing and resources to be sustainable into the future.

Delivery models in 2017 - 2022:

- The changes to primary and community based health care in Stockton emerging from the Better Health Programme "New Models of Care" (see diagram 2). BCF is a key enabler in the "planned care" area of this model
- Supporting adult social care using iBCF, ensuring that services are well placed to meet the changing needs of the population
- Ensuring that the joint commissioning of services, initiated by the Better Care Fund, becomes the model for person-centred multi-disciplinary planning and delivery – particularly in the area of Intermediate Care

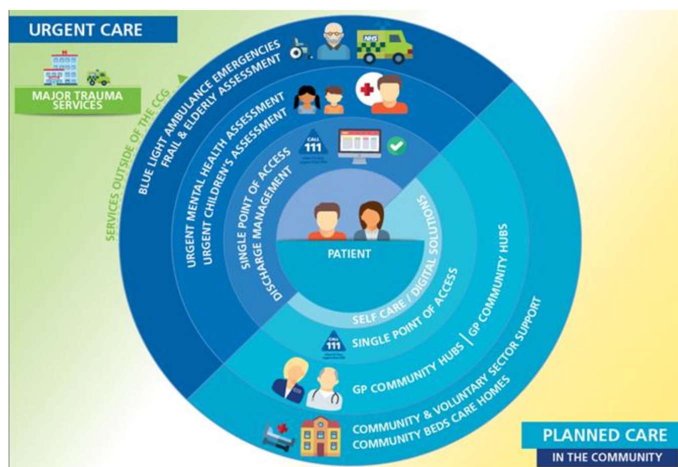
New Models of Care

In line with four of Stockton-on-Tees Borough Council's Adult Social Care Strategy objectives ('working in partnership', 'ensuring most effective and appropriate use of our own and our providers' workforces', 'maximise use of scarce financial resources' and 'continuing to work closely with the NHS'), the system change required is the creation of functionally integrated holistic teams that are linked to GP practices including community services, allied health professionals, social care, specialist nurses and the Voluntary and Community Sector.

The system change required is the creation of functionally integrated holistic teams that are linked to GP practices including community services, allied health professionals, social care, specialist nurses and the Voluntary and Community Sector. The integrated health and social care teams will be based around a 'Community Hub' population of 30-50,000 to provide joined up, accountable and personalised services. Integrated teams will pool expertise to deliver a bespoke service at the benefit of individual patients.

The diagram below demonstrates how primary care will become integrated into the identified model and services will transition to community hub settings, through physical or virtual delivery models with the overall focus of the Multi-Speciality Community Provider (MCP) model being early intervention and prevention with one focussed Single Point of Access supporting a number of hubs across Hartlepool and Stockton-on-Tees.

Diagram 2.



Local models of care

The STP outlines the intention to work with GP practices who will be brought together into groups of practices called 'community hubs' so they can share their skills to match the needs of local residents.

Community Hubs - GP practices will be brought together into groups of practices called 'community hubs' so they can share their skills to match the needs of local residents. Community hubs allow people to benefit from the knowledge and expertise of local GPs within their hub, and reduce the need for unnecessary attendance at hospital.

Care Co-ordination - The public have outlined that accessing services is confusing when unwell. The single point of access for the public will allow people to attend and be seen by the most appropriate services. The centre will have an overview of all health and social care services and teams, including professional teams working in hospitals and the community. This will ensure people are seen appropriately whether that is being assessed in hospital or staying at home with effective community support.

Discharge management - People can often stay in hospital longer than is necessary. Health and social care services are working closely to improve support for people leaving hospital, so they can be discharged quickly when it is medically safe to do so.

Care planning - Care plans will be developed that can be completed with people with long term or complex health needs (or their carers). Care plans will ensure their views, priorities and preferences are recorded including how the person wishes to be cared for should their circumstances change. The care plan will be shared with, and visible to, health and social care staff that are caring for the person which will reduce the need to repeat conversations and record details with several professionals.

Community and voluntary support - Will build and encourage the development of the voluntary sector so they can support peoples' care in the community, ensuring health and social care services are used well.

The BCF plan builds on services commissioned and developed over a number of years and has interdependencies with wider plans across health and social care, including Stockton-on-Tees Health and Wellbeing Strategy, Stockton-on-Tees Adult Social Care Strategy, Local A&E Delivery Board Plans, Stockton-on-Tees Local Plan and Stockton-on-Tees Corporate Plan and the **CCG Operational Plan.**

Stockton-on-Tees Joint Health and Wellbeing

This Better Care Fund plan for 2017/19 is a key deliverable of Stockton's Joint Health and Wellbeing Strategy 2012-2018 which has been developed by Stockton-on-Tees Borough Council. This strategy is Stockton-on-Tees overarching plan to improve the health and wellbeing of children and adults in our borough and to reduce health inequalities. This document has been informed by our Joint Strategic Needs Assessment (JSNA) and in consultation with residents, strategic partners and other stakeholders we have reviewed and redrafted our plan. The purpose of this strategy is to set out how the local health and wellbeing needs, as identified through the Joint Strategic Needs Assessment (JSNA), will be addressed. By its very nature the strategy focuses on tackling health inequalities and considers the wider determinants of health such as housing, education and the environment.

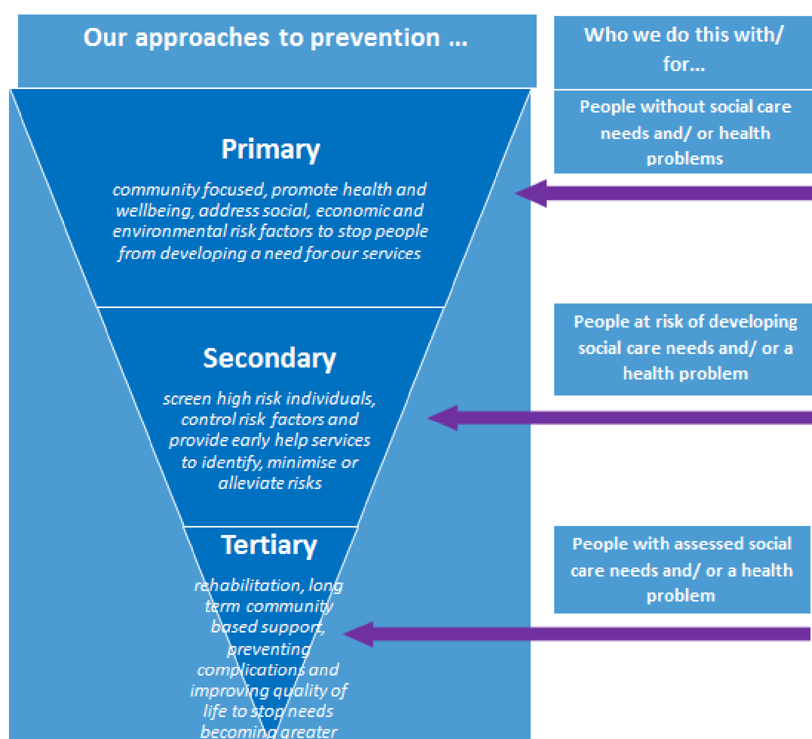
Stockton-on-Tees Borough Council's Adult Social Care Strategy has a shared, agreed vision for a sustainable health and social care economy. It acts as a single focus for improvement and change within Adult Social Care to be delivered individually and in partnership. It's overriding philosophy is to place people and communities at the heart of all we do and engage in evidence based decision making, planning and action to achieve our eight key objectives. At its heart is the vision of ensuring that people can get the right level and type of personalised support at the right time in order to help prevent, reduce or delay the need for ongoing support and maximse their independence.

To do this, Stockton-on-Tees Borough Council will aim to ensure do all they can, singularly and in partnership, to use evidence based approaches to preventing, delaying and reducing the need for reliance on adult social care as much as possible. Providing support, assessments and reviews when it is identified it is necessary.

Whilst the Strategy focuses on adults of all ages, Stockton-on-Tees Borough Council knows that to become an adult, of any age, each of our residents must first of all be a baby, a child and then a young person. With this in mind, we do not wait until a person becomes an adult to help maximise their independence. Instead, with regard to the objectives of the 'Stockton-on-Tees Health and Wellbeing Strategy' and using evidence about those who are at risk, we work in partnership with other Council teams and services and organisations outside of the Council that work with and for children, young people and adults of all ages.

The diagram below (Diagram 3) summarises Stockton-on-Tees primary, secondary and tertiary prevention based approaches to maximising independence across the Borough's adult population. This approach transfers directly to our actions on the ground.

Diagram 3.



A copy of Stockton-on-Tees Joint Strategic Needs Assessment can be found using the hyperlink.

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 strategy which support the wider objectives of the Health and Well-being Strategy. The following documents/strategies have key links with the BCF with the BCF Plan 2017-19

Joint Health and Well-being Strategy

The Joint Health and Wellbeing Strategy for Stockton-on-Tees sets out our commitment and approach to promoting health and wellbeing and tackling health inequalities in the borough. Within that, there is a recognition that the wider determinants of health such as employment, housing, education and the environment need to be considered.

Through the implementation of this strategy, Stockton-on-Tees will seek to achieve real and measurable improvements in the health and wellbeing of residents.

Our aim is “to improve and protect our resident’s health and to improve the health of the poorest fastest”.

We have shaped the plan around what we know, what works and identified a number of actions that will be taken forward. We have a strong commitment from our partners to help make a difference and to prioritise our plans to meet the issues identified in this strategy.

Local Account 2014-2015

The production of a Local Account by Councils had been promoted as part of the approach to sector led improvement. It was also seen as an element of the national Adult Social Care Outcomes Framework (ASCOF) which was introduced in 2011 as part of a revised approach to monitoring the effectiveness of Council provision for adult social care.

Although the publication of a Local Account was not a statutory requirement, there had been an expectation that Councils would produce a Local Account. The large majority of Councils did so for the first time in 2011/12 and were doing so again for 2012/13.

The aim of Stockton-on-Tees Local Account is to support greater transparency and accountability by reporting to residents, in an accessible format, on how the Council had addressed priorities and improved outcomes for those in need of social care, how the Council had responded to feedback from service users/stakeholders, as well as future priorities.

Stockton Corporate Plan

The Stockton-on-Tees Corporate Plan is our strategic planning document, sitting at the top of a range of supporting strategies. It sets out what the council, working in partnership, will to do deliver better outcomes across the Borough. It informs our budget setting and financial strategies and is an essential tool for planning and delivering services. It also helps our staff understand how the work they do makes a real difference to the people of Stockton-on-Tees and shows our partners how we contribute to local priorities.

Economic Growth Plan

This Economic Growth Plan is part of a series of documents that set out Stockton-on-Tees Borough Council’s economic baseline, its long-term vision and ambitions and medium-term growth plans. The Economic Growth Plan sets out our activities for growth that will be delivered over a 3-year period Stockton-on-Tees Borough Council’s Long-term vision is ‘The businesses and people of Stockton-on-Tees are part of a thriving and productive Tees Valley economy; a City Region that is driving economic growth across northern and national economies’.

Market Position Statement

The Stockton-on-Tees Market Position Statement aims to set out our understanding of our local population, our current provision and our commissioning intentions over time. The MPS will be developed year on year to give a full picture of all care and support services available in Stockton-on-Tees rather than only focussing on services directly arranged by the Council.

Director of Public Health Report

The Stockton-on-Tees Director of Public Health Report builds on previous year reports and the theme of health inequalities underpins it. The focus of this report however is the life course, it include a key recommendation for each stage of life.

Support for Previous National Conditions

This BCF plan will continue to support previous BCF National Conditions including:

Delivery of 7 day services: a range of services are in place during weekends, bank holidays and out of hours periods to prevent unnecessary admissions including telecare, domiciliary care support focused on reablement, community equipment services that support safe and timely discharges and services that support hospital discharge through the Integrated Discharge Team and Trusted Assessor arrangements for a number of pathways including care home residents and support for people returning to their own homes.

ICT Systems and Data Sharing: Since the start of BCF, it has been recognised that sharing information between care providers to inform the best decisions at the point of care and for the patient to only have to their story once, would improve patient care and outcomes, whilst also improving patient experience. The development of a fully integrated digital care record has been identified as a key outcome to achieve through the BCF. Achievements to date include:

- Sharing GP records with Out of Hours primary care services, by integrating the Medical Interoperability Gateway (MIG) into the provider's clinical system.
- Sharing of GP information with the 15 regional Acute, Mental Health, Out of Hours and Ambulance Providers. Initially just for urgent and emergency care, then rolled out Trust wide.

All GP practices in Stockton-on-Tees, except one, have signed up to sharing their information through the Information Sharing Gateway (ISG). The ISG is a regional online portal that hosts the data sharing agreements between each of the organisations where the data flows.

It has been recognised that developing a system for sharing a fully integrated digital care record at a locality level was potentially unaffordable and patients access services across the region, meaning that it needed to be developed at a larger scale. The Great North Care Record is a project led by Connecting Health Cities, partnering with GP practices, hospitals, community, ambulance, mental health trusts and Local Authorities aiming to develop an agreed set of information from each organisation immediately available between health and care professionals using a secure, electronic system to help provide the best treatment.

The Great North Care Record, will develop and procure a system through using Application Programming Interfaces (APIs) and will also develop a consent model that lets the citizen determine preferences regarding who can view their data and also the purpose the data can be used for (direct care, commissioning of services and potentially research).

A joint approach to assessments and care planning: the care co-ordination model within primary care is based on risk stratification and frailty scores and aims to target multi professional resources at those people who would potentially benefit the most from proactive intervention that supports admission avoidance.

Progress is being made across a number of commissioned services and initiatives to promote a joint approach to care planning include a holistic health and wellbeing service that is undertaken by the Stockton-on-Tees MDS Service. This service looks at a person's entire health and social care needs, including welfare and aims to put in place a holistic care plan for up to 6 weeks to enable them to remain in their own home independently, for as long as possible. This assessment is then built upon by other community teams to ensure that people do not have to repeat their story to numerous health and social care professionals.

Proactive Intensive Community Liaison Services (PICLS) provides integrated assessment which considers the person's spiritual/religious and cultural needs, and preferences in an ethnic context to create a fully personalised assessment. Assessment also incorporates a range of methods to understand aspects of the person's mental health, psychological, physical and social needs. Develop emergency health care plans in collaboration with the person and their carers to ensure they received the appropriate level of support, and have clear contingency action plans in place. Co-producing care plans help them to manage more difficult times and unplanned changes in their circumstances including plans for end of life care. Where appropriate, a joint assessment with the most appropriate professional of the MDS will be undertaken. On completion of the assessment, the service will fully engage and involve the person in their care planning process and provides them (and their carer) with a copy of their emergency health care plan.

One of the main focuses of the Integrated Personal Commissioning (IPC) programme has been to develop a person centred care plan that looks at the individual and what is important to them. We have developed a single care plan with people and professionals called 'My Voice, My Choice' that is being embedded across the system in Primary care, Community Services, Acute setting, Adult Social Care and the Voluntary Sector in order to reduce duplication but most importantly to allow the person to only have to tell their story once. The plan is also available online for people to access in their own homes and complete themselves where they are able to.

The Integrated Discharge Team joins up assessment and care planning for people when they are ready to be discharged from hospital. Ongoing care co-ordination is provided to people who have eligible social care needs and require a longer term package of support through locality care management teams working in partnership with a number of services including community nursing Teams Around the Practice, Intensive Community Liaison Service and Community Mental Health Teams for Older People to support people with dementia in care homes and in the community.

Agreed Outcomes of the BCF Plan:

- More accessible and effective integrated care to support older people and their carers to stay healthy with long term conditions through early invention and prevention avoiding unnecessary complications and acute crisis
- Improved experience for older people who are admitted into hospital, ensuring that they do not remain in an acute hospital bed for longer than is clinically necessary
- Early diagnosis, treatment and ongoing support for people with dementia and their carers through good access to services and information promoting independence for as long as possible
- Improved health, wellbeing and safety of people living in care homes
- Enabling people to tell their story only once through agreed joint assessment and care planning processes
- Improved partnership and collaborative working
- Reduce duplication of services with people seeing the right person, right place right time

3. Background and Context

Key Issues and Challenges

The health and social care economy in Stockton-on-Tees faces a range of significant challenges:

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 a reduction in this demand by putting in place a number of strategies around early intervention and prevention and supporting people to stay independent in their own homes where appropriate, for as long as possible. It is essential that 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 require support to enable them to maintain their caring role.

Stockton-on-Tees is a Borough of wide contrasts made up of a mixture of busy town centres, urban residential areas and picturesque villages. The Borough covers approximately 20,000 Hectares (equal to 200 square kilometres or 49.4 thousand football pitches) with a population of about 194,000 people living in 84,000 dwellings. Tackling health inequalities caused due to local of income; where people live; or by any other potential disadvantage, including people with protected characteristics under the Equality Act 2010, remains a priority.

According to the Index of Multiple Deprivation (IMD 2015), the Borough is ranked 88th most deprived out of the 326 local authorities in England. But, whilst 28% of the population live within the top 20% of most deprived areas of England, 28% live in the 20% least deprived areas.

An Ageing Population
People are living longer and, whilst the increase in life expectancy is welcomed, this presents challenges for health and social care services as people living longer often have complex health conditions and require significant levels of support to remain independent. The number of older people who are living alone is also increasing and it is estimated that 12,000 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.

The Borough's population has increased by 5.6% since the 2001 Census. In future, in total, the Borough's population is projected to increase by 7% in 2030, then by a further 3% in 2039. This equates to an additional 20,000 residents in 2039 versus 2014.

The table shows that the overall proportion of residents in the Borough who are aged 65 – 90+ years remains the smallest out of all of those three age groups illustrated between 2014 and 2039. But, as a single proportion of the Borough's population, it is the only one projected to grow (from 17% in 2014 to 23% in 2030 and then to 24% in 2039) between 2014 and 2039. In contrast, the 0 – 39 years age range is predicted to shrink from 49% of the total population in 2014 to 48% in 2030 and 47% in 2039. Also in contrast, the 40 - 64 years age

range is predicted to shrink from 34% of the total population in 2014 to 29% in 2030 and to remain at 29% in 2039.

Within that overall projected increase, the following ‘age group’ specific changes are estimated, Table 1.

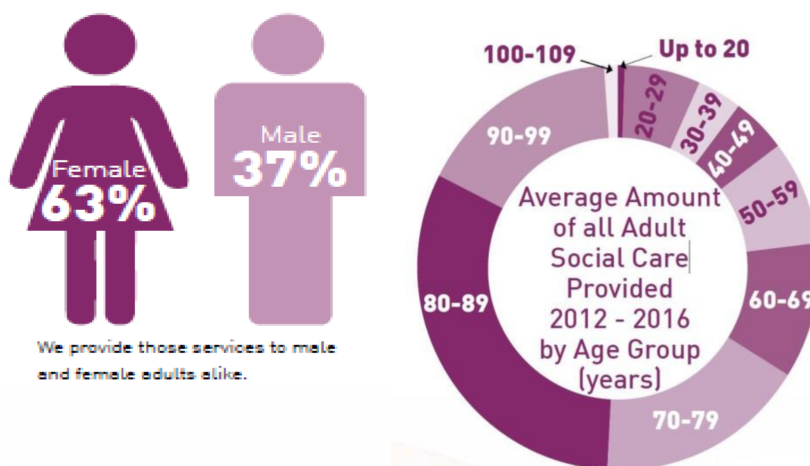
Table 1.

Age Groups (Years)	2014 (No. People)	2030 (No. People)	2039 (No. People)	Total Projected Change 2014 – 2030 (%)	Total Projected Change 2030 – 2039 (%)
0 - 39	96,000	100,000	101,000	4%	1%
40 - 64	65,000	61,000	61,000	-6%	0%
65 – 90+	33,000	47,000	52,000	42%	11%

Each year, on average, Stockton-on-Tees deliver 17,085 adult social care service provisions.
On average, we provide those services to adults aged 18 to 109. Primarily our clients are aged 80 – 89 years.

The diagram below (Diagram 4) demonstrates the average adult social care provided to specific age groups within the Borough, along with the male/female ratio split.

Diagram 4.



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. For Stockton-on-Tees this would mean that by 2021 there will be approximately 9600 over 65's with two or more LTCs.

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.

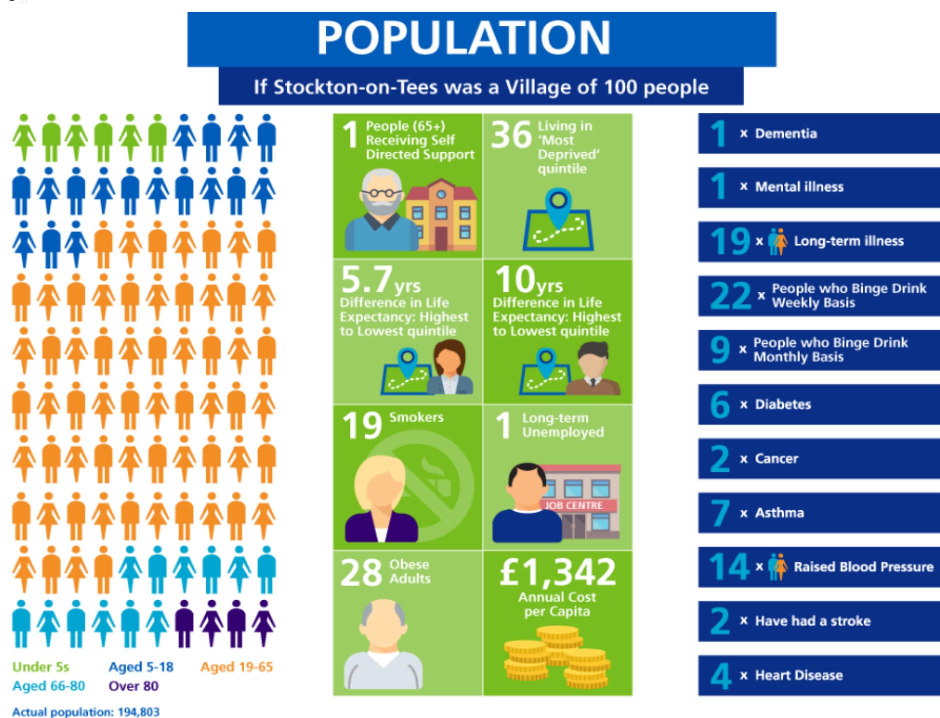
Given the ageing population and associated levels of need for health services, this growth in demand is expected to increase significantly over the next 5-10 years if services continue to support people in the current way. The demand on social care services and particularly long term care is also predicted to increase significantly over this time period.

It is anticipated that further integration of health and social care services will help to address these issues through:

- Risk stratification and targeting of resources at those people who are most at risk of poor health outcomes and most likely to require intensive health and social care services in the future
- Improved care planning, care co-ordination and care delivery
- Better use of limited resources through multidisciplinary assessment and responses.
- A shift from reactive services to a more planned approach focusing on early intervention and prevention

Diagram 5 illustrates the prevalence of long term conditions and demand for health and social care if Stockton-on-Tees was a village of 100 people.

Diagram 5.



Wider Determinants of Health:

As the Marmot Review 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 recognises these wider determinants of health and promotes earlier intervention through a more holistic approach to care planning, which incorporates low level services, early intervention and prevention, housing issues, social isolation and healthy lifestyle issues.

Workforce Challenges:

Locally the review of current systems and processes helps to take advantage of new opportunities and approaches to healthcare; however the future challenges cannot be met by one organisation and the importance of working with stakeholders and partners to deliver effective change is a priority, whilst ensuring that views and opinions from users of services are taken into account. Collaborative working is underway across the STP footprint to better understand the implications of proposed STP intentions on workforce with a particular focus on primary and community care implications and requirements.

From a health perspective, many challenges relate to the availability of clinical specialist skills and workforce to consistently ensure senior decision making clinicians are available for an extended day, seven days a week, supported by sufficient numbers of junior doctors, nurses, health scientists etc.

A high proportion of GPs are over the age of 50 which creates a risk in terms of expected retirements; the challenge is in ensuring that there are enough newly qualified GPs to replace this cohort.

Nursing and midwifery are being affected by recruitment difficulties and high vacancy rates across the nursing profession and specialist nursing roles. Factors include the impact of graduate-entry nursing on skill mix: attrition and numbers undertaking undergraduate courses.

Actions being taken include:

- Investment in the primary care workforce: this includes increasing the number of staff working in primary care in substantive posts and training schemes, through a range of recruitment, retention and education initiatives aimed at the entire primary care workforce encompassing practice nurses, pharmacists, health care assistants and practice management staff
- Investment in the band 1-4 workforce to reflect an increasingly patient facing role. This includes enhancing competencies to ensure that the workforce can deliver their current roles and also, where appropriate, additional roles traditionally undertaken by other staff.
- Introducing new roles, changing skill mix and expanding roles of staff; for example advanced practitioners and healthcare scientists undertaking roles previously assigned to medics and physician's associates, working across secondary and primary care in a variety of services.
- Ensuring that the continuing workforce development of staff is reflected in the investment by employers but also by Health Education England North East.
- Continued work with care homes, hospices and the voluntary sector to understand their education and workforce issues.
- Working collectively and individually to reduce turnover and increase retention of the workforce and seek to deliver a more efficient and effective use of bank and agency staff.

From a social care perspective, recruitment and retention of key professionals (social workers and Occupational Therapists) has not been a particular challenge locally. However, it is recognised that there is an ageing workforce in some areas and succession planning is essential in order to ensure that sufficiently qualified and experienced staff are available in the future to meet local need. Turnover of qualified staff (particularly within social work) has been a challenge in recent years as experienced social workers have moved on and been replaced by newly qualified social workers undertaking their Assessed and Supported Year in Employment (ASYE). This approach is very positive for the newly qualified professional but the protected caseload and the commitment required from assessors and mentors creates pressures within the wider workforce in the short term.

One of the most significant pressures within adult social care relates to commissioned services and specifically the recruitment and retention of staff (in particular, qualified nursing staff and experienced Registered Managers). Having competent and knowledgeable staff is an essential element of effective and safe care and support, and is a key element of the current Care Quality Commission regulations for care providers. There have been a few cases on the past 3 years where independent care home providers have taken the decision

to stop delivering nursing care and offer residential care instead due to the difficulties in recruitment and retention of nurses.

Market Challenges:
The Care Act 2014 strengthened the role of Local Authorities in market management and requires local authorities to help develop a market that delivers a wide range of sustainable high-quality care and support services for their communities.

Local authorities are also required to engage with local providers, to help each other understand what services are likely to be needed in the future, and what new types of support should be developed. Stockton-on-Tees Borough Council (the Council) continues to engage through the published Market Position statement and through existing events and forum that bring key stakeholders together.

Although the market in Stockton-on-Tees remains engaged and dynamic, we still face challenges around an increase in the number of people requiring support but also the complexity of care and support needed, maintaining the quality of the care and support offered and ensuring we continue to develop alternative solutions that allow people to be supported sooner.

We have continued to focus on these areas and will be introducing a new care at home framework in 2017/18, continue to growth in the use of assistive technology and a range of low level services that promote independence, including signposting and advice, a handyperson service, lunch clubs, carers support and support for people with dementia and their carers / families.

Continuing Healthcare is also a pressure in terms of the assessments and significant cost pressure on CCGs spending nationally:

- There has been a 16% increase in spending on CHC between 2013/14 and 2015/16
- 4% of CCG spend is accounted for by CHC
- £5,247m expected spend on CHC, NHS funded nursing care and assessment costs by 2020/21 if no action is taken (an increase from £3,60m in 2015/16)

Performance:

There are a range of areas where Stockton-on-Tees performs very well in relation to health and social care, the Regional Carer survey shows that service users and their carers report that they have been included in discussions about the care and they find it easy to find information about services. Stockton-on-Tees also performs well with a high proportion of people receiving a personal budget and also those who receive this as a direct payment.
Stockton-on-Tees also has a high proportion of people who use Reablement services who then go on to independence. However, there are also areas where there are currently some significant challenges.

Data from the NHS/Social Care Interface Dashboard is summarised in the table below.

Table 2.

Metric	Rank
Emergency Admissions (65+) per 100,000 65+ population	13 of 151
Length of stay for Emergency Admissions (65+)	120 of 151
Total Delayed Days per day per 100,000 18+ population	32 of 151
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	36 of 151
Proportion of older people (65 and over) who are discharged from hospital who receive reablement/rehabilitation services	102 of 151
Proportion of discharges (following emergency admissions) which occur at the weekend	132 of 151

Overall Stockton-on-Tees is ranked 55 of 151 local authorities based on these indicators.

Resource Challenges

The sharp and continued fall in resourcing in public services creates significant challenges which will be met by transformational approaches to preserving services.

From a social care perspective, by 2019/20 Government funding to the Local Authority will have been cut every year since 2010/11. The Medium Term Financial Plan approved by Stockton-on-Tees Borough Council in February 2017 identified that the Council faced a gross budget deficit of £18.5m in 2017/18 rising to £25.8m by 2020/21. The implementation of a range of actions reduces the savings required to £9.9m in 2017/18 rising to £19.2m by 2020/21. These remaining savings will be addressed by the Council's Big Picture savings programme and through actions to reduce social care growth.

Each year the CCGs are faced with a significant challenge in achieving financial balance. Our committed expenditure is often greater than our expected income and therefore to achieve balance we are faced with a financial efficiency target. In 2017/18 the CCG has an efficiency target of £14.8 million, this target is broken down across a number of schemes across a range of areas (Elective, Non Elective, Medicines, CHC). The BCF Plan and associated work will help to impact on a number of these schemes.

The CCGs updated forecast position shows the organisation to be on track to achieve its key financial targets and Business Rules as set by NHS England. However, if expenditure continues at the current rate (i.e. "Do Nothing") the CCG is facing a significant financial risk.

Demand for health care services increases every year in Stockton-on-Tees, there were 10,160 emergency admissions to hospital for people aged over 65 in 2016/17 an increase from 9,339 admissions in 2015/16 (9%). In addition the range of services offered has changed significantly in recent years with some services that were traditionally provided by hospitals now being delivered in the community. There is an increasing need for an integrated approach to the management of patients, particularly those with long term and complex conditions.

BCF plans are ideally placed to proactively influence pathways across health and social care boundaries in order to ensure equitable access for people and reduce variation in approaches to delivering care.

4. Progress to Date

Our BCF 2016/17 plan set out to deliver the following priorities:

- Improving discharge pathways across health and social care to reduce delayed transfers of care
- Develop a concept to deliver a model for supporting a Single Point of Access across Health and Social Care to improve the triaging process for the public and professionals to people receive the right service, right time in the right place.
- To build on the MDS model with a view to developing a commissioning model that supports further integration/collaborative working of Community Adult Health and Social Care services for early intervention and prevention in relation to intermediate care.
- Digital Integration – Medical Interoperability Gateway to be rolled out initially across Health and then be part of the regional Great North Care Record this strand is also linked to the Digital Transformation Workstream (part of the STP governance).
- Long Term Care – care co-coordination putting the person at the centre of care delivery including assistive technology
- Evaluation of existing schemes to mainstream into core services depending on outcomes.

Below outlines the progress made on these six priorities;

Delayed Transfers of Care

A number of Better Care Fund initiatives and linked developments have been implemented that aim to improve the discharge process. Fundamental to the success of this work was to develop a new integrated vision/ approach which all key partners agreed to. A set of key principles were presented at the North of Tees Partnership Board including:

- A focus on improving patient flow
- Development of an Integrated Health and Social Care Discharge Team
- Further development of Trusted Assessment
- Integrated Community Assessment
- Sharing of Risk
- Funding Implications

All partners have shown huge commitment and have made significant progress. The first priority was to develop an Integrated Discharge Team (IDT) which would be an enabler to address a number of the other key principles. Senior Social Worker input was identified as a gap and BCF funds used to address this. The IDT team now consists of representatives from:

- NTHFT Discharge Liaison Service
- NTHFT Emergency Care Therapy Team
- NTHFT Acute Therapies
- LA Assessment Reablement Teams

- Social Workers from locality teams
- CHC Nurse Assessor
- Citizens Advice Bureau/ Stockton-on-Tees Welfare Advice Network (SWAN)

Support for people returning home post discharge from hospital was also identified as an issue and therefore the CCG and LA jointly commissioned a domiciliary care provider to provide up to 14 days support to allow early/ safe discharge for the patient.

CCG involvement in NHS England's Integrated Personal Commissioning Programme (Stockton) facilitated further acceleration of this work enabling all partners to become part of a '100 Day Challenge' which was sponsored by Senior staff from the organisations but led and progressed by staff from the IDT. This empowered staff to develop and test ideas using a Plan, Do, Study, Act approach to test the 'norm' with regular feedback and review of results to form a set of longer term recommendations. Developments included:

- A Home Safe, Sooner "Working together to get you home safety" communication campaign for patients and staff which included awareness, posters, roller banners etc.
- A workforce vision and model for the IDT ensuring co-location and a joint vision
- An information sharing agreement to allow the sharing of health and social care information
- Members of IDT being Trusted Assessors
- A joint health, social care and voluntary sector 'Integrated Discharge Support Plan' and Assessment document based on the Integrated Personal Commissioning Programme 'My Voice, My Choice' plan which provides a more personalised approach focusing on what is important to the patient
- Senior Social Workers attending the IDT 'huddles' on the wards to facilitate discharge. Senior Social Workers were also available onsite and contactable via a mobile phone for all ward staff
- Various engagement and training for the workforce including vision/ model and the 'Home Safe Sooner' campaign, Personalisation, information and documentation
- A welfare advisor being part of the IDT to address welfare issues and links with the voluntary sector
- Identification of patient needs, discussions with patients and feedback sought
- Creation of an IDT hub to display PDSA tests, ideas, thoughts etc and to allow staff to drop-in on stated times to discuss suggestions/ issues
- Drop-in sessions in ward areas for patient and families to discuss early discharge planning
- Work on supporting restarts of care packages and returns to care homes for assessment
- Structured interviews with health and social care staff

All partners have been extremely positive in relation to this integrated and innovative approach to discharge in particular in relation to empowering the staff to develop solutions to issues they are familiar with whilst seeking senior and commissioning support/ input when required. The work was presented recently to senior CCG/ LA staff including NHS England with excellent feedback and agreements made around the next steps. NHS England are

keen to promote this integrated model/ approach to discharge to other areas/ organisations as an example of best practice.

As well as excellent patient/ staff feedback recent results indicate that the number of delayed days has reduced by 35% between Q3 (2016/17) to Q4 (2016/17).

The team recently won an award for Best Innovation Project at the North East, Cumbria, Yorkshire and Humber Commissioning Awards and partners are committed to continuing to build upon the principles, learn from the work to date and develop integrated approaches to further impact on delays and improve the patient experience.

Single Point of Access - Clinical Triage

NTHFT are currently commissioned to provide a Single Point of Access service for NHS Community Services, which has been enhanced through BCF to add clinical triage to improve responses. Prior to the implementation of the Clinical Nurse Triage all calls were managed by the SPA administration operators without clinical input based within the service to assist in the triage of planned and unplanned complex calls.

The introduction of the enhancement to the service was to prevent both patients and referrers from being passed around the system unnecessarily and to ensure individuals were signposted to the right service at the earliest opportunity.

The aim of the service is to improve care of patients and their relatives and support people in their own home. If a person or their relative has any concerns or questions about their condition they can call the service at any time of the day or night. The service model introduced ensures that the telephone service will be covered by experienced nurses who can give advice, arrange visits, organise admission to hospital and provide information about other services available. It also provides the opportunity for referring professionals to speak directly to a nurse, which potentially reduces any delays with communication and the referral process, ensuring the right care for urgent and non-urgent referrals, helping to prevent avoidable hospital admissions and effectively manage long-term conditions in the community.

Further developments of the SPA to create an Integrated SPA across health and social care are planned in 2018/19.

Multi-Disciplinary Service - Early Intervention and Prevention

We established a Multi-Disciplinary Service (MDS) which went live on 4th October 2015. Included within 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 who are employed between Stockton-on-Tees Borough Council and North Tees and Hartlepool Foundation Trust. 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 and the Stockton-on-Tees Falls Service, ensuring that there are links to housing needs.

They deliver a free of charge service for up to six weeks, based on a 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-on-Tees Welfare Advice Network.

We have been very pragmatic about how we established the MDS. We agreed jointly, post September 2016 between North Tees and Hartlepool Foundation Trust and Stockton-on-Tees Borough Council to second our staff into the new 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. A business case was approved for the service to be mainstreamed in September 2016.

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.

Housing Occupational Therapy

The Housing Occupational Therapy Service based within the MDS is specialist service focussed on the housing need of people and families where there is a changing health or medical condition of a household member that mean their housing is no longer appropriate.

The main aims of the service are:

- To ensure people are rehoused into suitable accommodation as quickly as possible.
- Ensuring that the right people are prioritised appropriately for scarce social housing.
- Providing minor aids and adaptations to houses in the short term to keep people
-

  safe whilst waiting to be rehoused.

The Housing Occupational Therapy Service was originally established in February 2013 and has been funded by the Better Care Fund since April 2015. It became part of the Multi-Disciplinary Service in February 2016 and now undertakes full well-being assessments and complements the work of the Well-being Team. A Business Case was approved to mainstream this service in October 2016.

The main purpose of the Housing Occupational Therapy Service is to ensure that people with a changing medical condition are prioritised for the most appropriate social housing and

in the short to medium term are able to stay in their own homes with suitable aids and adaptations.

Prior to this service if a member of a household had a changing medical condition that affected their suitability to remain in their homes they needed a GP letter which would then be sent to the Housing Authority (the local authority) so that they could be put on the housing allocations priority register for appropriate social housing.

Stockton-on-Tees Falls Prevention Service
The Falls Prevention Service is to provide falls prevention information, advice and support to individuals aged 65 and over, who are identified at risk of falling or have been referred into the service under the service criteria. This service currently also sits within the MDS Service. The service will also provide information and advice to organisations that refer into the service.

The service currently offers:

- An integrated falls pathway that favours a multi-disciplinary / multi-agency approach to falls prevention for stakeholders;
- Improved partnership working by involving others in the delivery of the falls prevention agenda - e.g. Voluntary groups etc.
- Falls prevention awareness training to relevant stakeholders and referring agencies.
- Falls assessment training to appropriate frontline professionals /care homes.
- Improved identification of vulnerable people at risk of falling;
- General advice and support to staff in order to reduce the risk of falls within their caseload.
- Triage referrals that come into the service for appropriateness as per the admission criteria;
- Multifactorial risk assessments
- Provision of multifactorial interventions which may include the requirement for onward referrals to services following risk assessment
- Monitor referrals and target any increase in referral activity from individual referrers and provide further targeted information/advice/education.
- Service user's care pathway from receipt of the referral to discharge.

Digital Integration

There are two elements to the Digital Integration strand:

- The use of Digital Technology (Digital Health) to help people stay in their own homes / prevent admissions to hospital
- Integration of systems using API's and the sharing of information to ensure effective decision-making across health and social care

Digital Health
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.

We have supported two projects as set out in table below:

Project	Objective	Aim
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 (207 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-on-Tees 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. Current performance management information shows that participants maintained the stability of care home placements for longer than would have been possible without the support from assistive technology and reduced the volume of A&E call outs for “high risk” residents in care homes, with only 34 admissions being made in 6 months for 207 residents who had over 500 recorded falls alerts over the same period.
2	Preventative Dementia Care	This project has been based on national good practice and is aimed to identify up to 50 people with a diagnosis of dementia and 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, offering telecare to support and targeting and management of risks in the home , and to build on the findings of the Smarter Homes for the future project. Recent performance management information shows that Participants maintained the measurable quality of life for service users participating and prevented up to 28 Ambulatory attendances for the 24 participating service users.

Smarter Homes for the Future 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.

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.

Long Term Care

Stockton-on-Tees Information Directory

We developed a Stockton-on-Tees 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.

In 2016/17 we have significantly strengthened our directory and added an online Care and Support Plan which people can develop themselves or with support from anyone in the Care and Support system (Health / Social Care / VCSE). The plan is called 'My Voice My Choice' and is a standard planning tool used by everyone.

We have also successfully secured funding through the Local Government Improvement Programme to create the ability for this plan to be integrated with other Health and Social Care systems subject to explicit consent from the person themselves.

The Stockton-on-Tees Information Directory continues to evolve to include advice and support for residents of the Borough.

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.

Care Homes Education and Training Alliance

In recognition of current market conditions and challenges within the care home sector, the CCG and Local Authority actively engaged with providers to understand their perspective and to identify opportunities where support can be provided to the market. One of the outcomes has been the development of a bespoke North Tees Education and Training Alliance programme available to all homes across Hartlepool and Stockton-on-Tees led by NTHFT in collaboration with partners. The North Tees Health & Education Alliance (NTHEA) was developed specifically to deliver this piece of work.

Commissioned through the Better Care Fund this unique collaboration between NTHFT, TEWV FT, Stockton-on-Tees and Hartlepool Borough Councils and Alice House Hospice delivers training and support to care home staff on maintaining the health and wellbeing of residents, end of life care, dementia, delirium and falls awareness.

The training programme for the 4 specific areas commenced in February 2017 and at mid-August (half way through the programme) 780 members of staff had attended training sessions and 64% of the care homes in Hartlepool and Stockton-on-Tees had confirmed or booked training.

The NTHEA is also already proving to be an effective communication tool between various services and the care homes for new policies and guidance relevant to the training being delivered.

National Early Warning Score (NEWS)

Care homes have also been offered the opportunity to implement a new digital technology solution to collect National Early Warning Scores (NEWS) and to support decision making. Following the success of another local CCG in commissioning NEWS, BCF funding has been used to fund the introduction of 38 devices across care homes in Hartlepool and Stockton-on-Tees. Two homes have been identified to trial this approach and have been using the equipment to monitor residents when deterioration is identified and to request the appropriate clinical response.

In addition awareness sessions are being provided for Community Matrons, Rapid Response Nurses, and Clinical Triage Nurses based in the Single Point of Access who will be able to access readings for residents known to them and use NEWS as part of their assessments. On-going sessions will be arranged to raise awareness for District Nursing teams in view of rolling out the technology and NEWS into residential homes where the community nurses have many patients.

Improving Pathways of Care for Dementia

The Livewell Dementia Hub (the Hub) opened in May 2015 and provides a one-stop-shop for dementia in Stockton-on-Tees. By bringing together a wide range of local organisations, the Hub provides a single first point of contact for information about dementia and support that is available locally. This streamlines the referral process and ensures the service users are receiving the right information at the right time. It also provides a free venue for a number of organisations to provide support services and groups. There were 371 information requests from people with dementia (PWD), carers and professionals in 2016/17. The Hub also organises monthly dementia friends sessions to increase people's awareness of dementia as well as other ad hoc relevant training sessions.

The Hub has developed an interactive dementia service map to illustrate local support services for PWD throughout their journey. It helps the service users navigate the care system. The map can be accessed via the Stockton-on-Tees Information Directory and the hard copies are available to service users, GP practices, hospitals and community services. The map will be updated every 6 months. It has been shared by the North East Clinical Network and the Academic Health Science Network. Other areas have adopted the

template. The North East Dementia Alliance is looking into using the template to develop a regional dementia service map.

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 PWD 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.

There is also a plan to look at outreaching to other community groups and settings to improve the accessibility.

Additionally, a number of pilots were commissioned in 16/17:

<u>Project 1 - Increase awareness</u>
A leaflet to promote the benefit of early diagnosis and intervention has been circulated in secondary and primary care. It has been shared by the North East Clinical Network. Information on the Hub has been sent to all people on the GP dementia registers in Stockton-on-Tees.

<u>Project 2 - Dementia volunteers</u>
This project encouraged PWD and their carers to become 'expert dementia champions' to promote awareness and reduce stigma of dementia. It also encouraged them to take part in local voluntary services to improve their community involvement and promote a positive image of dementia. The project completed in December 2016 and 7 volunteers remain active. They attended 12 events to promote their experience using a standard presentation that they developed.

<u>Project 3 - Information and early support</u>
Continued funding of the Dementia Advisor Service for another 12 months proved to be value for money. The service helps people with diagnosed and undiagnosed dementia and their carers, families and significant others by providing them with specialist information and advice, identifying their support network and coping strategies and signposting them to appropriate services. It also works towards increasing awareness of dementia, reducing stigma and encourage people to seek professional help through dementia friend sessions, information sessions and promotional events. The service exceeded majority of the KPIs set out.

- There were 281 referrals.
- 14 dementia friends sessions delivered with 127 people attended
- 201 information sessions and drop-ins with 574 people received information.
- The service received 79% service users' satisfactory rate.

Further funding for the service has been secured from March 2017 to 2019 with additional KPIs on response rate and support people to complete the 'My Future Wellbeing Tool' as part of the advance care planning.

Project 4 - Live well with dementia and support for carers

The 12 month pilot formed part of the post diagnosis support through provision of 22 weeks of activity-based Maintenance Cognitive Stimulation Therapy for PWD in a group setting in 3 localities and one-to-one in service users' own homes to improve their independence and psychosocial wellbeing. The programme allowed carers to receive advice, develop peer support or have a choice of taking a break in order to improve their resilience.

In 2016, there were:

- 141 PWD referred onto the programme with 111 completed the full programme.
- Overall 98% of them showed an improvement in their Dementia Quality of Life Score.
- 90% have moved onto other support groups.
- 57 carers were supported and over 1,600 respite hours provided for them, making a potential saving of more than £21,000 on sitting service.
- There was 100% carers' satisfactory rate received.
- A long term self-sustained peer support group for PWD and carers has been developed with support from the Hub and Young at Heart ULO.

Further funding to extend the project for another 12 months was secured in December 2016 to collect more robust data.

From January to May 2017, there have been:

- 75 PWD referred onto the programme with 3 completed the full programme.
- 21 carers have been supported and 526 respite hours provided for them, making a potential saving of £7,364 on sitting service.
- There was 100% carers' satisfactory rate received.
- 2 more long term peer support groups have been developed with support from the Hub and the AgeUK Teesside.

A business to continue the service is being developed. There are plans to explore a specific programme for people with moderate to late stage dementia and to work with the Hub to improve education for carers.

Project 5 - Workforce development

There were 20 sessions of Tier 1 and Tier 2 dementia awareness training were delivered to home care providers and health and social care professionals. Over 170 professionals attended and 100% of them showed an increase in their confidence and knowledge. In 17/18, there is a plan to link with Tees Care Alliance and Tyne and Wear Care Alliance to bring training courses including dementia awareness, positive approach to care and end of life funded by the Health Education England to up-skill the workforce in Stockton-on-Tees.

Project 6 – Halcyon Day Centre support worker

As part of the preventative care strategy in the Halcyon Day Centre, a dementia specialist support worker has been funded by the Strand. Approximately 30 clients attending the day centre each week have a formal diagnosis of dementia with a significant number (approximately 70) of the remainder of clients having symptoms of cognitive impairment and behaviour that challenges. Of the 30 clients with a formal diagnosis of dementia, 22 of those clients attend the centre 3 - 5 days per week. The remainder attend 1 – 2 days per week. Between 5- 10 clients with dementia and cognitive impairment (including behaviour that challenges) are supported within the specialist Kitwood Unit within the Halcyon Day Centre.

The Kitwood Unit provides specialised support from a small group of care assistants who are able to assist clients who benefit from a quieter environment and focused attention. A pathway has been developed with the Hub and the Dementia Advisor Service for clients with undiagnosed dementia to ensure the clients and their families receive sufficient information and support. 14 care staff have been trained to carry out the Abbreviated Mental Test (AMT) in September 2016. So far 25 clients have been screened for underlying memory problems during their reviews and referred to the Hub for further information and advice.

The support officer for the dementia diagnosis project can support clients to attend the memory clinic operated at the Hub next door to the Halcyon Centre if necessary. This approach is making an impact on the overall diagnosis rate.

Project 7 – Young at Heart peer support group

The 12 months pilot aims to support and facilitate PWD and their carers to develop user-led, self-sustained weekly peer support group in Billingham. Attending regularly peer support group would reduce isolation and increase their resilience. So far, 3 PWD and 6 carers attend the group weekly.

Project 8 – Touch Screen Technology in care home

A pilot to encourage care home residents to engage in various activities using tablets in 2 care homes for 3 months was completed with positive outcomes. The pilot aimed to provide tablets for care homes and train care staff to use the tablets with their residents to improve their quality of life by engaging in various activities such as reminiscence, games, entertainment and music. The pilot showed an improvement in cognitive functioning, physical functioning, social interaction and positive wellbeing; and a reduction in negative wellbeing in over 90% of the residents who took part. It also demonstrated 77% reduction in falls in 4 residents who had high level of behaviours that challenge. Staff saw a positive change in the residents' wellbeing during and after the use of the tablets and improved the communication with them. Funding to roll out the scheme to further 6 care homes has been secured and due to start in July 2017.

Proactive Community Liaison Service (PICLS)

Up to 70% of hospital beds are occupied by older people and half of them may have dementia and/or delirium. People with dementia are likely to have longer hospital stay due to their complex comorbidity and social difficulties. We have therefore, commissioned a Proactive ICLS to 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. It offers early integrated assessment and intervention through working

closely with primary care and community services to identify people with moderate to severe dementia via the GP dementia registers.

The PICLS aims to offer a proactive and integrated model of care to people who have diagnosis of dementia to support them at home for as long as possible and reduce their need for permanent care home or risk of admission to hospital. The service also provides education and support to care homes and community staff to raise awareness of dementia and delirium. Outcomes from the 3 quarters demonstrate that the service is making an impact on the reduction in unelected hospital admission. The Emergency Health Care Plans (EHCPs) created have helped PWD and their carers to manage their conditions and care home staff to use proactive thinking on specific management and strategies to prevent hospital admission.

- Since the service was commissioned, there were 300 referrals received with 19 declined the service.
- 100% (281/281) of patients seen within 4 weeks.
- 74% (209/281) of patients assessed within 5 days. The remaining 26% was seen outside the timescale at the service users' request.
- A total of 230 (81%) EHCPs have been created. The remaining 19% has already had one in place.
- There were 161 End of Life (EOL) conversations with family and carers. The others were deemed to either already have a good understanding, already have a good plan in place; the conversation was not appropriate at the time or the family declined.
- 184 patients received psycho-education.
- 100% of people who completed the Friends and Family Test reported that they would recommend the service to a friend or family remember.
- 11 sessions of delirium awareness training delivered with a total of 78 attendees.
- There have been over 12,000 views on the delirium awareness video on YouTube.
- The delirium awareness work won the Northern Lights Dementia Quality Improvement Awards in March 2017.
- On line delirium resource is fully live and has been accessed regularly via the Stockton-on-Tees Information Directory.

Delirium causes significant mortality and morbidity but it is preventable. Large proportion of acute hospital admissions come from care homes for patients with infection and delirium. Joint funding with Hartlepool Borough Council, Tees, Esk and Wear Valleys and Health Education England East was secured for the production of a delirium awareness video and promotion materials. Comprehensive electronic delirium awareness resources are available in the Stockton-on-Tees Information Directory.

The Proactive ICLS has developed a delirium training programme for clients, carers, GPs, care homes and health and social care professionals to increase awareness, early detection and management of delirium. The Proactive ICLS also delivered dementia and delirium training as part of the CCG Care Home Training Programme.

Integrated Personal Commissioning

IPC was launched in April 2015 as a partnership between NHSE and the Local Government Association and is a new approach to joining up health, social care, the Voluntary, Community and Social Enterprise (VCSE) sector and other services at the level of the patient. The vision is to enable patients, their carers and families to control the resources available to them across the whole system in order to develop their own personalised care and support plan and personal budget. This approach supports patients to develop their knowledge, skills and confidence to self-manage their own health. Stockton-on-Tees is a demonstrator site within this programme and a partnership approach between Hartlepool and Stockton-on-Tees CCG, Stockton-on-Tees Borough Council, Catalyst and North Tees and Hartlepool Foundation Trust has been created to develop and implement IPC in Stockton-on-Tees. Each demonstrator site focused on significant cohorts of people to develop IPC, in Stockton-on-Tees the cohort of people over the age of 65 with Long Term Conditions was chosen with an initial focus on people with respiratory conditions. In Stockton-on-Tees we have aligned both IPC and the BCF together in order to improve the care and support available for people over the age of 65.

Over the past two years work has been undertaken with partners across the system and people with lived experience to develop and deliver IPC in Stockton-on-Tees and there has been significant progress made that has been recognised both locally and nationally. Due to the progress and maturity of the IPC programme in Stockton-on-Tees NHS England commissioned the Nesta People Powered Results Team to work alongside the programme to develop the model, test it out and start to 'scale up' the programme across the system. This process has developed the programme further into looking at new cohorts of people that would benefit from this approach including frailty to supporting their health and social care needs.

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-on-Tees Service Navigation Project

In 2016/17 this also included:

- 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.

VCSE Services and Social Prescribing

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.

Following a formal review of three social prescribing services, the Pooled Budget Partnership Board has agreed funding to secure these services until the end of March 2018. These services all have objectives which support the outcomes of the Better Care Fund:

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-on-Tees 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.

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 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.

Performance against National BCF Metrics in 2016/17

Performance in relation to the BCF national metrics in 2016/17 is outlined below:

Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing homes, per 100,000 population - ASCOF measure 2A(2)		**Published Data**	**Published Numerator**	**Local Data**	***BCF Plans***		**Variance from Plan**	
		2014/15	**2015/16**	**2016/17 PROVISIONAL ONLY**	***2015/16***	***2016/17***	**2015/16**	**2016/17**
Stockton-on-Tees LA	**Rate**	**1090.5**	**698.6**	**860.6**	***840.1***	***837.5***	-141.5	+23.1
	Numerator	362	237	298	*285*	*290*	-48	+8
	Denominator	33195	33925	34625	*33925*	*34625*	-	-

The 2016/17 outturn of 860.6 admissions per 100,000 populations is 8 admissions above target and whilst disappointing reflects an increase in demand that is robustly monitored and challenged through the admissions panel.

Although the target for 2016/17 was 298 admissions when the target was 290, this reflects the increase in demand for residential/nursing care due to increasing numbers and the complexity of people, but also identifying that the target for the year had not been achieved.

This was a very challenging target for us to achieve, maybe unrealistic as in 2016/17 we had numerous people admitted to residential care who could not be kept safe within the community setting as they were subject to DoL's and the had risks that exceeded that of community care. We also had a period of time during 2016/17 whereby our extra care services were full to capacity and this resulted in people being admitted on a short term basis into residential care.

Proportion of older people still at home 91 days after discharge from hospital into reablement/ rehabilitation services:

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (effectiveness of the service) - ASCOF measure 2B(1)		Published ASCOF 2B(1) Data		Local Data	*BCF Plans*		Variance from Plan	
		2014/15 (Q4 / Q3)	2015/16 (Q4 / Q3)	Q3 2016/17 (Q4 / Q3) PROVISIONAL ONLY	*2015/16*	*2016/17*	2015/16	2016/17
Stockton-on-Tees LA	%	**89.9**	**88.9**	**71.6**	***86.4***	***89.1***	+2.5	-17.5
	Numerator	60	120	58	*121*	*123*	-1	-65
	Denominator	70	135	81	*140*	*138*	-	-

The 2016/17 target of 89.1% of older people at home 91 days after discharge from hospital was not met as the actual was 71.6%.

This challenging target continues to be closely monitored internally to understand the reasons behind not achieving the annual target.

Operationally the drop in outturn has been attributed to a number of factors including;

- Change in the client make up of those discharged into reablement having more complex needs than in previous years with the more 'able' clients being diverted from hospital.
- There are now less people referred for therapy exercise only, following changes to health service criteria.
- Inappropriate discharges from hospital.

Non-Elective Admissions:

Stockton-on-Tees LA (based on patient Local Authority of Residence)				
Number of Non-Elective Admissions (General and Acute) - by Age Group (SUSNECS data)	2015/16 YTD	2016/17 YTD	Variance	% Variance
Age Group				
0-19	4988	4899	-89	-1.8%
20-64	10337	11284	+947	+9.2%
65 & over	9339	10160	+821	+8.8%
Total (all ages)	**24664**	**26343**	**+1679**	**+6.8%**

There was an overall increase of 6.8% in NEL admissions in 2016/17 compared to the previous year, with a 17.2% increase in ambulatory care admissions. BCF is performance managed based on all NEL admissions regardless of age, although the BCF plan and initiatives are focused on the over 65s. The increase in non-electives has been across all age bands with the exception of the 0-19s. The Q4 position also showed a reduction in non-elective activity for the over 65s compared to Q2 and Q3 (16/17) indicating that the BCF schemes are having an impact.

Non-elective admissions from care homes are also decreasing reflecting the impact of services/ schemes such as aligning community matrons to care homes and the care home training and education programme.

Delayed Transfers of Care (DToCs) – Stockton-on-Tees

	2016/17			
Delayed transfers of care from hospital per 100,000 population (18+)	**Q1 2016/17 (Apr16-Jun16)**	**Q2 2016/17 (Jul16-Sep16)**	**Q3 2016/17 (Oct16-Dec16)**	**Q4 2016/17 (Jan17-Mar17)**
Quarterly Rate (Actual)	**400.0**	**439.0**	**909.8**	**591.7**
Quarterly Rate (Plan)	***130.1***	***130.1***	***130.1***	***129.3***
Numerator (Actual)	615	675	1399	915
Numerator (Plan)	*200*	*200*	*200*	*200*
Denominator	153769	153769	153769	154639

Stockton-on-Tees didn't achieve the ambitious plan to reduce last year's DToC figures by 50% although has been a 35% reduction from Q3-Q4 which reflects the significant work detailed below.

Dementia diagnosis: Estimated diagnosis rate for people with dementia

Stockton-on-Tees HWB					
Estimated diagnosis rate for people with dementia	**Snapshot**			***BCF Plans***	
	Mar 15	**Mar 16**	**Mar 17**	***2015/16***	***2016/17***
Percentage	79.08%	81.75%	82.50%	***68.98%***	***81.67%***
Numerator = QOF Dementia register (all ages) based on GP Practice locality to determine HWB	1882	1953	1971	*1648*	*1951*
Denominator = Denominator figure submitted in the BCF Plans template for appropriate financial year and HWB	2380	2389	2389	*2389*	*2389*

In 2016/17 we have achieved our 2016/17 target for Dementia diagnosis rates.

Local performance report

To complement the reporting/ performance of the national BCF metrics we have produced a more detailed local BCF Performance Report which provides a more detailed update on the following:

- The six national performance metrics which are used to determine the success of the Better Care Fund for example a detailed breakdown of non-elective admissions by age, by source of admission and by HRG Chapter
- The position in relation to the local set of performance measures
- Specific outcomes and successes linked to the BCF schemes
- Actions/ next steps

Please see Appendix 1 (separate attachment) – Copy of Quarter 4 BCF Performance Report

5. Evidence Base and Local Priorities to Support Plan for Integration

The Stockton-on-Tees BCF plan will look to support the delivery and shift towards improving 'population health' - moving from fragmentation to integration in care delivery, but also tackling the wider determinants of the health and wellbeing of our population.

Building on the success of 2015/16 and 2016/17 the 2017-2019 BCF plan aims to deliver through partnership working a plan of action to support future health and social care integration opportunities to address the local needs of the population.

Plan of Action

Issue	Challenge	Action
Over performance against emergency admissions (65 and over) metric.	To contribute to reducing avoidable hospital admission for over 65 population.	Further trend analysis to better understand impact of BCF funded schemes and CCG commissioned services to inform future commissioning plans. Contribute to the CCGs Quality Innovation, Productivity and Prevention programme (QiPP) to deliver the proposed CCG NEL trajectory. Scope early intervention and intermediate care services across health and social care to determine new of model of care to support a reduction in non-elective activity.
Over performance for length of stay for emergency admissions (65 and over).	To contribute to reducing length of stay relating to emergency admission for over 65s.	Further trend analysis to identify areas of variation and over performance across clinical pathways in relation to excess bed days. Work closely with the Acute Trust to ensure delivery of the 'Supportive Proactive and Safe Discharge' 2 year CQUIN scheme.
Over performing on total delayed days per 100,000	To contribute to reducing hospital delayed discharge days.	Jointly commission a fully integrated discharge team across health and social care.

		Improve patient discharge pathways promoting a 'home first' concept. Agree one joint assessment and care plan as part of the discharge process. Roll out the trusted assessor role across discharge pathways. Reduce the number of CHC assessments undertaken in the acute setting. Improve the weekend discharge pathway. Monitor current pilot scheme to ensure effectiveness as part of transfers of care work.
Low number of people being discharged on a weekend following an emergency admission over 65's.	To increase the number of patients discharged on a weekend following an emergency admission – over 65's.	Work in partnership across Health and Social care to determine services in and out of hospital required to support and improve weekend discharges. Build on the Discharge to Assess Model to support discharges set out above in relation to improving delayed transfer of care.
Under performing on the proportion of people 65 and over who are still at home 91 days after discharge from hospital into reablement /rehabilitation services	To improve the number of people who are at home 91 days post discharge from hospital into reablement/ rehabilitation	Further analysis of reasons why people are not still at home after 91 days. Better targeting of reablement resources. Development of integrated approach to intermediate care, which will include reablement.
Growth of over 65 population with long term conditions and the impact on health and social care services by 2020.	Reduce impact of long term conditions and promote self-management and self-care.	Increased focus on equipping people to be resilient and self-reliant through: Social prescribing and supporting the VCSE

		Continued promotion and development of Stockton-on-Tees Information Directory of Service Digital care solutions Further integration of services to reduce duplication and ensure that resources are used effectively across health and social care to manage increasing demand.
Adult Health and Social Care Market	Support the development and sustainability of a vibrant market for health and social care.	Use of iBCF to support sustainability of the care market. Maintain positive working relationships with the market to understand and anticipate pressures and influence market shaping.
Reducing resource across the health and social care services	Maintaining and improving current services and performance in the context of reducing resources and increasing demand.	Improve information, advice and signposting that supports people to maintain their health, wellbeing and independence without input from statutory services. Further integration of services to reduce duplication and ensure that resources are used effectively across health and social care to manage increasing demand. Use of the iBCF to protect adult social care. Use of iBCF to reduce pressures on the NHS through new models of care.

6. Better Care Fund Plan 2017-2019

Building on the successes of 2016/17 and previous years, the BCF Plan for 2017-2019 will support further integration and partnership working that delivers improved outcomes for older people:

- New Models of Care
- Integrated Hospital Discharges
- Community Integrated Intermediate Care
- Integrated Single Point of Access
- Care Home Support
- Dementia support
- Digital Technology
- Use of iBCF Grant

New Models of Care

Primary Care, Care Co-ordination

A care co-ordinator service has been funded (A&E Delivery Board) to address pressures regarding non-elective admissions for over 65s. The two year pilot supports frail elderly residents over the age of 65 and provides a person centred care and support planning approach through direct links with general practices. Patients aged 65 and over who are living with moderate or severe frailty are initially identified using a Frailty Tool such as the Electronic Frailty Index (eFI) and severity confirmed following a review by a clinician in the practice (this is now a core element of the GP GMS Contract). Care co-ordinators will focus on those identified with a moderate frailty.

Many elderly people have highly complex needs and struggle to coordinate with all the relevant services directly. Ensuring seamless service provision significantly decreases the risk of the patient deteriorating and thereby reduces the overall cost of care and the likelihood that additional interventions will be needed in future. In addition it can provide support to enable a patient to recover some independence to the point where some interventions may no longer be needed.

The Care Coordinator supports interdisciplinary care by bringing together the different professionals and VCSE representatives whose help the patient may need; the Co-ordinator is also responsible for monitoring and evaluating the care delivered. Each piece of work the care co-ordinator does begins with a meeting with the patient, carers, and other family members to discuss their needs, the services available to them and the help they want to maintain their health and wellbeing. The care plan is completed on this basis and the Co-ordinator is then responsible for contacting other care departments or agencies to ensure access to support is available.

Community Hubs

The STP outlines the intention to work with GP practices who will be brought together into groups of practices called ‘community hubs’ so they can share their skills to match the needs of local residents.

Integrated Hospital Discharge

Patient flow and discharge planning is pivotal, and work to implement the high impact changes will continue. Reducing unnecessary delays in discharging older patients from hospital is a key priority for the CCG and Local Authority not only from a system/ patient flow perspective but more importantly because we know that longer stays can lead to worse health outcomes and can increase long-term care needs.

A self assessment of local progress against the High Impact Change Model was undertaken and provided to the Local A&E Delivery Board in June 2017. The self assessment identified that significant progress has been made in relation to early discharge planning, monitoring of patient flow, multi agency discharge teams, discharge to assess, seven day services, focus on choice and enhancing health in care homes. Some of the positive initiatives that were highlighted, which had been commissioned through the BCF Pooled Budget, were the Domiciliary Care Providers Home from Hospital Service that provides very short term low level support to older people on discharge from hospital who have not been assessed as having ongoing social care needs; pharmacy support for care homes, which has had a positive impact in terms of reducing safeguarding alerts and improving outcomes for care home residents; and a training and education programme for care homes, incorporating use of NEWS, which promotes early identification and intervention when a resident is experiencing a decline in their health.

The CCG and partners will continue to build upon the principles, learn from the work to date and develop integrated approaches to further impact on delays and improve the patient experience.

Integrated Intermediate Care

It is recognised that, while there are some very effective services operating in relation to intermediate care, there is still potential for duplication and silo working in the way that services are managed and accessed. A review of all intermediate care services will be undertaken to establish a new integrated intermediate care model building on the success of the MDS model and other co-located services. This will incorporate a number of services and initiatives focused on admission avoidance including:

- Proactive early intervention and identification enhanced social care and / or health support in a person's normal place of residence to prevent an admission; and
- Development of step up provision

As well as steps focused on supporting someone to return to their home, and regain their independence following a hospital admission, exacerbation or crisis including:

- residential rehabilitation;
- residential step down provision;
- intermediate care;
- mobile rehabilitation; and
- reablement support.

The ultimate aim is to bring services together as a single model that makes more effective use of resources and provides a seamless service to the person who needs support.

Integrated SPA (iSPA)

The vision is for an integrated single point of access across North Tees (Hartlepool and Stockton-on-Tees Borough Council) providing a multi professional triage and care plan development service to improve pathway access and delivery for health, social and voluntary, community and social enterprise services ensuring people get access to the right early help and specialist support.

Consultation in the concept delivery phase of the project has been mainly with partner organisations who are involved directly in the Integrated Single Point of Access. This was achieved through a recent 3P event

The main purpose of the iSPA is to bring together expertise across organisations to strengthen information sharing, risk assessment and joint decision making to ensure people and their families receive the right services at the right time.

The following criteria will demonstrate success of the iSPA:

- Effective pathways for people requiring health and/or social care needs
- Improved rates of response to referrals with timely decision making, less delay associated with information gathering and reduced duplication;
- Reduction in number of re-referrals;
- Reduction in the number of hospital admissions for people known to Out of Hospital services
- Reduction in the number of people requiring admission to care homes
- More holistic triage of people's needs;
- Increased referrals to non-statutory services for simple needs

Dementia Care and Support

Due to increased demand on the Hub and local data which shown that there is a significant number of service users have difficulties accessing the Hub due to transport, co-morbidities and behaviours that challenges, a proposal for an additional Hub Officer for 2 year fixed term to work proactively with the wider community to help increase awareness and understanding of dementia will be submitted. The officer will also reach out to hard to reach communities including Black, Asian and Minority Ethnic (BAME) communities, rural communities and others to ensure all residents of Stockton-on-Tees are able to receive right information at the right time in the right place. The outreach work will provide the 'spokes' to the existing hub model.

Funding for a programme of eco-therapy to address social isolation and loneliness in people with dementia has been approved for 2 years commencing in October 2017 has been approved. The Green Links Project is a user-led weekly programme that promotes horticulture, befriending, social interaction, physical activity and encourages service users to seek information and support when necessary. It also provides opportunities for carers to

socialise, network and improve their health and wellbeing if they attend sessions alongside the PWD and opportunities for carers to take short breaks on weekly basis.

Following an engagement event with the housing sector, a dementia housing forum has been established to maintain a partnership between dementia services and the housing sector. The forum also aims to empower the individual schemes to become more dementia friendly organisations, improve their tenants' wellbeing and promote local community initiatives. It will help their members to identify training needs to up skill their staff so they can identify their residents who are presenting with symptoms of dementia and refer onto appropriate services for formal diagnosis and support at early stage.

Digital Technology

Digital Health

We are continuing to work with our Health and Social Care colleagues to develop solutions to support people to stay in their own homes / prevent admissions to hospital. This programme will link with the work of the Digital Transformation Workstream.

We have also started to look at 'Access Anywhere' which is a tool similar to SKYPE which would allow people to have consultations remotely with a GP or other health or social care professional. It is early days in the testing of this product but the principles are felt to be sound.

ICT Systems and Data Sharing

Building on our success with the Medical Interoperability Gateway (MiG), the next stage of the integration work is being led by the Great North Care Record. We have had an input to the development of a specification for this system to ensure that Social Care is also included in any integration solution – although Information Sharing remains an issue. All our developments continue to be in line with our Local Digital Roadmap which is monitored through the Digital Transformation Workstream (part of the STP / BHP governance).

We have been successful in our bid for funding through the Local Investment Programme to support the development of the next phase of our 'My Voice My Choice' project. 'My Voice My Choice' in an online tool which allows people, with our without support, to develop their own Care and Support Plans. The LIP funding will support the development of an API which will allow the sharing of the Care and Support Plan with other systems. We are working with Connected Health Cities on the development of the Information Sharing model which will be based on the patient providing explicit consent to share with Health and Social Care professionals as appropriate. We will also use the LIP to develop an interface into one of the current Health and Social Care systems which then provides the first stages of integration. This learning will be shared with the Great North Care Record and more widely through the national LIP project.

Use of iBCF

The iBCF will be used to support key local priorities to ensure the sustainability of the local care market, protect adult social care services that would otherwise be subject to significant cuts and reduce pressures on the NHS through new models of care.

The projected use of the iBCF Grant will be spent on the following schemes during 2017-2019:

Scheme	Detail
IDT Senior Social Worker (backfill)	Backfill monies have been used from iBCF to support a secondment of a Social Worker to the Integrated Discharge Team for 1 year. It was agreed that the monies would fund the backfill for 3 years in order to ensure that the post was backfilled in a timely manner which will offer much needed stability within the SW teams.
Rosedale - Improvement of facilities	Monies made available for two key projects at the Rosedale Centre: · Additional car park facilities – scheme for 17 car parking spaces identified. Planning permission applied for. Construction work planned to take place in autumn 2017. · Bariatric bedroom / storage room extension. Initial plans drawn up & now being revised into detailed plans for submission for planning permission. Will create additional one bedroom suitable for client with "Extra size" needs including ceiling track hoist & appropriate equipment plus storage room for hoists, wheelchairs, walking frames, etc.
Reablement/Community Provision – extra OT/SW	In order to strengthen the social care market it is anticipated that extra resource will be funded in order to increase capacity within the existing reablement assessment team.
Smarter Working within SW Teams	Social Work teams have all been given smart phones and laptops to enable smarter working. It is anticipated that a further roll out will continue in October 2017 which will give all SW staff access to remote online working in real time.

Extra Care Packages to support discharge from hospital	The scheme provides additional capacity within the healthcare economy (through the provision of 5 additional discharge support beds) to accommodate increasing levels of demand for patients being discharged from hospital. The scheme will ensure: · Increased availability of acute bed capacity · Timely discharge into the community · Increase of reablement capacity in the community and, · Enable evaluation of the scheme for potential further development
Direct Payment Rates	The funding will be used to stimulate the market place for Direct payments and encourage a higher take up of Personal Assistants. The DP rate was £9 per hour and has been increased to £10.24 from 3rd July 2017.
Redesign of In-House Day Options	Temporary funding for a Development Manager to lead on the redesign of in-house Day options within Stockton-on-Tees Borough Council. Also additional support staff whilst the review is on-going.
Care Home Fees	The Council has undertaken an extensive exercise with Providers to review Care Home fees, including a backdated element to 2012.

Use of Disabled Facilities Grant Funding

The government has significantly increased the funding made available to local authorities in recent years to ensure the provision of an efficient and effective Disabled Facilities Grant (DFG) service. The national funding allocation rose from £220m in 2015/16 to £395m in 2016/17 (a 79% increase). In Stockton-on-Tees our funding allocation increased from ***£712k (2015/16) to £1,247,000 (2016/17***) and we saw a further increase to ***£1,360,283*** for 2017/18. This substantial increase in funding has afforded the Council the opportunity to review existing arrangements to ensure that adaptations continue to play a significant supporting role in enabling the Boroughs residents remain (for as long as possible) independent in their homes. Examples of recent changes implemented include:

Broadening the criteria for the Equipment Loan scheme (ramps and stair lifts) to ensure the scheme supports those residents with our borough with life limiting illness, supports safe hospital discharge, supports carers continue with their caring role and prevents admission to 24-hour care.

The introduction of a range of discretionary financial assistance packages to support applicants pay for work in excess of the maximum DFG grant award value and to support

applicants that do not have the financial means available to pay their financial contribution. By using our discretionary powers we are seeking to prevent undue delays or applicants 'dropping out', which will inevitably place pressures on social and/or health services.

In addition to delivering our statutory DFG service, the Council also operates a fast track DFG process and an equipment loan scheme (as detailed above). All schemes are aimed at ensuring we are able to respond quickly and effectively to the bespoke needs of individuals.

During 2016/17 183 DFGs were completed, at an average cost of £5,500k per DFG. The most common adaptations delivered in the borough were the provision of level entry showers, followed by stair lifts and ramps improvements. The majority of DFG's were to owner occupiers 73%, however we are starting to see an increase in the number of DFG applications being received from both Registered Provider and Private Rented Sector tenants. In addition a further 83 applicants received support through our Equipment Loan Scheme.

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. We continuingly seek to ensure that our service delivery remains fit for purpose and delivers value for money. In terms of value for money we continue to ensure effective procurement (often cross LA and/or with Registered Housing providers) with the aim of maximising the resources we have available and keeping waiting times to a minimum.

7. Risk

The BCF risk log identifies a range of risks associated with the delivery of the BCF plan and the mitigating actions in place.

There is a risk that:	Likelihood	Potential impact	Overall risk factor	Mitigating Actions
There is insufficient information and data at the correct level and quality to effectively monitor outcomes and ensure overall delivery of the BCF plan.	1	3	3	• Health and social care information teams work together to ensure that information is collected and presented meaningfully to inform planning and service development. • BCF work streams provide assurance that existing and planned developments deliver required outcomes. Reviews are undertaken to refine plans and there is potential to disinvest in schemes that fail to deliver outcomes • National performance measures are used where appropriate and where these are not available, locally agreed indicators are developed.
The schemes are not in line with existing NHS or LA delivery plans undoing existing good practice.	1	4	4	• Partners continue to be involved in development of BCF plans to ensure that organisational plans are aligned. • The agreed governance arrangements ensure that the impact of decisions relating to BCF implementation are considered by all partners on the North of Tees Partnership Board. • Plans build on the good practice already in place

				prior to BCF.
There is insufficient time for schemes to have the impact in the short term on performance and savings.	2	4	8	• Plans build on existing good practice. • Existing services will contribute to delivery of the BCF plan. • Contractual mechanisms are used where appropriate to ensure that changes are delivered within agreed timescales.
As current funding to social care is reduced there will be a detrimental impact on the delivery of savings and BCF outcomes.	4	5	20	• BCF funding to maintain social care provision has been agreed for 2017/18. • The North of Tees Partnership Board will continue to monitor the impact of changes to social care funding and risks posed to the BCF. • iBCF will enable further protection of social care services along with support for the care market.
Workforce skill mix and availability to deliver the new pathways of care is not adequate.	3	4	12	• Workforce planning and development with Health Education North East and NHS England Local Area Team continues. Difficulty recruiting nurses across the health and social care system remains a challenge.
Shifting resources to fund new integrated services destabilises current providers, particularly in the acute sector.	2	4	8	• This has been managed successfully to date and will continue to be reviewed regularly.

Risk Share/ Contingency Arrangements

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 increased emergency admissions into hospital and increased admissions into residential care, within contingencies set aside within the respective organisation, overseen by the Pooled Budget Partnership Board.

8. National Conditions

National condition 1: Jointly Agreed Plan

The Better Care Fund plan has been jointly developed by partners, specifically:

- Hartlepool and Stockton-on-Tees CCG
- North Tees and Hartlepool NHS Foundation Trust
- Tees Esk and Wear Valleys NHS Foundation Trust
- Stockton-on-Tees Borough Council

This joint planning enables partners to develop services that will contribute to reducing pressures on urgent care and prevent people needing emergency care in hospital or a permanent care home admission. It is expected that this will continue in 2017/18 and beyond as part of wider transformation plans (STP).
0
Joint planning has been supported by a range of events focused on specific developments within the BCF plan, engagement events with older people and carers and the work of the North of Tees Dementia Collaborative.

The use of the Improved Better Care Fund grant to local authorities was formally agreed through the BCF Pooled Budget Partnership Board in August 2017, having previously being agreed in principle. The iBCF will be used for ensuring the sustainability of the local care market, protecting adult social care services that would otherwise be subject to significant cuts and reducing pressures on the NHS through new models of care.

The DFG allocation will be used to continue funding adaptations that support people to live independently in their own homes. Use of the DFG allocation is reported to the BCF Pooled Budget Partnership Board on a quarterly basis and recent reports evidence a significant reduction in waiting times for adaptations.

National condition 2: Social Care Maintenance

In line with our Better Care Fund plan for 2016/17 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-on-Tees and increased in order to deliver the schemes outlined in the BCF plan and address the implications of the Care Act.

In 2017/18 the total amount from the BCF that has been allocated for the protection of adult social care services is £8.531m including the capital funding for disabled facilities grant and for 2018/19 is £8.919m.

The Better Care Fund monies have 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 2016/17 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.

National condition 3: NHS commissioned out-of-hospital services

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.

The Financial Summary in the planning template shows that there is an investment in NHS Commissioned out of hospital services of £4,900,329. This is broken down by:

Out of Hospital Investment	Stockton- on-Tees
Community Health	£1,225,424
Mental Health	£1,406,737
Social Care	£1,617,256
Other	£650,912
Total	**£4,900,329**
Minimum contribution required	£3,785,783

The local area's share of the £1 billion previously used for the payment for performance set out in the BCF Allocations is £4,900,329. This shows that there has been a greater investment in NHS Commissioned out of hospital services of £1,114,546 than the minimum required.

National Condition 4: Managing Transfers of Care

A self-assessment of local progress against the High Impact Change Model has been undertaken and an update was provided to the Local A&E Delivery Board in June 2017. The self-assessment identified that significant progress has been made in relation to early discharge planning, monitoring of patient flow, multi-agency discharge teams, discharge to assess, seven day services, focus on choice and enhancing health in care homes.

Some of the positive initiatives that were highlighted, which had been commissioned through the BCF Pooled Budget, were the additional domiciliary provision to support new and existing packages of care for those people going home sooner until further assessment can be made. The funding of additional an additional social worker to be part of the Integrated Discharge Team within the hospital. Reconfiguration of the Community Matron Model (not BCF funded) to support the care home sector and in particular those patients being discharged back to care homes under an agreed pathway until further assessment can be undertaken as appropriate. Commissioning training and education programme for care homes, incorporating use of NEWS, which promotes early identification and intervention when a resident is experiencing a decline in their health.

Further work is needed to develop and embed trusted assessor models, as approaches are currently being developed and piloted but are not well established across the health and social care system. There is a well-established Discharge Group across Stockton-on-Tees which has representation from Health, Social Care and VCSE partners who are all working collaboratively to improve discharge from hospital avoiding the need for a prolonged and unnecessary stay. Following the Self-assessment in June 2017 the group will undertake further assessment to determine and assure continuous improvement across the high impact actions which will inform the Discharge Groups' action plan.

In June 2017 the A&E Delivery Board received a presentation regarding the self assessment against the High Impact Change Model.

9. Overview of funding contributions

Funding	2017/18	2018/19
CCG Minimum Contribution	13,322,169	13,575,291
Local Authority Additional Contribution	200,000	200,000
Disabled Facilities Grant	1,360,283	1,473,959
iBCF Allocation	3,803,989	5,056,249
TOTAL	**18,686,441**	**20,305,499**

As demonstrated within the BCF Planning Template, the Pooled Budget includes amounts earmarked for specific purposes as follows;

Care Act 2014 Care Act funding is included with the Pooled Budget and will be utilised to support services for Carers, such as direct payment and respite provision.

Carer's breaks Funding used for Carers specific services.

Reablement Funding to maintain reablement capacity to help people regain their independence and reduce the need for ongoing care.

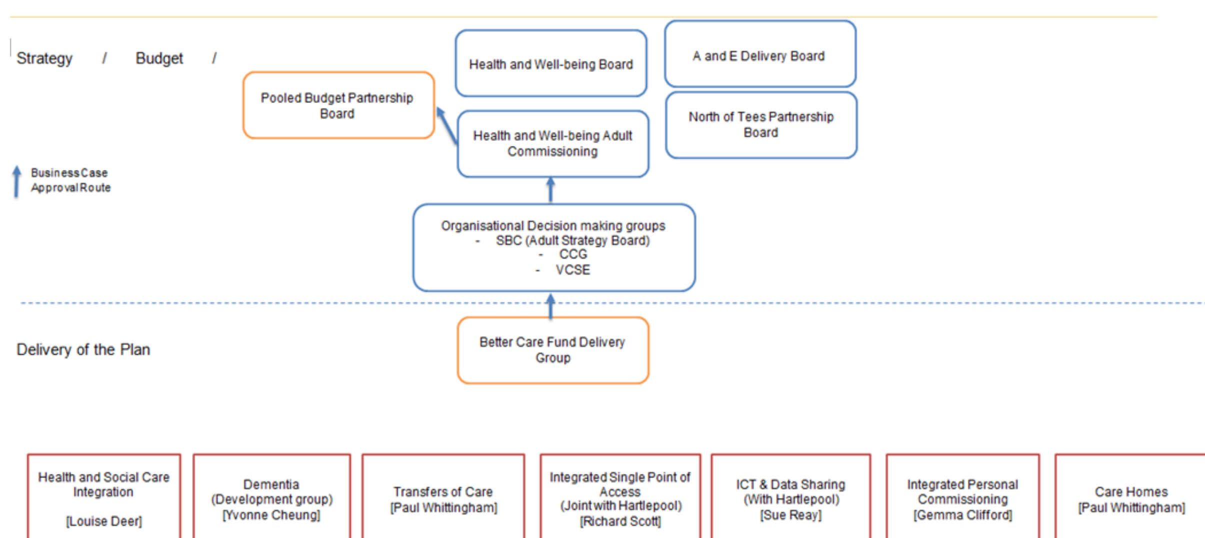
DFG Funding for the provision of Statutory Disabled Facilities Grants.

iBCF The Improved Better Care Fund is included with in the Pooled Budget.

10. Programme Governance

Robust governance arrangements have been in place since 2014 for the Stockton-on-Tees Better Care Fund Plan and were agreed by the Health and Wellbeing Board in. These governance arrangements reflect the partnership approach that is required to effectively deliver the integrated approach described in the Better Care Fund Plan but also acknowledge 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 new governance for the Stockton-on-Tees Better Care Fund (BCF) programme management arrangements for 2017/19:



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-on-Tees health and social care system; and progressing any joint commissioning implications and requirements arising from the Better Care Fund.

The plan has been signed off by the Health and Wellbeing Board which also includes providers, voluntary and community sector representatives, and other partners in accordance with its terms of reference.

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 BCF 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**.**

The BCF Delivery Group is responsible for; ensuring delivery on the 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 and holding the BCF Implementation Group accountable for; 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, including performance and finance; ensuring other groups are updated and assured of progress.

The BCF Project Implementation Groups 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 ensures that decisions are taken through their own internal governance structures and information is shared. For example the CCG Exec and Governing Body will be kept appraised of developments and 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.

11. National Metrics

Non-Elective Admissions

The target set for NEL within the BCF plan is taken from the CCG 2017/18 Operational Plan. For HaST CCG in 2017/18 this shows a 1.1% reduction from the 2016/17 levels with a slight increase of 0.7% in 2018/19 (detailed in the tables below):

FOT 16/17	40274
FOT 17/18	39,815
FOT 18/19	40,106

2017/18			
Annual activity % change	-1.10%		
Annual activity actual	-459		
Apr-17	3,114	Q1	9,323
May-17	3,040		
Jun-17	3,169		
Jul-17	3,207	Q2	9,526
Aug-17	3,114		
Sep-17	3,205		
Oct-17	3,344	Q3	10,058
Nov-17	3,365		
Dec-17	3,349		
Jan-18	3,563	Q4	10,908
Feb-18	3,541		
Mar-18	3,804		

2018/19			
Annual activity % change	0.7%		
Annual activity actual	291		
Apr-18	3140	Q1	9,402
May-18	3067		
Jun-18	3195		
Jul-18	3232	Q2	9,602
Aug-18	3140		
Sep-18	3230		
Oct-18	3368	Q3	10,128
Nov-18	3388		
Dec-18	3372		
Jan-19	3585	Q4	10,974
Feb-19	3564		
Mar-19	3825		

Please note the figures provided in the table above are from the CCG submitted plans which were calculated using 5 months actual and 7 months forecasted to give a 2016/17 forecasted Outturn from the data we held at the time. This will therefore differ from the 2016/17 figures included in the BCF Plan as this uses the full year actual figures. There will also be slight differences when comparing CCG plans to BCF plans due to the CCG mapping which is applied when calculating the NEL activity figures in the BCF Planning Template.

The CCG have a history and proven track record of delivering planned reductions. As a result of this proven track record we feel justified in setting our ambition of non-elective reductions at the level we have. The Better Care Fund is one of the initiatives that will support the reduction in all non-elective (NEL) admissions; others include GP Variation and Rightcare.

Early intelligence/ activity in 2017/18 is indicating an overall reduction in NEL admissions compared to the same period in 2016/17. For example, in terms of UTIs there was 41% reduction in activity and a 38.3% reduction in cost.

Admissions to Residential Care

There have been some data quality issues associated with this indicator over the two years. These issues have been resolved and the performance is expected to be much better than previously reported in 2014-16.

We also now monitor the net impact of admissions and discharges alongside budget expenditure on residential and nursing care to provide confidence in the stated position. Although the admissions may appear high, the length of stay is reducing.

It is too early to determine whether or not the new better care fund services are having a direct impact on this performance indicator, but overall the performance is improving and is anticipated to improve during 2017-19. Stockton-on-Tees will contine to:

- Continue to demonstrate 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.
- Client Financial Services to continue to provide financial assessment prior to the meeting of the Panels.
- Identify the most appropriate services, aiming to keep people in their own homes for as long as possible, including Intermediate Care and Reablement services.

All the BCF schemes are aimed at keeping people in their own homes and reducing permanent admissions to residential and nursing care homes and in particular the Dementia Strand projects, including one of the digital health projects, which are aimed at supporting people and their carers.

2017/18 Target
The target set for 2017/18 is 290 admissions. This is a challenging target, although it is maintaining the current target for 2016/17. This reflects the increasing numbers coming through for residential/care home to panel and also the complexity of need.

A range of services will be maintained that offer alternatives to residential care and further initiatives are planned that aim to target admission avoidance, as outlined in priorities for 2017-2019.

2018/19 Target
The target set for 2018/19 is to maintain the performance target of 290 admissions. This again reflects the growing need and complexities.

Effectiveness of Reablement

Stockton is already a high performing Council with respect to this performance indicator and the main aim of all the improvements and developments in the service is to continue to improve the performance where possible but also to maintain the high performance currently achieved. To ensure this is the case, wherever the target has not been met, an evaluation is undertaken of each case to see if anything different could have been done.

The whole of the Council's Intermediate Care and Reablement services have been reviewed and a new pathway developed to support the discharge from hospital process. This will ensure that the right services are put in place and that when someone is enabled, they are 'stepped down' to the Multi-Disciplinary Services where appropriate to receive a full well-being assessment.

2017/18 Target
The target set for 2017/18 is 84.1%, which represents a 5% decrease on 2016/17 performance. It is anticipated that this can be achieved through;

1. Better understanding the reasons why people are not still at home 91 days after discharge and then targeting resources more effectively.
2. Working more closely with NHS partners to ensure appropriate discharges into reablement services are made

2018/19 Target
The target set for 2018/19 is 84.1%, which represents a maintenance of the 2017/18 figure.

Delayed Transfers of Care

NHSE provided guidance on what the expected level of DTOC's should be by November 2017. This guidance also indicated the expected level of Social Care Delays. The Trust and Local Authority have recently reviewed the DToC information and how delays are attributable, based on the national criteria. As a result of this performance will include more NHS delays and less Social Care delays going forward, however there remains an overall expected reduction in line with NHSE targets. The DToC trajectory submitted therefore meets the overall target that has been set and more accurately reflects the split between Social Care and NHS delays.

The trajectory set for Stockton-on-Tees requires the total number of delayed days to be below 399 by November 2017. This is a slight increase from the Q4 position but will mean maintaining the reductions made since the Q3 position. Through continued partnership working we feel that this target is deliverable.
The trajectory is set in line with the DTOC submission already submitted for 2017/18. They account for the required reduction due by Nov-17 and then aim to maintain this position going forward into 2018/19.

Supportive Proactive and Safe Discharge CQUIN

The CCG is also working closely with the Trust on the new Supportive Proactive and Safe Discharge CQUIN should also support the proposed reductions, this two year CQUIN aims to improve patient outcomes, improve patient flow and reduce delayed discharges. In year one (2017/18) acute providers are required to:

- Map existing discharge pathways, roll-out new protocols, collect baselines/trajectories
- Increase the proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% from baseline (Q3 and Q4 2016/17)

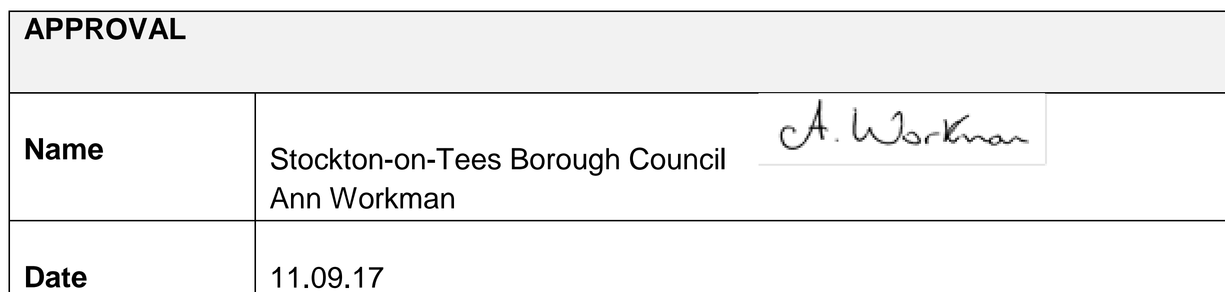
In year 2 (2018/19) providers are required to:

- Increase the proportion of patients admitted via non-elective route discharge from acute hospitals to their usual place of residence within 7 days of admission by 7.5% from 2017/18.

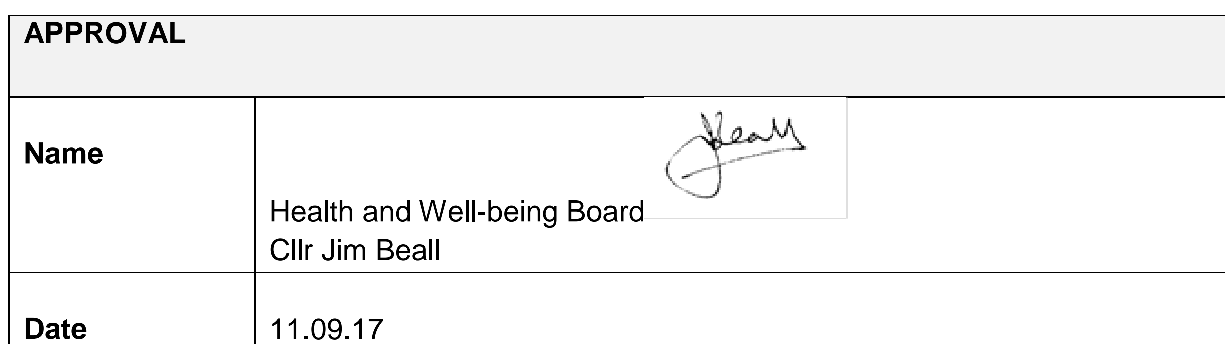
Dementia Diagnosis Rate

In 2017/18 and 2018/19 it is the intention to maintain the existing 2016/17 diagnosis rates of which we are currently achieving this target by an additional 0.88%.

12. Approval and sign off



APPROVAL	
Name	Stockton-on-Tees Borough Council Ann Workman
Date	11.09.17



APPROVAL	
Name	Health and Well-being Board Cllr Jim Beall
Date	11.09.17

APPROVAL	
Name	Hartlepool and Stockton-on-Tees CCG Ali Wilson
Date	11.09.17

13. Key Lines of Enquiry Checklist

Below outlines the page references where you will evidence for the Key Lines of Enquiry. Please note that these specific references are not the entire evidence for the KLOE's, the complete plan should be read in its entirety and the evidence used throughout to satisfy the KLOE's.

	BCF Planning Requirements	KLOEs to support assurance of the planning requirements	Where
National condition 1: jointly agreed plan (Policy Framework)	1. Has the area produced a plan that all parties sign up to, that providers have been involved in, and is agreed by the health and well being board? 2. In all areas, is there a plan for DFG spending? And, in two tier areas, has the DFG funding been passed down by the county to the districts (in full, unless jointly agreed to do otherwise)?	1. Are all parties (Local Authority and CCGs) and the HWB signed up to the plan? 2. Is there evidence that local providers, including housing authorities and the VCS, have been involved in the plan? 3. Does the Narrative Plan confirm that, in two-tier areas, the full amount of DFG Money has been passed to each of the Districts (as councils with housing responsibilities), or; where some DFG money has been retained by the Upper Tier authority, has agreement been reached with the relevant District Councils to this approach?	Narrative plan pages 4 & 58 Narrative plan pages 3 & 58 N/A as Unitary Authority Planning Template
National condition 2: Social Care Maintenance (Policy Framework)	3. Does the planned spend on Social Care from the BCF CCG minimum allocation confirm an increase in line with inflation* from their 16/17 baseline for 17/18 and 18/19 **1.79% for 2017/18 and a further 1.90% for 2018/19*	4. Is there an increase in planned spend on Social Care from the CCG minimum for 17/18 and 18/19 equal to or greater than the amount confirmed in the planning template? 5. If the planned contributions to social care spend from the BCF exceed the minimum, is there confidence in the affordability of that contribution? 6. In setting the contribution to social care from the CCG(s), have the partners ensured that any change does not destabilise the local health and care system as a whole? 7. Is there confirmation that the contribution is to be spent on social care services that have some health benefit and support the overall aims of the plan? NB this can include the maintenance of social care services as well as investing in new provision	Narrative Plan Page 57 Narrative Plan Page 53 & 54 Narrative Plan Page 52, 54 & 57 Narrative Plan 52 & 57 Planning Template

National condition 3: NHS commissioned Out of Hospital Services (Policy Framework)	4. Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?	8. Does the area's plan demonstrate that the area has committed an amount equal to or above the minimum allocation for NHS commissioned out-of-hospital services and this is clearly set out within the summary and expenditure plan tabs of the BCF planning template? 9. If an additional target has been set for Non Elective Admissions; have the partners set out a clear evidence based process for deciding whether to hold funds in contingency, linked to the cost of any additional Non Elective Admissions that the plan seeks to avoid? 10. If a contingency fund is established; Is there a clear process for releasing funds held in contingency into the BCF fund and how they can be spent?	Planning Template Narrative Plan Pages 55 & 57 N/A Narrative Plan page 53

National condition 4: Implementation of the High Impact Change Model for Managing Transfers of Care	5. Is there a plan for implementing the high impact change model for managing transfers of care?	11. Does the BCF plan demonstrate that there is a plan in place for implementing actions from the high impact change model for managing transfers of care? Does the narrative set out a rationale for the approach taken, including an explanation as to why a particular element is not being implemented and what is approach is being taken instead? 12. Is there evidence that a joint plan for delivering and funding these actions has been agreed? 13. If elements of the model have already been adopted, does the narrative plan set out what has been commissioned and, where appropriate, link to relevant information?	Planning Template Narrative plan pages 56 Narrative plan page 56 Narrative plan page 56
Local vision for health and social care	6. A clear articulation of the local vision for integration of health and social care services?	14. Does the narrative plan articulate the local vision for integrating health and social care services, including changes to patient and service user experience and outcomes, and a strategic approach to housing, social care and health, cross-referenced and aligned to other plans impacting on integration of health and social care such as STPs or devolution deals? 15. Is there an articulation of the contribution to the commitment to integrate health and social care services by 2020 in line with the intent set out in the 2015 spending review and the BCF policy Framework? 16. Is there a description of how progress will continue to be made against the former national conditions 3, 4 and 5 in the 2016/17 BCF policy framework?	Narrative plan pages 5 through 14 outlines KLOE 14 and 15 in detail Narrative plan page 12
Plan of action to contribute to delivering the vision for social and health integration	7. Does the BCF plan provide an evidence-based plan of action that delivers against the local needs identified and the vision for integrating health and social care?	17. Is there a robust action plan that addresses the challenges of delivering the vision, including: • Quantified understanding of the current issues that the BCF plan aims to resolve • Evidence based assessment of the proposed impact on the local vision for integrating health and social care services through the planned schemes and joint working arrangements	Narrative plan pages 15-22, 41-43 and Appendix 1

Approach to programme delivery and control	8. Is there a clear, jointly agreed approach to manage the delivery of the programme, identify learning and insight and take timely corrective and preventive action when needed?	18. A description of the specifics of the overarching governance and accountability structures and management oversight in place locally to support integrated care and the delivery of the BCF plan? 19. A description of how the plan will contribute to reducing health inequalities (as per section 4 of the Health and Social Care Act) and to reduce inequalities for people with protected characteristics under the Equality Act 2010? 20. Does the narrative plan have a clear approach for the management and control of the schemes? including as a minimum: • Benefit realisation (how will outcomes be measured and attributed?) • Capturing and sharing learning regionally and nationally • An approach to identifying and addressing underperforming schemes	Narrative plan page 58 - 59 Narrative plan page 15 Narrative plan pages 58 – 59 Appendix 1
Management of risk (financial and delivery)	9. Is there an agreed approach to programme level risk management, financial risk management and, including where relevant, risk sharing and contingency?	21. Have plan delivery and financial risks, consistent with risks in partner organisations, been assessed in partnership with key stakeholders and captured in a risk log with a description of how these risks will be proportionally mitigated or managed operationally? 22. If risk share arrangements have been considered and included within the BCF plan, is there a confirmation that they do not put any element of the minimum contribution to social care or IBCF grant at risk? 23. Is there sufficient mitigation of any financial risks created by the plan if a risk share has not been included?	Narrative plan pages 51-52 Page 54 Market Position Statement – narrative plan page 12 Narrative plan page 53 Narrative plan page 53

Funding contributions: . Care Act, . Carers' breaks, . Reablement . DFG . iBCF	10. Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose and this is appropriately agreed with the relevant stakeholders and in line with the National Conditions?	24. For each of the funding contributions, does the BCF evidence: • That the minimum contributions set out in the requirements have been included? • How the funding will be used for the purposes as set out in the guidance? • That all relevant stakeholders support the allocation of funding? • The funding contributions are the mandated local contributions for: • Implementation of Care Act duties • Funding dedicated to carer-specific support • Funding for Reablement • Disabled Facilities Grant? 25. Does the planning template confirm how the minimum contribution to Adult Social Care and the funding for NHS Commissioned Out of Hospital Services will be spent? 26. Does the BCF plan set out what proportion of each funding stream is made available to social care and that the improved Better Care Fund has not been offset against the contribution from the CCG minimum? 27. Is there agreement on plans for use of IBCF money that meets some or all of the purposes set out in the grant determination?	Narrative plan page 55 Page 57 Planning Template Narrative plan page 63 Planning Template Planning Template Narrative plan page 57 Planning Template Narrative plan page 48-49
Metrics – Non Elective Admissions	11. Has a metric been set for reducing Non Elective Admissions?	28. Does the narrative plan include an explanation for how this metric has been reached, including an analysis of previous performance and a realistic assessment of the impact of BCF schemes on performance in 2017-19? 29. Has a further reduction in Non Elective Admissions, additional to those in the CCG operating plan, been considered?	Planning Template Narrative plan page 60 N/A

Metrics – Non Elective Admissions (additional)	12. If a metric has been set for a further reduction in Non Elective Admissions, beyond the CCG operating plan target, has a financial contingency been considered?	30. Has the metric taken into account performance to date and current trajectory and are schemes in place to support the target? See also National Condition 3.	Narrative plan page 60 Planning Template
Metrics Admissions to residential care homes	13. Has a metric been set to reduce permanent admissions to residential care?	31. Does the narrative plan include an explanation for how this metric will be reached, including an analysis of previous performance and a realistic assessment of the impact of BCF schemes on performance in 2017-19?	Planning Template Narrative plan page 60
Metrics – Effectiveness of Reablement	14. Has a metric been set for increasing the number of people still at home 91 days after discharge from hospital to rehabilitation or reablement?	32. Does the narrative plan include an explanation for how this metric will be reached, including an analysis of previous performance and a realistic assessment of the impact of the reablement funding allocation for health and social care and other BCF schemes on performance in 2017-19?	Planning Template Narrative plan page 61
Metrics Delayed Transfers of Care	15. Have the metrics been set for Delayed Transfers of Care?	33. Have all partners agreed a metric for planned reductions in delayed transfers of care across the HWB that is at least as ambitious as the overall HWB target for reductions of DToC by November 2017? 34. Is the metric in line with the expected reductions in DToC for social care and NHS attributed reductions for the HWB area set out in the DTOC template? 35. If the local area has agreed changes in attribution from those set out in the template is there a clear evidence base and rationale for those changes? 36. Does the narrative set out the contribution that the BCF schemes will make to the metric including an analysis of previous performance and a realistic assessment of the impact of BCF initiatives in 2017/19 towards meeting the ambition set out in the local A&E improvement plan? 37. Have NHS and social care providers been involved in developing this narrative?	Planning Template Narrative plan page 62 across KLOE 33, 34, 35, 36 and 37 Related schemes and models impacting DTOC beyond BCF A&E improvement plans

Integrity and completeness of BCF planning documents	16. Has all the information requested in the DTOC and planning templates been provided and are all the minimum sections required in the narrative plan elaborated?	38. Have the DTOC template, Planning template and Narrative plans been locally validated for completeness and accuracy as per the planning requirements? (Better Care Support Team will carry out central data validation)	DTOC template Planning Template Narrative plan page 62