North Tyneside Council

Adult Social Care, Health and Wellbeing Sub-Committee

1 November 2017

Thursday, 9 November 2017 in Room 0.02, Ground Floor, Quadrant, The Silverlink North, Cobalt Business Park, North Tyneside commencing at **6.00pm**.

Agenda Item		Page
1.	**Apologies for Absence** To receive apologies for absence from the meeting.	
2.	**Appointment of Substitute Members** To be notified of the appointment of any Substitute Members.	
3.	**Declarations of Interest** You are invited to **declare** any registerable and/or non-registerable interests in matters appearing on the agenda, and the nature of that interest. You are also invited to disclose any dispensations in relation to any registerable and/or non-registerable interests that have been granted to you in respect of any matters appearing on the agenda. Please complete the Declarations of Interests card available at the meeting and return it to the Democratic Services Officer before leaving the meeting.	

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Agenda		Page(s)
4.	**Minutes** To confirm the minutes of the meeting held on 5 October 2017.	3 – 9
5.	**Urgent Care** To receive an update and discuss the next phase of the work on urgent care (20 minutes)	10 – 34
6.	**Better Care Fund** To receive an update on the Better Care Fund. (10 minutes)	35 – 129
7.	**A Smoke Free North Tyneside** To consider the plans which are in place across partners in North Tyneside to reduce smoking; and to seek assurance that they are robust enough to achieve the challenging ambitions that have been identified. (20 minutes)	130 – 149
8.	**Safeguarding Adults Board Annual Report 2016-17 and Action Plan 2017-18** To receive a report which gives an overview of the work undertaken by the Safeguarding Adults Board during the past year. (20 minutes)	150 - 206
9.	**Feedback from meeting with Carers Representatives** To receive feedback from a meeting with carer's representatives about respite care and services for carers. (10 minutes) **The following item is for information only and will not be presented to the Sub-committee.**	
10.	**Loneliness and Isolation** To receive an information report on initiatives in place to combat loneliness and isolation in North Tyneside.	

Members of the Adult Social Care, Health and Wellbeing Sub-Committee

Councillor Ken Barrie
Councillor Linda Bell
Councillor Pamela Brooks
Councillor Joanne Cassidy
Councillor Karen Clark (Deputy Chair)
Councillor Marian Huscroft
Councillor David McGarr
Councillor Alan Percy
Councillor Margaret Reynolds
Councillor Lesley Spillard
Councillor Alison Waggott-Fairley

Adult Social Care, Health and Wellbeing Sub-Committee

5 October 2017

Present: Councillor K Clark (Chair)
Councillors K Barrie, L Bell, P Brooks, J Cassidy, M Huscroft, T Mulvenna, A Percy, M Reynolds, L Spillard

Also Present: Councillor G Bell, Cabinet Member for Adult Social Care

ASCHW26/10/17 Apologies

Apologies for absence were received from Councillor A Waggott-Fairley.

ASCHW27/10/17 Substitute Members

Pursuant to the Council's constitution the appointment of the following substitute Member was reported:-

Councillor T Mulvenna for Councillor A Waggott-Fairley

ASCHW28/10/17 Declarations of Interest and Dispensations

There were no declarations of interest or Dispensations reported.

ASCHW29/10/17 Minutes

Resolved that the minutes of the meeting held on 7 September 2017 be confirmed and signed by the Chair.

ASCHW30/10/17 Northumbria Healthcare Foundation Trust - Nursing

Debbie Reape, Interim Director of Nursing at Northumbria Healthcare Foundation Trust gave a presentation which provided an update on nursing and midwifery at Northumbria Healthcare Foundation Trust (the Trust).

Plans were underway and a working group had been established for the production of a new Nursing and Midwifery Strategy 2018-2020. Staff engagement was key to the development of a new strategy and the Trust had used its Nursing Conferences as away to gather views 'live data'.

The Trust had a number of ways to check what was happening in its clinical areas including; a daily monitoring process was place to monitor - staffing levels, patient numbers and acuity; clear escalation processes were in place and incident reporting; chief matron overview and matron rounds; 15 steps programme covering acute and community; and patient experience.

A huge amount of work had taken place in relation to recruitment including the use of social media, press, journals, job fairs and Trust open days. There was also a new campaign which targeted elderly care.

Although there was a national shortage of nurses, the Trust had one of the highest retention rates in the UK with a stability factor of 91%. Presently the Trust had 4% registered nursing and midwifery vacancies. There were 82 new registrants commencing in October 2017 this was much higher than the normal average of 30.

The Trust carried out regular Nursing surveys to ascertain what was important to nurses; some of the key things were teamwork, access to training, work life balance and staff health and wellbeing.

The Trust had also put in place a number of new retention strategies; during the presentation these were described in more detail.

The Trust were also growing their own and providing opportunities for staff through different access routes to nurse training. During the presentation these were described in more detail.

Members heard about the digital care programme. This was a clinically led programme to enhance how the Trust used technology, with the objective to better support the patients, clinicians, nurses, therapists, pharmacists and the wider teams who provided care.

A member was concerned that as nursing had become more professional in recent years some of the patient priorities such as good personal care, help with feeding, medication etc maybe left to lower banded nurses . Debbie Reape agreed that these were important issues however didn't envisage the need to employ greater number of registered nurses but to look instead at what other roles could be established to supplement nursing. To alleviate pressure from registered nurses she mentioned that ward medicine assistants (band 3) were now employed to work between the pharmacy and the wards.

The Chair thanked Debbie Reape, for the presentation.

ASCHW31/10/17 Better Care Fund

Kevin Allan, Programme Manager for Integration Care Older People, presented a report which provided an update on the Better Care Fund (BCF).

Mark Adams, Anya Paradis, Lesley Young-Murphy of the North Tyneside Clinical Commissioning Group (CCG) and Jacqui Old the Council's Head of Health, Education, Care and Safeguarding (HECS) attended the meeting to respond to members questions.

The Better Care Fund was now in its third year of operation. The current planning cycle covered two years, 2017/18 and 2018/19.

The national planning requirements for the BCF were published by the Department of Health, Department of Communities and Local Government, and NHS England on 4 July 2017.

The planning requirements had set out the following national conditions:

1. That plans be jointly agreed by the Authority and CCG, and signed off by the Health and Wellbeing Board
2. The NHS contribution to social care must be maintained in line with inflation
3. Agreement to invest in NHS-commissioned out-of-hospital services

4. Implementation of the High Impact Change Model for reducing delayed transfers of care

The deadline for submission of plans to the national bodies was 11 September 2017; however the CCG and the Authority were unable to agree a plan. The CCG had submitted a plan which had not been agreed by the Authority.

Because the plan had not been agreed, it could not be approved, and would be considered by a national escalation panel scheduled for 19 October 2017. The terms of reference and working methods of the escalation panel were set out in Appendix 1 to the report.

A table illustrating the required amounts of social care expenditure, together with the proposals made by the CCG was included in the report. The amount proposed by the CCG was over £2m less than the required amount.

Prior to escalation, the BCF national support team had appointed an independent facilitator to work with both parties to attempt to seek agreement on the content of the plan. The facilitator was an experienced manager who has had recent experience in assisting the parties in another Health and Wellbeing Board area to reach agreement on their BCF plan. He was currently carrying out discussions with officers of both North Tyneside Council and North Tyneside CCG.

In the interim, the CCG had continued to make payments to the Authority at the levels agreed in the previous year, and those services continue to operate as normal. The services which were funded by the BCF in 2016/17 were summarised in Appendix 2 to the report.

In examining the Better Care Fund the sub-committee asked a range of questions which were responded to appropriately, including:

Why were the CCG proposing to reduce the BCF by £2m when national guidance clearly stated that contribution must be maintained in line with inflation and could not be less than the amount paid in 2016/17?

The CCG explained that the funding would be used in a slightly different way and that this had been discussed between the CCG and Council over the last couple of years. At the sub-committee's request Mark Adams of the CCG agreed to circulate a paper which explained why the CCG were proposing £2m less to the Council, what the intentions were for the money and what changes would be made to the services currently funded through the BCF.

What impact would a reduction of £2m income for social care have on Council services, employees and local residents?

The Head of HECS explained that the CCG had not given any explicit detail in relation to what services would be de-commissioned. If the Council were not to get the £2m funding the CCG would have to work up specifications for what they wanted to commission, this would take time especially if there was a need to plan for redundancies. She expressed concern that the funding loss would have a significant impact on preventing hospital admissions, hospital discharge and transfer of care. The CCG explained that they had a statutory duty to spend public money wisely and that any de-commissioning of services would be subject to an impact assessment. They stressed that the CCG and the Council had a collective roll to work together to make informed decisions.

How had the savings made from the closure of The Cedars been used?

The Head of HECS informed the sub-committee that some of the savings had been re-invested in rehabilitation services and some had helped to make savings for the CCG. She also clarified that the savings had totalled £1.041m and were in addition to the £2m reduction in BCF.

What was the Council Tax precept for social care used for?

The Head of HECS explained that funds raised through the precept had gone into the adults social care budget and had been used mainly to offset increased demand for services and the introduction of the living wage.

What was the Improved Better Care Fund (IBCF) and how was this funding being used?

The Head of HECS explained that the IBCF is a direct grant paid to the Council for social care. The three main criteria were to provide social care, facilitate hospital discharges and avoid admissions and winter pressures. The IBCF funding totalled approximately £5m in 2017/18 and needed to be used to alleviate pressures relating to the minimum wage and increase capacity in the system. The CCG mentioned that it was a requirement that they signed off the IBCF plans and that this had not yet happened.

When was it anticipated that the CCG would make savings on beds at North Tyneside General Hospital (NTGH) in order to develop intermediate care - as stated in a report to the sub-committee on 6 October 2016 (Previous Minute ASCHW 29/10/16)?

The CCG explained that a number of beds at NTGH were not being utilised and in line with the Older Persons Plan would be de-commissioned from the site. The CCG were considering how the savings could be used differently but the main aim would be to get people home from hospital quicker. A need had been identified for step up and step down beds as an alternative to hospital admission. The CCG were working with Northumbria Healthcare Foundation Trust on this matter.

When did communications about the £2m reduction and potential changes to services start?

The CCG informed the sub-committee that discussions had started between the CCG and the Council in 2015; and reiterated the importance of working together on how to spend the BCF and how things could be done differently.

What were the implications for the CCG if they were told to pay the Council the £2m?

The CCG explained that it would cause them significant difficulties as they were still under legal directions; and potentially this may send them back into special measures. They still had a financial deficit and some of the savings would be put into the recovery plan.

There was some discussion about the reduced capacity within the independent sector, and the sub-committee expressed concern that this could lead to people staying in hospital longer than needed because of delays in getting domiciliary care. The CCG said that a block of money was available for the independent sector and that they would being looking what investment to make in this area. The Head of HECS agreed that the sustainability of the independent sector was important; and that there was planned investment via the IBCF in relation to the minimum wage to help increase capacity within the sector.

The sub-committee heard that the CCG, Council and the facilitator would be meeting before the escalation panel meeting on the 19 October 2017. They were advised that this may not be the end of the process as the escalation panel may recommend that all parties get back together again with the facilitator to reach an agreement.

The Chair thanked officers for attending the meeting and stressed the importance of retaining positive working relationships.

It was **agreed** that the CCG would circulate a paper which explained why the CCG were proposing £2m less to the Council, what the intentions were for the money and what changes would be made to the services currently funded through the BCF.

ASCHW32/10/17 North Tyneside's approach to improving mental health in children, young people and working age adults

The Director of Public Health introduced the section relating to children and young people's mental health; and Anya Paradis of the CCG and Scott Woodhouse, the Council's People Based Commissioning introduced the section relating to working age adults.

North Tyneside had two key mental health strategies:

- North Tyneside Children and Young People's Mental Health and Emotional Wellbeing Strategy 2016 - 2021
- North Tyneside Joint Adult's Mental Health and Wellbeing Strategy 2016-21

The report provided a detailed update on key progress in relation to Children and Young Peoples mental health. This was broken down into four areas; promoting resilience, prevention and early intervention; improving access to support; services for high risk and vulnerable groups; and developing the workforce.

The report also provided details on the progress to date in relation to Working Age Adults. This was broken down into six areas; improving health and wellbeing; prevention and early intervention; access (helping people to get the right support at the right time) including a crisis; personalisation (ensuring the right services are in place and are responsive to the needs of the individual); integration (doing things collaboratively and together, public bodies and community/voluntary sector); and support recovery (helping people to get better and be less reliant on care and support services).

In relation to developing the workforce; resources had been committed for motivational interviewing and Cognitive Behaviour Therapy training for around 100 staff working with children and young people across the workforce last year. A member asked how many people who had received the training were still with the workforce. The Director of Public Health believed that the majority of staff who had received training were still with the workforce and that this could monitored.

A member mentioned that the youth council were very interested in young people's mental health issues and asked if they had been involved in the development of the resource pack for schools. The Director of Public Health confirmed that they had been involved and were active members of the strategy group, they had also been part of the launch event.

The Chair thanked officers for the report.

ASCHW33/10/17 Older Person's Mental Health

Susan Meins of the Council's People Based Commissioning Team, informed the sub-committee about the draft Mental Wellbeing in Later Life North Tyneside Joint Strategy 2017-2022.

The final draft Strategy would be presented to the Mental Health Integration Board for approval in November 2017. Following this the draft Strategy would then be circulated for wider consultation in December and January.

An action plan was currently being developed to take forward the issues identified as part of this work.

It was anticipated that the Mental Wellbeing in Later Life Strategy and Action Plan would be published early 2018.

Susan Meins ask members not to share the draft Strategy as this stage, as it required more work before it was circulated for wider consultation. She also offered to come back to a future sub-committee to talk about the Strategy and provide an update.

In response to a members query, Susan Meins said she would be happy to receive comments on the draft Strategy by email.

The Chair thanked Susan Meins for the report.

ASCHW34/10/17 Northumberland, Tyne and Wear, North Durham Sustainable Transformation Plan

The Chair gave a verbal update on the establishment of the Northumberland, Tyne and Wear, North Durham Sustainable Transformation Plan Joint Health Scrutiny Committee.

Councillors Gary Bell, Ian Grayson and Margaret Hall had been appointed the Authority's three representatives on the Joint Committee; and Councillors Karen Clark, Naomi Craven, Mathew Thirlaway were appointed as the named substitutes.

The first meeting of the Joint Committee would be hosted by Gateshead Council at Gateshead Civic Centre; no date had been set but it was likely to be around the middle of November 2017.

Meeting: Adult Social Care, Health and Wellbeing sub-committee

Date: 9th November 2017

Title: North Tyneside Integrated Urgent Care Service

Author: Mathew Crowther Tel: 0191 293 1161

Organisation: North Tyneside CCG

Wards affected: All

1. Purpose of Report

North Tyneside CCG attempted to procure a new integrated urgent care service to replace the existing walk-in services at Battle Hill, Rake Lane, and the borough-wide GP Out of Hours Service earlier this year. Unfortunately the CCG was unable to identify a provider capable of delivering the service specification and has therefore had to revisit its planning assumptions and postpone implementation until 1st October 2018.

The rationale for reforming local urgent care services remains valid; the current system is confusing for patients, makes inefficient use of increasingly limited clinical resources, and is financially unsustainable for the CCG. North Tyneside CCG is therefore proposing a second round of procurement to secure a single integrated urgent care service on revised terms. This service will consist of:

- An Urgent Treatment Centre offering GP-led healthcare to patients with minor injuries and minor ailments on an appointment and walk-in basis from 08.00 – 22.00 7 days a week.
- An Out of Hours Home Visiting Service providing access via NHS 111 to GP-led healthcare for patients at home. This service will operate from 18.30 – 08.00 on weekdays and 08.00 – 08.00 at weekends.

The service will also integrate with:

- Extended access to primary care services offering patients access to 1,000 additional appointments with North Tyneside GP practices every week.
- A&E streaming services which will assess walk-in patients and direct them to the most appropriate point of care – including back to a booked appointment with a North Tyneside GP.
- The development of a regional Clinical Advisory Service which will offer patients from across the North East greater access to telephone-based clinical care.

The overall aim will be to manage demand for A&E services more effectively and proactively encourage patients to use services which are appropriate to their needs.

As a result of the proposed changes, the CCG felt that it could not support moves to re-open overnight walk-in access to urgent care services at Rake Lane Hospital because:

- There is no clinical evidence to suggest that the suspension of overnight access to urgent care services has had a detrimental impact on safety, clinical quality, or the performance of the local urgent and emergency care system as a whole.
- Provision of core A&E services for patients with serious and potentially life-threatening conditions remains a priority for the local system as we head into winter. The CCG sees little value in redeploying clinicians from frontline A&E services in order to staff a walk-in service which typically saw just a handful of patients during the overnight period, the majority of whom presented with only very minor injuries and ailments.
- The CCG is no longer proposing to commission a 24 hour walk-in facility as part of its future model of urgent care provision.

The CCG is currently undertaking an engagement exercise to explain its rationale to the public and gather feedback before a final decision is made.

2. Recommendations

OSC is asked to note the contents of the attached report and approve:

1. The continued suspension of overnight access to walk-in services at Rake Lane Hospital
2. The CCG's plans to commission a new single integrated urgent care service for North Tyneside from 1st October 2018.

3. Details

Relevant details can be found within the attached report.

4. Appendices

North Tyneside Integrated Urgent Care Service

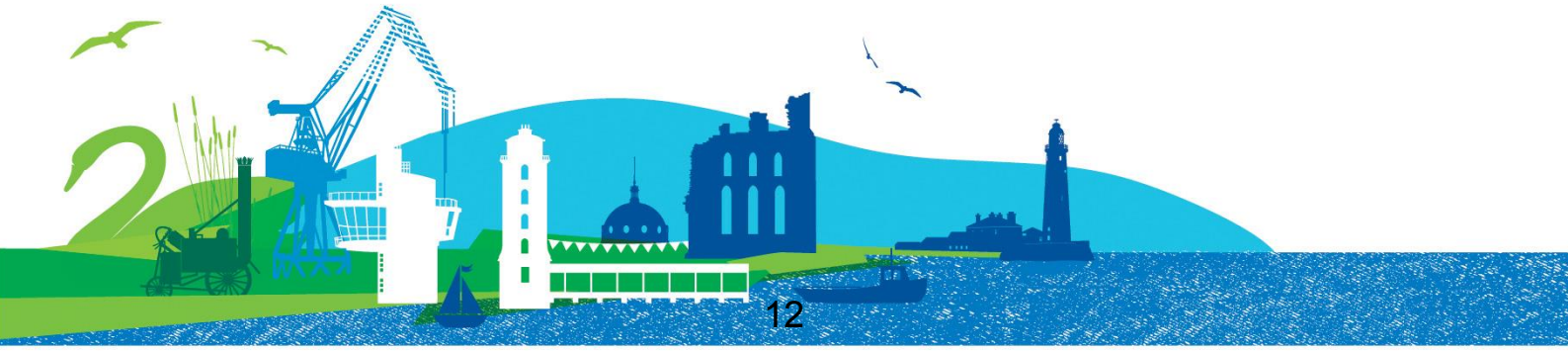
5. Background Information

The following documents have been used in the compilation of this report and may be inspected at the offices of the author:

- Right Care, Time & Place - Business Strategy and Case for Change
- North Tyneside Integrated Urgent Care Service Specification
- Integrated Urgent Care Procurement Evaluation Strategy
- Engagement Strategy
- Right Care, Time & Place – Lessons Learned

NHS
North Tyneside
Clinical Commissioning Group

NORTH TYNESIDE INTEGRATED URGENT CARE SERVICE



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1. Introduction

This report marks the beginning of a new phase in the CCG's efforts to reconfigure urgent care service in North Tyneside. The CCG committed to review local urgent care services as part of its five year *Urgent & Emergency Care Strategy 2014 – 2019.* Major reconfiguration of local services is necessary because the current system is:

- Unaffordable. The opening of the Northumbria Specialist Emergency Care Hospital (NSECH) in June 2015 increased the cost of the urgent and emergency care system in North Tyneside by around £2 million per annum and has contributed significantly towards the CCG's financial deficit. The CCG must therefore take action to place the local urgent care system on a financially sustainable footing for the future.
- Inefficient. The current system consists of a mixture of different services all offering overlapping access to urgent care within a relatively small geographic area. This represents poor value for money and an inefficient use of our finite clinical resources.
- Confusing. Patients have told us that they find the existing urgent care system confusing and difficult to access properly. They do not always understand the distinction between urgent and emergency care and have difficulty identifying which services are most appropriate for their needs. Many have indicated that they would prefer a simplified 'one stop shop' for urgent care in North Tyneside.

The CCG launched the *Right Care, Time & Place* initiative in January 2015 with the aim of:

- Consulting with the public on future scenarios for the delivery of urgent care in North Tyneside.
- Decommissioning the existing urgent care centres and out of hours service from 30th September 2017.
- Commissioning a single integrated urgent care service from 1st October 2017.

Unfortunately the CCG was unable to identify a provider capable of delivering the new service and a procurement exercise ended in July 2017 without a contract being awarded.

The CCG has subsequently taken stock of its positions and engaged in discussions with a number of partner organisations about the best way to achieve the desired outcomes for patients and the local health economy. After careful consideration the CCG has concluded that:

- None of the issue which prompted the decision to reconfigure urgent care services have been satisfactorily addressed. The local urgent care system is still unaffordable, inefficient and confusing for patients.
- Procurement remains the most effective way of securing an improved service model and greater financial efficiency.
- Changes to national guidance and the application of 'lessons learned' from the first procurement make it more likely that another procurement would be successful.

The CCG has therefore decided to:

- Extend the existing urgent care centre and out of hours contracts for a further 12 months
- Revise the service specification and financial envelope for the new urgent care service
- Competitively tender the contract with the aim of mobilising the new service by 1st October 2018.

2. Urgent care services in North Tyneside

2.1. Current state

North Tyneside CCG currently commissions the following urgent care services:

- North Tyneside General Hospital ('Rake Lane') Urgent Care Centre (Northumbria Healthcare)
- Battle Hill Walk-in Centre (Freeman Clinics)
- GP Out of Hours Service (Vocare)

North Tyneside residents also frequently access the following services with urgent care needs:

- Northumbria Specialist Emergency Care Hospital (NSECH) (Northumbria Healthcare)
- Royal Victoria Infirmary (RVI) (Newcastle upon Tyne Hospitals)
- Newcastle walk-in centres at Ponteland Road and Molineux Street (Newcastle upon Tyne Hospitals)

North Tyneside residents with urgent care needs will also have access to GP extended access services at evenings and weekends from September 2017 onwards.

2.2. Future state

The specification for the new urgent care service will be different from the one the CCG tried to procure in 2016/17 because:

- The outcome of the procurement indicated that there were not providers capable of delivering this service specification.

- This specification does not comply with new guidance issued by NHS England in July 2017.
- The commissioning requirements for urgent care during the out of hours period will change as a result of the regional re-procurement of NHS 111 in early 2018/19.
- The local urgent care system has changed since the original specification was drawn up in 2016/17, with A&E streaming and extended access to primary care services all being rolled out later this year.

However our overall objectives will remain exactly the same:

- Consolidate urgent care services onto a single site in North Tyneside.
- Integrate the delivery of in hours and out of hours services.
- Integration of emergency care, urgent care and primary care.
- A financially sustainable urgent care system.

2.3. National and local context

NHS England has instructed CCGs to replace the existing mix of urgent care centres, walk-in centres and Type 3 A&E departments with Urgent Treatment Centres by December 2019. The new Urgent Treatment Centres will:

- Open for at least 12 hours a day.
- Be staffed by a GP-led clinical workforce.
- Have access to simple diagnostics, e.g. urinalysis, ECG and in some cases X-ray.
- Offer patients booked appointments via NHS 111 and general practice as well as walk-in options.
- Increasingly be able to access routine and same-day appointments, and out of hours general practice, for both urgent and routine appointments, at the same facility.

Requirements for the out of hours period are also changing as a result of:

- Further integration between in-hours and out of hours care and extended access services in primary care reducing the need for a distinct GP centre visiting service.
- Responsibility for telephone-based appointments during the out of hours period will be passed to a regional clinical hub within NHS 111.
- Increased use of skill-mix solutions and technology will reduce the cost of delivering the home visiting element of the out of hours service.

3. Patient and public involvement

The CCG carried out a public consultation on the future of local urgent care services in 2015/16 and tried to secure an outcome which was consistent with the views expressed by the public. Unfortunately it was not possible to award a contract for that service and consequently the CCG has had to revisit the type of urgent care service it wishes to commission. In doing this we have been mindful of the need to adhere to the principles which underpinned the original consultation and to address as many of the issues raised by the public as possible.

Those issues were:

- Negative past experiences of accessing walk-in services in North Tyneside made some members of the public hesitant about using a new urgent care service.
- There was uncertainty about the differences between emergency care and urgent care and which services it was most appropriate to access for a given healthcare need.
- The perceived value of the service would depend on the facilities available and the skill-mix of the staff.
- Concern about the closure of services and the impact that additional activity would have on waiting times at the new urgent care center.
- The most important factor was the location of the urgent care center and its accessibility by car and public transport.
- The public preferred a single site solution because they wanted a simple urgent care system that was easy for them to navigate.

The following table contains a list of frequently asked questions from the original urgent care consultation and a response from the CCG, outlining how the proposal to commission an Urgent Treatment Centre will address those needs.

Frequently asked questions	**Response**
Why can't we keep all of the existing services in place?	The CCG cannot afford to continue funding two separate walk-in services and a separate GP out of hours services. The current system results in money being wasted on the duplication of services within a relatively small geographic area. National policy has also changed and all CCGs are required to have urgent treatment centres in place by December 2019. Therefore doing nothing is not an option we can consider.
Will these new proposals make the current urgent care system easier to	Yes. The CCG plans to replace an array of services offering similar levels of care in different locations, at different times of

understand and navigate?	the day, with a single integrated Urgent Treatment Centre.
How will I access the new service?	Patients will be encouraged to book an appointment via NHS 111. Those who choose to walk-in will still be seen but may have to wait longer.
Will one urgent care service be able to cope with the level of demand?	Yes. This will be a brand new service that is different from the existing walk-in centres and out of hours service. It will have the staff and equipment needed to cope with the increased level of demand.
Will I be able to walk into the new service 24 hours a day?	No. The CCG tried to procure a 24/7 urgent care service earlier this year and couldn't. Demand for urgent care during the overnight period is so low that the cost of keeping a service running overnight cannot be justified. The Urgent Treatment Centre will be open from 08.00 to 22.00. Outside those hours patients with an urgent care need will be able to access out of hours services via NHS 111 or attend A&E.
Why can't the CCG just commission a new service at Rake Lane / Battle Hill?	The CCG is required to follow public sector procurement rules which state that contracts should be awarded in a way which is fair, transparent, and achieves value for money. This should be achieved through competitive tendering process, unless there are compelling reasons not to do so. Awarding a contract to an existing provider simply because they own a particular set of premises, when other suitable locations are available in the borough, could be construed could be construed as a breach of those regulations and may result in the CCG being subject to legal action.
Does the outcome of the public consultation – which showed a clear preference for the service to be located at a particular site – make any difference?	No. The outcome of the public consultation does not override UK and EU law on public sector procurement. The CCG has to allow any suitable provider an opportunity to bid to deliver this service.
Where will the new service be based?	Organisations that bid to provide the service will have to nominate a suitable site from which to deliver it. The CCG will

	define what constitutes a 'suitable site' but will not pre-determine the location. This will be decided by the outcome of the procurement.
Will the new service be accessible by public transport and will it have adequate parking facilities?	Transport and accessibility will be one of the areas that will be assessed as part of the procurement. The CCG will ensure that proposed location is as accessible as possible.

4. Service model

The development of the service model has been informed by:

- Lessons learned from the urgent care procurement in 2017/18.
- NHS England commissioning guidelines
- The regional Urgent & Emergency Care Network strategy for developing clinical capacity within NHS 111
- The local context in which the service will operate, particularly with regards the proposed implementation of extended access to primary care services and A&E streaming in 2017/18.
- Evidence of what works well in other parts of the country.

The core aims of the service will be to:

- Provide safe, high quality, care to the people of North Tyneside.
- See, treat and discharge at least 95% of patients within four hours of arrival at the Urgent Treatment Centre.
- Provide care to patients presenting with minor ailments and minor injuries (Type 3 A&E) and ensure that patients presenting with more serious conditions are rapidly escalated to a Type 1 A&E.
- Ensure that an appropriate clinician is available to complete out of hours home visits within nationally agreed timescales during the commissioned service hours.
- Improve integration with the relevant parts of the local health economy, including primary care, A&E services, and NHS 111, to ensure that patients the most appropriate care for their needs.

The service will consist of an Urgent Treatment Centre and an Out of hours Home Visiting Service.

4.1. Urgent Treatment Centre

4.1.1. Acceptance criteria

The Urgent Treatment Centre will operate as a Type 3 A&E unit for patients presenting with minor injuries and minor illnesses. This will include (but not necessarily be limited to) the conditions set out below.

Minor Injuries:

- Superficial cuts including wound closure (Suturing, stapling, gluing, steri-strips)
- Bruises
- Ear Injury
- Minor eye conditions/infections – conjunctivitis, styes, removal of superficial foreign bodies
- Injury of severity not amenable to simple domestic first aid
- Trauma (minor) to hands, limbs or feet
- Minor Burns and scalds
- Insect, animal or human bites
- Risk of tetanus
- Minor head injuries without loss of consciousness
- X-ray diagnostics for potential fractures and foreign bodies
- Muscle and joint injury
- Sprains and strains
- Back pain and tendonitis
- Suture removal
- Dressings
- Urinalysis
- Nebuliser and oxygen therapy
- ECG
- Plastering
- Physiological Observations (BP, HR, Sp02, Temp, RR, BM, Peak Flow)

Minor Ailments:

- High Temperatures
- Abscesses
- Headaches
- Headaches & dizziness
- Coughs, colds, flu-like symptoms
- Hay fever / allergies
- Ear, nose and throat infections
- Eye care e.g. conjunctivitis, styes, removal of superficial foreign bodies
- Abdominal pain, indigestion, constipation, vomiting and diarrhoea
- Dermatological and skin complaints e.g. rashes, minor allergic reactions, burns, scabies, head lice, sunburn
- Genito-urinary problems e.g. urinary infections, thrush and menstrual problems
- Falls in patient of any age without history of dizziness or blackout
- Breathing problems e.g. asthma
- Chest infections
- UTI

The Urgent Treatment Centre will not treat patients who have an 'emergency' (i.e. potentially life-threatening) condition and those cases must be stabilized and immediately referred to a Type 1 A&E. Examples of conditions which will not be dealt with by the service include:

Conditions Requiring Emergency Care:

- Haemodynamically unstable
- Sepsis
- Significant trauma
- Fluctuating levels of consciousness
- Breathing unsafe
- Acute abdominal pain
- Suspected stroke
- Acute severe headache
- Overdose
- Suspected meningitis
- Cardiac chest pain suspected myocardial infraction or unstable angina
- Status epilepticus
- Sub-arachnoid haemorrhage
- Major burns
- Major Motor Vehicle Traffic Accident (MVTA)

4.1.2. Service specification

The key features of the service specification are:

- A GP-led Type 3 A&E unit open 08.00 – 22.00, 365 (366) days per year.
- Open to patients of all ages.
- An appointment based service. Appointments available via NHS 111 and the A&E streaming services at NSECH / RVI (for North Tyneside patients only).
- Patients with a pre-booked appointment will be seen, treated and discharged within 30 minutes of arrival.
- Patients without a pre-booked appointment (walk-ins) will be seen, treated and discharged within 4 hours of arrival.
- Patients without a pre-booked appointment will be clinically assessed with 15 minutes of arrival and may be offered a booked appointment with a local GP (in the extended access to primary care hubs) or other suitable service, e.g. community pharmacy, as appropriate.
- The service will have access to the following diagnostics on-site at all times:

- D-dimer/XDP
- Troponin
- Blood Monitoring
- Electrolytes (K+)
- Lactate
- Ultrasound or clear referral pathway for ultrasound
- Urine Dipstick

- The service must also provide a minimum of 24 hours per week of on-site radiography (imaging and interpretation) and clear referral pathways for patients who require an x-ray outside of those times.

4.1.3. Integration with other relevant services

Type 1 A&E departments

Patients with emergency care needs will be transferred to a Type 1 A&E via an ambulance or their own transportation.

The Urgent Treatment Centre will also integrate with Type 1 A&E assessment and streaming services to ensure that, wherever possible, patients who attend A&E with an urgent care need can be referred back to a booked appointment in the Urgent Treatment Centre.

Mental health liaison services

Patients with a mental health need could be referred to a number of existing services, including the psychiatric liaison service, crisis service and/or their own GP.

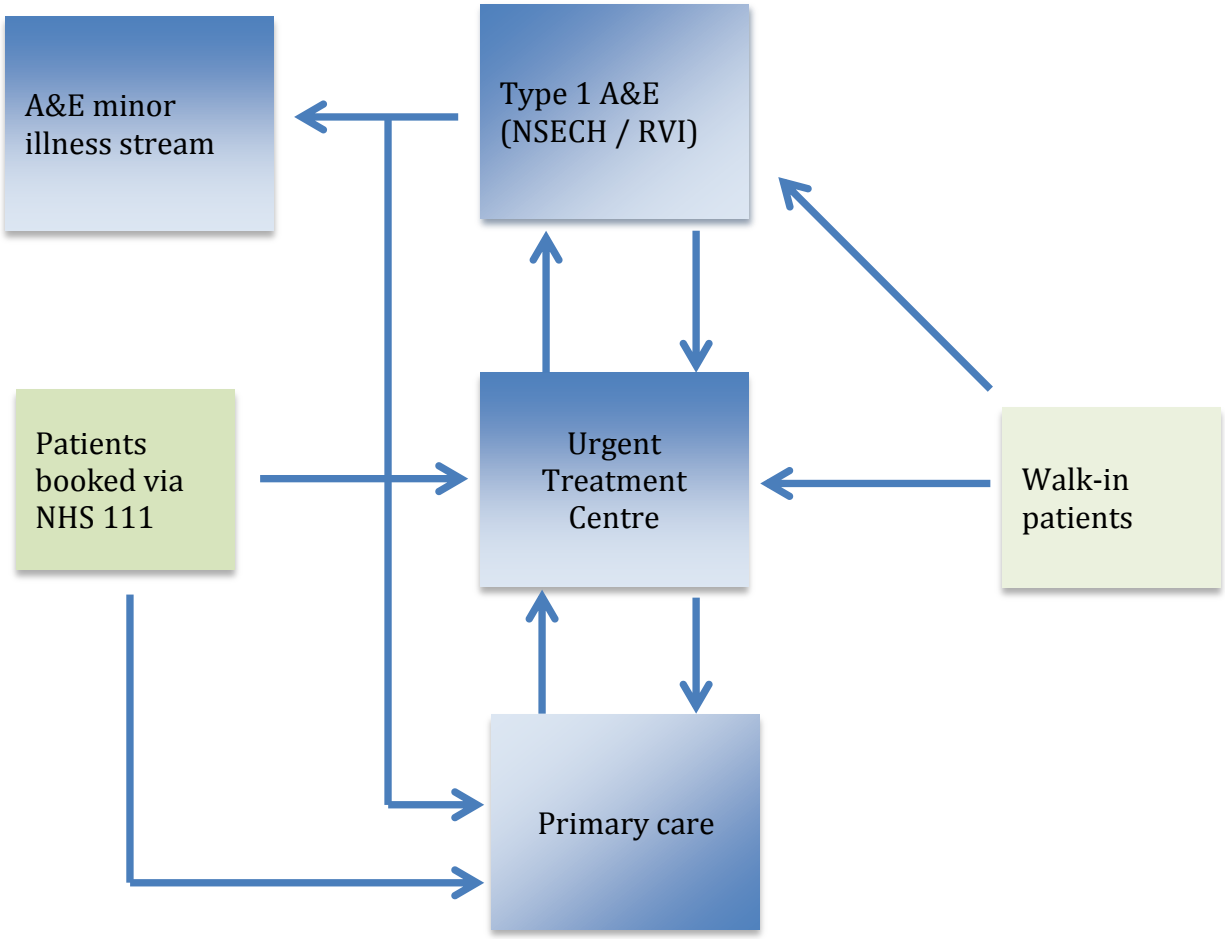
Primary care

Patients who present at the Urgent Treatment Centre with minor ailments should be offered to the opportunity to access the same-day appointments which are being made available to support the extended access to primary care scheme that will begin from September 2017. The CCG will also seek to support the integration of community pharmacies within the local urgent care system.

NHS 111

The Urgent Treatment Centre will be an appointment-based service with the appointment ledger being fully open to direct booking via NHS 111.

The chart below illustrates how the activity will flow between the various parts of the reconfigured urgent and emergency care system.



4.2. Out of Hours Home Visiting Service

The current Out of Hours service consists of three distinct elements:

- Centre visits (booked appointments) at Rake Lane Hospital
- Telephone appointments
- Home visits

By October 2018 the constituent parts of the current service will be replaced with the following:

- Centre visits will be delivered by the Urgent Treatment Centre. The rollout of extended access to primary care services will also provide North Tyneside residents with access to 224 hours of additional clinical time at evenings and weekends.
- Telephone advice and appointments will be delivered by the Integrated Urgent Care Service (commonly referred to 'the clinical hub') in NHS 111. This

service will be commissioned separately as part of the re-procurement of NHS 111 due to take place in early 2018/19.
- The CCG will commission a separate Out of Hours Home Visiting Service to provide North Tyneside residents with access to home-based care at evenings, weekends and bank holidays.

This model is similar to the one currently being implemented in South Tyneside and is based upon the principle of improving patient experience and outcomes through the integration of service delivery. The integration of the disparate elements of in-hours and out of hours urgent care also makes much more efficient use of finite clinical resources and creates financial efficiencies.

4.2.1. Out of Hours Home Visiting Service Specification

The key features of the service specification are:

- The service will operate from 18.30 – 08.00 Monday to Friday and 08.00 – 08.00 on weekends and bank holidays.
- Initial call handling, triage and the booking of appointments will be handled by NHS 111.
- The service will be delivered from an accessible clinical hub.
- A GP-led workforce. Providers must ensure that patients are treated by the clinician best equipped to meet their needs. Where it is clinically appropriate, patients must be able to have a face-to-face consultation with a GP.
- Appointments must be delivered within the timeframes specified by the relevant National Quality Requirements (NQRs).
- Activity dealt with by the Home Visiting Service will include (but not be limited to):
    - Patients with terminal illness
    - Patients who are housebound or have mobility issues that prevent them accessing care in an Urgent Treatment Centre / A&E setting
    - Patients for whom a physical journey could lead to unnecessary deterioration of their condition or unacceptable discomfort
    - When necessary, in accordance with local agreement, to pronounce life extinct
- Clinicians in the Home Visiting Service will have access to the following as a minimum:
    - defibrillator
    - oxygen
    - oxygen saturation monitor
    - nebuliser
    - non-controlled drug box
- The Provider will put in place arrangements to be able to access controlled drugs should these be deemed to be necessary. Practitioners must be up to date with required training in the use of this equipment.
- Clinicians undertaking home visits must be accompanied by a driver who will act as security and support.
- Alliance working arrangements with NHS 111 will be mandated via the service specification and contract.

4.3. Comparison with the previous urgent care procurement

The following table outlines the key differences between the specification for this service and the one which the CCG tried to commission previously.

Original model	New model	Rationale for change
Open to walk-in activity 24/7	Open to walk-in activity between 08.00 and 22.00	Overnight activity levels did not justify the cost of 24/7 opening. The proposed opening hours cover the existing peaks in urgent care activity.
GP on-site 24/7	GP-led. Patients who require a GP appointment must receive one within the nationally specified timeframe (or 4 hours if the patient walks into the service). Staff must have sufficient access to a GP to allow them to see, treat and discharge patients within the required timeframe.	Availability of GPs to staff a 24/7 service and the affordability of doing so.
Radiography services available on-site 16 hours per day, 7 days a week.	A minimum of 24 hours on-site provision per week.	Availability of radiographers to adequately staff the service.
Patients seen, treated and discharged within 2 hours of attending the walk-in centre	Walk-in patients seen, treated and discharged within 4 hours of attending the Urgent Treatment Centre. Patients with a booked appointment seen within 30 minutes of arrival.	Affordability of operating a 2 hour waiting target.
Non-clinical assessment of walk-in patients within 15 minutes of arrival	Clinical assessment of walk-in patients within 15 minutes of arrival	Compliance with NHSE commissioning guidelines.
Contract includes telephone-based appointments during the out of hours period	Telephone-based care during the out of hours period commissioned separately as part of a regional clinical hub	This service will be commissioned via the regional contract for NHS 111 from 2018/19.

5. Activity analysis

The CCG carried out a ward-level analysis of urgent care activity to determine the likely impact of centralising provision on a single site. The following assumptions underpinned this work:

- The results were split into two scenarios looking at the potential impact of a coastal location and a location in the western wards of the borough
- 40% of the minor ailments activity displaced from a closed service will not re-present in the new Urgent Treatment Centre. Evidence from other parts of the country indicates that a significant proportion of patients will be reabsorbed back into primary care or revert to self-care once a conveniently located access point to urgent care is closed.
- Activity displaced from closed services will be reapportioned according to existing patterns of service usage at ward-level.
- Activity levels will increase by 0.5% per annum as a result of demographic pressures.
- The activity forecasts **do not** include any assumptions about the ability of clinical streaming, extended access to primary care, and other service changes to alter the flow of activity into or out of the new service.

The data is shown in the tables below.

WESTERN LOCATION	16/17	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
NTGH	23,528	23,528					
Battle Hill	30,393	30,393					
GP Out of Hours	8,345	8,345					
NSECH	23,646	23,646	25,065	26,569	28,163	29,853	31,644
RVI	12,419	12,419	12,494	12,556	12,619	12,682	12,745
Molineux St	4,021	4,021	4,041	4,061	4,082	4,102	4,123
Westgate Road	486	486	488	491	493	496	498
New UTC			**58,241**	**58,532**	**58,824**	**59,119**	**59,414**
Total	102,838	102,838	100,328	102,209	104,181	106,251	108,424

COASTAL LOCATION	16/17	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
NTGH	23,528	23,528					
Battle Hill	30,393	30,393					
GP Out of Hours	8,345	8,345					
NSECH	23,646	23,646	23,764	23,883	24,002	24,122	24,243
RVI	12,419	12,419	13,164	13,954	14,791	15,679	16,619
Molineux St	4,021	4,021	4,262	4,518	4,789	5,076	5,381
Westgate Road	486	486	515	546	579	614	650
New UTC			**52,945**	**53,209**	**53,475**	**53,743**	**54,011**
Total	102,838	102,838	94,650	96,110	97,637	99,234	100,905

Activity in the Out of Hours Home Visiting Service was calculated by applying a demographic inflator to the baseline figure for 2016/17. As the location of the service

is unlikely to influence the number of people requiring a home visit during the out of hours period, the results are shown on a single table below.

	16/17	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
Home Visiting Service	1,626	1,626	1,634	1,642	1,651	1,659	1,667

The activity forecasts indicate that:

- The new Urgent Treatment Centre will receive 52,000 – 58,000 attendances in its first full year of operation.
- Activity levels will depend on the location of the service.
- A coastal location will attract fewer patients and result in higher activity flows into Newcastle-based services.
- A service located in the west of the borough will result in an increase in the number of patients presenting at NSECH with urgent care needs.
- Activity levels will decrease overall as a result of these changes, regardless of where the new service is located.
- There will be no significant change in demand for home visits.

6. Financial analysis

The CCG needs to set a contract value which strikes an appropriate balance between quality, value for money and attractiveness to potential providers. This will be done by applying national tariff prices and local cost indicators to the different elements on the service in order to arrive at an overall financial envelope for the procurement.

The new service will be commissioned on a block contract basis in order to minimise the level of financial risk to the commissioner and encourage the provider to manage demand more effectively. This will be a single contract for both in-hours and out-of-hours urgent care provision that may be held by one provider, or a number of providers working on an alliance basis. The contract will be for three years initially, with an option to extend for a further two years if necessary.

The baseline financial position for the current urgent care system is set out below.

Contract	**Current contract value (£m)**	**16/17 activity levels**	**Unit costs. (£)**
Rake Lane walk-in centre	3.0	23,528	127
Battle Hill walk-in centre	1.1	30,393	36
Out of Hours	1.5	15,592	96
NSECH	4.9	23,646	207
RVI	2.1	12,419	169
Newcastle walk-in centres	0.1	4,507	23
Total	**5.6**		

The data highlights the significant funding disparities that exist between current services and the need to move urgent care onto a footing that is financially sustainable for the CCG and the wider system.

The activity forecasts in Section 4 indicate that the Urgent Treatment Centre element of the service will see 52,000 – 58,000 attendances per annum in its first full year of operation. If the service were funded as a Type 3 A&E unit via a tariff-based contract then the cost of the contract would fall within the range of £3.2m to £3.6m per annum.

The Out of Hours Home Visiting Service will see 1,634 patients in its first full year of operation at an estimated cost of £280 per patient (based on 2017/18 prices). This equates to a total estimated cost of £457,520 per annum.

The cost of providing the service is therefore forecast to be between £3.6m and £4m. On that basis the CCG has opted to set the value of the proposed contract at £3.8m per annum, which represents the mid-point of our forecast estimate.

The CCG will also set aside a contingency fund of £0.6m to offset any increase in tariff-based activity costs that occur as a result of increased patient flows into Type 1 A&E units. The contingency will also be used to cover any other unforeseen costs which may occur as a result of service provision being centralised on a single site.

7. Impact on the local health economy

One of the strategic aims of these proposals is to create a local urgent care system that is capable of facilitating a significant downward shift of low acuity activity into more appropriate clinical settings. In practical terms this means making it easier for patients who have unnecessarily presented at a Type 1 A&E to be directed back to their local urgent care service, whilst also shifting non-urgent primary care activity from the Urgent Treatment Centre back to routine and extended access primary care services.

The following section provides a summary of the anticipated impact of the new service on patients and the other constituent parts of the local health economy.

7.1. Patient population

The new service will provide the residents of North Tyneside with a clear and accessible route into the local urgent care system. The offer of booked appointments should help smooth existing peaks and troughs in activity and reduce waiting times for patients using the service. The financial efficiencies realised from the current system will also improve the sustainability of the local health economy as a whole, reducing the need for further reductions in spending in other areas of the local NHS.

7.2. Type 1 A&E departments

The Integrated Urgent Care Service will help reduce pressures on neighbouring Type 1 A&E departments by providing them with access to booked appointments for patients who present at NSECH and the RVI with minor ailments. This will ensure that the highly specialised clinical resources which are available at our A&Es are reserved for those patients who need them the most, improving the quality and performance of the local health economy.

7.3. Primary care

The Urgent Treatment Centre will integrate with extended access primary care services in order to help spread demand for same-day access across a wider array of local services. The service will also provide an 'overspill' for local GP practices struggling to accommodate requests for same-day appointments and in turn will direct patients with very minor conditions and routine primary care needs back an appointment with their GP.

7.4. Community pharmacies

Community pharmacies are an under-utilised resource within the current urgent care system and could play a much greater role in the management of patients with minor ailments. The CCG hopes to increase integration between the Urgent Treatment Centre, community pharmacies and NHS 111 to ensure that patients with very minor ailments can be safely dealt with in a pharmacy setting.

7.5. Newcastle and Northumberland

The activity forecasts in Section 4 indicate that any change to the local urgent care system is likely to result in an increase in the number of North Tyneside residents travelling out of the borough for urgent care. The CCG has already discussed the various scenarios that are under consideration with are partners in Newcastle and Northumberland and they are aware of the potential consequences of the proposed changes.

8. Market analysis and procurement

8.1. Market Engagement

The aims and objectives of market engagement are:

- Explore service model solutions for delivery of urgent care services
- Assist in the development of service models which are innovative, sustainable, provide equitable access to high quality and safe and effective services at the right time and in the right place
- Gain an understanding of the markets preferred financial and contractual models
- Gain an understanding of the workforce required to deliver services
- Explore how the social, economic and environmental well-being of the North Tyneside area could be improved
- Gain an understanding of the required duration of a suitable mobilisation phase for the service
- Gain an understanding of the capability and capacity of providers interested in delivering the service.

Having already undertaken one complete round of market engagement and procurement, the CCG has already gained a number of insights into market conditions and used these to inform the revised service specification and financial envelope.

8.2. Feedback from providers

The following feedback was gathered from providers during previous rounds of market engagement.

Service Model

- The market shows a good understanding of the rationale for developing a more integrated approach to urgent care services and the particular issues in North Tyneside.
- There are differing attitudes and approaches to the appropriate management of clinical risk in an urgent care setting, with some providers being more open to the idea of redirecting patients to services located off-site.
- There were also differing attitudes towards demand management and particularly the issue of who has responsibility for managing patient expectations and demand. Some providers felt that this sat wholly with the commissioner, whilst others adopted a more collaborative approach.
- All providers were capable of delivering a GP-led multidisciplinary workforce.
- All providers confirmed that they could see, treat and discharge at least 95% of patients within 4 hours.

Premises

- Rake Lane and Battle Hill were both identified as potentially suitable sites for the new service.
- Wallsend Library was also identified as a potentially suitable site.
- Providers without existing access to premises in North Tyneside were willing to enter into partnership agreements with other organisations in order to deliver some or all of the service.

Financial / Contractual Models

- Single provider, prime-provider and partnership-based contractual arrangements were all put forward as possible mechanisms for delivery of the service.
- Providers were generally satisfied with the suggestion of a three year contract with the option to extend for a further two years. However five years plus two years was also put forward by one provider.
- A variety of financial models were suggested, including tariff, a ‘cap and collar’ arrangement and block payments, with various pros and cons associated with each.

- Two providers advised the CCG to adopt a tariff-based model, one suggested a block allocation that was sufficiently generous to mitigate activity risks, and three providers outlined a block and tariff combination.
- Three providers advised that any model adopted should ensure that risk is shared.
- Two providers asked that the CCG should consider the cost implications of setting KPIs i.e. targets for responsiveness may require additional staff.
- One provider suggested that an open procurement was not necessary given the outcome of the original public consultation.

Capability & Capacity

- There is sufficient understanding, level of interest and competition between potential providers within the marketplace
- Providers who participated have experience in delivering urgent care services and four providers currently deliver these within the North East region
- One provider outlined support would be required in respect of workforce planning to ensure recruitment of qualified GPs.
- Support will be required from the CCG for promotion of new services.
- One provider indicated that a single tender action could be justified on the grounds of access to suitable premises.

Mobilisation

- Providers suggested mobilisation periods ranging from 3 to 6 months, with responses being largely dependent on individual circumstances (i.e. whether the provider was already delivering an existing urgent care service in North Tyneside).

Integration

- All providers could advise how integration would be achieved but advised there would be cost implications in achieving interoperability across the North Tyneside area.

8.3. Lessons learned from the previous urgent care procurement

The following learning was also used to inform the development of the new service model:

- The value of the contract has been increased from £3.3m to £3.8m
- The service specification has also been altered to reflect the latest national guidance, reducing the need for comprehensive on-site access to radiography and the continual presence of a GP on-site.
- The accessibility of existing premises will be determined before the procurement starts

- Providers without access to existing premises will be required to submit a joint memorandum of understanding, co-signed by their partner organisation, as part of the compliance and control checks of the procurement process.

8.4. Procurement options

The following table describes the options that are available to the CCG and their suitability in the context of this procurement.

Procurement Process	Description	Consideration
Not to procure	Allow the current provision to expire.	This option would leave a gap in service provision.
Open Procedure (Part B Services – therefore the basic principles of the Open Procedure will be followed to commission this service)	This allows an unlimited number of interested providers to tender against defined parameters. This procedure is open and transparent and is the recommended procedure if low numbers of interested providers are known.	Market engagement exercises have demonstrated a relatively low number of providers who can deliver services, however it does demonstrate that there is sufficient competition to run a competitive procurement process.
Restricted Procedure	This is a two-stage procedure. The first stage allows an unlimited number of interested providers to tender but allows the contracting authority to set the minimum criteria relating to technical, economic and financial capabilities that the suppliers have to satisfy. Following evaluation and short-listing, a minimum of five suppliers (unless fewer qualify) are invited to tender in the second stage.	A longer timescale is required for this process but it is important to use this process if there are a significant number of providers within the market likely to respond. As identified in the market engagement exercises there are a limited number of interested providers.
Competitive Dialogue	This procedure is appropriate for complex contracts where contracting authorities are not objectively able to define the technical means capable of satisfying their needs or objectives, and/or are not objectively able to specify the legal and/or financial make-up of a project. A pre-qualification questionnaire should be completed to select the candidates to participate in the dialogue. The contracting authority enters into a dialogue with bidders to identify and define the means best suited to satisfying	There are lengthy and variable timescales associated with this process. There is a known service model and evidence from potential providers that this could be delivered through market engagement exercises.

Procurement Process	Description	Consideration
	their needs. The dialogue may be conducted in successive stages with the remaining bidders being invited to tender. Must consider if there is any reason (artistic or technical expertise or the need to protect exclusive rights) that warrants the contract being carried out by a particular person or authority - If no: competitive dialogue, if yes: negotiated procedure may be considered.	
Negotiated Procedure	The Negotiated Procedure is sometimes referred to as a single tender action where a contract is awarded to a provider without competition. Although it is not a term that is defined in the EU Directives or UK Regulations, Regulation 14 of The Public Contracts Regulations 2006 refer to the "negotiated procedure without prior publication of a contract notice" (see para 5.1). This allows a contracting authority to depart from the Regulations' usual obligations on open competition and transparency and negotiate a contract directly with one or more providers. **Its use is limited to a few defined circumstances in which it is considered strictly necessary.** If the negotiation is being conducted with one provider then this is in effect a single tender action.	Justification on the decision to award without open competition is critical for audit purposes and to overcome challenges that there are no other providers within the market with capability and capacity to provide the required service. Through market engagement and analysis a number of providers have been identified. There are no compelling reasons for the CCG not to invite competitive tenders.

8.5. 'Open' versus 'closed' procurement

During the previous rounds of market engagement it was suggested that the CCG run a closed procurement process with the owner of the Rake Lane site on the grounds that the consultation had identified that as the public's preferred location for a new urgent care service.

The CCG obtained the following legal advice on this matter:

- The CCG must comply with public sector procurement regulations which state that "contracts should be awarded in a way which is fair, transparent, and achieves value for money. This should be achieved through competitive tendering process, unless there are compelling reasons not to do so."
- The outcome of the consultation does not constitute a compelling reason to exclude other potential providers from bidding to deliver the service.
- The CCG should therefore seek to commission the service from any suitable site in North Tyneside.

- Failure to carry out a competitive tender could be construed as anticompetitive behaviour and expose the CCG to the risk of legal challenge.
- The CCG should write to the owners of the existing urgent care centres to ascertain whether they are willing to allow other providers to bid to deliver services from their premises.

9. Recommendations

Although the CCG failed to secure a new urgent care service in 2017/18 the rationale for carrying out a re-procurement remains sound. The local urgent care system is still confusing for patients, financially unsustainable and makes poor use of limited clinical resources. It is therefore necessary for the CCG to press ahead with a second round of procurement in order to secure as many of its original objectives as possible.

CCG Governing Body is asked to approve the following:

- North Tyneside CCG will decommission the existing urgent care services at Rake Lane, Battle Hill, and the Out of Hours service from 30th September 2018.
- These services will be replaced by an Integrated Urgent Care Service consisting of an Urgent Treatment Centre and an Out of Hours Home Visiting Service from 1st October 2018.
- The contract will be awarded for three years (with the option to extend for a further two years) at an annual value of £3.8m.
- The contract will be awarded by a competitive procurement.
- The CCG will specify that the service can be provided from any suitable location in North Tyneside. The location of the service will therefore depend on the outcome of the procurement and the chosen site of the winning bidder.

10. Related documents

North Tyneside Integrated Urgent Care Service Specification

Integrated Urgent Care Procurement Evaluation Strategy

Engagement Strategy

Right Care, Time & Place – Lessons Learned

Meeting:	OSC Adult Social Care, Health and Wellbeing Sub-committee
Date:	November 9th 2017
Title:	Better Care Fund update

Author:	Kevin Allan	**Tel:** 0191 643 6078
Service:	Health, Education, Care and Safeguarding	
Directorate:	Deputy Chief Executive	
Wards affected:	All	

1 Background

The Better Care Fund is now in its third year of operation. The current planning cycle covers two years, i.e. 2017/18 and 2018/19.

The national planning requirements for the BCF were published by the Department of Health, Department of Communities and Local Government, and NHS England on 4th July 2017.

2 Current status of the BCF plan

The previous meeting of the Committee heard that the CCG and the Authority had been unable to agree to a plan prior to the deadline for submission of plans to the national bodies was September 11th 2017. Since that date, the CCG and the Authority have reached agreement at officer level. The proposed BCF plan has been resubmitted to the BCF assurance process, subject to the agreement of the Health and Wellbeing Board, which will consider the plan on 16th November.

2 Key points of the BCF plan.

The plan is attached to this report as Annexe 1.

The plan will be considered by the Cabinet on 13th November, by the Health and Wellbeing Board on 16th November, and by the Governing Body of North Tyneside CCG on 28th November.

If approved by the Health and Wellbeing Board, the Council, and the CCG, the plan will meet the national conditions, i.e:

I. That plans be jointly agreed by the Council and CCG, and signed off by the Health and Wellbeing Board
II. The NHS contribution to social care must be maintained in line with inflation
III. Agreement to invest in NHS-commissioned out-of-hospital services

IV. Implementation of the High Impact Change Model for reducing delayed transfers of care

As suggested by the national BCF guidance, the BCF Plan is a continuation of the 2016/17 plan, featuring many of the same services.

There are differences from the previous year, due to the full-year effect of changes to intermediate care, which were agreed in 2016/17, but only took effect in the last quarter of 2016/17.

The Cedars Intermediate Care Centre closed in 2016/17 and therefore does not feature in the 2017/18 BCF plan. The CCG commissioned a new Community Rehabilitation Service, which commenced in January 2017. The full-year effect of the closure of that service and the full year cost of the new Community Rehabilitation Service is included in the 2017/18 BCF plan.

The CCG and the Authority will work in collaboration during 2017/18 to review and rebase existing schemes within the BCF document, ensuring value for money and positive quality outcomes, identifying opportunities to include (where appropriate) system and service changes, working within the current financial envelope. Any changes to services provided will take effect from April 2018 for 2018/19, or later as agreed between the two organisations. Any changes must ensure that the North Tyneside BCF plan continues to comply with the BCF national requirements. Both organisations will work together to ensure that the residents of North Tyneside get the best return for investment in the BCF.

3 The Improved Better Care Fund

2017/18 is the first year in which the Improved Better Care Fund (iBCF) has been implemented. This funding is paid directly to local authorities as a direct grant under Section 31 of the Local Government Act 2003 (power to pay grants to local authorities). There is a requirement that it is pooled into the local BCF Plan and the grant conditions stipulate that it must be spent on:

(a) meeting adult social care needs;
(b) reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and
(c) ensuring that the local social care provider market is supported.

There is no requirement to spend across all three purposes, or to spend a set proportion on each. For North Tyneside, the value of the iBCF is £5.043m in 2017/18 and £6.773m in 2018/19. The iBCF is paid subject to certain grant conditions. Briefly, the iBCF may be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported. A recipient local authority must:

a) pool the grant funding into the local Better Care Fund, unless an area has written Ministerial exemption;

b) work with the relevant CCG and providers to meet National Condition four (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19; and

c) provide quarterly reports as required by the Secretary of State.

The Plan proposes that the Improved Better Care Fund be used as follows:

	2017/18 Gross Contribution £'000	2018/19 Gross Contribution £'000
Meeting adult social care needs:		
Effect of demographic growth and change in severity of need	1,270	1,892
Reducing pressures on the NHS:		
Ensuring that the local social care provider market is supported:		
Impact on care home fees of paying the national living wage	2,145	2,776
Impact on domiciliary care fees of paying the national living wage	384	496
Impact on other increased fees (ISL, day care, direct payments, etc.) of paying the national living wage	1,244	1,609
TOTAL	5,043	6,773

4 Changes to the BCF plan

As suggested by the national BCF guidance, the BCF Plan is a continuation of the 2016/17 plan, featuring many of the same services.

There are differences from the previous year, due to the full-year effect of changes to intermediate care, which were agreed in 2016/17, but only took effect in the last quarter of 2016/17.

The Cedars Intermediate Care Centre closed in 2016/17 and therefore does not feature in the 2017/18 BCF plan. The CCG commissioned a new Community Rehabilitation Service, which commenced in January 2017. The full-year effect of the closure of that service and the full year cost of the new Community Rehabilitation Service is included in the 2017/18 BCF plan.

The CCG and Local Authority will work in collaboration during 2017/18 to review and rebase existing schemes within the BCF document, ensuring value for money and positive quality outcomes, identifying opportunities to include (where appropriate) system and service changes, working within the current financial envelope. Any changes to services provided will take effect from April 2018 for 2018/19, or later as agreed between the two organisations. Any changes must ensure that the North Tyneside BCF plan continues to comply with the BCF national requirements. Both organisations will work together to ensure that the residents of North Tyneside get the best return for investment in the BCF.

Appendix 1 : Content of the BCF plan compared with 2016/17

Scheme ID	Scheme Name	Area of Spend	Commissioner	Provider	Source of Funding	2016/17 Expenditure (£)	2017/18 Expenditure (£)	2018/19 Expenditure (£)
POOLED FUND								
iBCF								
14	Impact on domicilliary care fees of national living wage	Social Care	Local Authority	Private Sector	Improved Better Care Fund		**384,000**	496,000
13	Impact on care home fees of national living wage	Social Care	Local Authority	Private Sector	Improved Better Care Fund		**2,145,226**	2,775,688
16	Effect of demographic growth and change in severity of need	Social Care	Local Authority	Private Sector	Improved Better Care Fund		**1,270,000**	1,892,000
15	Impact on other increased fees (ISL, day care, direct payments etc) of national living wage	Social Care	Local Authority	Private Sector	Improved Better Care Fund		**1,244,000**	1,609,000
	Improved Better Care Fund					**0**	**5,043,226**	**6,772,688**
LA Provide								
1	Community-based support, including Carepoint; reablement; immediate response and overnight home care; adaptations and loan equipment service; and CareCall / telecare	Social Care	Local Authority	Local Authority	CCG Minimum Contribution	7,013,000	**7,138,533**	7,274,165
12	Independent support for people with learning disabilities	Social Care	Local Authority	Private Sector	CCG Minimum Contribution	600,000	**610,740**	622,344
9	Care Act implementation	Social Care	Local Authority	Local Authority	CCG Minimum Contribution	597,000	**607,686**	619,232
10	Carers support	Social Care	Local Authority	Charity / Voluntary Sector	CCG Minimum Contribution	560,000	**570,024**	580,854

Scheme ID	Scheme Name	Area of Spend	Commissioner	Provider	Source of Funding	2016/17 Expenditure (£)	2017/18 Expenditure (£)	2018/19 Expenditure (£)
3	Intermediate Care - community services	Social Care	CCG	Local Authority	CCG Minimum Contribution	103,000	**421,411**	429,417
7	Seven-day social work	Social Care	Local Authority	Local Authority	CCG Minimum Contribution	63,000	**64,128**	65,346
8	Improving access to advice and information	Social Care	Local Authority	Local Authority	CCG Minimum Contribution	50,000	**50,895**	51,862
	The Cedars					1,041,000	-	-
	CCG Funding to Local Authority					**10,027,000**	**9,463,417**	**9,643,220**
CCG Commission								
4	Liaison Psychiatry - Working Age Adults	Mental Health	CCG	NHS Mental Health Provider	CCG Minimum Contribution	212,000	**617,859**	629,598
5	Liaison Psychiatry - Older People	Community Health	CCG	NHS Community Provider	CCG Minimum Contribution		**132,132**	134,643
24	Admission avoidance and discharge planning services	Community Health	CCG	NHS Community Provider	CCG Minimum Contribution	723,000	**724,177**	737,936
2	Intermediate Care beds	Community Health	CCG	NHS Community Provider	CCG Minimum Contribution	4,493,000	**3,653,432**	3,722,847
21	CarePlus (New Models of Care)	Community Health	CCG	CCG	CCG Minimum Contribution		**620,208**	631,992
19	End of Life Care - RAPID	Community Health	CCG	NHS Community Provider	CCG Minimum Contribution	314,000	**227,380**	231,700

Scheme ID	Scheme Name	Area of Spend	Commissioner	Provider	Source of Funding	2016/17 Expenditure (£)	2017/18 Expenditure (£)	2018/19 Expenditure (£)
6	Enhanced Primary Care in Care Homes	Primary Care	CCG	CCG	CCG Minimum Contribution		**100,000**	101,900
	CCG Commission from own funding					**5,742,000**	**6,075,188**	**6,190,616**
TOTAL POOLED FUND						**15,769,000**	**20,581,831**	**22,606,524**
NON-POOLED FUND								
11	Disabled Facilities Grant	Social Care	Local Authority	Private Sector	Local Authority Contribution	**1,307,000**	**1,416,617**	**1,526,533**
TOTAL VALUE OF BETTER CARE FUND						**17,076,000**	**21,998,448**	**24,133,057**

Better Care Fund plan 2017-10-24

Area	**North Tyneside**
Constituent Health and Wellbeing Boards	**North Tyneside**
Constituent CCGs	**North Tyneside**

Version History

Version	Notes	Author
2017-8-28	Discussed at BCF Partnership Board on 30.8.17	K Allan
2017-9-13	Added service descriptors based on material provided by T Dunkerton. Amalgamated services Added text to national metrics section	K Allan
2017-10-18	References to unapproved status of plan removed following discussions between L Young-Murphy and J Old Added dates of Board consideration Added Appendix 5 – reducing inequalities Added table 8 showing calculation of iBCF costs	K Allan
2017-10-24	Amended following meeting between K Allan, J Goldthorpe, and T Dunkerton on 23rd Oct. Removed several CCG-commissioned schemes.	K Allan

Contents

Introduction

This plan ensures continuity with the 2016/17 North Tyneside BCF, updated where appropriate to take account of service developments.

The BCF plan will take the North Tyneside health and care system closer to the goal of health and social care integration through:

- Continuing to Integrate the Council reablement services, immediate response and overnight home care, and hospital social workers with the admission avoidance services provided through the NHS (Carepoint)
- Implementing a new model of care for frail elderly patients in the Whitley Bay locality (CarePlus)
- Developing intermediate care services to increase resources for admission avoidance and improve recovery from illness, leading to fewer admissions to permanent residential care and reduced demand for NHS Continuing Health Care

In addition the BCF plan will maintain existing services which:

- Improve the coordination of mental and physical health services (Liaison Psychiatry)
- Enable equipment and adaptations to be rapidly provided to support healthy living at home (Adaptations and Loan Equipment Service)
- Provide 24/7 crisis support through assistive technology (Carecall / telecare)

The signatories to the plan are North Tyneside Council and NHS North Tyneside Clinical Commissioning Group. The services supported through the BCF are commissioned from a range of providers including Northumbria Healthcare NHS Foundation Trust, The Newcastle upon Tyne Hospitals NHS Foundation Trust, Northumberland Tyne and Wear NHS Foundation Trust, Age UK, and private social care providers. The development of these services have been discussed with providers through the commissioning intentions process.

The CCG and Local Authority will work in collaboration during 2017/18 to review and rebase existing schemes within the BCF document, ensuring value for money and positive quality outcomes, identifying opportunities to include (where appropriate) system and service changes, working within the current financial envelope. Any changes to services provided will take effect from April 2018 for 2018/19, or later as agreed between the two organisations. Any changes must ensure that the North Tyneside BCF plan continues to comply with the BCF national requirements. Both organisations will work together to ensure that the residents of North Tyneside get the best return for investment in the BCF.

The funding contributions are set out in Table 1 overleaf.

Table 1

	2017/18 Gross Contribution	2018/19 Gross Contribution
North Tyneside CCG		
Minimum CCG contribution	£15,538,604	£15,833,838
Additional CCG contribution		
Sub total	£15,538,604	£15,833,838
North Tyneside Council		
Disabled Facilities Grant	£1,416,617	£1,526,533
Improved Better Care Fund	£5,043,226	£6,772,688
Sub total	£6,459,843	£8,299,221
GRAND TOTAL	£21,998,447	£24,133,058

Table 2 shows a summary of BCF expenditure–

Table 2

Area of spend / scheme type / scheme name	Sum of 2017/18 Expenditure (£)	Sum of 2018/19 Expenditure (£)
Community Health	**£ 5,225,197**	**£ 5,324,476**
10. Integrated care planning	**£ 620,208**	**£ 631,992**
CarePlus (New Models of Care)	£ 620,208	£ 631,992
11. Intermediate care services	**£ 3,653,432**	**£ 3,722,847**
Intermediate Care beds	£ 3,653,432	£ 3,722,847
12. Personalised healthcare at home	**£ 227,380**	**£ 231,700**
End of Life Care - RAPID	£ 227,380	£ 231,700
9. High Impact Change Model for Managing Transfer of Care	**£ 724,177**	**£ 737,936**
Admission avoidance and discharge planning services	£ 724,177	£ 737,936
Mental Health	**£ 749,991**	**£ 764,241**
2. Care navigation / coordination	**£ 749,991**	**£ 764,241**
Liaison Psychiatry - Older People	£ 132,132	£ 134,643
Liaison Psychiatry - Working Age Adults	£ 617,859	£ 629,598
Primary Care	**£ 100,000**	**£ 101,900**
12. Personalised healthcare at home	**£ 100,000**	**£ 101,900**
Enhanced Primary Care in Care Homes	£ 100,000	£ 101,900
Social Care	**£ 15,923,259**	**£ 17,942,442**
11. Intermediate care services	**£ 421,411**	**£ 429,417**
Intermediate Care - community services	£ 421,411	£ 429,417
16. Other	**£ 5,701,807**	**£ 7,443,782**
Care Act implementation	£ 607,686	£ 619,232

Effect of demographic growth and change in severity of need	£ 1,270,000	£ 1,892,000
Impact on care home fees of national living wage	£ 2,145,226	£ 2,775,688
Impact on domicilliary care fees of national living wage	£ 384,000	£ 496,000
Impact on other increased fees (ISL, day care, direct payments etc) of national living wage	£ 1,244,000	£ 1,609,000
Improving access to advice and information	£ 50,895	£ 51,862
3. Carers services	**£ 570,024**	**£ 580,854**
Carers support	£ 570,024	£ 580,854
4. DFG - Adaptations	**£ 1,416,617**	**£ 1,526,533**
Disabled Facilities Grant	£ 1,416,617	£ 1,526,533
6. Domiciliary care at home	**£ 610,740**	**£ 622,344**
Independent support for people with learning disabilities	£ 610,740	£ 622,344
9. High Impact Change Model for Managing Transfer of Care	**£ 7,202,660**	**£ 7,339,511**
Community-based support, including Carepoint; reablement; immediate response and overnight home care; adaptations and loan equipment service; and CareCall / telecare	£ 7,138,533	£ 7,274,165
Seven-day social work	£ 64,128	£ 65,346
Grand Total	**£ 21,998,447**	**£ 24,133,059**

Table 3 – schemes categorised by source of funding (2017/18 only)

Sum of 2017/18 Expenditure (£)				
	CCG Minimum Contribution	Improved Better Care Fund	Local Authority Contribution	Grand Total
Community Health	**£ 5,225,197**			**£ 5,225,197**
10. Integrated care planning	**£ 620,208**			**£ 620,208**
CarePlus (New Models of Care)	£ 620,208			£ 620,208
11. Intermediate care services	**£ 3,653,432**			**£ 3,653,432**
Intermediate Care beds	£ 3,653,432			£ 3,653,432
12. Personalised healthcare at home	**£ 227,380**			**£ 227,380**
End of Life Care - RAPID	£ 227,380			£ 227,380
9. High Impact Change Model for Managing Transfer of Care	**£ 724,177**			**£ 724,177**
Admission avoidance and discharge planning services	£ 724,177			£ 724,177
Mental Health	**£ 749,991**			**£ 749,991**
2. Care navigation / coordination	**£ 749,991**			**£ 749,991**
Liaison Psychiatry - Older People	£ 132,132			£ 132,132
Liaison Psychiatry - Working Age Adults	£ 617,859			£ 617,859
Primary Care	**£ 100,000**			**£ 100,000**
12. Personalised healthcare at home	**£ 100,000**			**£ 100,000**
Enhanced Primary Care in Care Homes	£ 100,000			£ 100,000
Social Care	**£ 9,463,416**	**£ 5,043,226**	**£ 1,416,617**	**£ 15,923,259**
11. Intermediate care services	**£ 421,411**			**£ 421,411**
Intermediate Care - community services	£ 421,411			£ 421,411
16. Other	**£ 658,581**	**£ 5,043,226**		**£ 5,701,807**
Care Act implementation	£ 607,686			£ 607,686
Effect of demographic growth and change in severity of need		£ 1,270,000		£ 1,270,000
Impact on care home fees of national living wage		£ 2,145,226		£ 2,145,226
Impact on domicilliary care fees of national living wage		£ 384,000		£ 384,000
Impact on other increased fees (ISL, day care, direct payments etc) of national living wage		£ 1,244,000		£ 1,244,000
Improving access to advice and information	£ 50,895			£ 50,895
3. Carers services	**£ 570,024**			**£ 570,024**
Carers support	£ 570,024			£ 570,024
4. DFG - Adaptations			**£ 1,416,617**	**£ 1,416,617**
Disabled Facilities Grant			£ 1,416,617	£ 1,416,617
6. Domiciliary care at home	**£ 610,740**			**£ 610,740**
Independent support for people with learning disabilities	£ 610,740			£ 610,740
9. High Impact Change Model for Managing Transfer of Care	**£ 7,202,660**			**£ 7,202,660**
Community-based support, including Carepoint; reablement; immediate response and overnight home care; adaptations and loan equipment service; and CareCall / telecare	£ 7,138,533			£ 7,138,533
Seven-day social work	£ 64,128			£ 64,128
Grand Total	**£ 15,538,604**	**£ 5,043,226**	**£ 1,416,617**	**£ 21,998,447**

What is the local vision and approach for health and social care integration?

Our vision for integration is simple yet effective:

- Builds upon the Health and Well Being Strategy
- Safe and sustainable health and care services that are joined up, closer to home and economically viable
- Empowered and supported people who can play a role in improving their own health and well being

Our ***key aims for Health and Care by 2021*** are to:

- Experience levels of health and wellbeing ***outcomes comparable to the rest of the country*** and ***reduce inequalities*** across the NTWND STP footprint area
- Ensure a ***vibrant Out of Hospital Sector*** that wraps itself around the needs of their registered patients and attracts and retains the workforce it needs
- ***Maintain and improve the quality hospital and specialist care*** across our entire provider sector- delivering highest levels of quality on a ***7-day basis***

Relationship to the STP

This vision is expressed in the STP plan for Northumberland, Tyne and Wear, and North Durham, (NTWND) of which North Tyneside is a constituent part. The NTWND area has strong health and care services and has experienced the fastest increase in life expectancy of any region of the UK. But the health and wellbeing gap compared to the rest of the UK and health inequalities within the region remain stubbornly high. Poor population health leads to overuse of intensive health services and pressures on primary and social care, resulting in a system over-focussed on the treatment of ill health at the expense of preventing it. It also reduces productivity and hampers economic growth, entrenching income inequalities which contribute to poor health.

We are building on a long history of partnership working and through that collaboration the results have been positive and greater than any individual organisation could have achieved alone. As a footprint, NHS and Local Authority organisations in Northumberland Tyne and Wear and North Durham (NTWND) have come together to work in collaboration on closing the three gaps of health and wellbeing, care and quality and financial sustainability. We do so working at scale across the STP footprint and as distinct Local Health Economy (LHE) Areas: Northumberland and North Tyneside, Newcastle and Gateshead, South Tyneside, Sunderland and North Durham.

Our STP is built upon established programmes of work within each of our Local Health Economies as well as additional new proposals for transformation over the next 5 years with common priorities being delivered at an STP level. The NTWND health and social care system is one of the strongest in England. The three NHS Foundation Trusts serving North Tyneside all have “Outstanding” CQC ratings. Through the implementation of our programmes of work at all levels, our STP indicates how we propose to deliver financial stability.

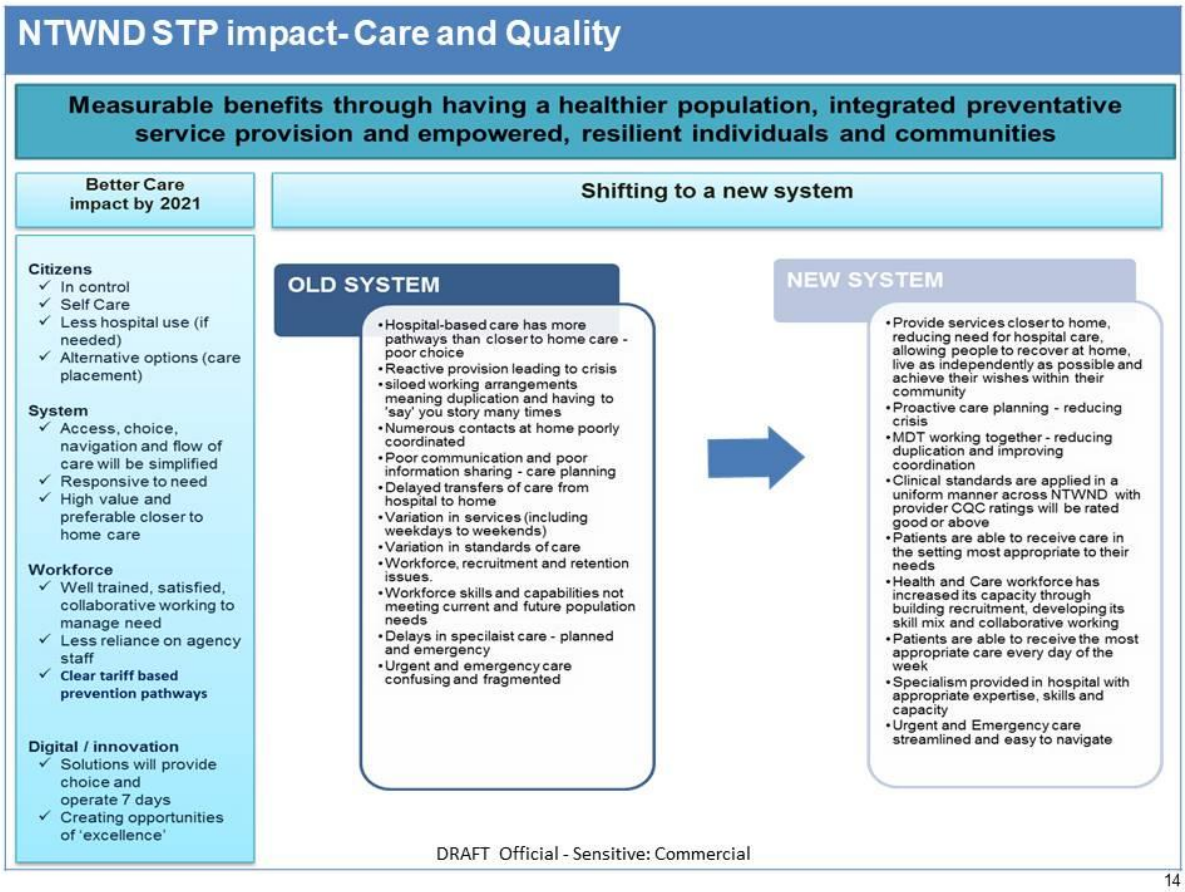
Looking forward to 2021, by doing nothing we will see the current gaps in our Health and Wellbeing and Care and Quality outcomes against the rest of the country widen. Our local NHS financial gap coupled with that of our local authorities’ financial constraints, if left unaddressed, will cause a decline in our local services resulting in an unsustainable health and care system.

The three key transformation areas are the same for the whole of the STP footprint:

1. Scaling up Prevention, Health and Wellbeing
2. Optimal use of the Acute Sector
3. Out of Hospital Collaboration

Our vision builds upon existing work underway within each of the Local Health Economy areas (LHEs) and enables us to take a transformative approach to addressing the key challenges we face across the system.

Figure 1 – STP: plan on a page



From Figure 1 above, three initiatives are strongly linked to this BCF plan:

The STP calls for	The BCF will:
Provide services closer to home, reducing need for hospital care, allowing people to recover at home, live as independently as possible and achieve their wishes within their community.	Maintain and develop the Carepoint service, which brings together a number of previously-separate services which aim to prevent admission to hospital and facilitate discharge from hospital. It sits under one management structure and is an access point for AART, Nurse Practitioners, Reablement, hospital discharges & CarePlus Team to ensure that "1 contact is all it takes from the referrer" and using an interdisciplinary approach to achieve safe and efficient admission avoidance and discharge.
Proactive care planning – reducing crisis	Continue to develop Care Plus as a

The STP calls for	The BCF will:
	proactive multidisciplinary service working alongside general practice aiming to minimise the impact of frailty on patients and communities. The objectives of the service are to • Improve quality of life for patients • Help patients achieve goals • Reduce hospital admissions • Proactive approach to care • Encourage and facilitate self-management • Reduce pressure on General Practice
Enhance people's ability to self-care; increase their self-esteem and self-efficacy	Enable equipment and adaptations to be rapidly provided to support healthy living at home (Adaptations and Loan Equipment Service) Provide 24/7 crisis support through assistive technology (Carecall / telecare)
Patients are able to receive care in the setting most appropriate to their needs.	Redesign intermediate care services to increase resources for admission avoidance and improve recovery from illness, leading to fewer admissions to permanent residential care and reduced demand for NHS Continuing Health Care
Patients are able to receive the most appropriate care seven days per week.	Ensure that hospital social work services are available seven days per week in order to minimise delays in transfer of care (Carepoint)

Relationship to the Health and Wellbeing Strategy

The Health and Wellbeing Strategy states that we will work within the four levels of service delivery, shown in Figure 2 below, to achieve better service integration.

Figure 2

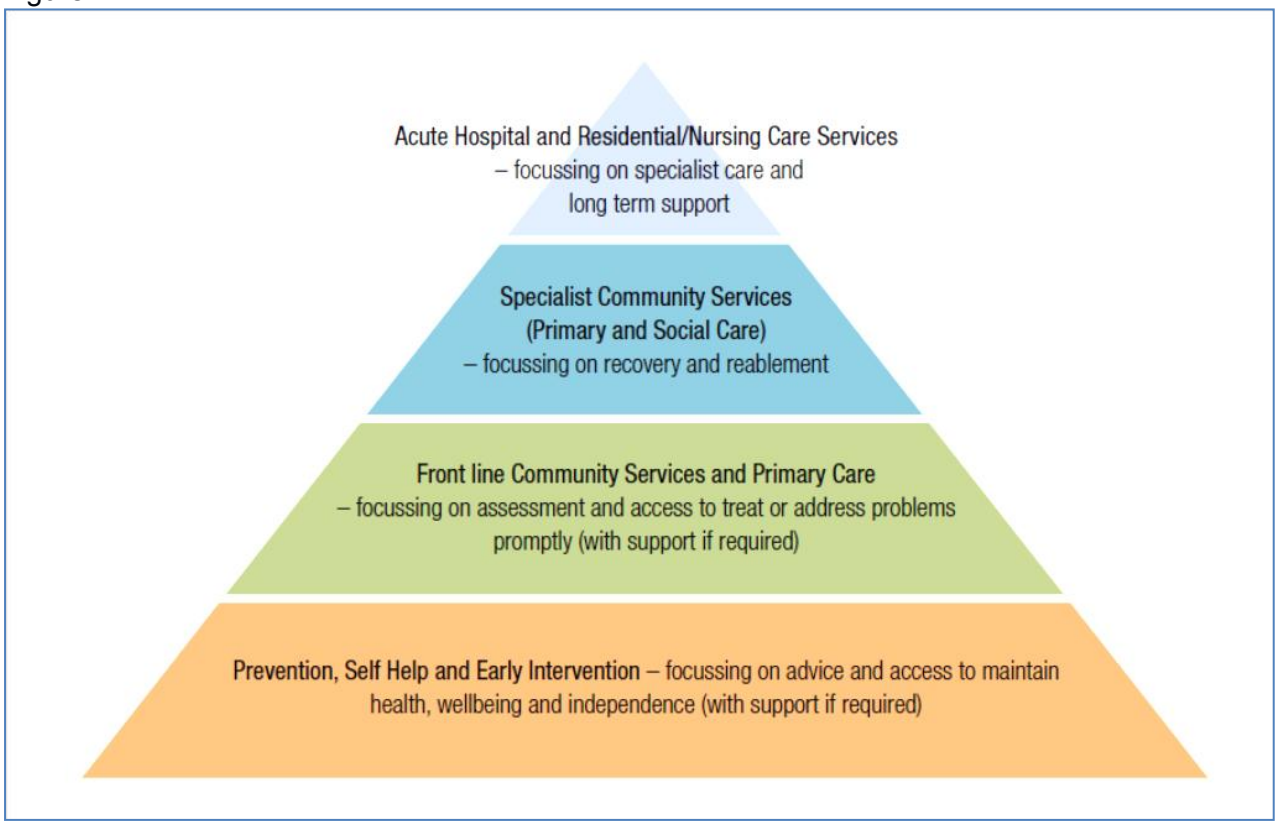


Table 4 shows how the BCF plan is aligned to these four levels:

Table 4

	BCF services
Acute hospital and residential/nursing care services – focussing on specialist care and long term support	• End of life care • Liaison psychiatry
Specialist community services (primary and social care) – focussing on recovery and reablement	• CarePlus • Admission avoidance • Carepoint • CareCall / Telecare • Adaptations and Loan Equipment Service • Intermediate Care Beds • Enhanced primary care in care homes
Front line community services and primary care – focussing on assessment and access to treat or address problems promptly (with support if required)	• Seven-day social work
Prevention, self-help and early intervention – focussing on advice and access to maintain health, wellbeing and independence (with support if required)	• Improving access to advice and information – North Tyneside SIGN and MyCare web portal • Support for Carers •

Background and context to the plan

Use this section to set out the background to the local health economy.
This should include:

- *Local demography and future demographic challenges*
- *Current state of the health and adult social care market*
- *Key issues and challenges that the plan will aim to address*

Key issues and challenges

In January 2017, the Health and Wellbeing Board, in discussing commissioning intentions, noted that the key challenges were:

Reducing budget:

- A reduction in core funding with the Council needing to save over £43.5m in next 2 years
- Additional pressures e.g. living wage
- Year on year reduction in public health ringfenced grant
- For 2017/2018 this means a significant reduction for adult social care, children's services, and public health.

Increasing demand

- Increasing numbers of children receiving social care services
- Increasing frailty and complexity of need in adult social care
- Focus on prevention and wellbeing
- Increasing life expectancy
- Health inequalities
- Pressures within learning disability services

The CCG reported the following challenges:

- Ageing population with increasing needs
- Health inequalities between localities
- Over reliance on hospital based services
- Increasing high cost drugs and medical technologies
- Minimal growth in financial allocations
- Historic CCG deficit (£19.3m)
- Forecast NHS cumulative financial gap over next 5 years if nothing changes of additional £80-90m
- Greater emphasis on planning and delivery at scale (Northumberland, Tyne & Wear footprint - £1.7m people)

Demography

The population of North Tyneside is 203,307[1]

8.9% of the population of North Tyneside, or 18,000 residents, are aged 75 years or older, compared to 8.1% of the United Kingdom population.

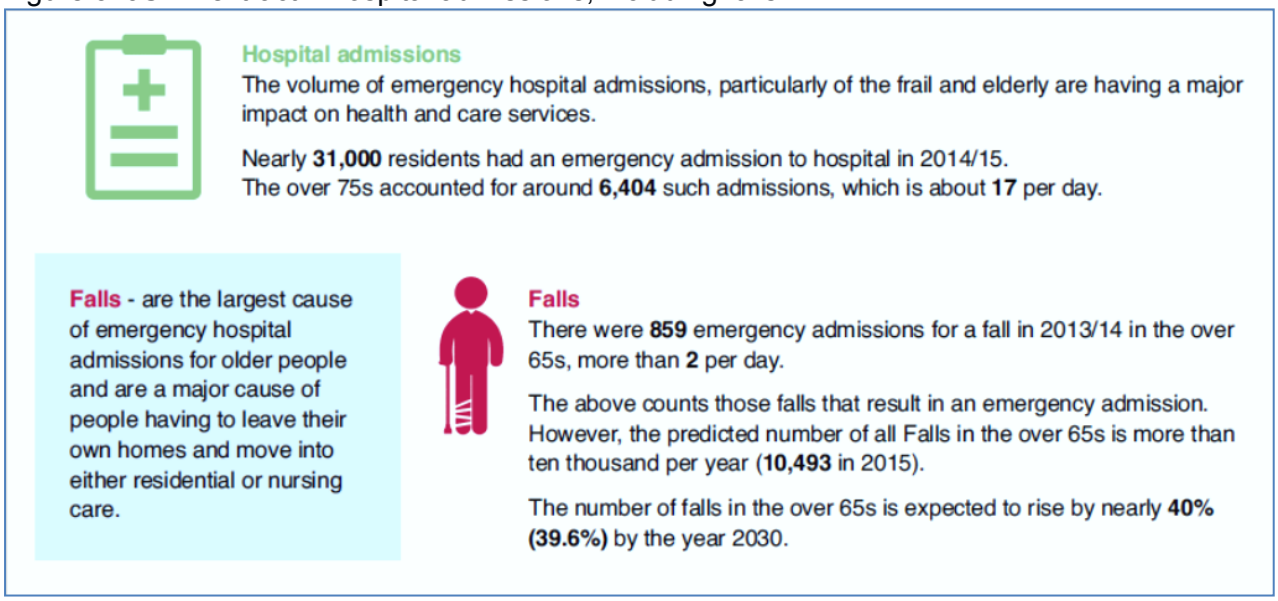
By 2039, the overall population is forecast to increase to 223,000, of which 33,000 will be aged 75+, forming 14.8% of the population. The rising number of older residents is a key driver of increasing demand for health and social care.

[1] Source: ONS 2016 mid-year population estimate

The 2015 Joint Strategic Needs Assessment[2] (JSSNA) includes key findings relating to emergency hospital admissions; mental health; learning disabilities; care homes; carers; and self-help/ prevention. This section outlines the key messages from the JSNA and shows how the BCF plan responds to those needs.

Emergency hospital admissions

Figure 3: JSNA extract – hospital admissions, including falls



In previous years North Tyneside has experienced a very high level of emergency hospital admissions.

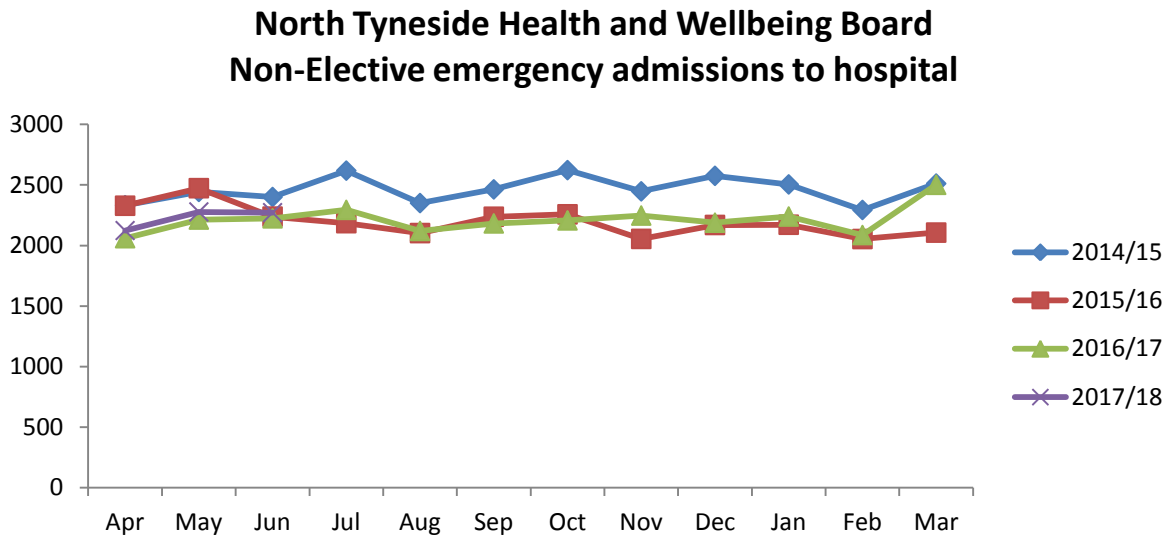
However in 2015/16 there was a substantial reduction in volume of emergency admissions, particularly following the opening of the Northumbria Specialist Emergency Care Hospital, the first UK hospital to specialise in emergency care.

Figure 4 overleaf shows the substantial downward shift in the level of emergency admissions which occurred in 2015/16. This change was partially maintained in 2016/16, except for an exceptional spike in March 2017.

Because of the substantial reductions which have already occurred, the BCF plan does not seek to predict any further reductions over and above those which are already set out in the CCG Operational Plan.

[2] http://www.northtyneside.gov.uk/browse-display.shtml?p_ID=564406&p_subjectCategory=387

Figure 4: monthly trend in non-elective emergency admissions. Source: RAIDR

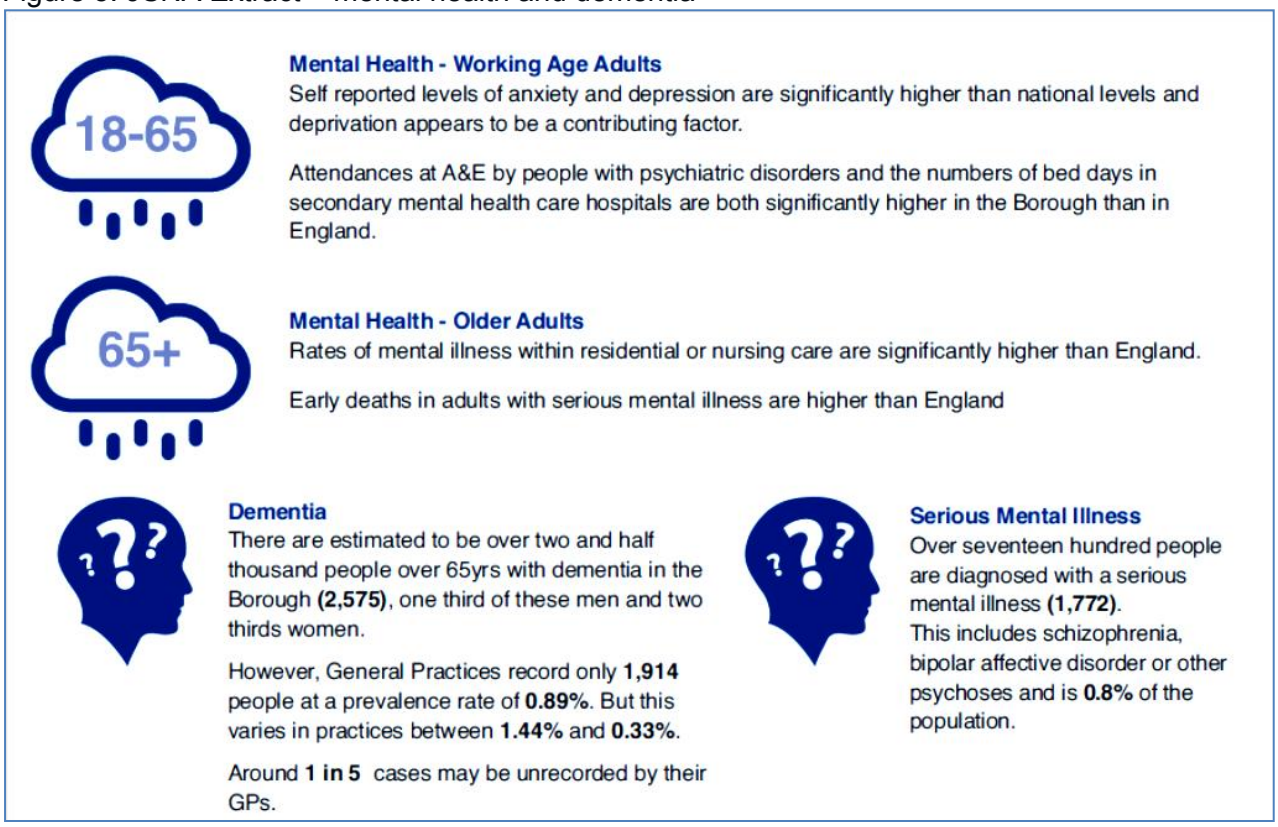


Nevertheless the BCF services will continue to play a role in maintaining the level of emergency admissions at the new lower level, particularly with regard to older people. For example:

- Carepoint will offer alternatives to admissions, facilitate quicker discharge, and ensure that community-based services can reduce the risk of re-admission.
- CarePlus will provide intensive support for those frail elderly patients at very high risk of hospital admission
- The redesigned intermediate care provision will increase the availability of “step-up” beds to avoid admission, and allow the implementation of a “discharge to assess” model.

Mental Health

Figure 5: JSNA Extract – mental health and dementia



In June 2016, the Health and Wellbeing Board agreed a Mental Health and Wellbeing Strategy for the period 2016-21. The purpose of the strategy, which related to 'working age' mental health, was to set out how the Clinical Commissioning Group (CCG), the Council, and its partners would work together to improve the mental health and wellbeing of the population of North Tyneside so reducing health inequalities, improving physical wellbeing, social interactions and job prospects. The strategy sought to implement national and local drivers to promote parity across mental and physical health care, good mental health and wellbeing, whilst further improving the quality and accessibility of services for people who had mental health problems. It also sought to devise, with providers, the public and service users, local approaches to mental health services.

The strategy would drive a partnership approach to developing support for people with mental health needs in North Tyneside. It would ensure that the best possible quality of life would be sustained for them and their families. This would be achieved by focusing on key priorities such as:

- Personalisation, supporting people to be at the heart of decision making, personal budgets and direct payments;
- Prevention, in both primary and secondary care;
- Improving health and wellbeing, in terms of lifestyle, inequalities, parity of esteem, mental and physical health;
- Supporting recovery, through primary care, talking therapies, social care and community services;
- Accessibility both in and out of hours, crisis response, suicide prevention, dual diagnosis, mental health and learning disabilities; and
- Integration of primary and secondary care, child and adolescent services and treatment.

The BCF includes an allocation of £2.9m (within the service line "NHS support to social care") to ensure the appropriate and timely assessment of customers and the continued provision of services to support people to live independently and well, including: older people; older people with a dementia; people with mental health issues; people with drug and alcohol issues; and those at risk of homelessness.

The BCF includes £0.75m funding for Liaison Psychiatry services, which are directly related to the provision of mental health services to those attending A&E.

In addition to the BCF-specific changes, the draft CCG operational plan includes details of actions with the following planned outcomes:

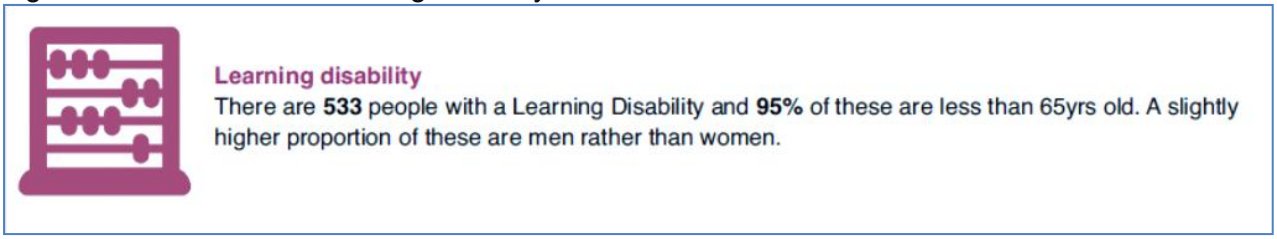
- Continue to exceed the national IAPT Access standard
- Achieve the national IAPT Recovery Rate
- Exceed national IAPT waiting time standards
- Achieve the national standard for Early Intervention in Psychosis
- Improved pathways for people experiencing a first episode of psychosis and reducing hospital admission
- Change the structure of CAMHS provision and base on THRIVE model principles
- Reconfigure pathways for childrens & adolescents mental health services where appropriate
- Establishment of CAMHS IAPT services in North Tyneside
- Improved management of eating disorders and smoother pathways and transitions between mental health providers
- Reduced admissions and length of stay in acute hospital settings as a result of liaison services at A&E

With regard to dementia, North Tyneside CCG currently has an early dementia diagnosis rate which exceeds the national target of at least two-thirds of the estimated number of people with dementia and we remain committed to improving our early dementia diagnosis rate in 2016/17. We are exploring considering options to improve post diagnostic support available to people in North Tyneside.

We will continue to maintain and improve on, the current early dementia diagnosis rate. The CCG and Council will produce a joint strategy on mental health services for older people, including dementia.

Learning disabilities

Figure 6: JSNA extract - learning disability



The BCF includes an allocation of £0.6m (within the service line "NHS support to social care) to support Independent Supported Living Schemes for people with learning disabilities. The Council supports around 670 people with learning disabilities.

In February 2015, NHS England publicly committed to a programme of transforming care for people with a learning disability and/or autism who have a mental health problem and whose behaviour challenges services. The Transforming Care Programme is focussed on moving away from inappropriate outmoded inpatient facilities and establishing stronger support in the community. In October 2015, NHS England published the report "Building the right support". The report outlines plans to accelerate the process of building the right community based services enabling the reliance on inpatients beds.

In response, North Tyneside CCG is, with the North Tyneside Learning Disabilities Partnership Board, developing a new model of care for people living in North Tyneside which will meet the national requirement as detailed in the NHS England report i.e. implement enhanced community provision, reduce inpatient capacity and roll out care and treatment reviews in line with published policy. The model will focus on:

- prevention, community support and early intervention programmes.
- Implementation of Positive Behaviour Support Pathways
- Improve crisis support

Work on this programme is in its early stages and plans are in place to ensure the development of the community based support model will interface with the North East and Cumbria Transformation Boards' beds proposal.

We expect the outcomes and impact of this work to be as follows:

- enabling the provision of wrap around care which deployed flexibly will maintain people in the community and avoid inappropriate hospital admissions.
- better management of crisis when it happens
- Reduce the usage of inpatient provision by 50%.

Carers, Self-help, and prevention

Figure 7: JSNA extract – Carers, Self-care, and prevention

The BCF includes an allocation of £0.3m (within the service line "NHS support to social care) to support prevention, self-help, and early intervention, including the provision of advice and information; crisis response and community alarms – and a further £0.412m for assistive technology and equipment.

£0.56m is allocated in the BCF to support carers.

Elected Major Norma Redfearn, launched the North Tyneside's Commitment to Carers in November 2015. The Commitment was developed in partnership between: Carers; North Tyneside Clinical Commissioning Group; North Tyneside Carers' Centre; North Tyneside Council; Carers Voluntary Sector Forum; and Healthwatch North Tyneside.

The Commitment and the Action Plan that accompanies it, builds on previous achievements in working with carers, and aims to achieve the best possible outcomes for all carers and the people they support.

Our commitment to carers is:

- 'To improve the health and wellbeing of all carers living in North Tyneside, and support them to have a life outside of caring.

- To actively promote open, honest working in co-production with carers.'

The North Tyneside Commitment to Carers' is based upon six priorities:
- Earlier identification of carers and the provision of quality information;
- Improved communication;
- Improved carer health, wellbeing and support;
- Support that enables carers to go to/continue to work or in education;
- Carers have access to emotional support; and
- Smooth transition of support from children's to adult services

Collectively North Tyneside Carers' Centre, North Tyneside CCG and North Tyneside Council have been progressing the actions in the Commitment.

The Action Plan was last updated in November 2016. Where relevant, the Action Plan has been cross referenced with the recommendations made by Overview and Scrutiny following their review of Carers Support and Respite Provision, as there were some similar actions identified in that piece of work. A report was made to the Health and Wellbeing Board in March 2017.

The Council and NT CCG both continue to provide funding to support NT Carers' Centre, who are critical to the delivery of our Commitment to Carers' and also the provision of practical support to carers living in North Tyneside.

Further information on progress in supporting carers is contained in Appendix 5 of this document, on page 82.

Care homes

Figure 8: JSNA extract – care homes

The Council funds around 750 people every year who live in nursing homes and residential care homes, in addition to supporting 2,200 people who receive support in their own homes.

The BCF funds three services of particular relevance to care homes:

a) A specialist nursing service for end of life patients residing in a North Tyneside Nursing Homes/Residential Homes. The objectives of the service are to:
   - Support patients to die in their usual place of residence
   - Increase the quality of healthcare through a nursing home training programme
   - Implement advance care plans and emergency healthcare plans for anticipated emergencies and exacerbations
   - Reduce inappropriate hospital admissions at the end of life or palliative phase
   - Reduce A&E attendances

   The specialist nursing service for end of life now covers all nursing homes and 20 out of 34 residential homes. By the end of 2016/17 it will be rolled out to all residential care homes.

b) A "hospice at home" service, which aims to ensure that all patients in non-palliative settings:
   - receive emergency palliative care, trying to keep people in their place of choice:
   - are offered emotional and practical support, for patients, family, and carers;
   - receive specialist support when needed

c) In addition, the CCG operates a GP Enhanced Service for primary care in care homes, which aligns care home residents to GP practices (subject to patient choice) and ensures proactive care of care home residents.

As a result of these services, in 2015, 34.2% of patients died in the place of their choice; an increase from the 2014 average, which was 29.3%

Accident and Emergency attendances by care home residents aged 75+ fell by 2.1% in 2015 compared to 2014, whereas A&E attendances by other persons aged 75+ increased by 4.9% in the same period.

In addition, the CCG funds an enhanced service for primary care in care homes, which aligns general practices with named care homes (subject to patient choice). Under this scheme practices will:

Evidence base and local priorities to support plan for integration

Impact of the 2017/17 BCF plan

The BCF Partnership Board monitored the impact of the plan through a range of indicators which included, but was not limited to, the national BCF metrics.

The range of measures used is shown in Table 5 below. In most cases, a particular measure relates to more than one service, and there is not a one-to-one relationship between the implementation of a service and a change in an associated metric.

The following tables and graphs show the change in each metric over the period 2016/17.

Table 5: performance against national and local metrics

Metric	Relates to these services	2015-16	2016-17	% change	Preferred direction
Total number of emergency admissions	Proactive care and admission avoidance	26,372	26,562	0.7%	Lower is better
Number of emergency bed days	Proactive care and admission avoidance	89,084	99,027	11.2%	Lower is better
Number of avoidable admissions	Proactive care and admission avoidance	1,920			Lower is better
Number of Accident and Emergency attendances	End of life care	76,906	80,001	4.0%	Lower is better
Number of Accident and Emergency attendances of persons aged 75+	Increased use of telecare	11,939	12,234	2.5%	Lower is better
Number of emergency admissions for patients aged 75+	Seven-day social work	6473	6178	-4.6%	Lower is better
Average length of stay of hospital admissions, for patients aged 75+	Seven-day social work	9.7	10.3	6.2%	Lower is better
Number of referrals	Seven-day social work	589	468	-20.5%	Lower is better
Proportion of service users who are supported to live independently at home (ASC 14)	Immediate response and overnight home care				Higher is better
Number of permanent admissions into residential care per 100,000 of the population (ASCOF 2A)	Immediate response and overnight home care	816			Lower is better

Metric	Relates to these services	2015-16	2016-17	% change	Preferred direction
Number of new service users this period	Immediate response and overnight home care	226	259	14.6%	Higher is better
Number of visits to service users this period	Immediate response and overnight home care	10,195	12,838	25.9%	
Number of hospital admissions of service users this period	Immediate response and overnight home care	26	45	73.1%	Lower is better
The proportion of calls to the Care Call crisis response service resulting in A&E attendance	Immediate response and overnight home care NHS Support to Social Care	0.5%	0.4%	-24.7%	Lower is better
The number of people using the Care Call crisis response service	Immediate response and overnight home care NHS Support to Social Care	4,323	4,387	1.5%	Higher is better
The proportion of calls to the crisis response service resulting in A&E attendance (ASC78)	NHS Support to Social Care	0.5%	0.5%	0%	Lower is better
Proportion of Older People (65+) who are still at home 91 days following discharge from hospital into reablement/rehabilitation services (ASCOF 2B pt1)	Reablement	92.5%	92.0%	0%	Higher is better

Metric	Relates to these services	2015-16	2016-17	% change	Preferred direction
The proportion of older people aged 65 and over offered reablement services following discharge from hospital (ASCOF 2B part 2)	Reablement	4.2			Higher is better
Mean average change in EQ-5D score for clients of the reablement service	Reablement				Higher is better

Better Care Fund plan

The BCF schemes/services

Table 6 summarises the scheme name, type, and value; this is followed by a brief description of each scheme

Table 6

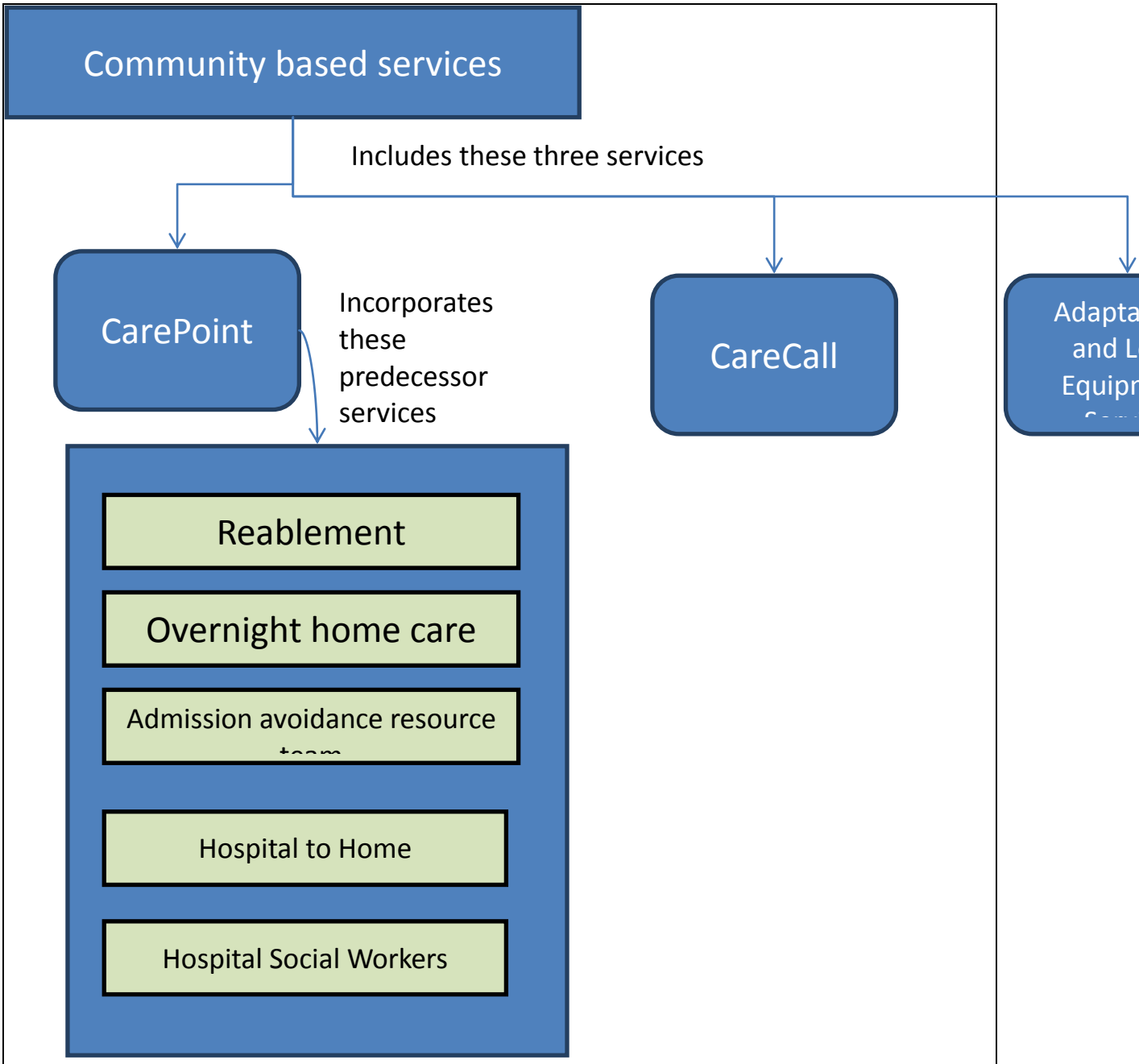
		Sum of 2017/18 Expenditure (£)	Sum of 2018/19 Expenditure (£)
1	Community-based support, including Carepoint; reablement; immediate response and overnight home care; adaptations and loan equipment service; and CareCall / telecare	£ 7,138,533	£ 7,274,165
2	Intermediate Care beds	£ 3,653,432	£ 3,722,847
3	Intermediate Care - community services	£ 421,411	£ 429,417
4	Liaison Psychiatry - Working Age Adults	£ 617,859	£ 629,598
5	Liaison Psychiatry - Older People	£ 132,132	£ 134,643
6	Enhanced Primary Care in Care Homes	£ 100,000	£ 101,900
7	Seven-day social work	£ 64,128	£ 65,346
8	Improving access to advice and information	£ 50,895	£ 51,862
9	Care Act implementation	£ 607,686	£ 619,232
10	Carers support	£ 570,024	£ 580,854
11	Disabled Facilities Grant	£ 1,416,617	£ 1,526,533
12	Independent support for people with learning disabilities	£ 610,740	£ 622,344
13	Impact on care home fees of national living wage	£ 2,145,226	£ 2,775,688
14	Impact on domicilliary care fees of national living wage	£ 384,000	£ 496,000
15	Impact on other increased fees (ISL, day care, direct payments etc) of national living wage	£ 1,244,000	£ 1,609,000
16	Effect of demographic growth and change in severity of need	£ 1,270,000	£ 1,892,000
19	End of Life Care - RAPID	£ 227,380	£ 231,700
21	CarePlus (New Models of Care)	£ 620,208	£ 631,992
24	Admission avoidance and discharge planning services	£ 724,177	£ 737,936
Grand Total		**£ 21,998,447**	**£ 24,133,059**

Brief description of each scheme

Ref	Scheme Name	Scheme type	Area of spend
1	**Community-based support, including Carepoint; reablement; immediate response and overnight home care; adaptations and loan equipment service; and CareCall / telecare**	High Impact Change Model for managing transfers of care	Social Care

Commissioner	Provider	
North Tyneside Council	North Tyneside Council	
Funding source	2017/18 Expenditure (£)	2018/19 Expenditure (£)
CCG Minimum Contribution	7,138,533	7,274,165

Brief description
Community-based services is an amalgamation of out-of-hospital services which aim to promote independence and avoid admissions to hospital. It includes Carepoint; CarePlus; the adaptations and loan equipment service; and Carecall/ Telecare



Carepoint
The Carepoint service brings together a number of previously-separate services which aim to prevent admission to hospital and facilitate discharge from hospital. The predecessor services were:

- North Tyneside Council's reablement service, including immediate response, overnight home care and Community Rehabilitation Team
- North Tyneside Council's hospital-based social workers
- Northumbria Healthcare FT's admission avoidance resource team
- Northumbria Healthcare FT's "hospital to home service"

During 2015/16, all the predecessor services became located on the North Tyneside General Hospital site, although there is more work to be done to identify more suitable accommodation.

An operational manager has been appointed by Northumbria Healthcare to manage the integrated service.

It sits under one management structure and is an access point for AART, Nurse Practitioners, Reablement, hospital discharges & CarePlus to ensure that "1 contact is all it takes from the referrer" and using an interdisciplinary approach to achieve safe and efficient admission avoidance and discharge. The team has e a holistic focus on the entire patient pathway from hospital to home. This proactive and preventative approach will ensure seamless transitions and help to avoid unnecessary admission and readmission to hospital.

Further details of the CarePoint service are given in Appendix 2 on page 75.

Care Call Crisis Response team

Supports approximately 3,500 people across the Borough of North Tyneside linked to the call centre via either a community alarm or GMS solution.

Telecare solutions, which will enhance avoidance of admission to hospital targets, fast track hospital discharges through using 24/7 mobile response and monitoring.

Care Call carries a full range of stock to enable the service to provide equipment, replace and replicate at a short notice. We currently have in excess of 6,000 pieces of equipment in use within North Tyneside. We are members of and have close working relationships with CHUtec (Centre for home usable technologies) EPG (Effective prescription guide) to ensure we remain at the forefront of available technologies

There will be an increase in the support for patients with long-term conditions as the service have the ability to provide a rapid response and if necessary monitor the patient through telehealth monitors.

The service will be able to work in partnership with NEAS in the prevention of emergency calls due slips trips and falls providing and monitoring falls sensors and by providing a falls awareness check of the living environment.

Medication monitoring solutions can be used in place of medication prompts which will reduce the number of medication only domiciliary care calls which are carried out to support health needs.

Adaptations and Loan Equipment Service (ALES)

ALES provide equipment & adaptations for North Tyneside residents requiring these due to age, illness or disability. The service is accessed by Occupational Therapists, Physiotherapists, Social Workers, District Nurses, Health Visitors, and GPs on behalf of their clients/patients.

The service includes:-

- Provision of community nursing equipment
- Provision of equipment for daily living
- Provision of equipment for sensory impairment
- Short term wheelchairs
- Maintenance & servicing of equipment and adaptations
- Collection of equipment & decontamination & recycling
- Provision of adaptations for hospital discharge / palliative care
- Full design and implementation of adaptations in all tenures

- Feasibility of adaptations
- Assessment & Demonstration Suite.

Ref	Scheme Name	Scheme type	Area of spend
24	**Admission Avoidance and Discharge Planning services**	High Impact Change Model for managing transfers of care	Community Health

Commissioner	Provider	
North Tyneside CCG	Northumbria Healthcare NHS Foundation Trust	
Funding source	2017/18 Expenditure (£)	2018/19 Expenditure (£)
CCG minimum contribution	£724,177	£737,936

Brief description

This service relates to the Admission Avoidance Resource Team, hich works to reduce the need for emergency admissions and to facilitate early discharge, with a focus on elderly patients.

The service is managed as part of the Carepoint service. It is listed separately here, as aservices commissioned by the CCG, because our BCF risk management process provides for the CCG and the Council to separately absorb the risk of overspends in the service they commission.

Ref	Scheme Name	Scheme type	Area of spend
21	**CarePlus (New Models of Care)**	Integrated Care Planning	Community Health

Commissioner	Provider	
CCG	Northumbria Healthcare NHS Foundation Trust	
Funding source	2017/18 Expenditure (£)	2018/19 Expenditure (£)
CCG Minimum Contribution	603,000	631,992

Brief description

“Careplus” is a “new models of care” programme targeted to frail elderly patients. It aims to deliver high quality, cost effective care where inpatient hospital care is by exception.

The CarePlus team is in place now comprising GPs, geriatricians, nurses, social workers, and admin support, serving the Whitley Bay locality of North Tyneside. Arrangements are in place to share patient records with the patients’ registered GP

The service has four key components:

- Coordination of Care – to ensure patients actually receive the care they need when they need it and to eliminate waste and duplication.
- Standardised Care - to drive consistency and high quality while leveraging systems that encourage clinicians to find the most cost effective solutions to meet patient needs.
- Matching patients need with an appropriate care delivery model – Patients with complex chronic diseases need a different kind of care than patients with injuries or simple episodic diseases and therefore the philosophy of directing patients into the right care model or delivery channel applies to clinicians as well.
- Facilitate the development of health literacy- which will ensure that patients are supported to develop the confidence and knowledge to manage their own conditions.

CarePlus will bring improved outcomes for both patients and the health economy through:

- Patient centred care: the system comes to them
- The patient tells their story once
- Better, quicker, more consistent care across the whole system
- Caring for patients at home and within the community
- Reducing avoidable admissions
- A more efficient productive health economy with less duplication and waste

Care Plus will look after patients with the greatest needs in a different way. Patients with multiple/poly-chronic long term conditions will be offered proactive care planning from a core MDT, a rapid response service in line with escalation plans and a “pull service” to support early possible discharge when patients have needed hospital care.

An additional element of the service provides support through personal indepedence coordinators, recruited and managed by Age UK North Tyneside. Their role is to:

- Build a strong supportive relationship with the patient
- Address social isolation through connecting with the community
- Be the point of contact for the patient and their family/ carer
- Responsible for self-management support (patient activation)
- Bridge the gap between the clinician and the patient
- Assist in navigation of the health and social care system
- Facilitate patient independence

The outcomes of CarePlus will be evaluated using the impact on emergency admissions, avoidable emergency admissions, A&E attendances, and cost data. In addition the outcomes for the cohort receiving support from Age UK will be evaluated by the Nuffield Foundation.

Further detail is provided in Appendix 1 on page 72.

Ref	Scheme Name	Scheme type	Area of spend
19	**End of Life Service -**	Personalised Healthcare at Home	Community Health

	RAPID		
Commissioner		Provider	
CCG		Northumbria Healthcare NHS Foundation Trust	
Funding source		2017/18 Expenditure (£)	2018/19 Expenditure (£)
CCG Minimum Contribution		227,380	231,700
Brief description			

Hospice at home (rapid response end of life service)
The aim of this service is to ensure all patients in non-palliative settings receive emergency palliative care trying to keep people in their place of choice, offering emotional and practical support for carers and familiy members as well as specialist input where needed. Emergencies may arise from changes in condition, symptom problems, anxiety, distress or social crisis.

The CCG worked in collaboration with Northumbria Healthcare NHS Foundation Trust and Marie Curie, to develop three teams across the patch, backed up by a consultant for the whole area. This allows for economies of scale and also ensures sufficient back up with each other where there are pressure points.

The service model consists of two components. The first being a band 5 palliative care nurse and a band 3 Health Care Assistant providing a dedicated rapid response service. The second component will require a band 7 specialist nurse practitioner backed up by a consultant to deliver specialist palliative care input. This is designed to build upon existing work e.g. GPs and District Nurses in the community, nursing home staff and hospital ward teams to enhance the urgent and emergency palliative care delivery.

The new service has included some internal reconfiguration with the current specialist palliative care team and matched funding with Marie Curie will allow for a comprehensive multi-disciplinary palliative care team which can respond to patients needs urgently and allowing care to be delivered at home. This will prevent avoidable admissions and facilitate admission to and discharge from the palliative care unit where appropriate.

Ref	Scheme Name	Scheme type	Area of spend
5	**Liaison Psychiatry – older people**	Care Navigation / Coordination	Mental Health
Commissioner		Provider	
CCG		Northumbria Healthcare NHS Foundation Trust	
Funding source		2017/18 Expenditure (£)	2018/19 Expenditure (£)
CCG Minimum Contribution		132,132	134,643
Brief description			

Liaison psychiatry provides an interface between psychiatry and medicine focusing on providing improved management for patients with co-morbid physical and mental health conditions.

There are two complementary Liaison Psychiatry services included in the BCF:
20 Liaison Psychiatry – older people – provided by Northumbria Healthcare (this service)
4 Liaison Psychiatry – working age adults – provided by Northumberland, Tyne and Wear

FT.

This service addresses the mental and physical health needs for patients aged over 65 years focussing on hospital wards.

The liaison psychiatry service expanded to offer additional nursing and OT support and now operates on a 7 days a week basis, office hours Monday to Friday and 4 hour days on a Saturday and Sunday. Outside of these hours support is provided by the existing On Call Psychiatric rota.

The new team offers increased teaching and training to clinical and non-clinical staff. This ensures that the indirect benefits of the Liaison Team to reduce length of stay are delivered. Increasing staff complement has allowed a consolidated rolling programme of training for DGH staff.

The team works to a response time of one hour for patients in front-of-house settings and one working day for inpatients on a ward. This ensures the timely direct clinical input that in the RAID model was shown to reduce readmission rate**.**

Ref	Scheme Name	Scheme type	Area of spend
4	**Liaison Psychiatry – working age adults**	Care Navigation / Coordination	Mental Health

Commissioner	Provider	
CCG	Northumberland, Tyne and Wear NHS Foundation Trust	
Funding source	2017/18 Expenditure (£)	2018/19 Expenditure (£)
CCG Minimum Contribution	617,859	629,598

Brief description

Liaison psychiatry provides an interface between psychiatry and medicine focusing on providing improved management for patients with co-morbid physical and mental health conditions.

There are two complementary Liaison Psychiatry services included in the BCF:
20 Liaison Psychiatry – older people – provided by Northumbria Healthcare
4 Liaison Psychiatry – working age adults – provided by Northumberland, Tyne and Wear FT (this service).

This was a new service which started in October 2014 to provide an A&E based service for working age adults (16-64). The team was initially based at North Tyneside General Hospital but has now moved to The Northumbria Hospital at Cramlington and operates 11:00 – 24:30, 7 days per week. The service is for working age adults, but will also provide services for older people who attend A&E with a mental health need and who do not require admission due to physical health needs. All patients who present at A&E with an urgent mental health need are seen within 1 hour. Non-urgent referrals are seen within 24 hours.

Ref	Scheme Name	Scheme type	Area of spend
6	**Enhanced Primary Care in Care Homes**	Personalised healthcare at home	Primary Care

Commissioner	Provider	
CCG	General Practices	
Funding source	2017/18 Expenditure (£)	2018/19 Expenditure (£)
CCG Minimum Contribution	132,132	101,900

Brief description

A local Enhanced Service is in place which enables an improved primary care offering to be available to all eligible patients who are registered with a GP Practice within North Tyneside and who reside in a nursing home or residential home, in accordance with equality and diversity legislation.

The service is delivered by GP Practices within North Tyneside CCG boundary, and through mutual agreement (coordinated by the CCG), each participating GP Practice has been allocated an allocated link nursing/residential home. Residents not already a patient of the practice are asked to consider the additional benefits.

Participating practices ensure a tailored package of support and care centred on the residents as an individual. An important aspect of the support is the provision of a named or 'lead GP' who will be the reference point for the frail person and their carer, ensuring that all services are co-ordinated in a way that meets individual needs.

- Ensure regular scheduled visits by appropriately commissioned GP to review particular residents with new needs, perform routine reviews and to liaise with other health and social care professionals – including geriatricians.
- Undertake a comprehensive assessment of new patients on admission and develop a patient centred care plan within a specified time-period.
- Work in conjunction with pharmacists in the undertaking of a medication review at a frequency over and above essential GMS standards at least every six months and ensure a medication review is completed for patients recently discharged from an acute hospital admission
- Ensure prompt recognition of residents requiring imminent end of life care that identifies issues and goals, making appropriate treatment plans within a shorter period as needed
- Instigate advanced care plans for acute events and for preferred end of life care, in partnership with the resident, their family and their advocate
- Establish regular structured multidimensional reviews at least every six months, or sooner of clinically indicated

Ref	Scheme Name	Scheme type	Area of spend
2	**Intermediate Care beds**	Intermediate care services	Community Health

Commissioner	Providers
CCG	Northumbria Healthcare NHS Foundation Trust North Tyneside Council Akari

Funding source	2017/18 Expenditure (£)	2018/19 Expenditure (£)
CCG Minimum Contribution	3,653,432	3,722,847

Brief description

Intermediate Care beds – Phase one
As part of the agreement of total resources set out for the 2016/17 BCF, the local health economy reduced the amount of bed-based intermediate care. This was based on the recommendation of the North Tyneside Intermediate Care Bed Base Review February 2016., the result of which saw the closure of the Cedars Intermediate Care resource Centre in December 2016 which provided a 30-bedded local authority operated facility.

The Older Peoples' Partnership Board agreed a new model for the provision of intermediate care. Phase one of the new model begun in December 2016 with the development of a new 20 bedded community based Intermediate Care facility and adopting a multi-agency approach to deliver community based rehabilitation.

Royal Quays Intermediate Care Service
The Royal Quays development formed phase one of the Intermediate Care model. Opened in December 2016 following the closure of the Cedars, the service provides twenty community based intermediate Care beds. The model is based on a range of services that promote and enable faster recovery from illness, prevent unnecessary acute hospital admissions and premature admission in to long term care and in doing so, supports timely discharge from hospital and maximise independent living.

The nursing element of the service is provided by Akari healthcare with OT and Physiotherapy provided by Northumbria Healthcare NHS Foundation Trust. Clinical oversight is provided by Collingwood Medical Group with the rehabilitation being delivered by the Local Authority Community Rehabilitation Team.

The Transition Unit
In addition the community beds at Ward 23 were redesigned to facilitate complex management of frail older people through the transitional stage of discharge in to the community. The unit provides a light touch to medical care and is Nurse Practitioner led, targeting people who would otherwise face unnecessary prolonged hospital stay. All patients receive a comprehensive assessment resulting in a structured individual care plan that involves active therapy, treatment and accelerates recovery.

Provision of intermediate care Phase one
Table 1

Setting	Service	Number of beds	Average occupancy 2017/18
In-hospital	Transition Unit	29	80%

	NTGH Ward 3	24	96%
Out of hospital	Royal Quays	20	75%

Table 1 shows there are currently 73 intermediate beds in the system, but there is some spare capacity. This shows a bed reduction of 34 beds during 2016/17.

Table 2

Intermediate Care Bed Based Review Recommendations	Royal Quays Intermediate Care Service @ Princess Court	Transition Unit (Ward 23)
A single point of Access with one set of admission criteria	√	x
Real-time Knowledge of current capacity	√	√
MDT approach	√	√
Step Down Provision	√	√
Step up Provision	x	x
Discharge to Assess	√	√
Reduced reliance on acute medical beds	√	√

There are now plans in place to mobilise the step up element of Royals Quays which will utilise the remaining 25% capacity currently available.

Intermediate Care Phase 2

In May 2017, North Tyneside Clinical Commissioning Group held a "Future Care" event with invited delegates across health, social care, third sector, and private sector and patient representative groups setting out a future vision for community services. The event explored new ways of working that take in to account the growing aging population in North Tyneside identify what needs to change to ensure a sustainable and high quality health and social care system.

The development of phase one successfully demonstrated strong collaborative working and rebalances the provision of intermediate care from a heavily bed-based model to one with more community capacity. Part of this work was to adjust the staffing model of a ward at North Tyneside Hospital (Ward 23) to reduce costs and allow investment in alternative community provision.

Phase 2 will seek to further decrease dependency in acute bed usage and utilise and increase resources in community / social care provision. The change would also allow all key partners to strengthen the discharge to assess model, and increase in investment in community / home-care based intermediate care and rehabilitation, funded by a reduction in the capacity and acuity of bed-based provision.

A total allocation of £4,128,843 has been made within the BCF to consolidate the phase one development and strengthen community based support.

Ref	Scheme Name	Scheme type	Area of spend
3	**Intermediate Care – Community Services**	Intermediate Care Services	Social Care
Commissioner		Provider	

CCG	North Tyneside Council	
Funding source	2017/18 Expenditure (£)	2018/19 Expenditure (£)
CCG Minimum Contribution	421,411	429,417
Brief description		

Community Based Rehabilitation
A new Community Rehabilitation Peripatetic Team has now been established as part of the community based Intermediate Care model providing both community bed based and at home rehabilitation. This follows the agreement in 2016 between the CCG and the local authority that part of the savings arising from the closure of the Cedars will be used to fund a community based seven days a week services.

The Community Rehabilitation Officers sit within CarePoint and have close working relationships to other teams. The Rehabilitation officers oversee the rehabilitation needs of people being discharged from hospital (step down) and people at risk of an inappropriate admission to hospital (step up). The Rehabilitation Officers work with people with rehabilitation needs who are living in their own homes, extra care schemes, in permanent care where they may be at risk of an inappropriate hospital admission, in the Royal Quays intermediate care bed-based facility and work with people in hospital to 'pull' people through the system and promote a timely discharge where rehabilitation is a part of that person's assessed needs.

Ref	Scheme Name	Scheme type	Area of spend
9	**Care Act implementation**	Other	Social Care
Commissioner		Provider	
North Tyneside Council		North Tyneside Council	
Funding source		2017/18 Expenditure (£)	2018/19 Expenditure (£)
CCG Minimum Contribution		607,686	619,232
Brief description			

The Care Act 2014 aims to ensure that care and support:

- Is clearer and fairer
- Promotes people's wellbeing
- Enables people to prevent and delay the need for care and support, and carers to maintain their caring role
- Puts people in control of their lives so they can pursue opportunities to realise their potential

The Act requires local authorities to ensure the **provision of preventative services**. That is services which help prevent, reduce or delay the development of care and support needs, including carers' support needs.

The Act attempts to rebalance the focus of social care on postponing the need for care rather than only intervening at crisis point.

The Authority is required to establish and maintain a service for providing people in its area

with information and advice relating to care and support for adults and support for carers

The Care Act places a new duty on Local Authorities to arrange independent **advocacy** if a person would have substantial difficulty in being able to participate in or understand the care and support system.

The advocacy duty will apply from the point of first contact and if the individual is required to take part in one or more of the following processes described in the Care Act:

- A needs assessment
- A carers' assessment
- The preparation of a care and support or support plan
- A review of a care and support or support plan
- A child's needs assessment
- A child's carers' assessment
- A young carers' assessment
- A safeguarding enquiry
- A safeguarding adult review.

With regard to **market oversight, shaping, and provider failure**, the Act introduces

- A statutory requirement to collaborate and cooperate with other public authorities, including duty to promote integration with NHS and other services
- A duty for local authorities to step in to ensure that no one is left without the care they need if their service closes because of **business failure**
- CQC **oversight** of financial health of providers most **difficult to replace** were they to fail and to provide assistance to local authorities if providers do fail

Continuity of assessment - the Act seeks to clarify the assessment process for anyone wishing to move between different local authority areas, recognising that it is important to ensure that care and support is in place during the move, in order to maintain the person's wellbeing. Effective joint working between authorities will be essential to ensure that care continues without interruption, providing confidence to the individual.

The Act introduces a **national ninimum threshold for eligibility**, which sets out the minimum threshold for care & support needs which must be met by local authorities in all areas.

The guidance & regulations set out the requirements in order for assessments to be compliant. This includes providing a written explanation of how the eligibility criteria has been applied & a copy of the assessment.

The assessment should consider the person's strengths; what is working well & identify the assets available to them, both in their personal networks & the wider community.

The Act provides regulations to state when a local authority may or must enter into a **deferred payment agreement**, which will allow people to defer paying their care fees by taking out a loan from their local authority (secured against their property) to pay for care and support

The Act makes some significant changes in terms of the rights of **Carers:**

- Putting carers on the same footing as those they care for, in terms of eligibility for support.
- Removes the requirement to *ask* for an assessment
- Removes the requirement to be providing "substantial care on a regular basis".
- The Cared for Person does not need to have eligible needs in order for the Carer to

be considered eligible in their own right
- The only requirement is that the carer 'may have needs for support – whether currently or in the future'.

For North Tyneside Council, implementing the Care Act involves:
- New duties and responsibilities
- Changes to local systems and processes
- More assessments and support plans
- Responsibilities towards all local people
- Better understanding of self funders and the care market needed
- Training and development of the workforce
- Costs of reforms
- Preparation for reforms needed

The Local Government Association provided the example below of the costs involved in implementing the Care Act:

Care Bill implementation funding in the Better Care Fund		**Allocation £000's**
Personalisation	Create greater incentives for employment for disabled adults in residential care	*0*
Carers	Put carers on a par with users for assessment.	*97*
	Introduce a new duty to provide support for carers	*209*
Information advice and support	Link LA information portals to national portal	*0*
	Advice and support to access and plan care, including rights to advocacy	*64*
Quality	Provider quality profiles	*0*
Safe-guarding	Implement statutory Safeguarding Adults Boards	*24*
Assessment & eligibility	Set a national minimum eligibility threshold at substantial	*125*
	Ensure councils provide continuity of care for people moving into their areas until reassessment	*19*
	Clarify responsibility for assessment and provision of social care in prisons	*0*
Veterans	Disregard of armed forces GIPs from financial assessment	*8*
Law reform	Training social care staff in the new legal framework	*21*
	Savings from staff time and reduced complaints and litigation	*-60*
Advocacy	Independent Mental Health Advocacy	*41*
Impact of DWP policies on councils/providers	Pressures relating to pensions auto-enrolment (provider cost) and the announced 1% increase of working age benefits in 15/16 (reduced client contributions)	*52*
Total		***598***

(Prices at 2015/16 levels)

Ref	Scheme Name	Scheme type	Area of spend
16	**Effect of demographic growth and change in severity of need**	Other	Social Care
Commissioner		Provider	
North Tyneside Council		Private sector social care providers	
Funding source		2017/18 Expenditure (£)	2018/19 Expenditure (£)
Improved Better Care Fund		1,270,000	1,892,000
Brief description			
Meeting demographic growth – the Authority has been examining data trends in order to understand the changing pattern of demand in recent years. It has been working on redesigning the customer pathway which will enhance the preventative approach with improved facilities for early self-help and an increased focus on maintaining independence and use of an individual's own networks and community resources. This will help us to manage demand in future years, there is however clear evidence of increased demand within the system and this funding will contribute to paying for this additional activity.			

Ref	Scheme Name	Scheme type	Area of spend
13	**Impact on care home fees of national living wage**	Other	Social Care
Commissioner		Provider	
North Tyneside Council		Private sector social care providers	
Funding source		2017/18 Expenditure (£)	2018/19 Expenditure (£)
Improved Better Care Fund		2,145,000	2,776,000
Brief description			
Meeting increased care home fees – the Authority is working with local provider representatives to identify a fair increase for 2017/18 with a view to carrying out an exercise to inform rates for 2018/19			

Ref	Scheme Name	Scheme type	Area of spend
14	**Impact on domiciliary care fees of national living wage**	Other	Social Care
Commissioner		Provider	
North Tyneside Council		Private sector social care providers	
Funding source		2017/18 Expenditure (£)	2018/19 Expenditure (£)
Improved Better Care Fund		384,000	496,000

Brief description
Meeting increased domiciliary care fees – the Authority is reviewing the state of the local market and reviewing the current rates to identify if returning to a payment model with an increased rate for short calls is appropriate. It has been gathering benchmarking data from other authorities in the region and listening to providers' concerns to inform itself of the appropriate fee level.

Ref	Scheme Name	Scheme type	Area of spend
15	**Impact on other increased fees (ISL, day care, direct payments, etc) of national living wage**	Other	Social Care
Commissioner		Provider	
North Tyneside Council		Private sector social care providers	
Funding source		2017/18 Expenditure (£)	2018/19 Expenditure (£)
Improved Better Care Fund		1,244,000	1,609,000
Brief description			

Meeting other increased fees (ISL, day care, direct payments etc) – the Authority is reviewing the state of the local market and reviewing the current rates to identify what increase providers require to meet their costs. A care fund calculator model has been used to establish what rate should be paid. It has been gathering benchmarking data from other authorities in the region and listening to providers' concerns to inform itself of the appropriate fee level.

Ref	Scheme Name	Scheme type	Area of spend
8	**Improving access to advice and information**	Other	Social Care
Commissioner		Provider	
North Tyneside Council		Private sector social care providers	
Funding source		2017/18 Expenditure (£)	2018/19 Expenditure (£)
CCG Minimum contribution		50,895	51,862
Brief description			

North Tyneside Council have implemented two services in the first half of 2017 which significantly expand our advice and information services:

- MyCare- "My Care North Tyneside is an information and advice website about care and support options for residents in North Tyneside. My Care offers information and advice on a range of care and support options for you, your carer or your family members. It will ensure you are all informed, can make your own choices and remain independent in life. It will also help you to identify your support needs and the cost involved in paying for support. You can also browse the SIGN North Tyneside directory for services, groups and activities that may help you, your carer and your family."

Available at https://mycare.northtyneside.gov.uk

- MyCare will be further expanded to link to our new Social Care information system, Liquidlogic, allowing adult social care customers to communicate securely with staff in order to support their care.

MyCare links to SIGN North Tyneside, which brings together information about activities, support and services to help people with care and support needs living within North Tyneside. You can find out about support and equipment for your home, activities within your community, and services to meet your care and support needs. SIGN will be expanded to bring in more content from a variety of service providers.

Ref	Scheme Name	Scheme type	Area of spend
10	**Supporting carers**	Other	Social Care
Commissioner		Provider	
North Tyneside Council		Voluntary sector and private sector agencies	
Funding source		2017/18 Expenditure (£)	2018/19 Expenditure (£)
CCG Minimum contribution		570,024	570,024
Brief description			

Our commitment to carers is:

'To improve the health and wellbeing of all carers living in North Tyneside, and support them to have a life outside of caring.

To actively promote open, honest working in co-production with carers.'

The North Tyneside Commitment to Carers' is based upon six priorities:

1. Earlier identification of carers and the provision of quality information;
2. Improved communication;
3. Improved carer health, wellbeing and support;
4. Support that enables carers to go to/continue to work or in education;
5. Carers have access to emotional support; and
6. Smooth transition of support from children's to adult services.

Further information is provided in Appendix 5 on page 82

Ref	Scheme Name	Scheme type	Area of spend
11	**Disabled Facilities Grant**	Other	Social Care
Commissioner		Provider	
North Tyneside Council		Private sector providers of adaptations	
Funding source		2017/18 Expenditure (£)	2018/19 Expenditure (£)
Local Authority Contribution		1,416,617	1,526,533
Brief description			

The Disabled Facilities Grant (DFG) aims to:

- Enable people to live independently in their own home
- Minimise risk of injury for customer and carer
- Prevent of admission to hospital and long term care

- Reduce dependency upon high level care packages
- Improving quality of life and well being
- Maintain family stability
- Improve social inclusion
- Enhance employment opportunities of the disabled person
- Support the local economy

North Tyneside is a unitary authority, hence there are no separate housing authorities with a role in the DFG.
The provision by local authorities of Disabled Facilities Grants is a mandatory requirement by virtue of the Housing Grants, Construction and Regeneration Act 1996, as amended. They are issued subject to a means test and are available for essential adaptations to give disabled people better freedom of movement into and around their homes, and to give access to essential facilities within the home. As a unitary Authority, North Tyneside Council is the housing authority as well as the host of the BCF, therefore there is no requirement to include other councils in the arrangements.

Examples of adaptations include stair lifts, level access showers and home extensions. The programme is key in delivering the Government's objective of providing increased levels of care and support to both disabled and vulnerable people to help them live independently in their own homes

The DFG framework budget does not apply to the funding of adaptations to local authority properties but does apply to housing association homes.

Before issuing a DFG the Authority must satisfy itself that the works are necessary and appropriate to meet the needs of the disabled person and are reasonable and practicable depending on the age and condition of the property. Any grant award cannot exceed £30k.

Ref	Scheme Name	Scheme type	Area of spend
12	**Independent support for people with learning disabilities**	Domiciliary care at home	Social Care

Commissioner	Provider	
North Tyneside Council	Private sector social care providers	
Funding source	2017/18 Expenditure (£)	2018/19 Expenditure (£)
CCG minimum contribution	610,740	622,344

Brief description

The Council supports around 670 people with learning disabilities

The Council has undertaken a commissioning exercise to re-tender a range of community based supported living services that support people with learning disabilities to live independently in their own homes.

Services can provide support to an individual; or a small group of individuals in a single tenancy and are generally provided via an externally commissioned care provider service.

Within the new service specification, there are a number of key elements of the care and support arrangements, which are of benefit to health:

- Support and meet assessed eligible needs;

- Support individuals to access their GP and other health appointments as well as hospital appointments;
- Make sure eligible people have access to an annual health check and where appropriate a health action plan; and
- Staff are supported to identify and recognise basic health and well being issues and know how to support individuals to access on-going support.

These Services help support people in the community and not in hospital and where there is capacity the service will also support discharge from hospital.
Contract compliance and quality monitoring arrangements are the same as those for residential and nursing care

Ref	Scheme Name	Scheme type	Area of spend
7	**Seven-day social work**	High Impact Change Model for managing transfers of care	Social Care

Commissioner	Provider	
North Tyneside Council	North Tyneside Council	
Funding source	2017/18 Expenditure (£)	2018/19 Expenditure (£)
CCG minimum contribution	64,128	65,346

Brief description

This service enables the provision of a hospital-focussed social work service in the evenings and weekends with the objective of reducing hospital admissions and facilitating earlier discharge.

The staffing forms part of the Carepoint service described in Appendix 2.

The Improved Better Care Fund

The grant conditions for the Improved Better Care Fund require that the fund may be spent on:

- Meeting adult social care needs
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready
- Ensuring that the local social care provider market is supported

Table 7 below shows how these functions are supported by use of the iBCF in North Tyneside, in line with quarterly reporting to the DLCG:

Table 7

	2017/18 Gross Contribution	2018/19 Gross Contribution
Meeting adult social care needs:		
Effect of demographic growth and change in severity of need	£1,270,000	£1,892,000
Reducing pressures on the NHS:		

Ensuring that the local social care provider market is supported:		
Impact on care home fees of paying the national living wage	£2,145,000	£2,776,000
Impact on domicilliary care fees of paying the national living wage	£384,000	£496,000
Impact on other increased fees (ISL, day care, direct payments, etc) of paying the national living wage	£1,244,000	£1,609,000
TOTAL	£5,043,226	£6,772,688

Table 8 below shows how the costs, summarised in Table 7, have been calculated.

Table 8: calculation of costs related to the iBCF

Additional Spend	Actual and (robustly) forecasted additional spend in 16/17 and 17/18	Prorata within IBCF total for 2017/18	Expected additional cost in 2018/19	Total additional costs expected across 16/17 to 18/19	Prorata within IBCF total for 2018/19
National Living Wage					
Res/nursing	2,631	2,147	1,707	4,337	2,777
Dom care	470	384	305	775	496
Other	1,523	1,243	988	2,511	1,608
Total	4,624	3,773	3,000	7,624	4,881
Demographic Growth					
Learning Disabilities	1,000	816	900	1,900	1,216
Older People	556	454	500	1,056	676
Total	1,556	1,270	1,400	2,956	1,892
Total additional spend	6,180	5,043	4,400	10,580	6,773

Risk

The BCF Partnership Board oversees a risk log at both the strategic / programme and operational /scheme level.

The strategic risks that are monitored by the Board include

- Delays in agreeing the investment plan may lead to consequent delay in agreeing Cabinet or CCG Governing Body sign-off
- BCF schemes will increase demand for social care community-based services, resulting in higher waiting times for community care assessment.
- BCF schemes will increase demand for community-based health services, resulting in higher waiting times for community care assessment.
- The disruption associated with BCF schemes reduces social care related quality of life for service users.
- The disruption associated with Better Care Fund schemes impacts on patient experience of NHS services as measured through the Friends and Family Test

Risks at the operational level include:

- Number of service users lower than expected
- Number of service users higher than expected
- The service is less effective than expected in reducing hospital admissions
- Difficulty in recruiting staff
- Staff are recruited from other council services leading to difficulties elsewhere
- Staff are recruited from other health services leading to difficulties elsewhere
- Referrals lead to unexpected cost and/or volume increases in other council services, eg equipment
- Referrals lead to unexpected cost and/or volume increases in other health services
- Poor supplier response to procurement process
- Preferred supplier does not agree to contract terms
- Delay in service mobilisation

In 2017/18, all schemes funded by the BCF are already live, having commenced in 15/16, or 16/17 and therefore the risk level has been managed down as the schemes progressed through design and implementation.

Our risk sharing process, whereby the responsible commissioner for each BCF scheme accepts the risk of overspend for that scheme, ensures that the BCF cannot overspend.

Our market position statements can be found at
http://my.northtyneside.gov.uk/category/786/our-commissioning-intentions

National Conditions

National condition 1: jointly agreed plan

The plan was agreed at Officer level between the CCG and the Council on 18th October 2017.

The plan will be submitted to the Cabinet of North Tyneside Council on 13th November 2016

The plan will be submitted to the Health and Wellbeing Board on 16th September 2016

The plan will be submitted to the Governing Body of North Tyneside NHS Clinical Commissioning Group on 28th November 2017

North Tyneside is a unitary borough and therefore there is no separate housing authority
All of the services in this BCF are either existing services previously agreed with the providers of that services (including, where relevant, the voluntary and community sector, or where there are new services, the commissioning intentions have been discussed with the relevant providers.

National condition 2: social care maintenance

The list of schemes which have been classified as social care, are shown in Table 9 below.

Table 9

Area of Spen	Social Care		
Source of Fur	CCG Minimum Contribution		
		Sum of 2017/18 Expenditure (£)	**Sum of 2018/19 Expenditure (£)**
1	Community-based support, including Carepoint; reablement; immediate response and overnight home care; adaptations and loan equipment service; and CareCall / telecare	£ 7,138,533	£ 7,274,165
3	Intermediate Care - community services	£ 421,411	£ 429,417
7	Seven-day social work	£ 64,128	£ 65,346
8	Improving access to advice and information	£ 50,895	£ 51,862
9	Care Act implementation	£ 607,686	£ 619,232
10	Carers support	£ 570,024	£ 580,854
12	Independent support for people with learning disabilities	£ 610,740	£ 622,344
Grand Total		**£ 9,463,416**	**£ 9,643,221**

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

The list of BCF schemes which are classed as NHS-Commissioned Out of Hospital services is shown in Table 10 below. The value of these schemes is in excess of the required minimum.

Table 10

Area of Sp	(Multiple Items)
Source of	CCG Minimum Contribution
Commissi	CCG

		Sum of 2017/18 Expenditure (£)	Sum of 2018/19 Expenditure (£)
2	Intermediate Care beds	£ 3,653,432	£ 3,722,847
4	Liaison Psychiatry - Working Age Adults	£ 617,859	£ 629,598
5	Liaison Psychiatry - Older People	£ 132,132	£ 134,643
6	Enhanced Primary Care in Care Homes	£ 100,000	£ 101,900
19	End of Life Care - RAPID	£ 227,380	£ 231,700
21	CarePlus (New Models of Care)	£ 620,208	£ 631,992
24	Admission avoidance and discharge planning services	£ 724,177	£ 737,936
Grand Total		**£ 6,075,188**	**£ 6,190,617**

If an additional target has been set for Non Elective Admissions, can you provide evidence for deciding whether to hold funds in contingency, linked to the cost of any additional Non Elective Admissions that the plan seeks to avoid?
If yes, is there a clear process for releasing funds held in contingency into the BCF fund and how they can be spent?

Our target for Non Elective Admissions is drawn from CCG Operational Plans and there is no assumption of additional reductions arising from the BCF plan.

National Condition 4: Managing Transfers of Care

The High Impact Change Model is already being used to guide service developments, under the governance of the ECIP board which reports to the A&E Delivery Board for North Tyneside and Northumberland. Our current assessment and ambition for improvement is shown in the tables below. A grey cell indicates that we have moved beyond that status; a green cell represents our current status.

Change 1. Early discharge planning. In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected date of discharge to be set within 48 hours.

Not yet established	Plans in place	Established	Mature	Exemplary
Early discharge planning in the community for elective admissions is not yet in place	CCG and ASC commissioners are discussing how community and primary care coordinate early discharge planning	Joint pre-admission discharge planning is in place in primary care	GPs and DN lead the discussions about early discharge planning for elective admissions	Early discharge planning occurs for all planned admissions by an integrated community health and social care team
	Current state	planned by March 2018	aspire for March 2019	
Discharge planning does not start in A&E	Plans are in place to develop discharge planning in A&E for emergency admissions	Emergency admissions have a provisional discharge data set within 48 hours	Emergency admissions have discharge dates set which whole hospital are committed to delivering	Evidence shows X% of patients go home on date agreed on admission
			Current state	Aspire for March 2019

Change 2. Systems to monitor patient flow. Robust patient flow models for health and social care, icluding electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand, and to plan services around the individual)

Not yet established	Plans in place	Established	Mature	Exemplary
No relationship between demand and capacity in care pathways	Analysis of demand underway to calculate capacity needed for each care pathway	Policy agreed and plan in place to match capacity to care pathway demand	Capacity usually matches demand along the care pathway	Capacity always matches demand along the whole pathway
	Current state	aspire for March 2019		
Capacity available not related to current demand	Analysis of demand variations underway to identify current variations	Analysis completed and practice change rolled out across Trust and in community	Capacity usually matches demand 24/7 to match real variation	Capacity always matches demand 24/7 reflecting real variations
	Current state	aspire for March 2019		
Bottlenecks occur regularly in the Trust and in the community	Analysis of causes of bottlenecks underway and practice changes being designed	Analysis completed and practice changes being put in place and evaluated	Bottlenecks rarely occur and are quickly tackled when they do	There are no bottlenecks caused by process or supply failure
	Current state	aspire for March 2019		
There is no ability to increase capacity when admissions increase - tipping point reached quickly	Analysis of admissions variation ongoing with capacity increase plans being developed	Staff understand the need to increase capacity wen admissions increase	Capacity is usually automatically increased when admissions increase	Capacity is always automatically increased when admissions increase
	Current state	aspire for March 2019		
Staff do not understand the relationship between poor patient flow and senior clinical decision making and support	Staff training in place to ensure understanding of the need to increase senior clinical capacity	Staff understand the need to increase senior clinical support when necessary	Senior clinical decision making support is usually available and increased when necessary	Senior clinical decision making support available and increased automatically when necessary to carry out assessment and review
	Current state	Current state		

Change 3. Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector. Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients

Not yet established	Plans in place	Established	Mature	Exemplary
Separate discharge planning process in place	Discussion ongoing to create integrated health and ASC discharge teams	Joint NHS and ASC discharge team in place	Joint teams trust each others' assessments and discharge plans	Integrated teams using single assessment and discharge process
			Current state	aspire for March 2019
No daily MDT meeting in place	Discussion to introduce MDTs on all wards with Trust and community health and ASC	Daily MDT attended by ASC, voluntary sector and community health	Integrated teams cover all MDTs including community health provision to pull patients out	Integrated service supports MDTs using joint assessment and discharge processes
			Current state	aspire for March 2019
Continuing Health Care(CHC) assessments carried out in hospital and taking "too long"	Discussion between CCG and Trust to establish discharge to assess arrangements	Discharge to assess arrangements in place with care sector and community health providers	CHC and complex assessments done outside hospital in peoples homes/extra care or reablement beds	Fully integrated discharge to assess arrangements in place for all complex discharges
		Current state	planned by March 2018	aspire for March 2019

Change 4. Home First/Discharge to Asesss. Providing short-term care and reablement in people's homes or using step-down beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.

Not yet established	Plans in place	Established	Mature	Exemplary
People are still assessed for care on an acute hospital ward	Nursing capacity in community being created to do complex assessments in the community	People usually return home with reablement support for assessment	People return home with reablement support from integrated team	All patients return home for assessment and reablement after being declared fit for discharge
			Current state	aspire for March 2019
People enter residential/nursing care too early in their care career.	Systems analysing which people can go home instead of into care - plans for self funder advice.	People usually only enter a care/nursing home when their needs cannot be met through a care home	Most people return home for assessment before making a decision about future care.	People always return home whenever possible supported by integrated health and social care support.
			Current state	planned by March 2018
People wait in hospital to be assessed by care home staff	Work being done to identify homes less responsive to assess people quickly	Care homes assess people usually within 48 hours	Care homes usually assess people in hospital within 24 hours	Care homes accept previous residents trusting Trust/ASC staff assessment and always carry out any new assessments within 24 hours
	Current state	planned by March 2018		aspire for March 2019

Change 5. Seven-day service. Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs.

Not yet established	Plans in place	Established	Mature	Exemplary
Discharge and social care teams assess and organise care during office hours 5 days a week	Plan to move to 7 day working being drawn up	Health and social care teams working to new 7 day working patterns	Health and social care teams providing 7 day working	Seamless provision of care regardless of time of day or week
			Current state	aspire for March 2019
OOH emergency team provide non-office hours and weekend support	New contracts and rotas for health and social care staff being drawn up and negotiated	New contracts agreed and in place	New staffing rotas and contracts in place across all disciplines	New staffing rotas and contracts in place and working seamlessly
		Current state	aspire for March 2019	aspire for March 2019
Care services only assess and start new care Monday-Friday	Negotiations with care providers to assess and restart care at weekends	Staff ask and expect care providers to assess at weekends	Most care providers assess and restart care at weekends	All care providers assess and restart care 24/7
	Current state / planned by March 2018 / aspire for March 2019	Current state / planned by March 2018 / aspire for March 2019	Current state / planned by March 2018 / aspire for March 2019	Current state / planned by March 2018 / aspire for March 2019
Diagnostics, pharmacy and patient transport only available Monday-Friday	Hospital departments have plans in place to open in the evenings and at weekends	Hospital departments open 24/7 whenever possible	Whole system commitment usually enabling care to restart within 24hrs 7 days a week	Whole system commitment enabling care always to restart within 24hrs 7 days a week
	Varies between hospitals			
	Current state	Current state	planned by March 2018	aspire for March 2019

Change 6: Trusted assessors. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.

Not yet established	Plans in place	Established	Mature	Exemplary
Assessments done separately by health and social care staff	Plan for training of health and social care staff	Assessments done by different organisations accepted and resources committed	Discharge and social care teams assessing on behalf of health and social care staff	Integrated assessment teams committing joint pooled resources
		Current state	aspire for March 2019	
Multiple assessments requested from different professionals	One assessment form/ system being discussed	One assessment format agreed between organisations/professions	Single assessment in place	Resources from pooled budget accessed by single assessment without separate organisational sign-off
		Current state	aspire for March 2019	
Care providers insist on assessing for the service or home	Care providers discussing joint approach of assessing on each others behalf	Care providers share responsibility of assessment	Some care providers assess in each others behalf and commit to care provision	Single assessment for care accepted and done by all care providers in system
	Current state	planned by March 2018	aspire for March 2019	

Change 7: Focus on choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options. The voluntary sector is a great help to patients in considering their choices and reaching decisions about their future care.

Not yet established	Plans in place	Established	Mature	Exemplary
No advice or information available at admission	Draft pre-admission leaflet and information being prepared	Admission avoidance and information leaflets in place and being used	Patients and relatives aware that they need to decide about discharge quickly	Patients and relatives planning for discharge from point of admission
			Current state	aspire for March 2019
No choice protocol in place	Choice protocol being written or updated to reduce seven days	New choice protocol implemented and understood by staff	Choice protocol used proactively to challenge people	All staff understand choice and can discuss discharge proactively
			Current state	planned by March 2018
No voluntary sector provision in place to support self-funders	Health and social care commissioners co-designing contracts with voluntary sectors	Voluntary sector provision in place in the Trust providing advice and information	Voluntary sector provision integrated in discharge teams to support people home from hospital	Voluntary sector fully integrated as part of health and social care team both in the Trust and in the community
			Current state	aspire for March 2019

Change 8. Enhancing health in care homes. Offering people joined-up, coordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.

Not yet established	Plans in place	Established	Mature	Exemplary
Care homes unsupported by local community and primary care	CCG and ASC commissioners working with care providers to identify need	Community and primary care support provided to care homes on request	Care homes manage the increased acuity in the care home	Care homes integrated into the whole health and social care community and primary care support
				Current state
High numbers of referrals to A&E from care homes especially in evenings and at weekends	Specific high referring care homes identified and plans in place to address	Dedicated intensive support to high referring homes in place	No unnecessary admissions from care homes at weekends	No variation in the flow of people from care homes into hospital during the week
		Current state	aspire for March 2019	aspire for March 2019
Evidence of poor health indicators in CQC inspections	Analysis of poor care identifies homes where extra support and training needed	Quality and safeguarding plans in place to support care homes	Community health and social care teams working proactively to improve quality in care homes	Care homes CQC ratings reflect high quality care
			Current state	aspire for March 2019

A number of existing services, both within and outside the BCF, are relevant to implementation of the high impact change model. The schemes most strongly linked to this model, and included in the BCF, are summarised in Table 11 below. These are all existing services, in operation now.

Table 11

Scheme T	9. High Impact Change Model for M aging Transfer of Care		
Source of	CCG Minimum Contribution		
Commissi	(All)		
		Sum of 2017/18 Expenditure (£)	**Sum of 2018/19 Expenditure (£)**
1	Community-based support, including Carepoint; reablement; immediate response and overnight home care; adaptations and loan equipment service; and CareCall / telecare	£ 7,138,533	£ 7,274,165
7	Seven-day social work	£ 64,128	£ 65,346
24	Admission avoidance and discharge planning services	£ 724,177	£ 737,936
Grand Total		**£ 7,926,837**	**£ 8,077,447**

Overview of funding contributions

As confirmed in the planning template, the contributions to the BCF are as follows:

Table 12

	2017/18 Gross Contribution	2018/19 Gross Contribution
North Tyneside CCG		
Minimum CCG contribution	£15,538,604	£15,833,838
Additional CCG contribution		
Sub total	£15,538,604	£15,833,838
North Tyneside Council		
Disabled Facilities Grant	£1,416,617	£1,526,533
Improved Better Care Fund	£5,043,226	£6,772,688
Sub total	£6,459,843	£8,299,221
GRAND TOTAL	£21,998,447	£24,133,058

BCF guidance requires that funds are specifically identified for the Care Act; reablement; carer's support; social care; and iBCF. The following sections confirm the amounts and purposes of the these elements of the fund.

Implementation of the Care Act 2014

Table 13

	2017/18	2018/19
Care Act implementation	£607,686	£619,232

Reablement

Table 14

	2017/18	2018/19
The reablement service is included within the category of "community-based services" with the values shown here. The values shown are higher than the cost of reablement but the Authority is satisfied that the relevant contribution towards reablement has been included in the BCF.	7,138,533	7,274,165

Carer's Support

Table 15

	2017/18	2018/19
Carers Support	570,024	580,854

Social Care

Table 16

	2017/18	2018/19
Minimum mandated expenditure on social care, from the CCG minimum	£9,897,805	£10,085,863
Planned social care expenditure from the CCG minimum	£9,463,416	£9,643,221

The planned social care expenditure from the CCG minimum is, by agreement of the Council and the CCG, below the minimum mandated amount, by £434,389 in 2017/18 and by £442,642 In 2018/19.

The reason for this variance is that the CCG and the Council agreed to vary amounts paid to the Council from the CCG, after the submission of the 2016/17 planning template. The calculation of the "minimum mandated expenditure on social care, from the CCG minimum", shown in Table 16 and reproduced from the 2017-19 planning template, was based upon an inflationary update to the amounts stated in the previously submitted template.

The agreed plan incorporated a reduction of £678k in the amount paid from the CCG to social care, which was partly related to the closure of The Cedars Intermediate Care Centre and the development of a new model of intermediate care.

The changes to intermediate care were implemented only for the final quarter of the 2016/17 financial year. In 2017/18 the full-year effect of these changes would produce a reduced running cost of £730k compared to 2016/17 (see below), which the CCG will seek to reflect in a reduced contribution to the BCF,

Table 17

	£000s		
	2016/17	2017/18	Difference
The Cedars	1,041	-	
Intermediate Care Community Services	103	414	
Total	1,144	414	-730

Programme Governance

Describe the governance arrangements in place for the BCF plan and how you will provide 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?
You could include a diagram to show the programme governance structure.

The 2015/16 BCF s75 Agreement established a Better Care Fund Partnership Board which continues in existence.

The membership of the North Tyneside Better Care Fund Partnership Board is as follows:

North Tyneside Clinical Commissioning Group

- Director of Commissioning and Contracting
- Chief Finance Officer

- (or deputies to be notified to the other members in advance of any meeting);

North Tyneside Council
- Director of Adult Social Services
- Senior Business Partner
- (or deputies to be notified to the other members in advance of any meeting);

The Director of Commissioning and Contracting will be the Chair of the meeting and the Director of Adult Social Services will be the vice Chair.

Other officers will attend the Partnership Board as required by members

The Partnership Board shall:

- provide strategic direction on the individual Services
- receive the financial and activity information;
- review the operation of this Agreement and performance manage the individual Services;
- agree such variations to this Agreement from time to time as it thinks fit;
- review and agree annually a risk assessment and a Performance Payment protocol;
- review and agree annually revised Schedules as necessary;
- request such protocols and guidance as it may consider necessary in order to enable each Pooled Fund Manager to approve expenditure from a Pooled Fund;

Partnership Board Support

The Partnership Board will be supported by officers from the Partners as required.

Meetings

The Partnership Board will meet at least Quarterly at a time to be agreed, following receipt of each quarterly report of the Pooled Fund Manager.

The quorum for meetings of the Partnership Board shall be a minimum of one representative from each of the Partner organisations.

Decisions of the Partnership Board shall be made unanimously. Where unanimity is not reached then the item in question will in the first instance be referred to the next meeting of the Partnership Board. If no unanimity is reached on the second occasion it is discussed then the matter shall be dealt with by reference to the Chief Officer of the CCG and the Chief Executive of the Council. If the matter remains unresolved then it shall be dealt with in accordance with the dispute resolution procedure set out in the Agreement.

Where a Partner is not present and has not given prior written notification of its intended position on a matter to be discussed, then those present may not make or record commitments on behalf of that Partner in any way.

The BCF Partnership Board is supported by a BCF Pooled Fund Manager, who is jointly funded by the Council and the CCG. The role of the Pooled Fund Manager was set out in the 2015/16 BCF s75 Agreements as follows:

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36 The Partners have agreed:

a. That the Authority shall act as Host Partner for the purposes of Regulations 7(4) and 7(5) and shall provide the financial administrative systems for the Pooled Fund;

b. That the Programme Manager (who is a joint officer of the Authority and the CCG and an employee of the Authority) shall act as the Pooled Fund Manager for the purposes of Regulation 7(4) of the Regulations.

37 The Pooled Fund Manager in respect of each individual Service where there is a Pooled Fund shall have the following duties and responsibilities:

a. the day to day operation and management of the Pooled Fund;

b. ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Service Specification;

c. maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund;

d. ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;

e. reporting to the Partnership Board as required by the Partnership Board and the relevant Service Specification;

f. ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement;

g. preparing and submitting to the Partnership Board Quarterly reports (or more frequent reports if required by the Partnership Board) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Partnership Board to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met.

h. preparing and submitting reports to the Health and Wellbeing Board as required by it.

38 In carrying out their responsibilities as provided under Clause 8.2 the Pooled Fund Manager shall have regard to the recommendations of the Partnership Board and shall be accountable to the Partners.

The Partnership Board reports regularly to the Health and Wellbeing Board and the Adult Social Care, Health and Wellbeing Sub-committee of the Overview and Scrutiny Committee.

The Partnership Board works within the context of the work of the A&E Delivery Board, which covers the geography of both North Tyneside and Northumberland.

National Metrics

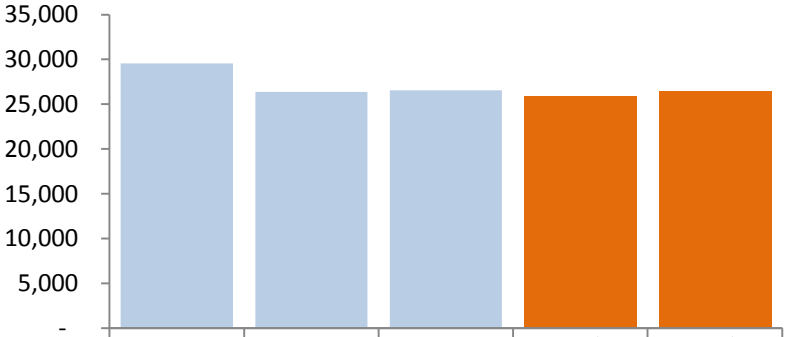
Summarise the metrics you have set for each of the four national metrics.
You should include an explanation for how each target has been reached, including an analysis of previous performance and a realistic assessment of the impact of BCF schemes on performance in 2017-19.

Non-elective Admissions

The level of emergency admissions for North Tyneside fell in 2015/16 and stayed at roughly the same level in 2016/17 (Figure 9 below)

The BCF plan reflects the trajectories set out in CCG operational plans. It has been assumed that there is no **additional** change expected due to the implementation of the 2017-19 BCF plan; this is because all of the BCF services were already in operation, funded by the BCF in 2016/17 (many of them having been in operation for some years) and therefore the effect of the BCF services on the level of emergency admissions has already taken place and is reflected in CCG operational plans.

Figure 9



	2014/15	2015/16	2016/17	2017/18 plan	2018/19 plan
Non-elective emergency admissions	29,557	26,372	26,562	25,949	26,526

Admissions to residential care homes: How will you reduce these admissions?

In 2017/18 and 18/19 we expect the actual number of permanent admissions to residential care to remain at approximately the same level of 300 cases per year. However this is in the context of a projected increase in popuation so that the rate of admissions wil fall slightly if the absolute number stays constant.

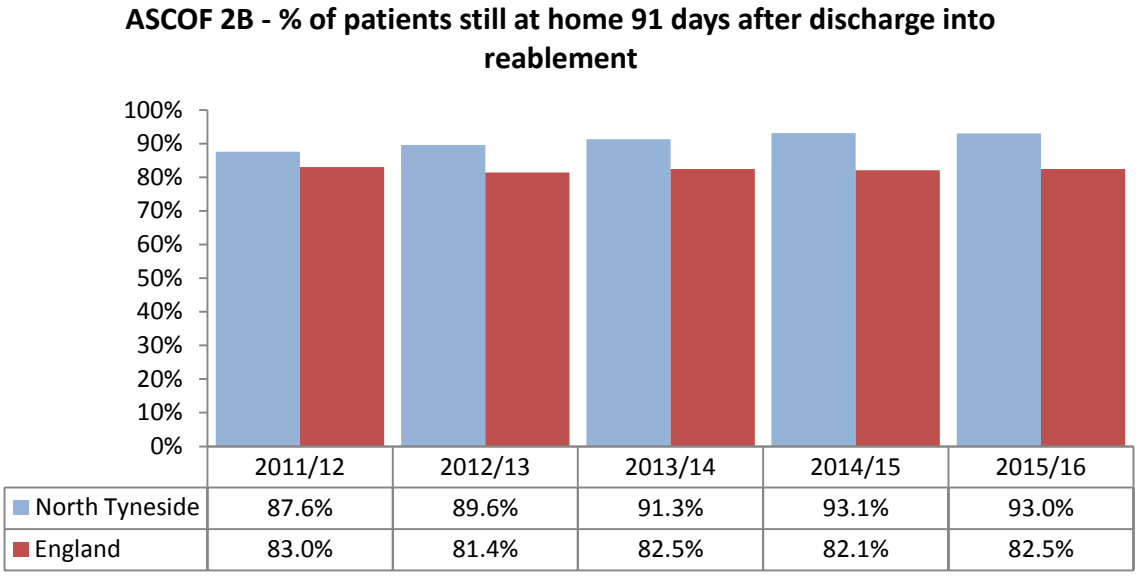
Our progress in implementing the High Impact Change Model will help to constraing growth in permanent admissions to residential care, by ensuring that early planning is carried out by multi-disciplinary teams to ensure that options other than residential care are actively

pursued at every stage of hospital discharge. We will continue to provide challenge by social care senior managers in panels considering funding for permanent residential care.

Effectiveness of reablement: How will you increase re-ablement?

Our rate for the effectiveness of reablement has been well above the England average for several years (see Figure 10 below). Within the previous year, our reablement service has been integrated within CarePoint, an integrated health and care service jointly provided by North Tyneside Council and Northumbria Healthcare NHS Foundation Trust. (see Appendix 2). We believe that the continued development of this integrated service will allow us to maintain our high measure of effectiveness of reablement.

Figure 10



	2011/12	2012/13	2013/14	2014/15	2015/16
North Tyneside	87.6%	89.6%	91.3%	93.1%	93.0%
England	83.0%	81.4%	82.5%	82.1%	82.5%

Delayed transfers of care

North Tyneside acknowledges the ambition for the reduction in the level of Delayed Transfers of Care, set out by the Department of Health, which call for a reduction as follows:

Total delayed days per day. Per 100,000 population aged 18+)	Baseline Feb-April 2017	Target November 17-March 2018
NHS reponsible	3.5	3.4
Social care responsible	0.4	0.2
Both responsible	0	0
Total	4.0	3.5

These ambitions are reflected in our BCF plan and we will aim to achieve them, whilst noting the following risks to delivery:

a) North Tyneside has a very low starting point – the ninth lowest rate in England – which reflects the adoption of best practice over many years, leaving less opportunity available for further reductions.
b) Only 16% of our delays are social care responsible and yet the national ambition proposes that 50% of the desired improvement comes from social care.
c) Despite a generally low level, there have been an increased number of delays from April-June 2017, which reflects the growing level of acute hoospital activity, and the fragile state of the social care provider market.

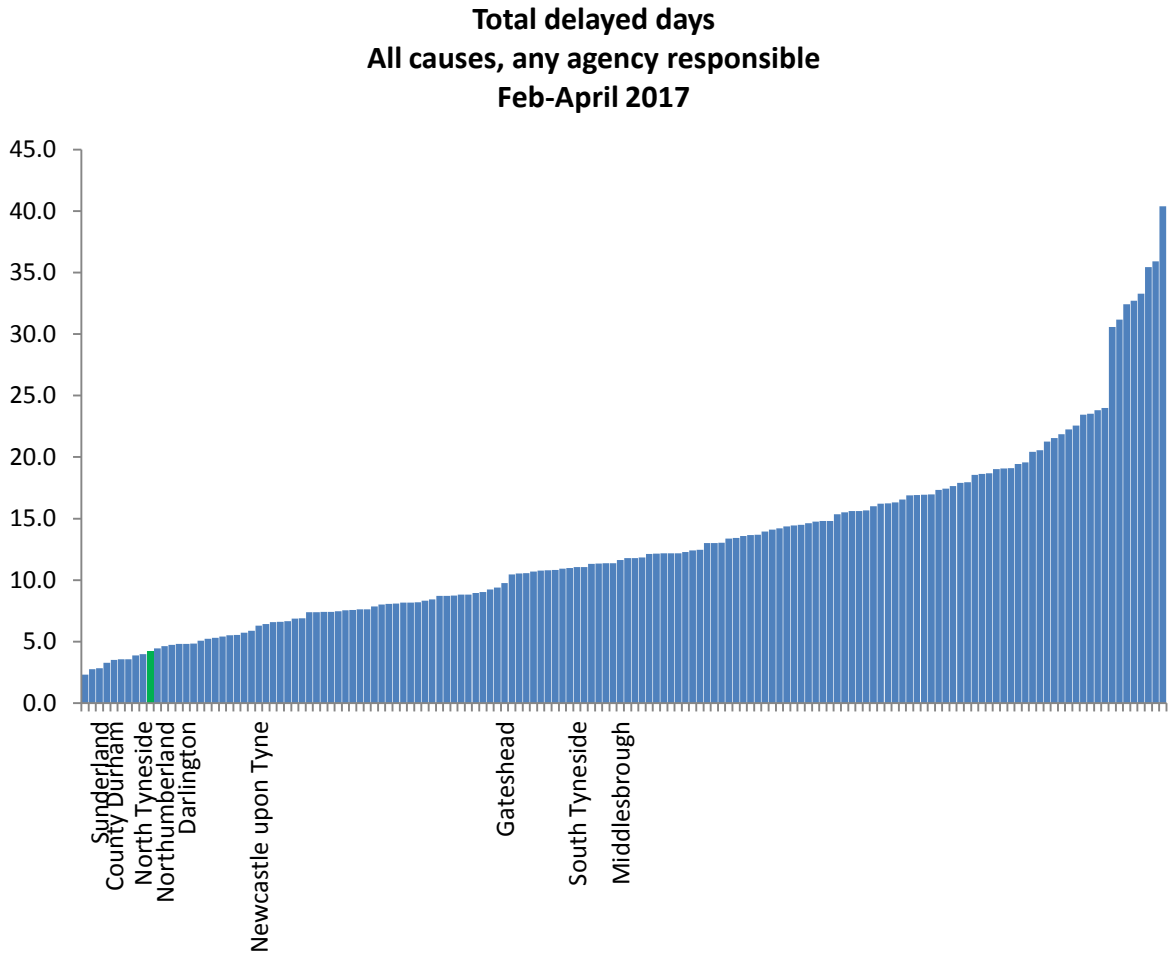
Whilst the level of delays in North Tyneside are relatively low, we are committed to maintaining them at that low level and to seek further reductions. Our plan to do so is inextricably linked with the further implementation of the High Impact Change Model for Managing Transfers of Care.

We will work through the A&E Delivery Board to pursue further implementation of the High Impact Change Model, in partnership with local acute and community service providers.

The current level of delayed transfers.

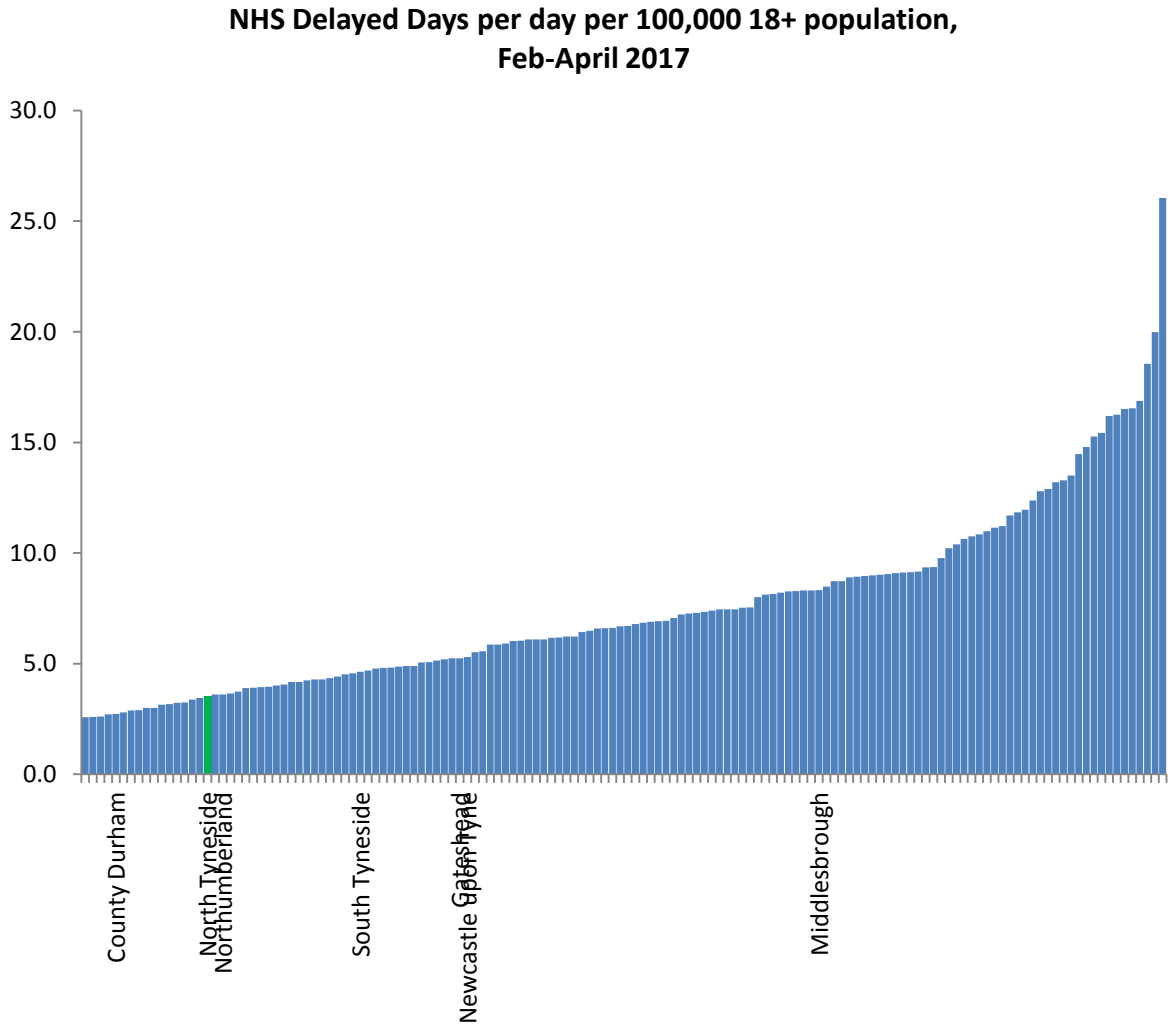
This section assesses the baseline situation, using the time period February-April 2017 which was the period quoted in the NHS-Social Care Interface Dashboard, which informed the national exercise in setting DTOC trajectories in July 2017.

Figure 11



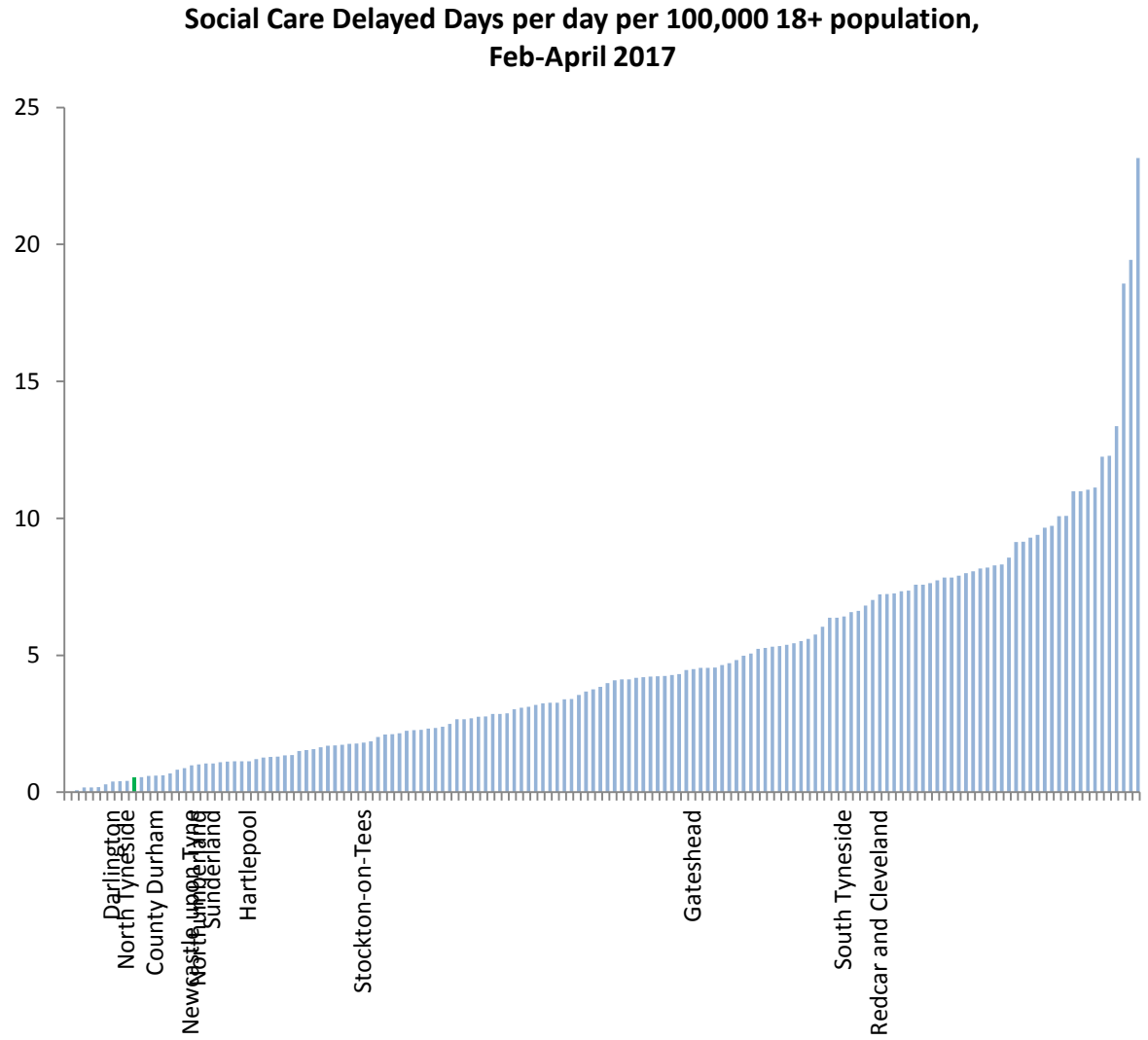
Error! Reference source not found. above shows that North Tyneside was towards the lower end of the range of values across England (where a low value is good).. North Tyneside had the 9th lowest number of delayed days out of 150 areas.

Figure 12



Error! Reference source not found. above shows only those delays which are classed as NHS-responsible. In this case, the North Tyneside position is 25th lowest out of 150 areas.

Figure 13



Error! Reference source not found. relates to delays which are classed as social-care responsible. North Tyneside is in 9th lowest place, within the best 10% of 150 areas and just outside the best 5%.

In addition to the low baseline position expressed above, **Error! Reference source not found.** below shows that following a significant reduction in 2014/15, the level of total DTOCs has remained steady despite demographic growth, compared to growth in England as a whole of 39% over the same time period (2014-15 to 2016-17).

Table 18

Year	NHS responsible delayed days	Social Care responsible delayed days	Both responsible delayed days	Total delays
2013-14	2538	1001	33	3572
2014-15	1916	811	107	2834
2015-16	2602	256	22	2880
2016-17	2487	400	6	2893
Grand Total	**9543**	**2468**	**168**	**12179**

The dominant causes of delays

Error! Reference source not found. below shows the major causes of delays for North Tyneside patients being discharged from our two local acute NHS Foundation Trusts. Three causes account for around 85% of days of delay:

- Waiting for further non-acute care
- Waiting for a care package in own home
- Patient/family choice

Table 19

Local Authority Name	NORTH TYNESIDE
FinancialYear	2016-17

Sum of TotalDelayedDays	Financial Year		
Causes for delay	NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	Grand Total
C_FURTHER_NON_ACUTE_NHS	15%	35%	34%
E_CARE_PACKAGE_IN_HOME	0%	27%	26%
G_PATIENT_FAMILY_CHOICE	65%	24%	25%
A_COMPLETION_ASSESSMENT	16%	8%	8%
H_DISPUTES	0%	3%	3%
F_COMMUNITY_EQUIP_ADAPT	4%	3%	3%
B_PUBLIC_FUNDING	0%	1%	1%
DI_RESIDENTIAL_HOME	0%	0%	0%
I_HOUSING	0%	0%	0%
DII_NURSING_HOME	0%	0%	0%

Error! Reference source not found. shows that the majority of delays are classed as NHS-responsible (84%); just under 16% are social-care responsible and almost none were the responsibility of both agencies.

Table 20

Local Authority Name	NORTH TYNESIDE
FinancialYear	2016-17

	Values			
Causes for delay	**Social Care responsible total delayed days**	**NHS responsible total delayed days**	**Both responsible total delayed days**	**Total Delayed Days**
C_FURTHER_NON_ACUTE_NHS	0	955	0	955
E_CARE_PACKAGE_IN_HOME	196	531	0	727
G_PATIENT_FAMILY_CHOICE	44	639	0	683
A_COMPLETION_ASSESSMENT	27	200	6	233
DII_NURSING_HOME	61	59	0	120
H_DISPUTES	61	12	0	73
F_COMMUNITY_EQUIP_ADAPT	11	60	0	71
B_PUBLIC_FUNDING	0	21	0	21
DI_RESIDENTIAL_HOME	0	7	0	7
I_HOUSING	0	3	0	3
Grand Total	**400**	**2487**	**6**	**2893**

Whilst the level of delays in North Tyneside are relatively low, we are committed to maintaining them at that low level and to seek further reductions. Our plan to do so is inextricably linked with the further implementation of the High Impact Change Model for Managing Transfers of Care.

We will work through the A&E Delivery Board to pursue further implementation of the High Impact Change Model, in partnership with local acute and community service providers.

Approval and sign off

Provide confirmation of who has signed up to the BCF plan

The plan will be considered by the Governing Body of NHS North Tyneside Clinical Commissioning Group on 28th November 2017

The plan will be considered by the Cabinet of North Tyneside Council on 13th November 2017

The plan will be considered by the Health and Wellbeing Board on 16th November 2017

Appendix 1 – The Care Plus service – information for general practices

INTRODUCING THE SERVICE

What is Care Plus?
Care Plus is a proactive multidisciplinary service working alongside general practice aiming to minimise the impact of frailty on patients and communities.

What are the objectives?
- Improve QOL for patients in the scheme
- Help patients achieve goals
- Reduce hospital admissions
- Proactive approach to care
- Encourage and facilitate self-management
- Reduce pressure on General Practice

Background
The scheme started as a pilot in the Whitley Bay locality. Despite limited resources initial results and feedback was positive. There have been some revisions to the initial model in response to feedback and it is likely that the model will continue to evolve.

The Care Plus team
GPs, consultants in care of the elderly, community matrons, pharmacists, Age UK Promoting Independence workers & volunteers, physiotherapist and occupational therapist.

Working closely with:
Social services, psychiatry of old age services, Admission Avoidance (AART) and other teams as needed

The Care Plus patient
We are looking for frail patients who are able to engage with and likely to benefit from input from the multidisciplinary team. There are a number of tools that can be used to identify frail patients. We recognise that no one of these is ideal and you may wish to use a combination. For example, running the electronic frailty index and then using your clinical knowledge of the patient. We would like you to let us know which tool you have used for service development purposes.

Examples of patients who may benefit
- Rockwood frailty score – should be 5 or 6, but even some patients scoring 4 may benefit
- EFI score indicating moderate frailty
- Falls
- Frequent GP appointments
- Recent hospital admission
- Multiple comorbidities
- Under multiple hospital specialties

- Polypharmacy
- Socially isolated
- Confidence problems
- Decline in functional status
    - Mobility
    - Continence
    - Increased dependence
    - Cognitive decline

We are not currently working with nursing or residential care patients, or patients needing end of life care. In the past we have found that the impact we can have on severely frail and bedbound patients is limited. Patients with significant mental health needs are unlikely to benefit from our service because we are unlikely to have anything additional to offer for these patients.
We are happy to discuss any referrals.

What Care Plus will offer
We aim to work intensively with the patient in the initial phase to optimise their health and wellbeing. As part of this we will devise a care plan in conjunction with the patient.

This care plan will be shared with the GP, OOH services and in the future the hospital via the MIG.

Acute admissions, out of hours contacts or any clinical changes will prompt a review.

The Care Plus team will work alongside general practice to meet demand from patients signed up to the scheme.

Care Plus – What you can expect from the team

GP
The Care Plus GP will perform a comprehensive medical review in line with the British Geriatric Society 'Fit for Frailty' guidance. This will include an initial assessment during which the GP will consider and address any reversible conditions, identify the impact of chronic disease and assess for frailty. The GP will then work in conjunction with the patient, their family and the MDT to develop a care plan to decide how best to apply clinical guidelines to optimise quality of life and minimise the impact of frailty. As part of the MDT the GP will input into a personalised care plan for the patient including treatment goals, management plans and plans for urgent care.

Geriatrician
The Care Plus geriatrician will also perform a similar role to the GP but in addition will be on hand where frailty is associated with significant complexity, diagnostic uncertainty or challenging symptom control.

Care coordinator
Central to the Care Plus team in coordinating patient care and liaising with relevant practitioners to deliver the personalised care plan. The care coordinator is the first point of call for patients with acute problems.

Community matron/ frailty practitioner
An experienced prescribing nurse will deliver community nursing care to keep Care Plus patients well and out of hospital where possible.

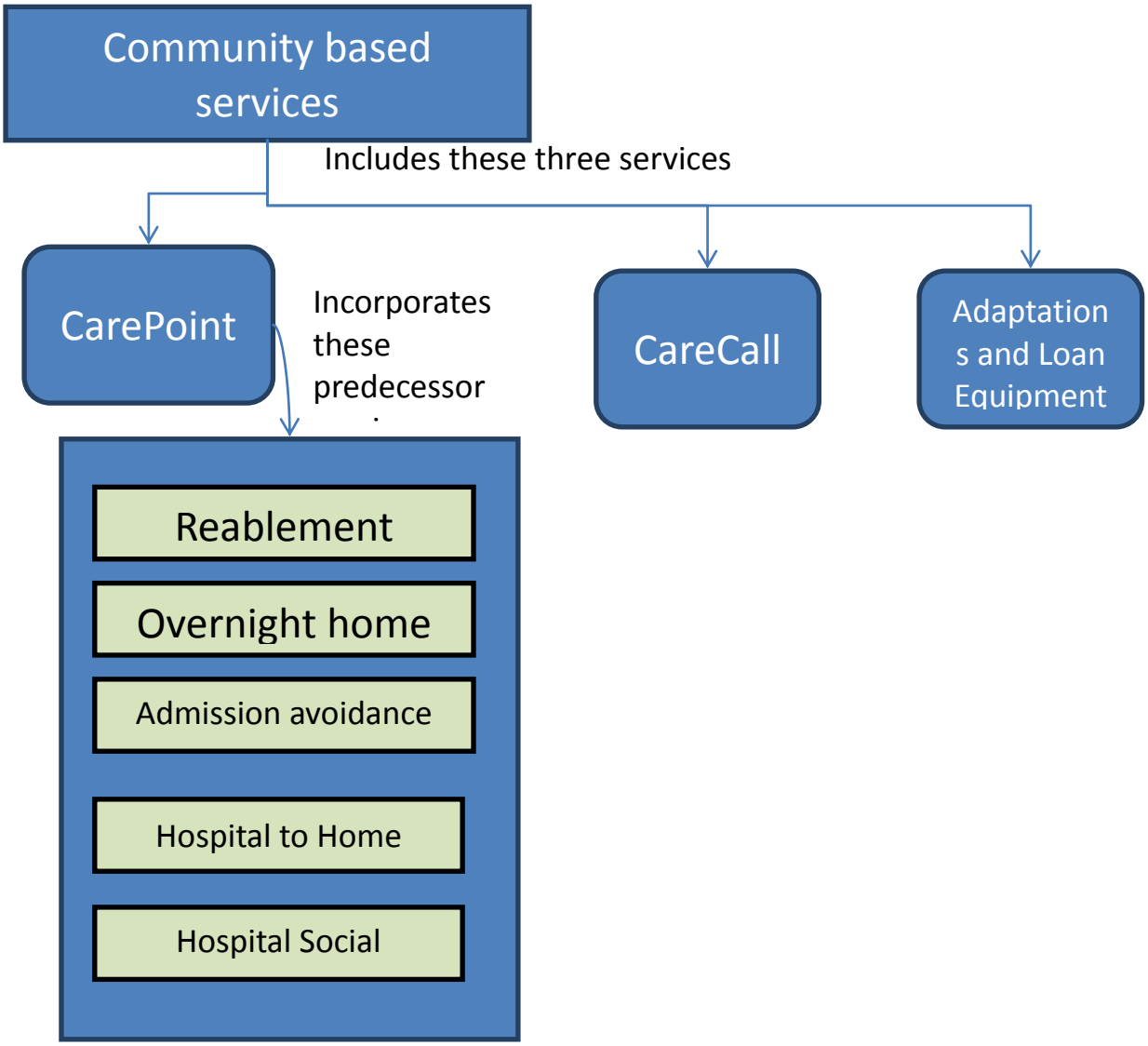
Pharmacist
The Care Plus pharmacist will carry out a personalised medication review. This will include an evaluation of the risks/ benefits of medications, consideration of polypharmacy and drug interactions, an assessment of patient compliance and patient education around medications.

Physiotherapist
The Care Plus physiotherapist will carry out assessment of patient mobility and transfers, consider any risks and determine whether mobility aids may be beneficial. They will work with patients in targeted rehabilitation programmes and falls prevention programmes as appropriate.

Occupational therapist
The Care Plus occupational therapist will carry out an assessment of the patient's ability to perform activities of daily living, a home assessment and identification of any risks. They will then work with the patient to overcome problems associated with frailty and maximise independence.

Age UK
An Age UK worker will carry out an initial patient assessment including details of household, family and support networks, ability to perform ADLs, interactions with others, ability to manage personal health care and financial activities, characteristics of home environment. They will identify personal goals and work with the patient to achieve these. This may involve signposting to third sector services or providing volunteers to help the patient achieve their goals.

Appendix 2 – CarePoint



Carepoint
The Carepoint service brings together a number of previously-separate services which aim to prevent admission to hospital and facilitate discharge from hospital. The predecessor services were:

- North Tyneside Council's reablement service, including immediate response, overnight home care and Community Rehabilitation Team
- North Tyneside Council's hospital-based social workers
- Northumbria Healthcare FT's admission avoidance resource team
- Northumbria Healthcare FT's "hospital to home service"

During 2015/16, all the predecessor services became located on the North Tyneside General Hospital site, although there is more work to be done to identify more suitable accommodation.

An operational manager has been appointed by Northumbria Healthcare to manage the integrated service.

It sits under one management structure and is an access point for AART, Nurse Practitioners, Reablement, hospital discharges & CarePlus to ensure that "1 contact is all it takes from the referrer" and using an interdisciplinary approach to achieve safe and efficient admission avoidance and discharge. The team has a holistic focus on the entire patient pathway from hospital to home. This proactive and preventative approach will ensure seamless transitions and help to avoid unnecessary admission and readmission to hospital.

CARE Point has access to resource availability and has the authority to deploy accordingly based on the needs of the individuals and to ensure optimal utilisation of commissioned services. This will ensure that care and support interventions are provided: at the right time; by the person with the most appropriate skills, in order to get the right care, first time, every time.

CARE Point ensures that adults are supported by an agile, multi-disciplinary, inter organisational team which avoids unnecessary admission and facilitates discharge, reducing length of stay. The team provides proactive and rapid response for adults and will maximise the capacity of the existing small teams across a range of agencies. Bringing the teams together affords the opportunity to review and reduce management infrastructure and to release resources to increase capacity at the front line.

Front of house functions

Safe and efficient discharge/admission avoidance

The multidisciplinary team works with clinicians to ensure that patients receive appropriate care by arranging packages of care directly from front of house to avoid admission or by facilitating efficient discharges. The team deals with all issues relating to community nursing, social care, and therapy, which will be accessed by a single point of entry.

Links with bed management

Team members link in the with the bed management function to monitor GP referrals in order to facilitate admission avoidance where possible.

Early identification of high risk patients

On a daily basis, "high risk" patients who have been admitted are identified, e.g. those who have had multiple attendances. They may be allocated to a team member to proactively coordinate care from admission to discharge, to ensure a clean transition into the community with preventative measures in place to prevent readmission – for example multidisciplinary discussions with relevant professionals around onward care following CGA(e.g. CarePlus),home based pharmacy assessment, etc.

Fast action for specific presentations to A&E

There is potential to scope out possibilities around fast action for specific A&E presentations, such as blocked catheters, urinary retention and constipation (i.e. ailments that could have been dealt with in the community), to avoid hospital admission.

Admissions from nursing homes

The team will monitor all admissions, and liaise closely with community matrons covering nursing homes, to ensure seamless care for this cohort of patients.

Back of house functions

Support to wards

Full hospital support in terms of discharge, including attendance and participation at identified ward MDTs, support for complex discharges, advice, and guidance re referrals to community services, in particular community nursing, reablement, patient information around social care charges and advice and guidance on referrals to residential care.

Referrals to community beds

Team members will contribute to multidisciplinary discussions and facilitate transfer to step up and step down community beds.

Links with ambulatory care

The nursing element of the team will link closely with ambulatory care – to scope out potential for referrals from A&E and diversion of patients referred to A&E by GPs, to ambulatory care to avoid admission.

Links with discharge lounge

The team will support the discharge lounge by encouraging usage on the wards, particularly for high risk patients. They will maintain close links with the pharmacist located in the discharge lounge to ensure high risk patient discharges are planned from admission to A&E and appropriate preventative measures are in place in community on discharge.

Incident Report Forms and learning

The team will have oversight of all IR1s relating to discharge from both acute and community side. The team leader will link with modern matrons and community clinical leads, attend IR1 meetings to ensure feedback and learning is cascaded to the relevant staff to close the gap on incident reporting, and to ensure new ways of working are adopted accordingly.

Reablement
Reablement is distinguished from other services through embracing a 'Social Model', which recognises the importance of emotional as well as physical recuperation. The kinds of support given through Reablement services are typically more varied than traditional home care support, are more intensive in nature, due to the goal of helping people to regain or acquire skills, and are tailored towards the individual's needs, goals and preferences.

There are however several essential elements that are defining features of the current Reablement service:

- The service is about helping people to do things for themselves, rather than doing things to or doing things for people.
- Is time limited with an active period typically of up to six weeks of intensive activity and support designed to promote people's independence.
- Is outcome focused with the overall goal of helping people back in to their own home or community.
- Involves goal setting agreed between the individual and the service.
- Ensures a personalized approach.
- Often involves intensive support.
- Delivers a dynamic approach to assessments and encourages on-going observation of the individual over a period of time, during which their needs and abilities may change.
- Builds on what individuals currently can do and supports then to regain skills to increase confidence and independence.
- Ensures individuals are provided with appropriate equipment and/or technology.
- Aims to maximize long term independence and reduce or minimize the need for on-going support after a period of reablement.

Reablement has both similarities and some differences when compared with intermediate care and rehabilitation services and prevention and it is essential that future service developments consider all four elements together to ensure a seamless service for people and not as separate entities as this would increase the risk of 'silo' working and potential for uncoordinated care and risk losing the opportunity to release efficiencies across the health and social care sector in the Borough.

Where reablement is in contrast to rehabilitation and intermediate care is that Reablement provides services for individuals who also have a social care need (which may result from a clinical need) and as such Reablement services tend to adopt a social model of support, though this can include individuals who have been through a period of Intermediate Care. Reablement users may also include those who have not been in hospital, and are not at high risk of admission to hospital or a care home, but who need support to continue living independently, following a deterioration in their daily living functioning, needing that bit of additional support to help them regain independence and prevent further deterioration.. Therefore Reablement should be seen as the vehicle to prevent some of the demarcations that currently exist between health and social care provision.

Hospital Based Reablement Discharge Social Work Team

Within NTGH there is a full hospital Social Work Department providing support to all the FOH & BOH wards from 8.30am – 5pm, Monday to Friday & Social Work cover from 9.00am – 5pm on Saturday & Sunday's.

The aims of the service are to:

- Provide comprehensive social work assessments and risk assessments
- Liaise with Community Teams regarding home circumstances and existing care packages
- Implement comprehensive person centred care packages
- Carry out outcome based assessments for Reablement and AART and make referrals
- Carry out CHC assessments
- Carry out Mental Capacity assessments
- Safeguarding
- Provide information and advice on Residential and Nursing Care Home placements
- Provide information and advice on Social Care, including charges
- Remove barriers to, and facilitate, efficient and safe discharge
- Set up care packages for palliative cases that require a rapid turnaround

Hospital to Home Team

Within NTGH there is a full time Team Lead/ Community Matron and 2.5 ftw Discharge Nurses they attend the daily board meeting at weekly MDT's on wards 2,3, 5 & 15 and provide support to all other wards and department by referral via the SPA from 8.30am – 5pm, Monday to Friday.

The aims of the service are to:

- Support multidisciplinary working
- Carry out outcome based assessment for Reablement and AART referrals
- Complete restarts of community care packages
- Assessment for IVAB at home
- Support with Palliative care discharges
- Community links/liaison with Social Care and District Nursing
- Support wards with Safeguarding issues
- Support wards with patient with housing issues
- Support delayed discharge
- Discharge to residential and nursing homes
- Continuing health care advice

Admission Avoidance Resource Team

The Admission Avoidance and Resource Team is made up of a range of healthcare professionals that offers urgent assessments for people in North Tyneside who are unwell to help them to remain in their own home and prevent an unnecessary hospital visit.

The team consists of;

- Clinical Lead
- Nurse Practitioners
- Nurses
- Occupational Therapists
- Physiotherapists
- Technical Instructor

The service provides an urgent care pathway for older people which ensures that patients

can be maintained in their usual place of residence with an integrated package of care where appropriate which:

- Keeps patients safe.
- Deals with immediate problems
- Identifying other related problems
- Responds to urgent needs appropriately
- Links with comprehensive geriatric assessment
- Ensures a care plan is in place

The service will aid early assessment, diagnosis and management of patients identified as having an urgent care need. Additional aims of the service include:

- Receiving referrals and clinical enquiries through a single point of access hotline service.
- Operating to evidence based pathways.
- Provision of assess, see, treat service for elderly patients with an urgent care need with a comprehensive follow up for any identified problem.
- Ensuring a care plan is in place.
- Maintaining high standards of care based on best evidence of older people using the geriatric assessment tool.
- Referral of patients promptly to an appropriate rehab/intermediate care/social care and or other alternative services as identified within the care plan.

The objectives of the service are:

- Deliver a clinician led service providing uniformity of care across the primary and secondary care pathway.
- Provide safe, high quality, cost effective and evidence based care for patients usually in their place of residency.
- Manage and reduce inappropriate hospital admissions by providing a responsive service and dealing with immediate problems.
- Promote patient independence structured programmes of health and social care through links with reablement and other adult social care services such as care call.
- Develop and inform local care pathways and protocols supporting an integrated approach to the care and treatment of older people.

Immediate Response Homecare

The service will be provided until the need for the immediate support is met or until an ongoing package of care is sought for long term support. The aim of the service will be to support the person to remain at home safely with regular planned visits to provide personal care, medication prompts and support with daily living tasks.

This will prevent unnecessary admission to hospital or short to long term care placements. It will also provide the right level of support to those who do not have any reablement potential. Investment in this area will enable the reablement service to focus on those patients who are at high risk of readmission to hospital as well as freeing up capacity to respond to seven day discharges.

The focus on admission avoidance has resulted in a robust system of response from a variety of teams including Reablement, AART, NP's, Out of Hours Nursing and the Community Nursing Support Team. These teams have worked together under an overarching admission avoidance banner to prevent avoidable admissions to hospital. This work is further supplemented by Community Matrons, including Specialist Palliative Care Matrons and Nursing Home Matrons.

Overnight Support
Additional support staff will be based with the Care Call Crisis Response Team, where staff will visit patients referred to the service specifically for overnight support.

This can be planned, timed interventions. The increase in support worker capacity will enhance the out of hour's services currently working across the Borough of North Tyneside, for example the out of hours nursing services, Carers Emergency Break Service. The aim of the service is to prevent admission or readmission to hospital and or long term care and to ensure that the person can be supported in their own home.

The staff will have access to a Council vehicle overnight, they will be monitored via the Jontek IT Lone Working module to ensure their safety and whereabouts are monitored and accounted for.

Patients at home as part of the admission avoidance pilot will have trained staff who can spend time with them offering relaxation methods and coping strategies to get them through the night when most patients with respiratory diseases become anxious during and exacerbation of condition.

The service will offer regular toileting calls to prevent continence problems and improve skin integrity. If a person needs to be turned in bed the service will be able to do provide this.

Appendix 3 – Supporting Carers

Extract from a report to the Health and Wellbeing Board, March 2017

1 Progress update – Adult Carers

To address some of the areas carers have told us require improvement, a pilot has been introduced in Adult Social Care to change how carers are supported from their first contact. It is hoped that this will improve and simplify how carers receive information, advice and support. The new model includes:

- Direct transfer from Gateway to the Carers' Centre where appropriate to provide quicker access to a trained professional who is able to provide specialist advice, information and signposting;
- Telephone access to emotional support provided by trained carer support workers;
- The introduction of a first level assessment carried out by the Carers' Centre to provide a proportionate response to carer needs;
- Two dedicated Carer Support Workers who have delegated authority from Adult Social Care to carry out Statutory Carers Assessments where appropriate and also 1:1 support where needed; and
- The introduction of an impact measurement tool completed by the Carers' Centre, used to establish the impact of the interventions being delivered. Improvements in emotional wellbeing and access to support networks appear to have the biggest impact for carers.

The pilot is continually being adapted based on feedback from staff in Adult Social Care, the Carers' Centre and carers.

Other key achievements in the first year include:

- A new carer training package for Adult Social Care staff has been developed and is now available on the Learning Pool, this includes young carer awareness;
- A quality assurance process for reviewing the quality of Carers Assessments carried out in Adult Social Care has been introduced;
- The Carers in Employment project (Government funded) is now successfully working with 13 large employers and has supported 229 individual working carers in North Tyneside to provide information on carers rights and support where identified;
- NT Carers' Centre has updated their newsletter and website to provide improved information for carers and professionals;
- The SIGN mobile app has been launched to improve signposting and information, NT Carers' Centre a key partner in this work;
- North Tyneside Carers' Centre produced a 'Key to Support' tool - which has been distributed to GP Surgeries to enable them to signpost carers to the Centre easily; and
- Healthwatch NT and CAB have undertaken a campaign to raise awareness to carers of their right to assessment.

We are now starting to produce some good data about carers so we understand the local picture more. Carers of people with dementia and mental health conditions are the primary health reasons for carers who are seeking support.

North Tyneside CCG has completed the NHS England Commissioning for Carers Principles self-assessment. For each principle, the CCG looked at what already exists in relation to:

- Provider policies on engagement which includes carers
- Standard contract service specifications
- Documentation, information and materials specifically targeted at carers
- Data and materials from services specifically commissioned to support carers

Using the data that was collected, the CCG rated themselves red, amber or green in relation to each question in the assessment. Examples of good practice included:

- Good carer engagement in learning disabilities with family carers actively involved in multi-disciplinary team discussions and care treatment reviews;
- The development of Proactive Care and New Models of Care has increased the number of patients with a care plan which includes information and input from the family carer;
- Local hospitals able to demonstrate strong leadership for carers issues with carers involvement noticeable in a number of services. For example, carers are invited to attend scrutiny groups in Northumbria Healthcare;
- Both NHS Trusts have robust policies in place that include carers. e.g. discharge policies; and
- Collaborative working with Trusts and other agencies in relation to staff training in recognising carers e.g. bespoke training delivered to medical students in relation to End of Life Care.

An event was then held on Carers Rights Day in November 2016 to validate the initial self assessment with stakeholders and carers. The comments gathered at this event are being used to develop an improvement plan. Stakeholders identified the following areas for improvement:

- Ensure information in GP surgeries is up to date and easily accessible
- Provide guidance to health professionals on the importance of engaging fully with carers at all stages of the persons care
- Ensure providers adhere to their discharge policies and involve family carers and main carers in the discharge planning process

There is also a commitment by the CCG to undertake a second self assessment in 17/18.

2 Young Carers

The Children and Families Act 2014 details the rights for young carers. Local Authorities are required to take reasonable steps to identify young carers in their area who have support needs and where appropriate carry out an assessment of those needs.

Much of the work in relation to young carers over the last year has involved working with the Carers' Centre, Children's Services and young carers to agree and establish a process to meet these requirements. Progress in this area includes:

- A process has been agreed with Children's Services for identifying and assessing Young Carers;
- The Early Help Assessment (EHA) now includes three prompt questions to identify if the young person could have caring responsibilities;
- Young Carers Assessment documentation has been developed;

- Additional actions have been agreed to support the roll out of the new process, including additional training for staff; and
- Young carers have developed a checklist of things they feel are important for professionals to consider when they are working with young carers, this information is being used as part of the training for staff.

3 Future Plans

Although we have made good progress on the North Tyneside Commitment to Carers', there is still much more to be done. Areas we have identified for further action in 2017/18 are:

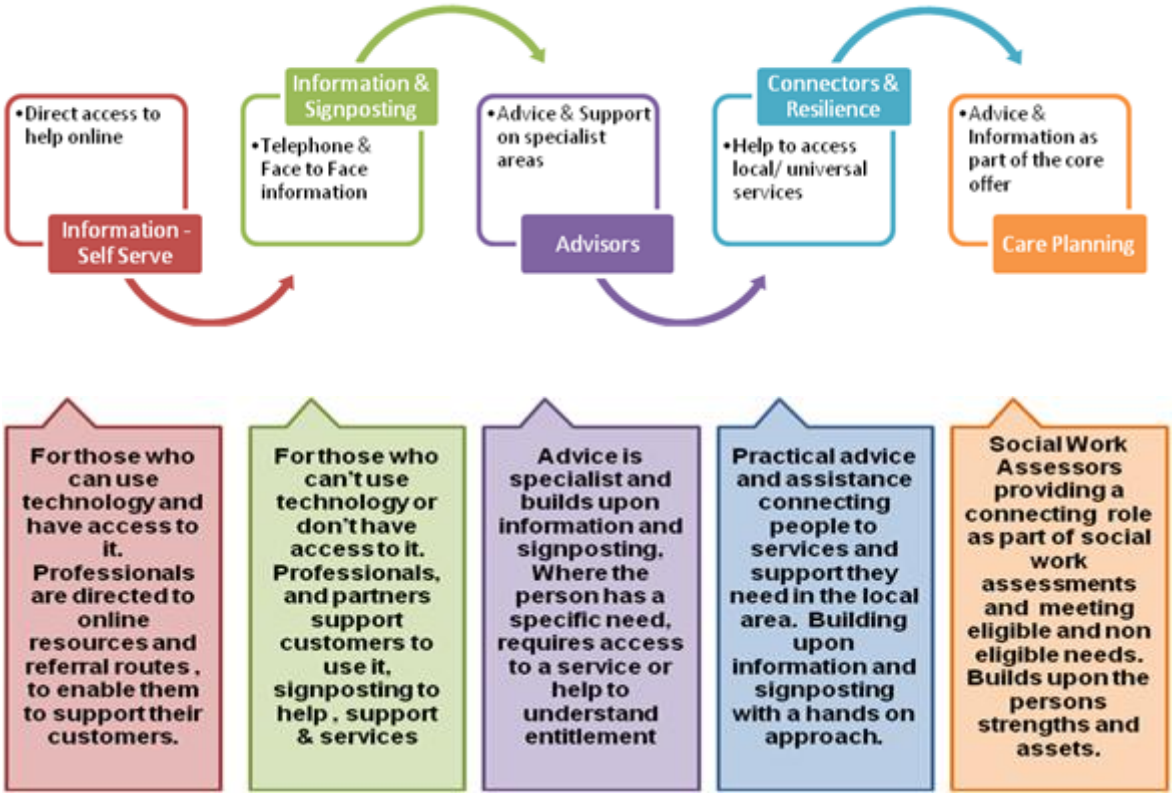
- Young Carer awareness – identification and assessment by all
- Carers and hospital discharge processes
- Collecting carers views of the current system and support – (including Healthwatch NT findings)
- Assistive technology to support carers and the use of the carers Jointly App
- Support for carers of people with mental health problems
- Review the use of the of the Carers Charter
- CCG priorities identified in the self assessment

Additionally, the new National Carers Strategy is due to be launched in the summer of 2017; therefore future plans will need to take account of the findings in this document.

Appendix 4 – reducing inequalities

How will the plan 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?

With regard to reduction of inequalities, all of the BCF services (except for "improving advice and information") are based on demonstrable need for health and/or care services, irrespective of age, disability, gender, race, religion/belief, sexual orientation, maternity/pregnancy, marriage/civil partnership, or gender reassignment The processes of assessment of need will ensure that the level of provision of services is matched to the level of need, thus contributing to the reduction of health inequalities.
The advice and information services, which are partially funded through the BCF, are a universal service but the method of access to the service is sensitive to the particular needs of each customer, in order to minimise barriers, as illustrated in the figure below and the following paragraphs.



Information- Self Serve – Direct access to online help
This is aimed at residents who have technology, have online access and who are able to use the My Care North Tyneside website and SIGN directory themselves. (They will probably already do many things online like online banking, booking holidays, ordering shopping).
Residents will be directed to My Care and SIGN via public promotion in the borough (leaflets/ posters/ bridge banners/ facebook/ twitter/ residents magazine), contact

with the Council at various points, contact with GP and other Health services, contact with SIGN organisations and the wider local CVS.
Professionals will also be directed to My Care and SIGN to support residents accessing their services. Online resources and referral routes will also be available to them to self serve.

Information & Signposting – Telephone & Face to Face information
This is aimed at residents who do not have technology, do not have online access and who are unable to access or use My Care North Tyneside website and SIGN directory themselves.
Residents will contact the Council, GP, Health and CVS and ask for advice, information and signposting. These organisations will then use My Care and SIGN with the customer to find what they need. This makes the first two tiers of the offer consistent and takes into account those residents who cannot access online resources themselves.
Regardless of which organisation they contact (customer services, gateway, CVS, GP) they will get the same consistent response.

Advisors – Advice & Support on specialist areas
This is aimed at more specialist advice around specific areas. Adult Social Care offers specialist advice around the social care process, assessment, financial assessment, support planning, occupational therapy, aids and adaptations, and so on.
Citizens advice also offer specialist advice around benefits and finance issues and are regulated by the FSA.

Connectors & Resilience – Help to access local/ universal services
This is aimed at adults who need more practical support with advice, information and signposting. They may have access to technology (or not), but need hands on assistance to connect them to support and to understand the relevant advice and information for their circumstances.
This type of support is usually provided by the Gateway Duty Team or Care & Connect Team and may involve them providing support over a period of hours, days or even weeks.
Care Planning – Advice & Information as part of the core offer
This is aimed at adults who have eligible needs (as well as non eligible needs) and who have been through the assessment process with the Community Wellbeing team. As part of the support planning process, the persons advice, information and signposting requirements should be included within their support plan, and reviewed to ensure it was relevant and the person benefitted from it. This approach helps to support not just their non-eligible needs but can also support eligible needs and remove the need for formal, paid-for care services.
This supports the strengths and assets approach.

Appendix 5 – former national conditions

Progress against the former national conditions 3, 4 and 5 in the 2016/17 BCF policy framework

Seven-day services

"Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate. "

The CCG and its commissioned providers continue to work toward full implementation of 7-day working, with both of the major acute providers supplying evidence through the Quality Reference Groups of their implementation of the 10 national clinical standards. The providers and CCGs will continue to work together to look at the key areas of implementation and where the organisations can work collaboratively to ensure the sustainability of 7-day working.
Both of our local acute Trusts have 7 day cover and access to diagnostic services.

The Northumbria Specialist Emergency Care Hospital is the first purpose-built hospital of Its' kind in England to have this level of medical cover. It has emergency care consultants working there 24 hours a day, seven days a week. Consultants in a broad range of conditions also offer services seven days a week, speeding up specialist care for patients in order to maximise chances of survival and a good recovery.

Newcastle Hospitals Trust has embedded 7 day working as a principle within its transformation and redesign programmes with continuous improvements and progress being made. Routine radiology and laboratory are available 7 days per week, although there is significant demand pressures. 24/7 Consultant cover in the Emergency Department. Newly recruited consultant job plans reflect the 7 day requirements and the Trust is keen to review the job plans of other staff to minimise delays and further develop 7 day working across its services.
Northumberland, Tyne & Wear Mental Health Trust is developing 7 day working for its mental health services, including its community services.

The Liaison Psychiatry Service operates 7 days per week.

North Tyneside Council provides a telephone service for all emergency calls for adult social care support, which is open 24 hours a day, 365 days per year.
The Council's contracts with home care providers require them to accept new starters, as well as delivery services to existing clients, 7 days per week.
The existing reablement service operates 7 days per week up to 10.00pm and the overnight home care service operates 24/7. The new Carepoint service will operate 7 days per week.

Data sharing
"Better data sharing between health and social care, based on the NHS number"

All North Tyneside general practices participate in the use of the Medical Interoperability Gateway (MIG) which enables data from general practice records, subject to patient consent, to be accessed in other care settings which include accident and emergency, out of hours primary care, and mental health settings.

The implementation was preceded by an extensive programme of engagement with general practices and secondary clinicians, resulting in sign-up to a data sharing agreement by each participating organisation. Data-sharing agreements are administered through the Cumbria Electronic Information Sharing Gateway which records how compliant an organisation is in regards to their Information Governance and the data flows they have agreed to. Organisations that have signed up to this tool can easily see which systems each other have in place to enable the safe sharing of information.

Patients are asked for explicit consent at the point of care when access to the MIG is proposed.

All parties across the region support the use of the Summary Care Record; when a patient from outside the area presents for treatment but is not covered by a data sharing agreement for the MIG, the Summary Care Record will be available as a backup.

North Tyneside Council already holds NHS numbers and are currently implementing new case management systems for both adults and children's social care which will include linkage to the Personal Demographics Service in order to maintain NHS numbers within the system. The system supplier is piloting integration with the Medical Interoperability Gateway.

Joint approach to assessment and care planning
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

The general practitioner is the identified lead professional for their patients who are at risk of hospital admission. GPs call on the support of community matrons, working alongside the GP with district nurses, social workers, and other relevant professionals in multi-disciplinary meetings within the established enhanced service for proactive care planning.

Case management is concentrated on those patients with the highest risk of hospital admission. Risk stratification is used to assist in identification of the patient cohort. 2.3% of the population aged 18+ are included in this model, of whom 98% have a named GP and 90% have a care plan.

In the Whitley Bay locality, the CarePlus provides a multi-disciplinary teams including GPs who specialise in the frail elderly, with consultant geriatricians, social workers,

community matrons, nurses from the mental health for older people service, admission avoidance team, and pharmacy. Age UK, who provide “personal independence coordinators” to support this group, as an integral part of the MDT. Dementia services are provided by our integrated Mental Health Services for Older People service; this includes co-located psychiatrists, psychologists, social workers, community psychiatric nurses, occupational therapists, ward-based nursing staff, residential and nursing care liaison team, and the challenging behaviour team. The service is steered by a joint operational board which includes health and social care membership.

Meeting: Adult Social Care, Health and Wellbeing Sub-committee

Date: 9th November 2017

Title: Treating tobacco dependency and achieving a smokefree generation in North Tyneside by 2025

Report from : North Tyneside Council, North Tyneside CCG and Northumbria Healthcare Trust

Report authors: H Douglas, T Dunkerton and J Stonebridge (Tel: 0191 643 2120)

Wards affected: All

1. Purpose of Report

This paper presents the current contribution of the Local Authority and the NHS in the treatment of tobacco dependency. This paper also contextualises how we will achieve a whole systems approach to reducing the prevalence of smoking to 5% by 2025.

2. Recommendations

The Committee supports the Local Authority, the CCG, Primary Care and Secondary Care in achieving a smokefree generation in North Tyneside by 2025.

The Committee endorses the following actions outlined in this report:

North Tyneside Council will:

- Continue to invest in community based universal stop smoking services
- Support services with low quit rates to improve the quality of the provision
- Provide training for stop smoking advisors (community, primary care and secondary care)
- Continue to coordinate and resource North Tyneside Smokefree Alliance
- Work with Northumberland, Tyne and Wear NHS Trust (NTW) and Northumbria Healthcare Foundation Trust (NHCFT) to treat tobacco dependency targeting those with mental health conditions and pregnant women.
- Work in our most deprived areas ensuring that stop smoking services are accessible
- Evaluate our electronic cigarette pilot, with a view to learn and further develop harm reduction services alongside the treatment of tobacco dependency

Northumberland Health Care Foundation Trust will:

- Continue the roll out of very brief advice training for all front line practitioners
- Systematically record of smoking status on all admitted patients
- Systematically offer of nicotine replacement therapy (NRT) to all admitted smokers
- Systematically offer of support to access behavioural support for all admitted smokers
- Audit practice in maternity services against NICE standards

North Tyneside CCG will:

- Develop a business case for an incentivisation scheme for all GP practices in North Tyneside to ensure that staff are trained in the delivery of very brief advice
- Introduce a new procedure to ensure that all respiratory patients who are current smokers will, at their annual review be offered treatment for tobacco dependency
- Develop guidelines on when primary care clinicians can prescribe pharmacotherapies to treat tobacco dependency alongside very brief advice.

North Tyneside Smokefree Alliance will:

North Tyneside Smokefree Alliance will continue to oversee the smokefree work undertaken by all of the partners and ensure that this work complements the programme of work outlined in the Cancer Locality Network and the Respiratory Rightcare Group. This includes the following actions that are jointly owned by North Tyneside Council, North Tyneside CCG and the acute trusts.

- The design of data packs for GP practices that captures the current baseline of smoking prevalence. These data packs will be updated annually and will include data and intelligence on smoking related activity such as the number of very brief advice interventions and numbers receiving pharmacotherapies.
- Design clinical pathways that cut across organisations e.g. stop before u op and discharge of patients from secondary care into the community and primary care
- Design patient specific pathways e.g. pregnant women and mental health service users.
- Design a digital platform to offer evidenced based tobacco dependency treatment for those who want to quit without formal support from services.

3. Details

North Tyneside has made considerable progress over the last decade in reducing smoking rates from 27.5% (2006-08)[i] to 16.4% (2016/17)[ii]. Whilst this progress is positive, smoking still remains the key driver for health inequalities with around half of the difference in life expectancy between the most and least affluent due to smoking.

Smoking remains the single largest cause of premature death, and accounts for half of the health gap between the poorest and the most affluent people in our populations.

The tobacco control plan for England[iii] sets out the national ambition to achieve a smokefree generation; which is defined as a smoking prevalence rate of 5% or below. In order to achieve a smokefree generation the following targets have been set:

- Reduce the prevalence of 15 year olds who regularly smoke from 8% to 3% or less by 2022.
- Reduce smoking prevalence amongst adults in England from 15.5% to 12% or less by 2022.
- Reduce the inequality gap in smoking prevalence between those in routine and manual occupations and the general population.
- Reduce the prevalence of smoking in pregnancy from 10.7% to 6% or less.by 2022
- Make all mental health inpatient services sites smokefree by 2018
- Create a smokefree NHS by 2020 through the 5 Year Forward View mandate[iv]
- Provide access to training for all health professionals on how to help patients – especially patients in mental health services - to quit smoking

- Help people to quit smoking by permitting innovative technologies that minimise the risk of harm.
- Maximise the availability of safer alternatives to smoking.

The national plan sets out some challenging targets, in particular the 5% prevalence rate. At present (2016) there are around 27,400 regular smokers in North Tyneside, in order to achieve a 5% prevalence rate 19,000 current smokers would need to quit and uptake amongst young people would need to fall to 3%.

Appendix 1: Treating tobacco dependency and achieving a smokefree generation in North Tyneside by 2025 provides an overview of the national and regional policy context as well as the progress made to date in tackling tobacco dependency and the future challenges for North Tyneside in achieving a 5% prevalence rate by 2025.

Appendix 2: Percentage of patients with a hypertension, asthma, COPD, stroke or CHD who, when asked reported smoking – GP Practice North Tyneside 2016/17

4. Background Information

The following documents have been used in the compilation of this report and may be inspected at the offices of the author.

- Modelled estimates using the Health Survey for England 2006-2008
- Smoking prevalence adults: Adult Population Survey 2016.
- DH analysis on Health Survey for England 2014 data
- PHE Local Tobacco Control Profiles
- PHE Segment Tool (North Tyneside)
- QOF database: NHS North Tyneside CCG; Smoking Prevalence 2016.
- ASH. Cost to Social Care: Local and Regional Estimates.
- NICE Return on investment tool for interventions and strategies to reduce tobacco use (2015)
- Towards a Smokefree Generation - A Tobacco Control Plan for England: (2017)
- NHS England. Next steps on the NHS five year forward view. 2017.
- PHE Models of delivery for stop smoking services: (2017). London.
- North East – North Tyneside Tobacco Commissioning Support Pack
- NICE PH Guidance 48: Smoking: acute, maternity and mental health services (2013)

[i] Modelled estimates using the Health Survey for England 2006-2008, Available at http://fingertipsreports.phe.org.uk/health-profiles/2010/e08000022.pdf

[ii] Smoking prevalence adults: Adult Population Survey 2016. https://fingertips.phe.org.uk/profile/tobacco-control/data#page/1/gid/1938132886/pat/6/par/E12000001/ati/102/are/E08000022

[iii] Towards a Smokefree Generation - A Tobacco Control Plan for England: Department of Health (2017) London: Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/630217/Towards_a_Smoke_free_Generation_-_A_Tobacco_Control_Plan_for_England_2017-2022__2_.pdf

[iv] NHS England. Next steps on the NHS five year forward view. 2017. Available at: https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

Appendix 1

Treating tobacco dependency and achieving a smokefree generation in North Tyneside by 2025

1. A national ambition for a smokefree generation

The tobacco control plan for England sets out the national ambition to achieve a smokefree generation; which is defined as a smoking prevalence rate of 5% or below. In order to achieve a smokefree generation the following targets have been set[1]:

- Reduce the prevalence of 15 year olds who regularly smoke from 8% to 3% or less by 2022.
- Reduce smoking prevalence amongst adults in England from 15.5% to 12% or less by 2022.
- Reduce the inequality gap in smoking prevalence between those in routine and manual occupations and the general population.
- Reduce the prevalence of smoking in pregnancy from 10.7% to 6% or less.by 2022
- Make all mental health inpatient services sites smokefree by 2018
- Create a smokefree NHS by 2020 through the 5 Year Forward View mandate[2]
- Provide access to training for all health professionals on how to help patients – especially patients in mental health services - to quit smoking
- Help people to quit smoking by permitting innovative technologies that minimise the risk of harm.
- Maximise the availability of safer alternatives to smoking.

The NHS Five Year Forward View[2] prioritises the role that prevention has in supporting people to live healthier lives. The treatment of tobacco dependency is key component of the preventive programme within NHS settings.

The national ambition as set out in the tobacco control plan has been used to inform the regional sustainability and transformation partnership (STP) prevention board work on treating tobacco dependency[3]. There is a regional taskforce that has been tasked with responsibility for the delivery of a smokefree NHS across the North East by 2020.

2. Purpose of the paper

This paper presents the current contribution of the Local Authority and the NHS in the treatment of tobacco dependency and it contextualises a whole systems approach to reducing the prevalence of smoking to 5% by 2025[3]. This regional ambition was endorsed by all 12 North East Health and Wellbeing Boards in 2014.

The focus of this paper is on the treatment of tobacco dependency; however it is important to highlight that there are other interventions and approaches in place that addresses tobacco control and health education including:

- Tobacco control (age of sale restrictions and illicit tobacco products)
- Health education in schools and workplaces on the harms of tobacco
- Smokefree environments (home and work place)

The delivery of the treatment of tobacco dependency and the above work streams is strategically overseen by North Tyneside Smokefree Alliance. The treatment of tobacco dependency is also a priority for the North

Tyneside Cancer Locality Network and the Northumberland and North Tyneside Rightcare Respiratory Group. The actions outlined in this report complement the work programmes of these groups.

3. Introduction

North Tyneside has made considerable progress over the last decade in reducing smoking rates from 27.5% (2006-08)[4] to 16.4% (2016/17)[5]. Whilst this progress is positive, smoking still remains one the principal causes of premature death and is the key driver for health inequalities with around half of the difference in life expectancy between the most and least affluent of the borough attributable to smoking. Smoking places a significant burden across the whole local health economy and society.

Smoking is an addiction which is largely taken up in adolescence and the majority of smokers start as teenagers. A survey undertaken in 2014 identified that 77% of smokers aged 16 to 24 began smoking before the age of 18[6]. One of the most effective ways to reduce the number of young people smoking is to reduce the number of adults who smoke in the population.

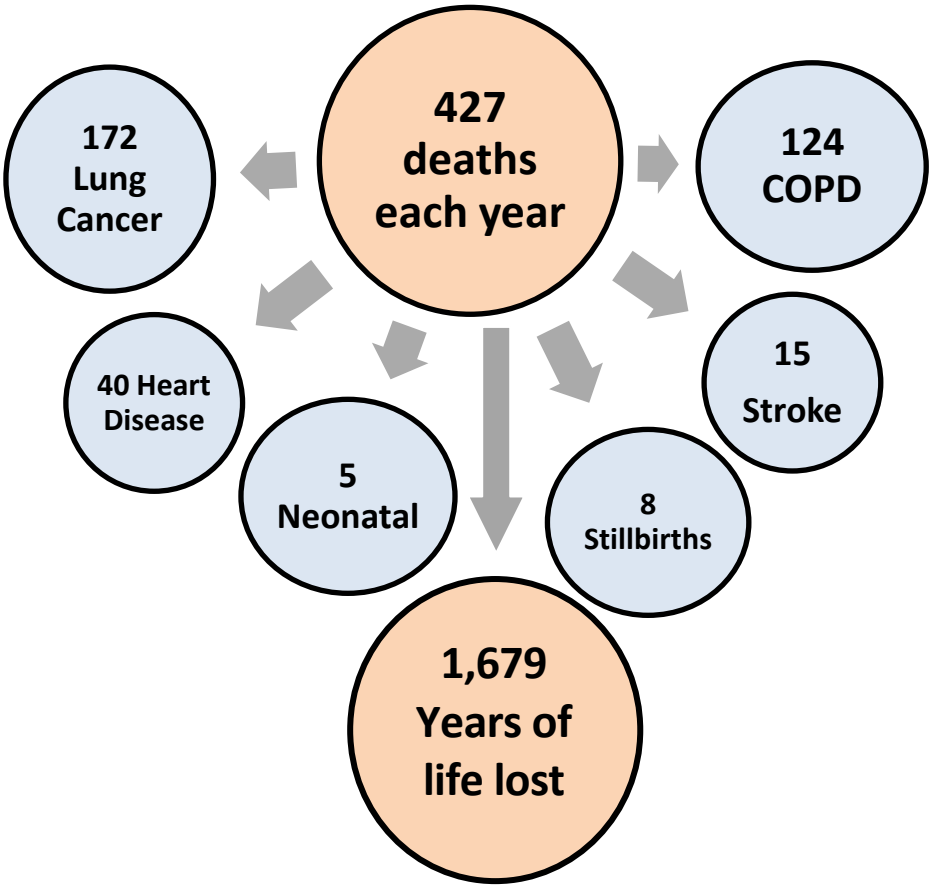
4. The burden of tobacco dependency in North Tyneside

Tobacco dependency has a huge impact upon mortality and morbidity in North Tyneside. The chart below presents smoking attributable mortality based upon three years of data (2013-2015). Chart 1 below presents the deaths in North Tyneside that are attributable to tobacco dependency[7-8].

There are around 200 lung cancer registrations each year in North Tyneside, of which 80% are attributable to tobacco dependency[5].

Each year there are 170 new cases of lung cancer in North Tyneside that could have been prevented.

Chart 1: Annual smoking attributable mortality in North Tyneside 2015/16 (data source PHE Tobacco Profiles[5])



The burden of tobacco dependency is not equally distributed. 40.5% of adults with a serious mental illness smoke; this is 2.5 times higher than the national rate[9]. People with a mental health condition die on average 10-20 years earlier than the general population[10].

Smoking prevalence amongst routine and manual workers in North Tyneside is 27.6% this is more than 10% points higher than the general population prevalence rate[5].

The burden of smoking related illness falls heaviest on our poorest and most disadvantaged communities. This is reflected at a GP practice level in North Tyneside by the percentage of patients with a hypertension, asthma, COPD, stroke or CHD who, when asked reported smoking. The GP practice with lowest prevalence rate is 7.8% in Beaumont Park Surgery and the practice with the highest prevalence rate is Redburn Park at 29.3% (2016)[11]. A graph outlining this data for each GP practice in North Tyneside is available in appendix 2.

5. The cost of tobacco on health and social care

Based upon the current smoking prevalence rate, the total annual cost of smoking in North Tyneside is in excess of £16m. Table 1 below presents the estimated cost of smoking on the health and social care system[12-13].

- There are around 3,000 smoking attributable hospital admissions in North Tyneside each year (2015/16)[5].
- The cost of smoking attributable hospital admission in North Tyneside is £53.50 per capita this is 41% higher than the England average[5].
- The cost per capita for smoking attributable hospital admissions in North Tyneside is amongst the highest in England. North Tyneside is ranked as the 8th highest spending area (2011/12)[5]
- It is estimated that smokers will need to access social care 4 years earlier than non-smokers[12]

Table 1: The estimated annual cost of smoking in North Tyneside 2017

Costs to local economy (loss productivity)	£2,398,119
The total additional spending on social care as a result of smoking for adults aged 50+	£ 6,129,033
Costs to non-smokers (passive smoking costs)	Adults: £293,681
	Children: £64,916
Healthcare costs:	£7,661,500

6. The challenge of achieving a smoking prevalence rates of 12% by 2022 and 5% by 2025

Since 2014 there has been an estimated 4,850 fewer adult smokers in North Tyneside. The chart below (chart 2) presents an estimation of how this reduction in smoking prevalence was achieved over a 3 year period. This model also estimates the number of quit attempts made either within the commissioned stop smoking services or as an unaided quit attempt. Notes on the data used in this model are detailed below.

It is important to highlight that tobacco dependence is one of the hardest addictions to break. The majority of regular smokers are addicted to nicotine. Nicotine is a substance that is inhaled when smoking tobacco in cigarettes. When nicotine is inhaled, it immediately rushes to the brain, activating the areas which produce feelings of pleasure and reward. When the blood level of nicotine falls this changes the levels of dopamine and noradrenaline and withdrawal symptoms such as restlessness, increased appetite, inability to concentrate, irritability, dizziness, constipation, nicotine craving, or just feeling awful will result. These withdrawal symptoms

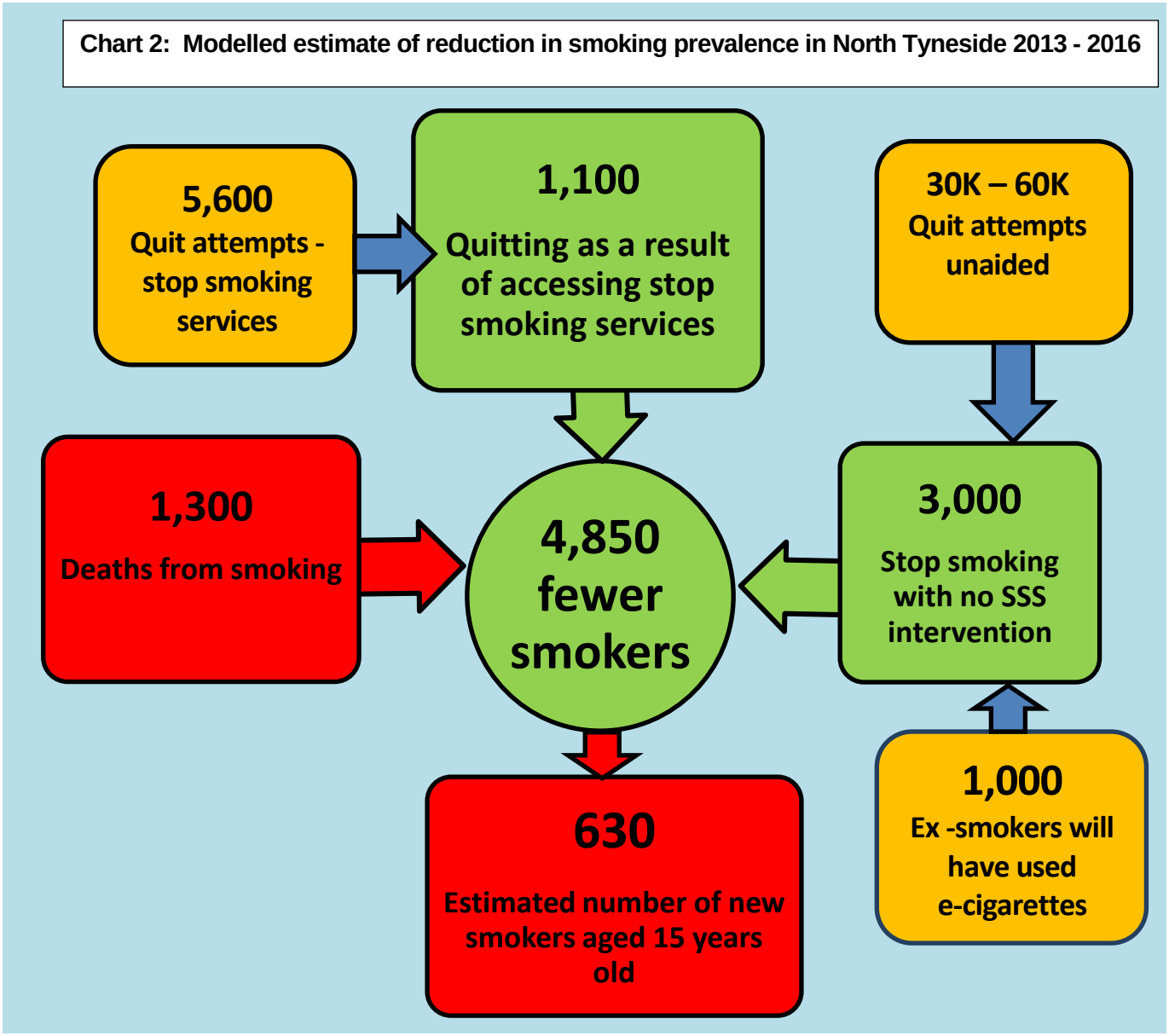
begin within a few hours after having the last cigarette. If they are not relieved by the next cigarette, withdrawal symptoms become worse.

A person will crave nicotine when they stop smoking and those cravings can be very strong, making it extremely difficult to quit smoking using willpower alone. Nicotine withdrawal symptoms usually reach their peak 2 to 3 days after quitting, and are gone within 1 to 3 months. It takes at least 3 months for the brain chemistry to return to normal after quitting smoking.

Two in every three smokers want to stop smoking but, without help, many fail to succeed. The main reason why smokers don't succeed, even though they want to stop smoking, is because nicotine addiction is so strong and so difficult to break.

The chart below highlights that the majority of smokers in North Tyneside quit smoking as a result of an unaided quit attempt. The model also provides the estimated number of quit attempts required to achieve the population level shift in prevalence rates. The large numbers required to attempt to quit presents some very real challenges, particularly in light of the national ambition.

Chart 2: Modelled estimate of reduction in smoking prevalence in North Tyneside 2013 - 2016



Notes on modelling:

1. Estimated number of new smokers was calculated using the number of 15 year olds reporting smoking (WAY Survey 2014) and applying this rate to 2013 – 2016.
2. Number of deaths was calculated using smoking attributable mortality (2013 – 2015) as a proxy measure. This will include ex-smokers and excludes smokers that died from non-smoking attributable causes.
3. Quitting as a result of accessing SSS was calculated using service use data for the period 2013-2016. A 12 month quit rate was calculated at 20% (SSS) by applying R West and R. Owen (2012) estimates of 52-continuous quit rates.
4. The estimate of those quitting with no support was derived by subtracting deaths and quitters from SSS, and adding in new smokers aged 15.
5. Number of quit attempts required for unaided quits was calculated by applying R West et al estimates
6. The 4,850 fewer smokers was calculated using APS North Tyneside prevalence data for years 2013 – 2016 and applying to 2016 mid-year population estimates.
7. E-cigarette use among ex-smokers was calculated at 30% (based upon 2016 data for ex-smokers that had reported having either used an cigarette or were still currently using one)

7. Translating the national tobacco control plan to North Tyneside

The national plan sets out some challenging targets, in particular the 5% prevalence rate. In 2016 there were around 27,400 regular smokers in North Tyneside, in order to achieve a 5% prevalence rate 19,000 current smokers would need to quit and uptake amongst young people would need to fall to 3%.

The table below (table 2) presents a comparison between the smoking prevalence rates for England and North Tyneside (2016). North Tyneside has significantly higher prevalence rates for the rate of 15 year olds smoking and the rate of pregnant smokers; North Tyneside has comparable rates for adults and routine and manual workers.

Table 2 also presents the estimated number of smokers that need to quit (non-tobacco dependent) in order to achieve the national targets in North Tyneside.

Table 2: Current position North Tyneside compared to tobacco control plan for England

National Targets	2016		Numbers needed to quit	Prevalence rate target
	England	North Tyneside		
Prevalence of 15 year olds who regularly smoke	8.2%	10.3%	153	3%
Smoking prevalence amongst adults	15.5%	16.4%	7,348	12%
			19,038	5%
Prevalence in routine and manual occupations is the same as general population	26.5%	27.6%	2.094	16.4%
			2,917	12%
			4,226	5%
Prevalence of smoking in pregnancy	10.7%	13.2%	164	6%

Significantly worse than England Average **Similar to England average**

The number of adult smokers that will be required to stop smoking by 2022 is 7,348, of this group 2,971 (40%) will need to be manual and routine workers.

The number of smokers needed to stop smoking to reach a 5% prevalence rate in North Tyneside is 19,038, of which 4,226 (22%) will need to be manual and routine workers.

Furthermore; we will need to stop the uptake of smoking amongst young people. A proxy measure for this is that there are around 150 fewer smokers each year aged 15 years old.

The number of women required to stop smoking during pregnancy is around 160 per year.

8. The numbers of smokers needed to attempt to quit in North Tyneside

Over the next four years (2018-2022) we need to help facilitate 7,348 smokers to become non-tobacco dependent, in order to achieve a 12% prevalence rate. The tables below presents a modelled estimate of the numbers needed to recruit in order to achieve this. The breakdown is based upon an assumption that the proportion of smokers who will die from smoking related illness will remain the same over the next 4 years, and that 65% of smokers will quit unaided (i.e. not via a formal stop smoking support provided in the

community and/or healthcare setting) and 33% will quit as a result of accessing evidence based stop smoking support. Conversion rates (number of quit attempts) to achieve a 52 week continuous quit rate have been applied based upon the National Centre for Smoking Cessation and Training (NCSCT) research[14]

Table 3: Number of smokers required to attempt to quit to achieve a 12% prevalence rate 2018-22

Method	2018 - 2022		
	Numbers required to quit per year	Numbers needed to attempt to quit	
		Per year	Per month
Unaided	1,200	12,000	1,000
Stop smoking services	600	3,000	250
Total	**1,800**	**15,000**	**1,250**

Table 4: Number of smokers required to attempt to quit to achieve a 5% prevalence rate 2018-25

Method	2018 - 2025		
	Numbers required to quit per year	Numbers needed to attempt to quit	
		Per year	Per month
Unaided	1,800	17,500	1,500
Stop smoking services	900	4,500	400
Total	**2,700**	**22,000**	**1,900**

The tables above present the scale of the challenge, and at present the current configuration of services that support the treatment of tobacco dependency, in particular the pharmacy based stop smoking services are not able to achieve the national and regional ambition alone. Therefore a whole system response to the treatment of tobacco dependency is required alongside other approaches that includes; reducing the numbers of young people commencing smoking and providing evidence based interventions to help smokers quit unaided.

9. National models of treating tobacco dependency

Public Health England published an evidence based appraisal of options for service models in the treatment of tobacco dependency[15]. The table below presents these interventions and where in North Tyneside these are currently provided and commissioned.

Table 5: Interventions to increase successful quit rates.

Intervention	Improves quit rates	Commissioning recommendation	Provided
Face-to-face individual support with pharmacotherapy Weekly sessions for an individual smoker with a trained stop smoking practitioner	200-300%	This is the current most common form of SSS delivery, needs to be supported via on-going training	Commissioned by NTC Provided in community pharmacies
Supported use of Pharmacotherapy Providing smokers with stop smoking medication(s) (varenicline, nicotine replacement therapy (NRT), bupropion) and give appropriate information and support to use it in a way that will maximise effectiveness. It just needs one appointment to get started and one follow-up to check progress.	50-100%	The easiest way to commission this is through GP prescriptions, but pharmacies may also be an option.	Not commissioned in primary care. Secondary care (NHCFT and NTW) Will start a patient on pharmacotherapy, and on discharge patients are signposted to the pharmacy service and primary care.
Online **And;** **Mobile digital applications**	Unknown	Websites/apps should not be the only support offered to smokers and should be offered in conjunction with the above.	Not provided or promoted

The new model options of service delivery makes recommendations for Local Authorities and NHS Commissioners on proving the following to the local population:

A. Universal specialist service that includes behavioural support and pharmacotherapy provided by a specialist service.
Trained practitioners, for whom delivering stop smoking interventions forms all or most of their role, provide weekly sessions of around 30 minutes, ideally face to face although later sessions may be conducted over the phone, to smokers who set a quit date in the second or third week of the programme and receive their choice of medication (either on prescription or through a locally devised voucher system). People are supported for at least four weeks following the quit date and may be seen in groups or on a one-to-one basis. Outcomes are biochemically validated by carbon monoxide (CO) readings at the end of treatment.

B. Pharmacy only services
Pharmacy staff are trained to deliver the specialist service as detailed above; the role of pharmacy staff is to provide one-to-one behavioural support, pharmacotherapy and CO readings at the end of treatment.

C. Stop smoking plus
This model has a three-tier approach that includes; providing specialist service or a pharmacy based service as well as providing brief advice alongside pharmacotherapy in a primary and secondary care setting and offer self-support for those who do not want professional support (digital and online support).

D. Hospital based stop smoking services
Providing behavioural support and pharmacotherapy to specific patient groups within a hospital setting e.g. pregnant women, patients with long-term conditions (diabetes, respiratory conditions).

The new models options report recommends that commissioning a universal specialist service should be the first consideration for all commissioners; however the report does acknowledge that if funds are not available for a full universal offer then consider providing this to priority groups, rather than taking a universal approach. The targeted groups include:

- Pregnant women
- People with mental health conditions
- Economically deprived communities
- Patients with long-term conditions

10. Current configuration of stop smoking services in North Tyneside

10.1 Universal services

At present North Tyneside Council commissions via the public health ring fenced grant, a specialist stop smoking service provided in 27 pharmacies across North Tyneside. The service engages 6% of the smoking population (national target to reach 5%). Outcomes for self-reported quits (35%) and CO validated quits (30%) are below the national average; 51% (self-reported) and 37% (CO validated)[16].

10.2 Targeted services

There are a number of priority groups that have been identified by the national tobacco control plan. In North Tyneside there are gaps in how the needs of these groups are met.

Pregnant women: North Tyneside has low numbers of pregnant women successfully reporting a quit in comparison to the national rate and this is evident in the higher rates of smoking at time of delivery in North Tyneside. However, implementation of the Babyclear initiative across maternity services (NUTH and NHCFT) has facilitated a reduction in rates of smoking at time of delivery. CO monitoring and smoking prevention and interventions are routinely undertaken at key points across the maternity care pathway. Women identified as smokers are offered advice and signposted to community based services for on-going support.

Mental Health: NTW NHS FT has successfully implemented a stop smoking pathway for inpatients. North Tyneside Council is working with the drug and alcohol service to train staff to become stop smoking advisors and enable staff to refer clients to their local pharmacy for on-going behavioural support and access to pharmacotherapies.

Economically deprived communities: North Tyneside Council is working with community organisations to train staff to become stop smoking advisors and to enable better access to the pharmacy based provision. In a review of the commissioned stop smoking services it was crucial that there was a concentration of pharmacies commissioned to treat tobacco dependency in our most deprived communities.

Patients with long-term conditions: Patients that have an inpatient stay in NHCFT will be offered behavioural support and pharmacotherapies, on discharge will be sign posted to the pharmacy based services and primary care.

11. Smokefree NHS by 2020

Smoking is a major contributor to hospitalisation; estimates suggest that 5% of all admissions are attributable to smoking and that approximately 1 in 4 hospital beds are occupied by smokers. Smokers tend to have longer lengths of stay, higher incidence of wound infections and readmissions than non-smokers and smoking during pregnancy carries significant health risks for both mother and baby[17].

The national tobacco control plan and the STP prevention board are committed to achieving a smokefree NHS by 2020. This means that all NHS acute trusts are compliant with NICE Guidance[18] which sets out the requirement to identify and treat patients for tobacco dependency. Further to this the Regional STP Prevention Board is requiring all CCGs have a clear collective vision on their commitment to a Smokefree NHS which includes treating tobacco dependence and implementing relevant NICE guidance by April 2019.

11.1 Smokefree Northumbria Healthcare NHS Foundation Trust

Significant progress has been made across the organisation to implement the policy which builds upon earlier work in outpatients to help reduce tobacco use prior to surgery. An overview of progress against the recommended standards is set out below:

Admitted patients:

- Systematically and consistently recording smoking status on every patient – Recording of smoking status is being embedded into the electronic nursing assessment document which will be implemented in January 2018. This will ensure that all patients have their smoking status recorded and facilitate a systematic approach to identifying nicotine dependence in admitted patients. Smoking status is already recorded as part of the routine assessment in Accident & Emergency.

- Offering rapid access to NRT – As part of the admission assessment those identified as smokers will be offered NRT to manage their nicotine dependence during their hospital stay. The outcome of the offer will be documented in the nursing assessment record.

- Offering access to support to quit and onward referral to on-going behavioural support –an in house stop smoking support team is being established which will provide support and advice for smokers during their hospital stay and advice and support on how and where to access on-going support on discharge. The Trust will continue to work collaboratively with the wider system to help inform and shape the pathway for patients following discharge from hospital to help increase the sustainability of their quit attempt.

- Training of front line staff to support them in delivering effective brief information and advice – brief intervention advice training on treating tobacco dependency has been embedded in the induction process for all staff. All nursing staff will complete this training as part of the implementation of the electronic nursing assessment document. The training is to be incorporated in the statutory and mandatory training requirements from April 2018.

The work is underpinned by a comprehensive communications and engagement plan aimed at patients and visitors. This includes messages about what being smokefree means and what advice and support is being made available to support this. Healthwatch North Tyneside are supporting this work.

Staff: The policy requires that staff are completely smokefree whilst at work, supporting staff to stop smoking is a key element of the organisations strategy to improve the health and wellbeing of its staff. The Trust provides all staff with access to in house stop smoking support which includes access to NRT. Regular communications and briefings are being disseminated to raise awareness about how and where to access support.

Recruitment literature has been refreshed informing new staff of the organisational policy in relation to smokefree.

11.2 Smokefree North Tyneside Primary Care

North Tyneside CCG and primary care are fully aware of the impact of smoking on the health and wellbeing of patients. Previously primary care was commissioned to provide behavioural support and pharmacotherapies as outlined by the NCSCT, however this intensive model of treating tobacco dependency did not work in a primary care setting.

Smoking is not permitted in or near GP practices in North Tyneside. Whenever a person attends a GP surgery they are encouraged to give their smoking status. During a consultation with any health care professional, smoking cessation advice will be given to any patient who is recorded as being a smoker.

11.3 Smokefree Northumberland and Tyne and Wear NHS FT

The most recent developments across the Trust have been the development of locality specific Smokefree referral pathways. These have been designed in conjunction with local community smoking cessation providers and are to be embedded within local clinical arrangements. This will be a significant achievement given the complexity of variation across such a large geographical area.

To support their use and to ensure on-going compliance to NICE guidance[20], there are now specific prompts added to the electronic health care record (Rio) to ensure that there is a seven day follow up of patients who have commenced treatment for tobacco dependency. In addition, in-patient areas now have a specific Smoking Cessation clinical record, including care plan, stop smoking course assessment form, record of smoking cessation report and a weekly record of NRT/ Smoking cessation medication report.

11.4 Smokefree Newcastle upon Tyne Hospitals

The Newcastle upon Tyne Hospitals NHS Foundation Trust is committed to providing an environment that is safe and protects its staff, patients and visitors without risks to health and has had a clear Smoke Free Policy in place for many years.

The Trust routinely enquires about patients smoking status and actively offers help and advice for patients to quit across all of its care settings, referring to local stop smoking services and providing Nicotine Replacement Therapy. Patients are informed of the Trust Smoke Free status in Patient Information leaflets relating to attendance or admission to hospital, or receiving care from Trust staff in patients own home

Staff can access training to support them delivering Smoking Brief Advice and Interventions and this is promoted as part of Making Every Contact Count

12. National tobacco control recommendations

Alongside the recommended treatment/service models there are a number of recommendations that support the smokefree agenda. This includes the following:

A. Reducing the number of young people taking up smoking

Discouraging young people from smoking remains a priority. Tobacco control is a key component of this, in particular enforcing age of sale laws. North Tyneside Trading Standards collates and responds to intelligence on illegal sales of tobacco.

North Tyneside School Improvement Service is implementing the NICE guidance and youth advocacy to support Young People to including; Stop Smoking Service information/campaign activity in schools/ Colleges/ Youth and other informal settings. This is due to be complete by December 2018.

B. Promoting the use of electronic cigarettes

Stopping smoking is hard and many smokers are turning to e-cigarettes to help them in their attempts. Stop smoking advisors are being trained on the use of e-cigarettes from a harm reduction perspective, this means that anyone using an e-cigarette alongside tobacco based products will be supported to quit in North Tyneside.

At a national level it has been recognised that there is a need to evaluate the effectiveness of e-cigarettes as a method to stop smoking. In North Tyneside we are currently running a six-month pilot in two pharmacies on the effectiveness of e-cigarettes as an alternative method to treat tobacco dependency. The findings from this evaluation are due September 2018.

13. Benefits to the Local Health Economy

Treating tobacco dependency is the job of the whole health and care system. The benefits of reducing the prevalence of smoking are experienced across the whole system. The tables below present the costs saved to the NHS (based upon the NICE return on investment tool[11]).

- **Achieving a prevalence rate of 12% will save the NHS £1m per year**
- **Achieving a prevalence rate of 5% will save the NHS over £2m per year**

Table 6: Annual Health Care Costs Saved – 12% smoking prevalence rate

	2017	2022	Healthcare cost saved
	16.4% Prevalence	12% Prevalence	
GP consultations	30,233	22,179	£310,240
practice nurse consultations	8,845	6,458	£28,095
outpatient visits	5,369	3,923	£235,192
hospital admissions	1,879	1,774	£267,795
prescriptions	16,981	12,439	£194,398
			£1,035,720

Table 7: Annual Health Care Costs Saved – 5% smoking prevalence rate

	2022	2025	Healthcare cost saved
	12% Prevalence	5% Prevalence	
GP consultations	22,179	9,365	£564,087
practice nurse consultations	6,458	2,660	£51,082
outpatient visits	3,923	1,622	£427,607
hospital admissions	1,774	1,583	£737,074
prescriptions	12,439	5,212	£353,485
			£2,133,335

Alongside the direct savings within the NHS there are wider benefits to the health and social care system, as well as increased economic productivity at a population level.

The limitations of the NICE return on investment tool means that there is not a comparable estimate of the benefits of a reduced smoking prevalence rate for the social care system in North Tyneside. However, given

that much of the demand placed on the adult social care system is as direct result of preventable ill health, reducing the number of smokers in North Tyneside will improve the health and wellbeing of the population and thus alleviate demand placed upon the social care system.

14. Summary – the challenges and the gaps

Achieving the national and regional ambition of a smokefree generation in North Tyneside will improve the health of the population, free up much needed resources in health and social care and have a positive impact upon the local economy and increase productivity.

14.1 Challenges

There are three key challenges that need to be addressed:

- We need to significantly increase the number of smokers attempting to quit i.e. to achieve the 12% prevalence rate we will need to recruit around 1,200 smokers each month. This figure acknowledges that the majority will experience numerous failed quit attempts before achieving a successful quit.
- Services need to achieve and sustain a higher 52 week continuous quit rate for those who have successfully stop smoking, this means that a higher 4-week quit rate is required within existing stop smoking services.
  And;
- We need to work collectively to identify the resources required to achieve a whole system's response to the treatment of tobacco dependency without any additional financial input

14.2 Gaps

There are a number of gaps in the current approach to treating tobacco dependency in North Tyneside:

1. There is no systematic targeted approach to treating tobacco dependency in the identified priority groups:
   - Pregnant women
   - People with mental Health conditions
   - Areas of high deprivation and high smoking prevalence
   - Patients with existing long-term conditions

2. Progress has been made within some specific parts of the system for example the significant work undertaken by Northumbria Healthcare Trust to implement NICE Guidance, the Trust's work towards smokefree status across all sites and the implementation of Babyclear within maternity services

There is a commitment from secondary care, North Tyneside Council and the CCG to work collaboratively to reduce smoking prevalence, however the current approach to this does not reflect the national proposed model and at present there are the following gaps:

- Very brief advice (VBA) is not systematically delivered in primary and some secondary care settings
- Prescribing pharmacotherapies alongside VBA, with four week follow-up is not being delivered in primary care and is not implemented in all secondary care settings
- Treating tobacco dependency amongst patients being referred for elective procedures is not being systematically delivered in primary care and community settings
- There is no digital platform in place that provides smokers with the tools and advice to help themselves to quit smoking.
- Services are not always targeted at the priority groups (outlined above), particularly when these groups have regular contact with health and social care services.

3. The clinical pathways across the whole system which includes community, primary and secondary care have not been fully developed. This means that patients being treated for tobacco dependency are unable to move seamlessly between services to continue their treatment.

15. Next steps

A whole systems response requires the components of the system to work together, so that the impact of the treatment of tobacco dependency in North Tyneside is greater than the sum of our parts.

North Tyneside Council, North Tyneside CCG, Primary care and the acute provider NHS trusts are committed to work collaboratively to establish a system wide model of stop smoking support that is underpinned by evidence of need and effectiveness.

The following describes the commitment and the actions that will be taken by each organisation to achieve a smokefree generation in North Tyneside:

15.1 North Tyneside Council will:

- Continue to invest in community based universal stop smoking services
- Support services with low quit rates to improve the quality of the provision
- Provide training for stop smoking advisors (community, primary care and secondary care)
- Continue to coordinate and resource North Tyneside Smokefree Alliance
- Work with NTW and NHCFT to treat tobacco dependency targeting pregnant women and those with mental health conditions.
- Work in our most deprived areas ensuring that stop smoking services are accessible
- Evaluate our electronic cigarette pilot, with a view to learn and further develop harm reduction services alongside the treatment of tobacco dependency

15.2 Northumberland Health Care Foundation Trust will:

- Continue the roll out of very brief advice training for all front line practitioners
- Systematically record of smoking status on all admitted patients
- Systematically offer of NRT to all admitted smokers
- Systematically offer of support to access behavioural support for all admitted smokers
- Audit practice in maternity services against NICE standards

15.3 North Tyneside CCG will:

- Develop a business case for an incentivisation scheme for all GP practices in North Tyneside to ensure that staff are trained in the delivery of very brief advice
- Introduce a new procedure to ensure that all respiratory patients who are current smokers will, at their annual review be offered treatment for tobacco dependency
- Develop guidelines on when primary care clinicians can prescribe pharmacotherapies to treat tobacco dependency alongside very brief advice.

15.4 North Tyneside Smokefree Alliance will:

North Tyneside Smokefree Alliance will continue to oversee the smokefree work undertaken by all of the partners and ensure that this work complements the programme of work outlined in the Cancer Locality Network and the Respiratory Rightcare Group. This includes the following actions that are jointly owned by North Tyneside Council, North Tyneside CCG and the acute trusts.

- The design of data packs for GP practices that captures the current baseline of smoking prevalence. These data packs will be updated annually and will include data and intelligence on smoking related activity such as the number of very brief advice interventions and numbers receiving pharmacotherapies.

- Design clinical pathways that cut across organisations e.g. stop before u op and discharge of patients from secondary care into the community and primary care
- Design patient specific pathways e.g. pregnant women and mental health service users.
- Design a digital platform to offer evidenced based tobacco dependency treatment for those who want to quit without formal support from services.

16. Recommendations

The committee supports the Local Authority, the CCG, Primary Care and Secondary Care in achieving a smokefree generation in North Tyneside by 2025.

The committee endorses the actions outlined in this report:

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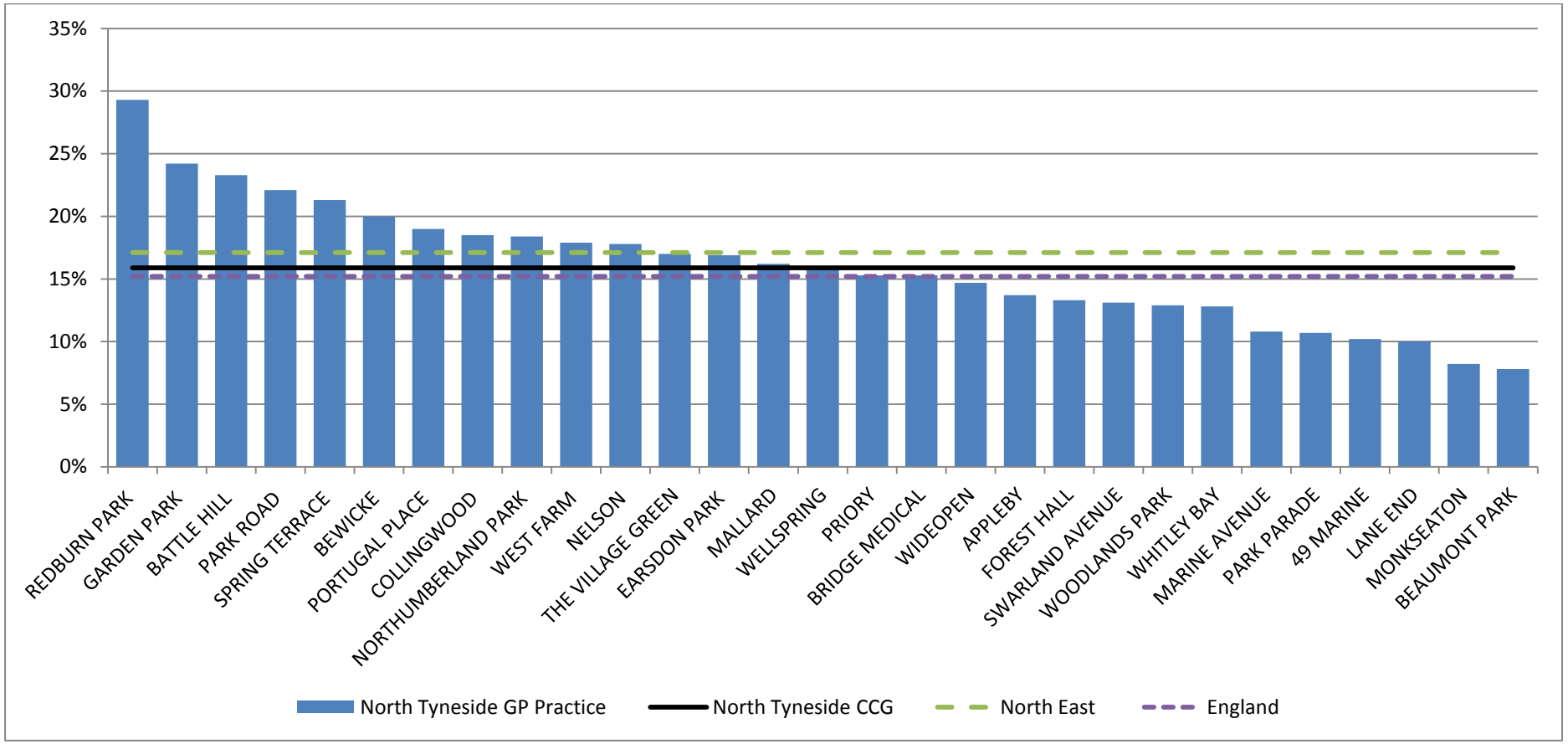
Appendix 2: Chart: Percentage of patients with a hypertension, asthma, COPD, stroke or CHD who, when asked reported smoking – GP Practice North Tyneside 2016/17



Meeting:	**Adult Social Care, Health and Wellbeing Sub-committee**
Date:	**9 November 2017**
Title:	**Safeguarding Adults Board Annual Report 2016-17and Annual Plan 2016-17**

Author:	**Ellie Anderson**	Tel: **0191 643 7354**
Service:	**Adult Social Care**	
Directorate:	**Health Education Care and Safeguarding**	
Wards affected:	**All**	

1. Purpose of Report

The purpose of this report is to provide the Adult Social Care, Health and Wellbeing Sub-Committee with an overview of the work undertaken by the Safeguarding Adults Board (SAB) during the past year. This report aims to provide assurance to the Committee that the SAB is an effective strategic body working across North Tyneside for benefit of individuals at risk of harm and abuse.

2. Recommendations

a) To consider the Safeguarding Adults Board Annual Report 2016-17
b) To consider that Safeguarding Adults Return 2016-17
c) To be aware of the Safeguarding Adults Board Annual Plan 2017-18

3. Details

a) To consider the Safeguarding Adults Board Annual Report 2016-17

The introduction of the Care Act in 2014 enshrined Adult Safeguarding in law for the first time. The main element of this is the duty to carry out Section 42 Enquiries into concerns and allegations of abuse for adults at risk of harm. The Care Act also makes it a statutory duty to have an effective multi agency Safeguarding Adults Board (SAB). North Tyneside has had a SAB in place for many years; however the formal recognition of this was welcomed by all partner agencies.

The aim of the SAB is to improve the experience of those adults at risk of harm in North Tyneside with a particular focus on preventing abuse and protecting the most vulnerable in our society. Within the Local Authority this comes under the Creating a Brighter Future work stream of Cared for, Safeguarded and Healthy.

The SAB annual report demonstrates how agencies work together and are formally held to account to make sure the whole safeguarding system is operating effectively to protect vulnerable people. The Safeguarding Adults Board (SAB) ensures that agencies have effective safeguarding arrangements in place that are working well and improving. Safeguarding requires a joined-up, multi-agency approach and rigorous governance is essential. The Board provides this quality assurance, oversight and scrutiny.

During 2016-17, both North Tyneside and Northumberland Safeguarding Adults Boards took the decision to join together and establish a single board. This arrangement was the rational next step following a track record of successful joint working within combined sub-committees. At the same time it was recognised that partners work seamlessly with communities, crossing local authority boundaries, and joining the Boards into one meant that all partners make the most of streamlined limited resources.

The SAB is made up of representatives from a range of agencies. These include:

- North Tyneside Council – officers and councillors
- Northumbria Police
- North Tyneside Clinical Commissioning Group CCG
- Northumbria Health NHS Foundation Trust
- Northumberland, Tyne and Wear, Mental Health NHS Trust NTW
- Tyne and Wear Fire Service
- Northumbria Community Rehabilitation Company CRC
- National Probation Service NPS
- Voluntary organisations
- Carers services, and
- Care Quality Commission CQC.

The SAB has, for several years, been very well supported by North Tyneside's Elected Members. Members have taken a keen interest in the issue of safeguarding, recognising the importance of this work to protect the most vulnerable in our society. This is important to demonstrate the leadership from the Local Authority at the highest level.

The joint SAB has an independent chair, Paula Mead who took up this position in 2016-17.

The SAB has developed an Annual Plan which covers the period 2016 – 2019 and sets out the business objectives for the Board in this period.

There are 6 key principles to the work of the Board as set out in the plan

- **Empowerment –** People being supported and encouraged to make their own decisions and informed consent.
- **Prevention –** It is better to take action before harm occurs.
- **Proportionality –** The least intrusive response appropriate to the risk presented.
- **Protection –** Support and representation for those in greatest need.
- **Partnership –** Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability**- Accountability and transparency in delivering Safeguarding

Outcomes

i) Empowerment

The Care Act requires us to ensure that processes for safeguarding follow the principle of Making Safeguarding Personal. This is about ensuring that an individual's views and outcomes are identified and recorded. In North Tyneside there is a robust system for recording these, which was fully in place across the whole period. During 2016-17, 80% of individuals who went through the safeguarding process had their individual outcomes met or partially met by the end of the process. It should be noted that there are times where outcomes stated by individuals are not achievable within the safeguarding process – for example if their outcome is that a member of staff must be dismissed.)

All safeguarding leaflets were refreshed to include easy read versions to ensure maximisation of the number of people who know what action to take if they are worried about a vulnerable person.

In North Tyneside we have also taken steps to improve support offered to people within the safeguarding process – including both formal and informal advocacy

ii) Prevention

A survey was sent to over 1600 people in the Borough to ask if they knew what to do if they were worried about a vulnerable person and over 77% responded yes.

We hosted the third annual SAFE week to raise awareness of safeguarding issues. A week of events in the borough coincided with a regional radio campaign headed by ADASS, including market stalls at North Tyneside General Hospital and North Shields Town Centre, stalls at summer festival events and coffee mornings arranged by providers. Also, the lighthouse and Tynemouth Pool went purple!

iii) Proportionality

We developed a Quality Assurance Framework for providers with a challenge event to ensure effective safeguarding arrangements are in place within partner agencies. A robust programme of training has been offered to providers

iv) Protection

We have worked with partner agencies, most notably the police and our other regional local authorities to agree the most appropriate response to Modern Day Slavery. We have agreed that in North Tyneside wherever possible we wish to keep the response a local response and we are currently working up operational guidance for staff on this matter, making best use of the assets we have in North Tyneside.
In addition there has been much work focussed on the issue of sexual exploitation in children and adults, ranging from policy and practice development to work in schools to strengthen young people's understanding of healthy relationships.
We have also developed strategies around the risk of radicalisation and rolled out mandatory training to all staff.

v) Partnership

We have reduces the strain on partner agencies in attending multiple meetings by joining Northumberland and North Tyneside SAB's – this facilitates attendance and partner involvement in producing the annual plan has been more robust this year.

The subgroups that sit below the SAB also work jointly meaning that we are learning from a broad range of experiences. Board members also benefitted from a 2 day training session from an external trainer to improve the efficacy of the Board.

vi) Accountability

All partners have been asked to contribute to the annual report and submitted agency reports which have been included in the overall report. It is pleasing to note that this level of involvement has been forthcoming from partners.

b) To note the data contained in the Safeguarding Adults Report 16/17

Key messages from the 2016-17 data:

- The number of referrals remains broadly in line with those from the previous year; there is a slight increase in reporting of lower level concerns. The number of cases taken forward into Section 42 Enquiry increased by 11.64% over the year although in quarter 4 there was a significant decrease (23%) suggesting the efficacy of training provided for staff is high.
- The main type of abuse is neglect or act of omission, followed closely by financial or material abuse, then physical abuse. These types of abuse have remained the highest recorded type of abuse and include medication errors and moving and handling issues.
- The main location of abuse (70% of cases) continues to be in individuals own home. This trend reflects the aim for people to continue to live independently in their own home for longer. However residential and nursing home combined make up the second highest location (25%).
- The trend of individuals' vulnerabilities continues in a similar pattern to previous years with people with physical disabilities experiencing the most harm. This will include older people with physical or mobility issues so is linked to the higher number of people over 65.
- 85% of cases have recorded an outcome of action taken and risk removed or reduced at the end of the safeguarding process. This highlights the positive impact that safeguarding can have on an individuals' life or situation. Only 15% of concerns have an outcome of risk remaining at the end of the process. This often relates to cases where capacitated individuals have made decisions to continue to live with a level of risk, which they feel is acceptable for them. This is in line with the Making Safeguarding Personal principle. We do, where appropriate and acceptable to the individual provide ongoing social work support to these individuals

c) To be aware of the Safeguarding Adults Board Annual Plan 2016-17

For its Business Plan for 2016-19, the SAB has adopted the key principles from The Care Act 2014 which underpin Safeguarding Adults. These are Empowerment, Prevention, Proportionality, Protection, Partnership and Accountability.

The Annual Plan 2016-17 has a particular focus on

- Sexual Exploitation
- Modern Slavery
- Making Safeguarding Personal
- Data analysis
- Raising awareness
- Effective training
- Quality Assurance Framework
- Prevent work

4. Appendices

SAB Annual Report 2016-17
SAB Annual Plan 2017-18

North Tyneside Safeguarding Adults Board

Annual Report 2016-2017

Contents

Foreward

Welcome to the publication of my first Annual Report as Independent Chair of North Tyneside and Northumberland Safeguarding Adults Board.

This report demonstrates how agencies work together and is formally held to account to make sure the whole safeguarding system is operating effectively to protect vulnerable people. The Safeguarding Adults Board (SAB) oversees this work, ensuring agencies have effective safeguarding arrangements in place that are working well and improving. Safeguarding requires a joined-up, multi-agency approach and rigorous governance is essential. The Board provides this quality assurance, oversight and scrutiny.

During 2016-17, both North Tyneside and Northumberland Safeguarding Adults Boards took the decision to join together and establish a single board. This arrangement was the rational next step following a track record of successful joint working within combined sub-committees. At the same time it was recognised that partners work seamlessly with communities, crossing local authority boundaries, as well as the necessity to streamline limited resources.
Our annual report provides local people with an account of the SAB's work over the past year to improve the safeguarding and wellbeing of vulnerable adults across North Tyneside and Northumberland. It reflects the activity of the Board and its sub-committees to achieve our agreed priorities for 2016/17.
Looking forward, my intention is to ensure that in North Tyneside and Northumberland we maintain a clear focus on these priorities within what is an increasingly complex and challenging environment. To achieve this the SAB has a clear plan in place to ensure it meets its responsibilities, responds to the needs and feedback from service-users, carers and the local community, and holds all relevant agencies to account.
My thanks go to the partner agencies that make up the SAB, and for their work and dedication during a time of huge demand and whose commitment and motivation delivers our shared priorities; it is a privilege to work them. I would also like to thank and recognise the contribution of the Health and Well-Being Portfolio Holders who bring another layer of independent scrutiny to the work of the Board.

Thank you for taking the time to read our annual report. I hope you find it interesting and useful, and are reassured that the SAB is committed to continual improvement and decisive action.

Paula Mead
NT & NLSAB Independent Chair

Local Safeguarding Data 2016-17

1745 adult concern notifications (ACNs) which is a 0.68% decrease when compared to 2015/2016.

422 Section 42 enquiries (11.64% increases on 2015/2016). There was a 23% decrease between Q1 and Q4 which may be due to an increase in awareness and training of staff.

Neglect and Acts of Omission (117 cases) was the most common form of abuse reports, with Financial or Material Abuse (112) being the second most frequent.

There were 78 cases of Physical Abuse and 63 cases of Psychological Abuse.

296 of cases resulting in an enquiry involved abuse in the person's own home, with 104 occurring in Care Homes (Nursing and Residential) and 48 in the community.

279 cases resulting in an enquiry involved a source of risk known to the individual.

106 cases involved a Service Provider and 101 cases involved strangers.

Of the cases which resulted in an enquiry, 252 resulted in the risk reduced and 108 had the risk removed completely.

62 cases ended with the risk remaining but with case management on-going to manage the risk.

Independent Provider Agencies were the most frequent referrers for safeguarding enquiries with a total of 89.

Social Care Staff referred 73 cases and Family/Friend/Neighbour referred 23 cases.

80% of people who were able to express their desired outcome, or had someone to speak for them, had their outcomes fully or partially met.

No Safeguarding Adult Reviews were completed in 2016/2017

Introduction

Safeguarding Adults

Safeguarding Adult's means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse for those individuals who are most at risk in our society.

1. The Care Act 2014

The Care Act 2014 sets out the definition for an adult at risk of harm as being an adult who:

a. has needs for care and support(whether or not the authority is meeting any of those needs),

b. is experiencing, or at risk of, abuse or neglect, and

c. as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The Act places responsibilities on the Local Authority and partner agencies in terms of responding to concerns about possible abuse or neglect.

The Act also makes it a legal requirement to have a Safeguarding Adults Board and the Board as a multi agency partnership must have an Annual plan, publish an Annual Report and commission Safeguarding Adults Reviews if the criteria are met.

2. Safeguarding Adults Boards SAB

In December 2016 North Tyneside and Northumberland SAB's agreed to merge to create one SAB that will cover the two geographical areas.

The SAB is made up of representatives from a range of agencies. These include:

- North Tyneside Council – officers and councillors
- Northumbria Police
- North Tyneside Clinical Commissioning Group CCG
- Northumbria Health NHS Foundation Trust
- Northumberland, Tyne and Wear, Mental Health NHS Trust NTW
- Tyne and Wear Fire Service
- Northumbria Community Rehabilitation Company CRC
- National Probation Service NPS
- Voluntary organisations
- Carers services, and
- Care Quality Commission CQC.

3. SAB Priorities from 2016-17

In 2016 agreed North Tyneside SAB set it's priorities for 2016-19 to be aligned to the six key principles in The Care Act 2014 which underpin all adult safeguarding work. These are:

Empowerment – People being supported and encouraged to make their own decisions and informed consent.

Prevention – It is better to take action before harm occurs.

Proportionality – The least intrusive response appropriate to the risk presented.

Protection – Support and representation for those in greatest need.

Partnership – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

Accountability- Accountability and transparency in delivering Safeguarding

As in previous years, and in line with The Care Act 2014, the SAB agreed an Annual Plan setting out the work that would be carried out by the SAB and its Sub Groups for 2016-17 to meet these priorities.

4. Empowerment

4.1 Making Safeguarding Personal

The Care Act 2014 determined that Making Safeguarding Personal is a key principle of Safeguarding Adults. This means that in any Safeguarding Adults situation the views of the adult at risk of harm, about what would make them feel safe is paramount, should be sought and wherever possible their outcomes should be identified and worked towards. North Tyneside Safeguarding Adults process requires that the questions are asked of the individual or their representative if they don't have capacity, that their outcome is recorded and then identified if these outcomes have been met or not.

The chart below shows the outcomes achieved during 2016/17 in line with making safeguarding personal. Overall, where identified, 80% of outcomes identified were achieved. Those outcomes not achieved are often not achievable due to the nature of the outcome identified, such as to return stolen money.

4.2 Service Users Engaged in the Safeguarding Process

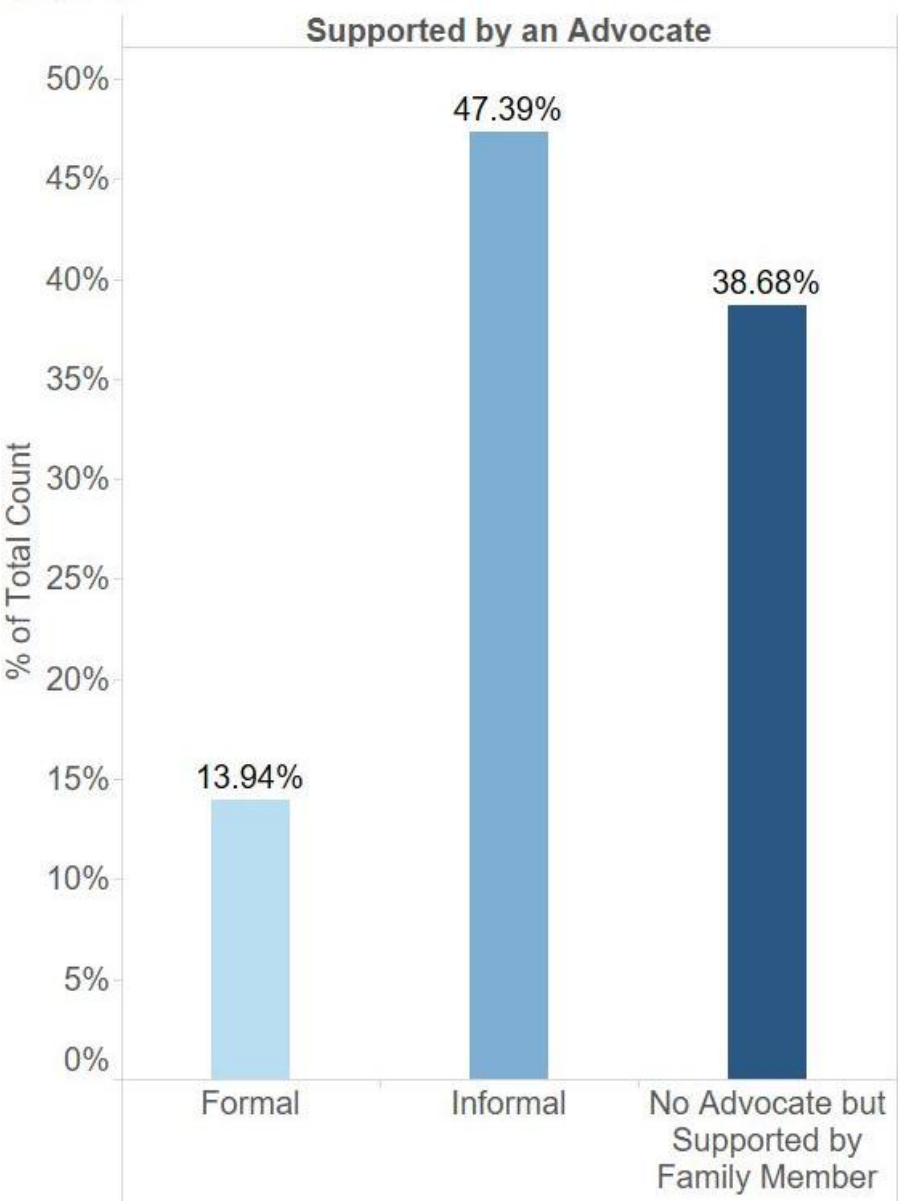
North Tyneside have reviewed and updated all leaflets to raise awareness for Safeguarding Adults. This includes an Easy read version. These have both been printed and are also available on the Local Authority website.
A leaflet has been developed to provide information Sheet for individuals and their relatives who are going through the Safeguarding process. The aim of this is to increase knowledge of the process for those people and to ensure they feel involved in meetings. This leaflet was taken to a relatives meeting in a care home to ensure that the leaflet was clear and easy to understand.

These can be found on the North Tyneside website here:

http://my.northtyneside.gov.uk/category/1033/safeguarding-adults

A training package has been developed and delivered to people who use services to increase their understanding of abuse and of the Safeguarding process. This was delivered twice in 2016-17 and had 26 people attend the training. See Training report page 10.

During 2016-17 the recording process for Safeguarding has been improved to include information about the use of advocacy for individuals in safeguarding cases. 47.39% of clients were supported by informal advocacy and 13.94% supported by a formal advocate, of those not supported 38.68% were supported during the safeguarding process by a family member or friend.



5. Prevention

5.1 Raising Awareness of Safeguarding

North Tyneside Council send out a survey to service users every year to gather information on a variety of issues. This is sent out to 1638 people across the borough. This year a specific question was included to ask people “Would you know what to do if you were worried about someone who was vulnerable?” 77.11% of respondents responded yes to this question, they would know what to do if they were worried about someone who was vulnerable.

5.2 SAFE Week (Safeguarding Adults for Everyone)

For the third year running North Tyneside has hosted a SAFE week. The aim of this is to raise awareness about Safeguarding adults to professionals, service users and the general public. In July 2016 there was a week of events across the borough. This week coincided with the Regional Radio Campaign funded by ADASS.

This included market stalls at North Tyneside General Hospital and in North Shields Town Centre.

Coffee mornings were hosted by several provider agencies for example in care homes to raise awareness about safeguarding for the residents and their relatives. These also proved to be very popular and fun.

Stalls were held at several of the North Tyneside Summer Festival events, for example at the Rising Sun Family Day and Segedunum.

During the course of the week several thousand leaflets were given out to members of the general public.

6. Proportionality

6.1 Closer working between partner agencies

The SAB has established a Quality Assurance Framework, which is sent out to all partner agencies to provide assurance regarding the Safeguarding arrangements they have in place. This was updated and sent out in November 2016. In order to verify the information each agency provided to the SAB, a challenge event was held in February 2017. This proved to be a positive way to hold discussions between representatives from different agencies in relation to their own safeguarding processes. The topics discussed included arrangements for recruiting and supervising staff; leadership and governance systems in place in each agency and the provision of training for staff across organisations. The outcomes of these discussions have formed part of the SAB Annual Plan for 2017-18, which are set out in the Business Plan 2016-19.

Please see website for more details:

http://my.northtyneside.gov.uk/sites/default/files/web-page-related-files/SAB%20Annual%20Plan%202017-2018.pdf

6.2 Training to improve decision making

North Tyneside Annual Training Report 2016-17

The purpose of this report is to give a summary of the training that has been delivered within North Tyneside over the past year. This will be the last single report from North Tyneside and it is the intention of the Workforce Sub-group to ensure all reports submitted in the future will be Joint with Northumberland.

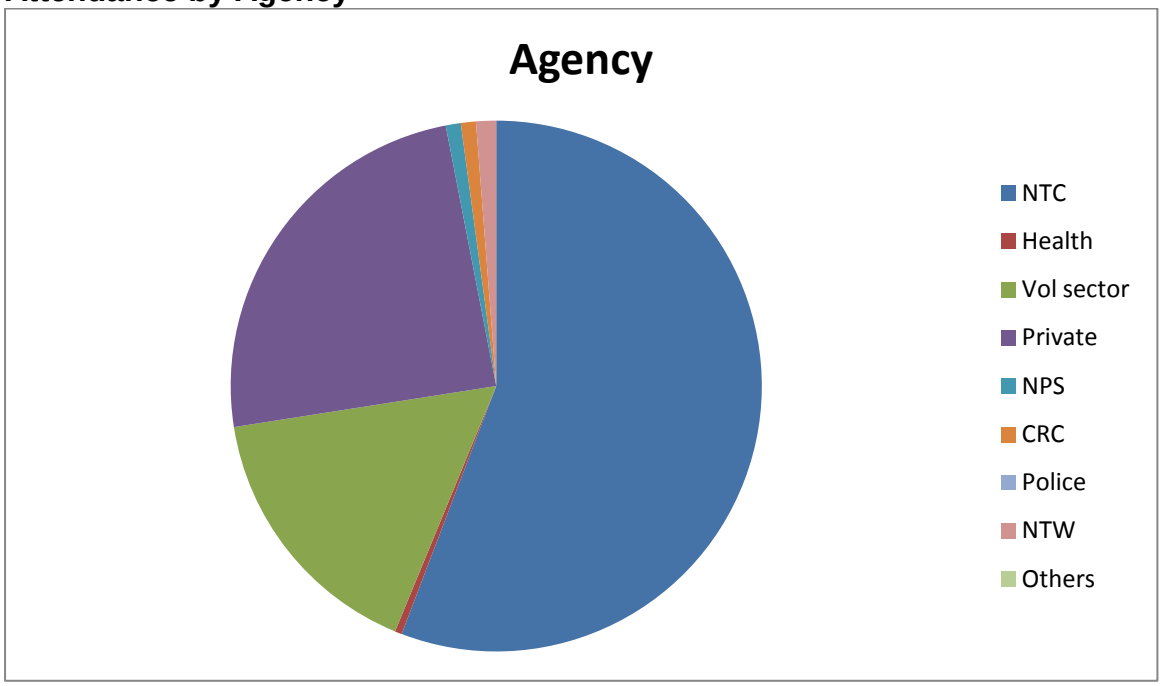
Multi-Agency

The table below lists the Adult Safeguarding Courses that have been delivered by North Tyneside from 1st April 2016 – 31st March 2017, attendance and frequency of delivery.

These courses are listed in the Adult Safeguarding Directory and are available for all partners to access as part of the Safeguarding Training Offer.

Course Title	Number of Courses	Number of Attendees
Safeguarding Adults – A Basic Awareness.	22	537
Safeguarding Adults: A Providers Perspective (2 day course).	2	20
Safeguarding Enquiries Call back session for Social Work Practitioners.	1	15
Financial Abuse and how to be financially aware.	1	15
MCA/Dols Fundamentals	6	103
Assessing Capacity, Best Interests and Dols Workshop	3	25
Self – Neglect Workshop	5	82
Sexual Exploitation Workshop	5	81
Keeping yourself Safe	2	26
Domestic Abuse for Adult Social care Practitioners	2	33
Multi – Agency Risk Assessment Conference (MARAC)	4	70
MAPPA	8	115
Prevent	17	516
Total :		**1638**

Attendance by Agency



The figures display that we do have a higher percentage of North Tyneside Council staff attending courses, quickly followed by the Private / Voluntary sector. We can also confirm that all CRC and NPS staff working into North Tyneside have completed appropriate Safeguarding Training this year.

Single Agency Training

The tables below highlight training currently being undertaken on a single agency basis across North Tyneside.

Health Training Figures

Course Name	
Safeguarding Adults - Level 1	85.2%
Safeguarding Adults - Level 2	68.4%
Mental Capacity Act - Level 1	94.1%
Mental Capacity Act - Level 2	72.6%
Deprivation of Liberty (DoLs)	68.9%

NTW Figures

Course	
Basic Awareness	94.6%
MCA	85%

This is a snap shot of the training currently being delivered by two of our main partners across the borough and offer assurance that training is taking place and is at a suitable level. The compliance percentages that have been recorded stipulate the overall figures Trust Wide, as these cannot be split by locality. The percentage figure is in relation to the identified staff within the trust that requires the training at each level and does not include every member of staff employed in the organisation. The compliance target for both organisations was 85% by the end of the year, this has been achieved.

Training Associates Figures

Organisation/ Provider	Number of Courses	Total Number Attended
New Prospects	5	33
Percy Hedley	8	83
Age UK	21	148
New Beginnings	0	0
Care Centre	0	0
St John Ambulance	1	21
Total :	35	**285**

The Training Associates are a group of individuals who have completed a train a trainer programme and deliver the North Tyneside endorsed training package to their own staff teams. Within the last year they have delivered the training package collectively to 285 staff members.
As part of the sub-group we have an agreed Quality Assurance programme, to ensure that training courses are appropriate for each level. A representative from the Training Associates group, Health and NTW all sit with the group and assurance can be given that the safeguarding policies are followed and training materials are of a good standard.

Evaluations
With the introduction of a new Learning Management System in October, a decision was taken that we would no longer continued to use the Initial Evaluations for training from the 1st October and would Instead choose to concentrate on the impact that training had on practice – with a more in-depth and reflective evaluation conducted 4-6 weeks after a training session had taken place.
The initial evaluations were therefore only collected between the 1st April – 1st October 2016. Initial evaluations were completed at the end of every safeguarding course conducted within this time frame with the results as follows :
Training continued to be very positive; with 100% of learners stating the training met their expectations. When asked about delivery methods 92% commented this had been excellent with the other 8% stating good. With the Knowledge and Helpfulness of the trainer 96% rated this area as excellent and the other 4% as good.
When asked how delegates will implement their learning in practice, the following are typical examples taken from the 'Basic Awareness' course:

- I now know the 10 categories of abuse and some possible signs that this is taking place. I will know when to report this to my line manager.
- I will be more observant within my role and ensure I complete my competencies.

- I will speak to service users, about how they can keep themselves safe.

Using the new learning management system from the 1st October, Impact Evaluations could be automatically sent out to delegates 4 weeks after attending a course with some specific questions, to support delegates to reflect on their practice and how they might have put their learning into practice. Some of the feedback includes:

- The team have displayed a better understanding on the process of safeguarding and have been able to demonstrate better practice in this area.
- The team now have confidence in applying the thresholds to determine if a case is a lower level or a safeguarding enquiry.
- The ten step procedure has been placed on the wall and all staff members understand their role at each step of the process.
- Staff clearly understands the difference between strategy discussion and strategy meetings, and when they should use each appropriately.

All clearly demonstrating, the impact that training has had upon practice.

7. Protection

7.1 Increased understanding of particular topics

The SAB identified several topics which needed particular scrutiny throughout the year. These included:

Modern Slavery
North Tyneside SAB along with Northumberland and Newcastle have developed North of Tyne Guidance for Staff regarding Modern Slavery. This focuses on how to identify concerns and informs staff what they should do if they have concerns. This was launched at a North of Tyne Conference held in November 2016. This saw 300 people attend a full day conference which covered a variety of topics, including modern slavery and trafficking, sexual exploitation, hate crime and domestic abuse. This was a very successful conference attended by a wide variety of professionals.



Sexual Exploitation
The SAB in conjunction with the Children's Safeguarding Board and Community Safety Partnership has established a joint Sub Group focusing on Sexual Exploitation. The Sub Group has developed and agreed a Strategic Action Plan. This brought together different work, which had already taken place regarding tackling sexual exploitation, and identified new areas of work which need to be done. As a result of the joint sub group a variety of actions have taken place, for example identifying a problem profile for North Tyneside which show the geographical areas of concern where individuals or groups may be at increased risk. A data set has been agreed so that the sub group can monitor the numbers of Safeguarding Adults concerns where sexual exploitation has been the cause of concern.

There has also already been a lot of training provided to raise awareness about sexual exploitation to a variety of different groups of people, in particular to schools, taxi drivers and staff working with those most at risk.

Prevent and Channel
There is a joint procedure which is in place across Children's, Adults and Community Safety for responding to concerns regarding possible radicalisation of young people or adults at risk of harm.
In North Tyneside there have been very low referral rates. In response to this exercises have taken place to ensure that members of staff are equipped to know how to manage such referrals.

Travelling Communities
During the past year work has been carried out by North Tyneside Council between Housing and Social Care for both Children's and adults to oversee the duties of the Local Authority towards travelling communities. This has included updating the response and assessment process that would happen at The Front Door as and when travelling communities are in the borough to ensure that steps are taken to identify anyone with vulnerabilities.

8 Partnership

8.1 Increased partnership working across Boards
There continues to be close working arrangements between the Children's Safeguarding Board, the Adults Safeguarding Board and the Community Safety Partnership in North Tyneside. This is demonstrated throughout this report with examples of joint working arrangements and shared policies. For example; the development of the joint Sexual Exploitation Sub group and the guidance for managing referrals regarding Chanel and Prevent.

8.2 To have an effective Safeguarding Adults Board
The Board members have completed a training need analysis to identify areas of required learning. From this Board members have received a two day training course from Belinda Schwehr. This focused on the roles and responsibilities of Board Members, as well as providing information on the legal aspects that underpin the duties of Safeguarding Adults Boards.

The Induction programme for new Board members has been revised and an E-learning training package has been developed to provide an overview of the roles and responsibilities as well as the purpose of both the adults and children's Boards. This is available to members of the Boards as part of their induction, but is also available to all other workers to improve the general understanding of Statutory Boards.

9 Accountability

9.1 Increased understanding of Safeguarding across all agencies

All partner agencies were asked to provide an overview of their work in Safeguarding for the past year. These reports provide a useful overview of the type of work being carried out in Safeguarding Adults across partner agencies.

- **North Tyneside Council**

To: North Tyneside and Northumberland Safeguarding Adults Board

From: Alison Tombs

Organisation: Adult Social Care North Tyneside Council

Date: 05.08.17

Title of Report: Partner Update for SAB 2016-17 Annual Report

1. **Please give an overview of your agencies Safeguarding arrangements, including any changes over the past year. This can include any involvement in SAB work. Please include the main issues or aims for your agency:**

   North Tyneside Council Adult Social Care has undergone a restructure during the past year. This has now been implemented. Social workers and Community Wellbeing Officers are now based in locality teams. The aim of this is to ensure that people who are in receipt of an adult social care service have an allocated worker who knows the geographical area they live in well.

   Members of the Safeguarding Team are now working into these locality bases to provide increased support to members of staff who are dealing with Safeguarding concerns

All new cases continue to come through the Gateway team to ensure appropriate triage is undertaken.

The Council continues to be the lead agency with responsibility for undertaking Safeguarding Adults Enquiries. North Tyneside has during the past year procured a new IT database system, which will improve the way in which safeguarding concerns are recorded and processed.

Senior Leadership for the Council have regular meetings with Safeguarding leads for Children's and Adults to ensure there is oversight for high profile safeguarding cases at the highest level within the council.

The Council is working with partner agencies to develop a Multi Agency Safeguarding Hub – MASH. This will be based with The Gateway Team and will respond to both Children's and Adults Safeguarding concerns.

2. Update of the last year's actions and achievements:

North Tyneside staff had a key role in the planning of SAFE week
North Tyneside continue to have lead role for conducting Safeguarding Enquiries
North Tyneside has a robust audit process for monitoring the quality of Safeguarding cases. Regular reports are provided to senior managers for oversight of this work.
The joint working across Children's, Adults and Community Safety in particular topics has resulted in improved outcomes for individuals, especially those at risk of sexual exploitation.

3. Financial / resource implications for your agency:

The Council continues to provide a high level of input into the SAB with an identified senior manager responsible for the Board, a new Information Governance and Safeguarding Manager to oversee the team and the strategic work undertaken by the Council.
North Tyneside also provides the administration of the SAB.

4. Next Steps/Future plans /priorities

To embed the new way of working across teams
To implement the MASH
To implement the new IT database system

- **North Tyneside CCG**

To: North Tyneside and Northumberland Safeguarding Adults Board

From: Adrian Dracup

Organisation: North Tyneside CCG

Date: 04.07.17

Title of Report: Partner Update for SAB 2016-17 Annual Report

1. **Please give an overview of your agencies Safeguarding arrangements, including any changes over the past year. This can include any involvement in SAB work. Please include the main issues or aims for your agency:**

   The CCG now has an integrated safeguarding team which comprises of the following staff:

   - Executive Director of Nursing: Chief Operating Officer
   - Head of Safeguarding: Designated Nurse Safeguarding Children.
   - Designated Nurse Looked after Children: Safeguarding Children and Adults officer.
   - Safeguarding Adults Lead: Safeguarding Children and Adults officer.
   - Named GP Safeguarding Children and Adults.
   - Designated Doctor Looked After Children.
   - Designated Doctor Safeguarding Children.

   The CCG is represented on the following:

   - Safeguarding Adults Board.
   - Communication and Engagement sub group.
   - Improving Practice and Performance sub group.
   - Safeguarding Adult Review Committee.

2. Update of the last year's actions and achievements:

In addition to the above the Clinical Quality Lead Nurse provides advice and guidance to North Tyneside nursing homes with regard to ensuring safe and high quality care is provided to residents. This is being further strengthened by the introduction of a joint care home contract with the local authority.

The CCG continues to provide regular training to primary Care staff on a variety of safeguarding issues including general safeguarding, domestic abuse and Multi-Agency Risk Assessment Conferences (MARAC), Peer review sessions for GP practice safeguarding leads and Work Shop to Raise Awareness of Prevent (WRAP) training; to date 24 out of the 29 GP practices have received WRAP training.

In April 2016, North Tyneside CCG (NTCCG) safeguarding leads, including the executive lead met with NHS England (NHSE) safeguarding team to assess the evidence that the CCG had provided with regard to the NHSE self-assessment tool. The key lines of enquiry contained within the self-assessment were elicited from the standards set out in the CCG Assurance Framework 2015/2016 Operating Manual. NTCCG was as being 'fully compliant' with the standards.

In November 2016, NT CCG received substantial assurance from an independent audit with regard to the organisations safeguarding arrangements.

The CCG however continues to develop new initiatives to improve the safeguarding arrangements within the organisation.

Safeguarding is a core part of the NHS contract with providers therefore through quality review groups the wider quality assurances are sought.

3. Financial / resource implications for your agency:

At a time of significant financial challenge the CCG have enhanced their safeguarding team capacity which demonstrates its continuing commitment to this core duty.

4. Next Steps/Future plans /priorities

Continue to attend and participate in the SAB and the sub groups, to assess and seeking assurance that effective multi-agency safeguarding arrangements are in place to safeguard adults at risk in North Tyneside.

Ensuring all new initiatives such Care Plus (Integrated care in the community) has safeguarding embedded within service policies, procedures and practice.

Continuation of the CCG and primary care training programme. Measure staff compliance with safeguarding adults training.
Disseminate the learning from Serious Adult Case Reviews, Domestic Homicide Reviews and lower level learning reviews where appropriate.

- **Northumbria Police**

To: North Tyneside and Northumberland Safeguarding Adults Board

From: Peter Storey

Organisation: Northumbria Police

Date: 05.09.17

Title of Report: Partner Update for SAB 2016-17 Annual Report

1. **Please give an overview of your agencies Safeguarding arrangements, including any changes over the past year. This can include any involvement in SAB work. Please include the main issues or aims for your agency:**

   The Safeguarding Department has been created within the Force Operating Model to coordinate the police response to the most vulnerable members of our community.

   It is clear in its principle that Northumbria Police will simply be outstanding in the delivery of services and will see a joined up approach to all areas of vulnerability across the force.

   The department will oversee and drive the force response in relation to the following areas:

   - Child Abuse
   - Missing Children
   - Domestic Abuse
   - Rape
   - Vulnerable Adults
   - MAPPA / MATAC
   - Reach

- Hate Crime
- Operation Sanctuary
- Trafficking
- Sex Workers
- ASB
- Safeguarding of Vulnerable Persons

The establishment of safeguarding has increased the number of staff working on vulnerability in North Tyneside. A project team has been initiated to develop new approaches to safeguarding and improve services to among others vulnerable adults.

2. Update of the last year's actions and achievements:

Operation Sanctuary is a Northumbria Police led, multi-agency operation which looks to target the behaviour of men who commit sexual offences against vulnerable adults and children. As a result of a successful home office innovation bid a south based hub has been developed from April 2016.
Social workers from North Tyneside work alongside workers from Changing lives, Bright futures and Barnardo's.

3. Financial / resource implications for your agency:

4. Next Steps/Future plans /priorities

- **Northumbria Healthcare NHS Foundation Trust**

To: North Tyneside and Northumberland Safeguarding Adults Board

From: Jane Abbott Professional and Operational Lead for Safeguarding

Organisation: Northumbria Healthcare NHs Foundation Trust

Date: 7.7.17

Title of Report: Partner Update for SAB 2016-17 Annual Report

1. **Please give an overview of your agencies Safeguarding arrangements, including any changes over the past year. This can include any involvement in SAB work. Please include the main issues or aims for your agency:**

   The Interim Director of Nursing has an executive board level responsibility for safeguarding.

   The Trust Safeguarding Board is chaired by the Interim Director of Nursing. Named and Designated Safeguarding professionals as well as the Leads for Mental Capacity, DoLS, Learning Disabilities and Adult safeguarding attend monthly. There is also senior representation from all Business Units. The Safeguarding Board monitors governance arrangements regarding safeguarding vulnerable people (both adults and children).

   The Safeguarding Board through its membership is responsible for ensuring safeguarding arrangements are in place Trust Wide, identifying risks through the risk register and monitoring action plans. The Trust Safeguarding Board is the corporate hub through which information is disseminated to all levels of staff within the Trust both at ground level and through the relevant governance structures of the Assurance Committee and the Trust Board of Directors

   The Professional and Operational Lead for Safeguarding Adults and Children provide quarterly and annual reports to Trust Board. The reports provide assurance that local arrangements are in place for safeguarding the vulnerable and the Trust is meeting its statutory requirements and is in line with National guidance.

   Child Protection systems and policies are up to date with robust and regular reviews, which are ratified by Trust Board. Including a process for following up

children who miss appointments and a system for identifying children where there are safeguarding concerns.

The safeguarding teams receive notification of safeguarding incidents reported within Datix (incidents), safeguarding children referrals and Adult PROTECT forms which provide an overview and support for all serious incidents.

The safeguarding leads link into Trust internal meetings where aspects of safeguarding are required such as Security meetings, SNF, Tissue Viability, IR1 meetings, and clinical governance meetings

2. Update of the last year's actions and achievements:

CQC Inspection November 2015

The Trust received a comprehensive Inspection in November 2015. The final report was received in May 2016 the Trust had an overall rate of Outstanding. Safeguarding featured highly within the reports, all staff were able to articulate to the inspectors their safeguarding responsibilities and duty of care, which shows that the training and supervision and support they receive is effective.

"All frontline staff we spoke with had a comprehensive understanding of the safeguarding process and were aware of their individual responsibilities regarding the safeguarding of both children and vulnerable adults"

"We saw evidence that referrals for vulnerable adults and children were regularly made and information was routinely sent to health visitors about all children who attended the department.
Staff knew about specific safeguarding topics such as sexual exploitation, people trafficking and female genital mutilation (FGM)"

NHCFT Safeguarding Strategy and Priorities are shaped by National and regulatory requirements as well as the Safeguarding Adult Board. The Safeguarding Team have delivered on all of the priorities identified in 2015-16 Annual report.

Key priorities for 2015-16	What we have achieved
Continue to deliver training across the Organisation to ensure all staff are aware of their safeguarding role and compliant with partnership board requirements.	Safeguarding training figures show high compliance
To further develop the views of service users in safeguarding decision making	Making safeguarding personal principles adopted where there are safeguarding concerns. The persons views are sought and considered.
To further raise awareness of Sexual Exploitation to front line services	SE task group established. Awareness raised in key frontline services such as A and E sexual health services, womens services.
Further develop the adult referral form and mechanism with our partner agencies	Form is now designed and tested. Launch of electronic referral form planned for May 2017
Development of training programme in relation to mental capacity and deprivation of liberties safeguards.	Training established, workbook developed and rolled out
The Trust is able to identify adults with a learning disability within acute care. Further work in tracking the patient journey required	RAPPA system in place. CQUIN target established. Patient tracker embedded.
Engage in multi-agency safeguarding adult and Children audit as part of quality and assurance agenda	NHCFT section 11 audit and the SAB Quality Assessment Framework as well as multi agency audit from SCR's, DHR's
Develop a Safeguarding Adults audit programme in line with the children's audit plan.	The Safeguarding Adult Team now have an annual audit plan which includes Safeguarding adults, Learning Disabilities, Mortality Review, MCA, MHA, DOLS
To continually review policies and procedures; timely and demonstrating evidence based / national directive.	All safeguarding policies have been updated following national directive and local learning.
To roll out new mandatory WRAP training under the Prevent agenda.	WRAP training established. 1st year target met for WRAP training

3. Financial / resource implications for your agency:

Highly publicised cases of abuse remind us of the importance of making sure that the most vulnerable adults and children in our care are listened to and have a voice. We all have a duty to our patients and their families to learn the lessons to ensure that the vulnerable in society are safe and protected.

This report is written at a time of change for the Health Service. This reporting period has seen many challenges, with changes in the NHS commissioning arrangements, in conjunction with continuing financial austerity and change across other partner agencies. These changes have and will in the future affected how we work with agency colleagues in social care and the police force, resulting in a greater responsibility being placed on health professionals for ensuring that the most vulnerable in our care are protected. Our safeguarding teams continue to support our staff through their expertise and knowledge and deliver training to enable our staff to take on this increased responsibility.

4. Next Steps/Future plans /priorities

The priorities for the Safeguarding Teams have been considered against the LSCBs and SAB Business Plans. Future priorities for the period April 2017-March 2018 include:

Key Safeguarding Priorities 2017-2018	
1.	Preventing harm and the protection of vulnerable children, young people and adults who access services through quality safeguarding training, supervision and support for staff.
2.	To further raise awareness of Sexual Exploitation of front line services
3.	To Raise awareness of Modern Day Slavery amongst all staff groups
4.	To embed the learning from SCR's, DHR 's and SLE's throughout the organisation to improve care and prevent further tragic events
5.	To further develop Adult supervision and across frontline services
6.	To further develop staff awareness in relation to mental capacity and deprivation of liberties safeguards.
7.	To further strengthen links between Community and Acute services to ensure seamless care for people with learning disabilities
8.	Engage in multi-agency safeguarding adult and Children audit as part of quality and assurance agenda
9.	To continually review policies and procedures; timely and demonstrating evidence based / national directive.

- **Northumberland, Tyne & Wear NHS Foundation Trust**

To: North Tyneside and
Northumberland Safeguarding Adults Board

From: Jan Grey Head of SAPP

Organisation: NTW NHS FT

Date: 29/6/2017

Title of Report: Partner Update for SAB 2016-17 Annual Report

Please give an overview of your agencies Safeguarding arrangements, including any changes over the past year. This can include any involvement in SAB work. Please include the main issues or aims for your agency:

1. Northumberland Tyne and Wear NHS Foundation Trust Lead officer for Safeguarding and Public Protection is the Executive Director of Nursing and Operations. A Nurse Director and Head of Safeguarding and Public Protection are identified named individuals who ensure the management of the trust Safeguarding and Public Protection team as well as ensuing a robust system is in place for safeguarding and public protection underpinned by sound clinical and corporate governance arrangements. The trust has a Safeguarding and Public Protection committee that meets 6 times a year. Trust board receive bi monthly reports including updates safeguarding children and adult boards.
   The trust Adults at Risk Policy has been reviewed, ratified and implemented in January 2017.
   The Safeguarding and Public Protection Team review every safeguarding adult concern, providing practitioners with advice, support and supervision where necessary.
   Two audits were undertaken in 2016/17 in relation to safeguarding. The first was an audit of the Safeguarding process and the second being an audit of the Safeguarding and Public Protection Team triage process. Both audits indicated full compliance with no key risks established.

2. Update of the last year's actions and achievements:

The Safeguarding and Public Protection Team have improved ways of working by reviewing the Triage model for access to advice, supervision and support. Access to triage is now via the completion of a web based form by a trust employee and reviewed by the triage worker. This enables the monitoring of all concerns in real

time including positive reporting of both significant harm and the identification of low level concerns that require a single agency plan to safeguard. The data of types of harm, threshold of harm and actual impact are presented to trust Quality and performance Committee on a quarterly basis. Also safeguarding assurance dashboards are submitted quarterly to the respective Clinical Commissioning Groups.
The Board of Directors, trust Safe groups and the NTW Nursing Conference 2017 have all received a presentation on domestic abuse in older people and coercive control. In 2016 the trust was inspected by the CQC and was given the grade outstanding.

3. Financial / resource implications for your agency:

The ability for the SAPP team to provide robust safeguarding support to trust services and current multi agency meetings whilst the process of change and differing demands are underway with the development of the MASH.

4. Next Steps/Future plans /priorities

To assist in the development and operationalisation of the MASH with partners.

- **Northumbria CRC**

To: North Tyneside and Northumberland Safeguarding Adults Board

From: Joanne Wallace, Reviewing and Quality Assurance Manager

Organisation: Northumbria Community Rehabilitation Company

Date: 05.07.17

Title of Report: Partner Update for SAB 2016-17 Annual Report

1. **Please give an overview of your agencies Safeguarding arrangements, including any changes over the past year. This can include any involvement in SAB work. Please include the main issues or aims for your agency:**

   The core role of NCRC is protection of the public. The focus of our work with service users (SU) is understanding and addressing their criminogenic and personal needs. Service users supervised by NCRC are involved in all aspects of their sentence, and are consulted in relation to completion of their sentence plan. NCRC promotes the early identification of any risk issues. If a service user is suspected of perpetrating abuse towards a vulnerable adult, or is vulnerable to abuse, the RO (Responsible Officer) will liaise as appropriate with the SGA team and/or relevant partnership agency.

   From 12th June 2017 Sodexo Practice Standards were implemented, which are a guide for operational practice and provide consistency of practice. The four areas are: early work, compliance, risk assessment and management, review and evaluate. The quality assurance team conduct monitoring exercises on a monthly basis which includes evaluating safeguarding work. A review took place to improve how feedback from case reviews, DHRs and serious further offence reviews are fed in to senior management and learning is embedded in to practice. A composite action plan is now competed and evaluated every month at senior management team.

2. **Update of the last year's actions and achievements:**

   NCRC works within a framework of a number of quality assurance arrangements including HMIP inspections, NOMS Operational Assurance, Contract compliance as well as internal mechanisms for monitoring. The quality assurance team

conduct monitoring exercises on a monthly basis which includes evaluating safeguarding work.

Development of Rehabilitation Activity Requirements (RARs), which are interventions based on desistance theory taking a strength based approach. took place. NCRC has the Positive Pathways programme and Positive Pathways Plus for domestic abuse perpetrators, as well as the following RAR interventions: Alcohol; Cannabis, Legal highs, Masculinity and Aggression, Victims and Values, Attitudes and Behaviour. These interventions are available to officers to deliver individually or in small groups depending on need and capacity.

Positive Pathways Plus is being reviewed and updated in order to incorporate additional exercises, consider what additional resources may be available, and explore stalking and harassment type behaviour.

3. Financial / resource implications for your agency:

As NCRC are no longer represented at SCB sub groups, we need to establish effective lines of communication and ensure we can both contribute to, and receive information/actions were relevant.

4. Next Steps/Future plans /priorities

Positive Pathways Plus is being reviewed and changed in order to incorporate stalking and harassment type behaviour.

NCRC needs to retain this focus on risk management and planning as these are core elements in case management. Risk management activities must focus on preventing or reducing the risk the service user may present to others, as well as any risks they may be vulnerable to. NCRC need to ensure that the outcomes and findings from reviews, inspections and quality assurance activities are taken forward, embedded into practice where necessary and the impact on service delivery can be evaluated. A timetable of practice development sessions has been established to address thematic and operational delivery priorities. The development sessions will include

- Compliance & Enforcement and the role of Management Oversight (use of professional judgement, defensible decision making, evidential recording, accountability.)
- Learning from Serious Further Offence Reviews and other serious case reviews (shared lessons learned and good practice examples, defensible decision making, informed future practice)
- Think Risk - Safeguarding Children & Adults (shared and extended practice knowledge, risk assessment skills, accountability and external liaison.)
- Think Risk - Domestic Abuse (shared and extended practice knowledge, risk assessment skills, accountability and external liaison.)

- **National Probation Service NPS**

To: **North Tyneside and Northumberland Safeguarding Adults Board**

From: Sheila Askew Senior Operational Support Manager

Organisation: National Probation Service – North of Tyne Cluster

Date: 29/06/2017

Title of Report: Partner Update for SAB 2016-17 Annual Report

1. **Please give an overview of your agencies Safeguarding arrangements, including any changes over the past year. This can include any involvement in SAB work. Please include the main issues or aims for your agency:**
   On 01/04/2017 NPS became part of her Majesty `s Prison and Probation Service – HMPPS, which replaced the National Offender Management Service. HMPPS is the new agency responsible for delivering the Governments vision and investment to make Prisons places of safety and reform and to continue to transform our work in the community.
   Our main purpose remains the same, to protect the public and prevent victims by changing lives.
   NPS has effective ways of assessing and managing risk of harm, sharing information with other public and voluntary services, whilst working with offenders to reduce reoffending, as well as a remit to work with victims of serious sexual and other violent crimes .It is also in a position to identify offenders who are themselves at risk of abuse and to take steps to reduce risk in line with the NPS National Partnership Framework , Safeguarding Adults Boards, June 2016

2. **Update of the last year's actions and achievements:**
   The NPS continues to focus on defining its role under the Care Act 2014, ensuring staff are aware of their responsibilities within the framework of that Act.
   The NPS has issued the following documents to staff
   NPS National Partnership Framework - Safeguarding Adults Boards -June 2015
   Safeguarding Adults at Risk - NPS Policy Statement - January 2016
   Safeguarding Adults at Risk - NPS Practice Guidance - January 2016

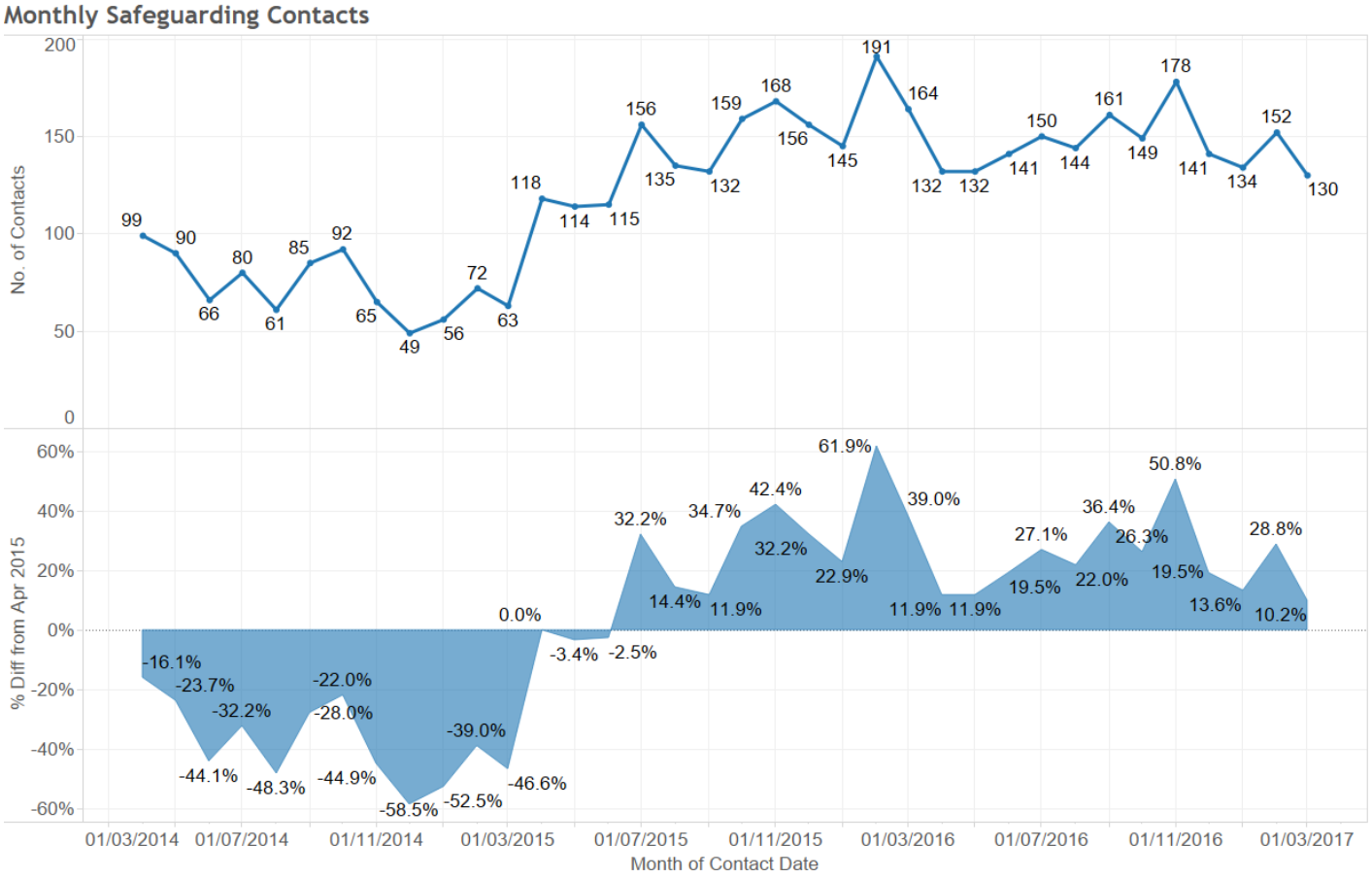
3. **Financial / resource implications for your agency:**
   The Framework document defines the contribution required from existing resources

4. Next Steps/Future plans /priorities

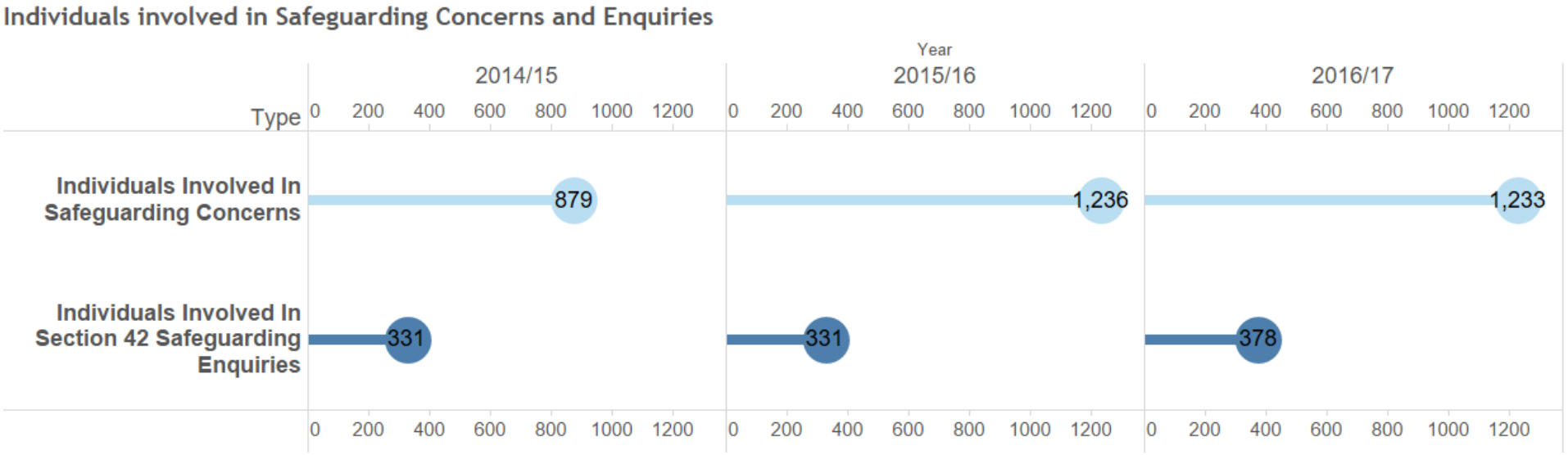
NPS priorities for 2017 / 18 are to ensure that staff complete the internal mandatory adult safeguarding training . This is comprised of e-learning and classroom events. NPS staff are also expected to take advantage of any multi agency adult safeguarding training available in their locations.
This will be tracked via NPS Staff Personal Development Reviews
Additionally appropriate representation on the Safeguarding Adults Board and relevant sub groups is also a priority for the NPS

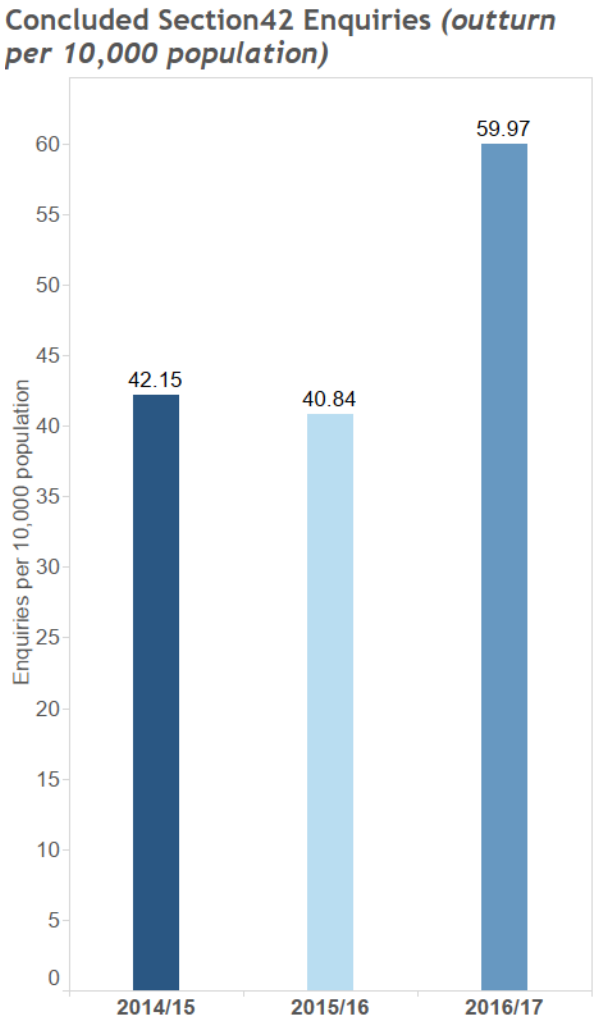
10 Performance Data

An improvement in training, awareness and closer working with social care teams improves the data reported within the social care system. There is continued on-going work to encourage agencies to report low-level concerns which could cumulatively be evidence of issues. A increase in noted from 2015 due changes to safeguarding recording and operational practise, the Monthly Safeguarding contacts shows the percentage difference per month in comparison to April 2015, November 2016 shows a reported 50.8% increase in concerns logged in comparison to April 2015. The increase continues during 2016/17 and is reflective of improved training, awareness and closer working with social care teams improves the data reported within the social care system. There is continued on-going work to encourage agencies to report low-level concerns which could cumulatively be evidence of issues.



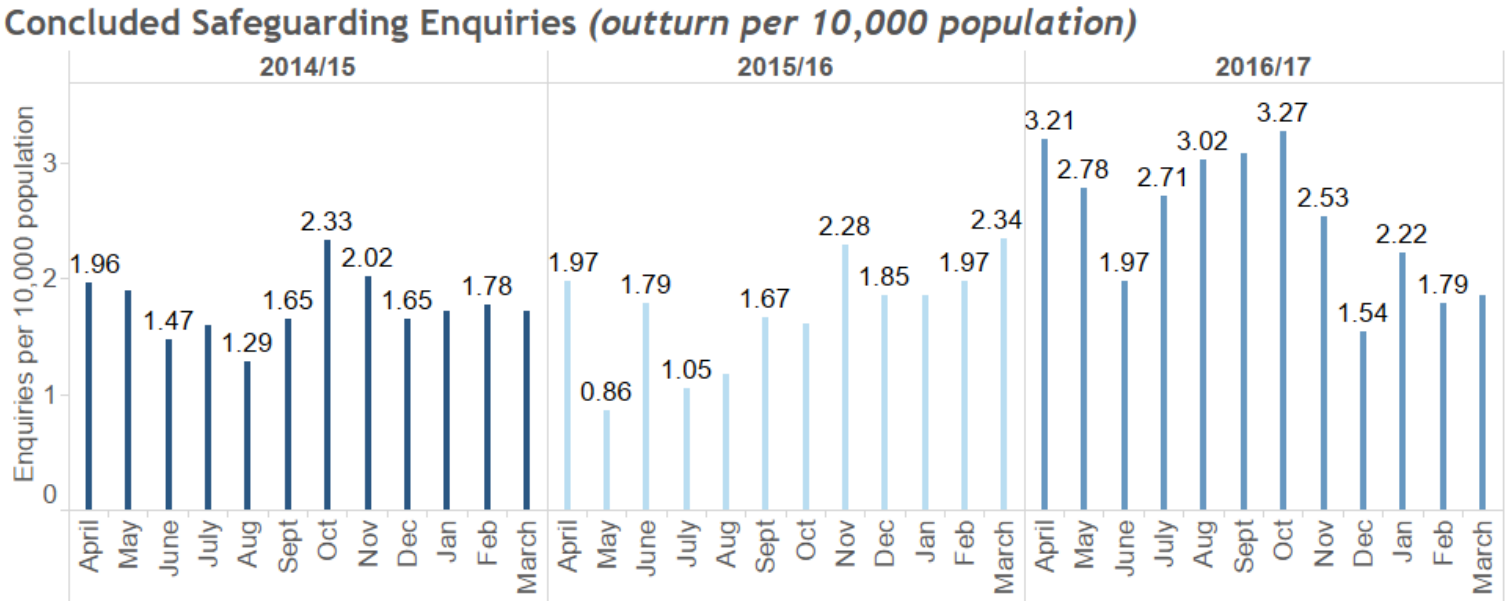
2016/17 reports a 30% increase in individuals involved in safeguarding enquiries in comparison to 2015/16.

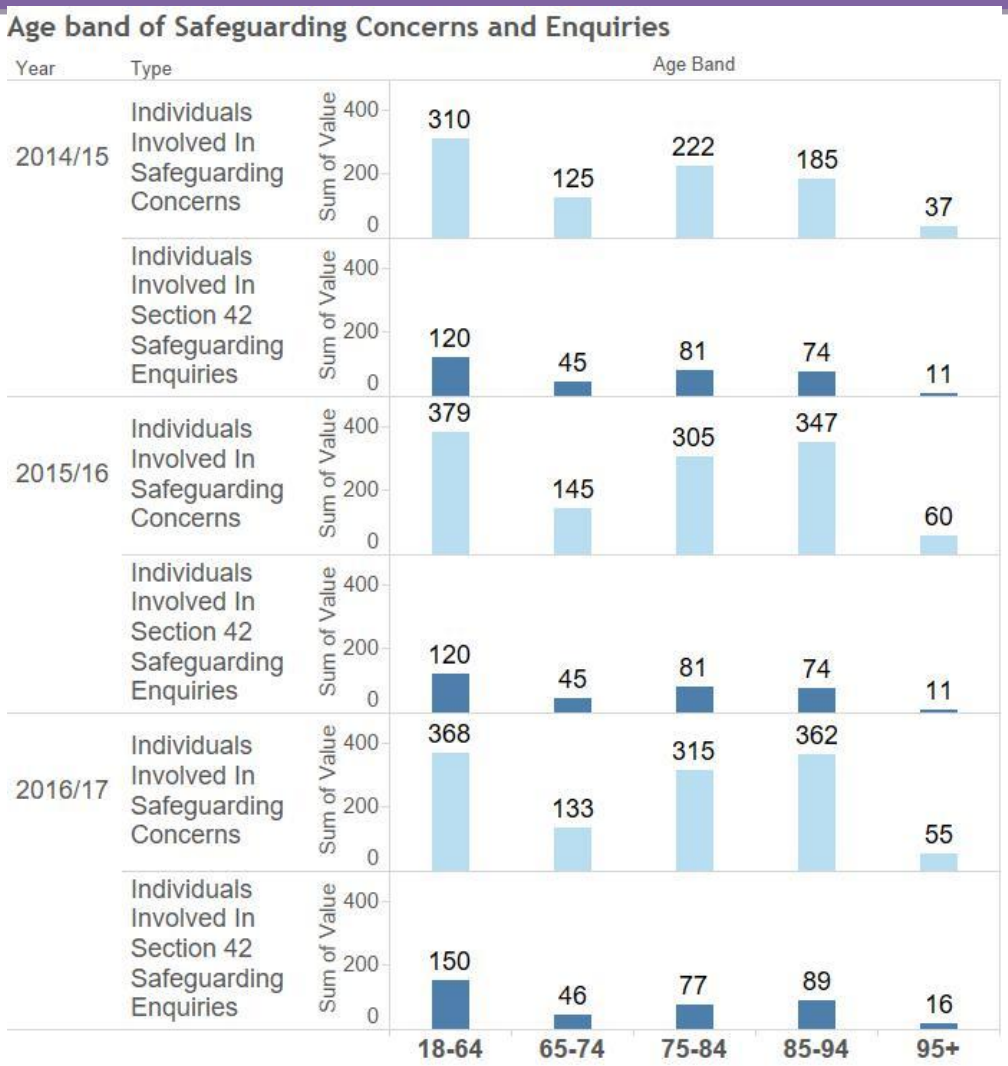




2016/17 reports a higher outturn of concluded enquiries in comparison to previous years. All years show a notable increase in enquiries during winter monthly with a slight reduction in the summer.

30% of contacts progressed to Enquiry during 2016/17 in comparison to 26% during 2015/16.

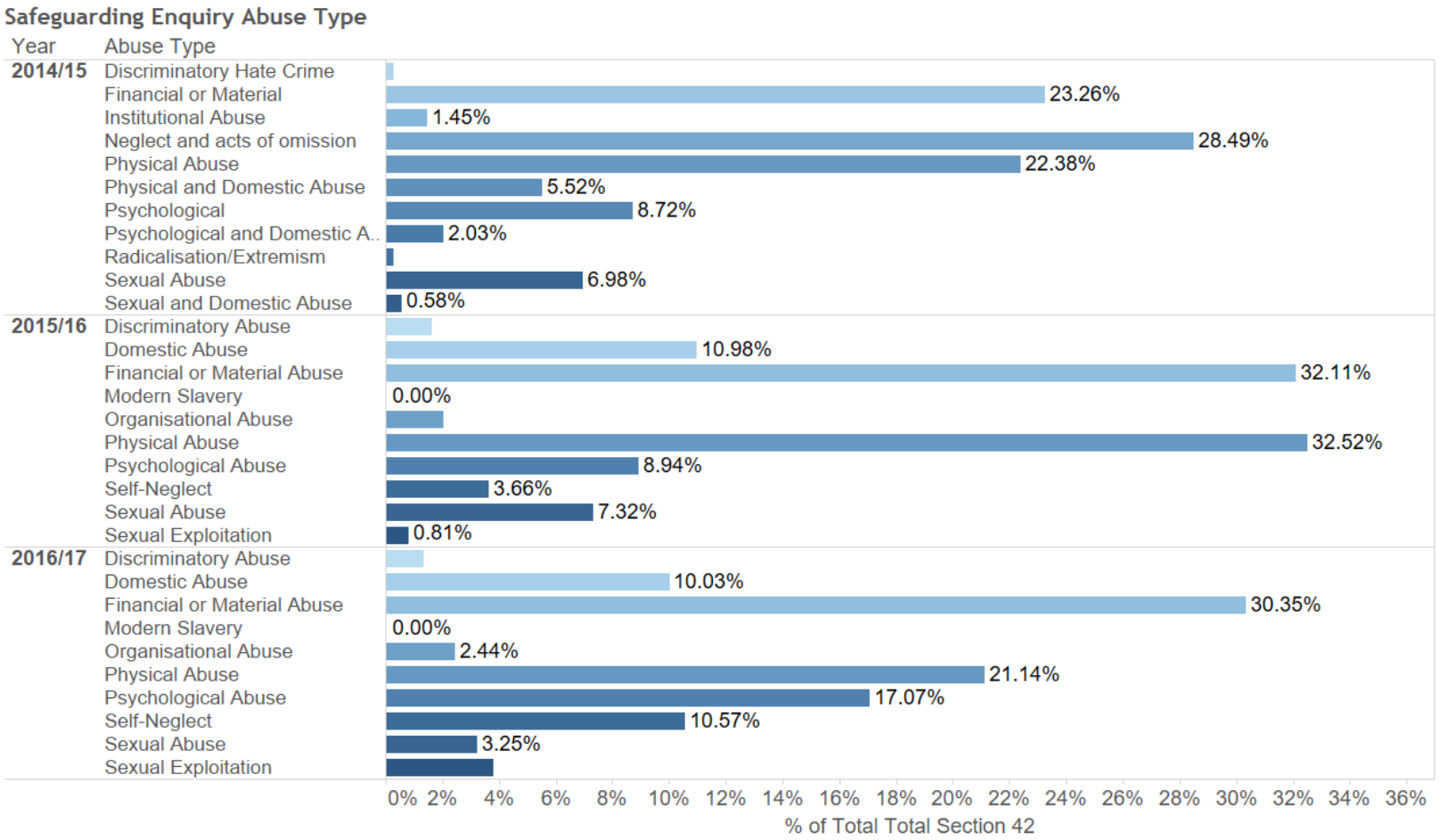




A increase in shown in the number of individuals with concerns logged for clients aged 75-85 and 85-94 for 2016/17 (shown below), however in comparison to 2015/16 those aged 75-84 have shown a reduction in the number of concerns proceeding to enquiry with a increase in enquiries for clients aged 85-94. A similar trend in shown for clients aged 18-64, a slight reduction in individuals involved in concerns but a increase of individuals aged 18-64 involved in Section 42 Enquiries.

All years show a higher proportion of abuse due to neglect and

acts of omission, Physical Abuse and financial abuse. 2016/17 shows an increase in financial where 30.35% of enquiries were due to financial abuse, in comparison to 23.26% in 2014/15. An increase in psychological abuse and self neglect is also shown during 2016/17 in comparison to previous years.



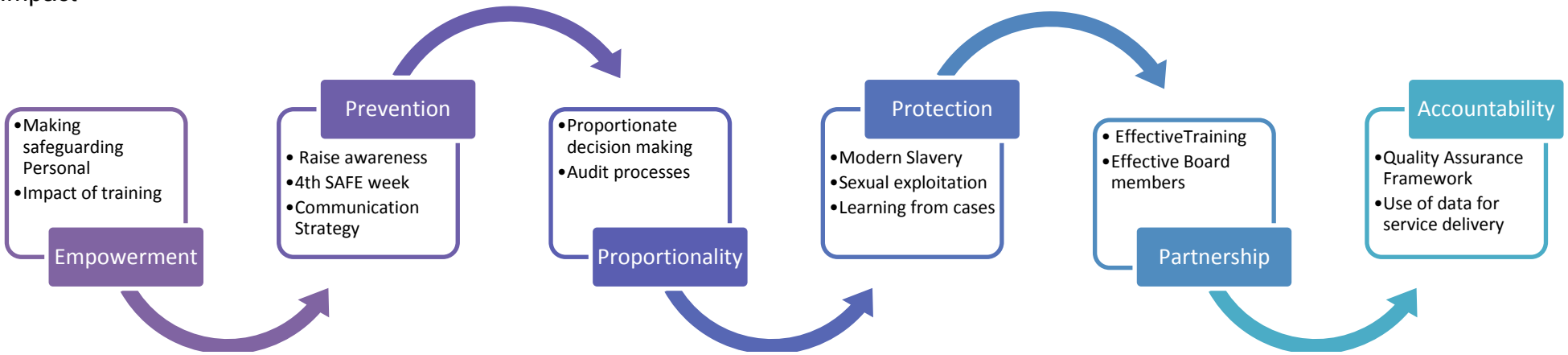
11Business Plan 2016-19

The SAB has agreed that it's priorities for the next three year's should be aligned to the six key principles which The Care Act 2014 states should underpin all adult safeguarding work.

- **Empowerment –** People being supported and encouraged to make their own decisions and informed consent.
- **Prevention –** It is better to take action before harm occurs.
- **Proportionality –** The least intrusive response appropriate to the risk presented.
- **Protection –** Support and representation for those in greatest need.
- **Partnership –** Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability**- Accountability and transparency in delivering Safeguarding.

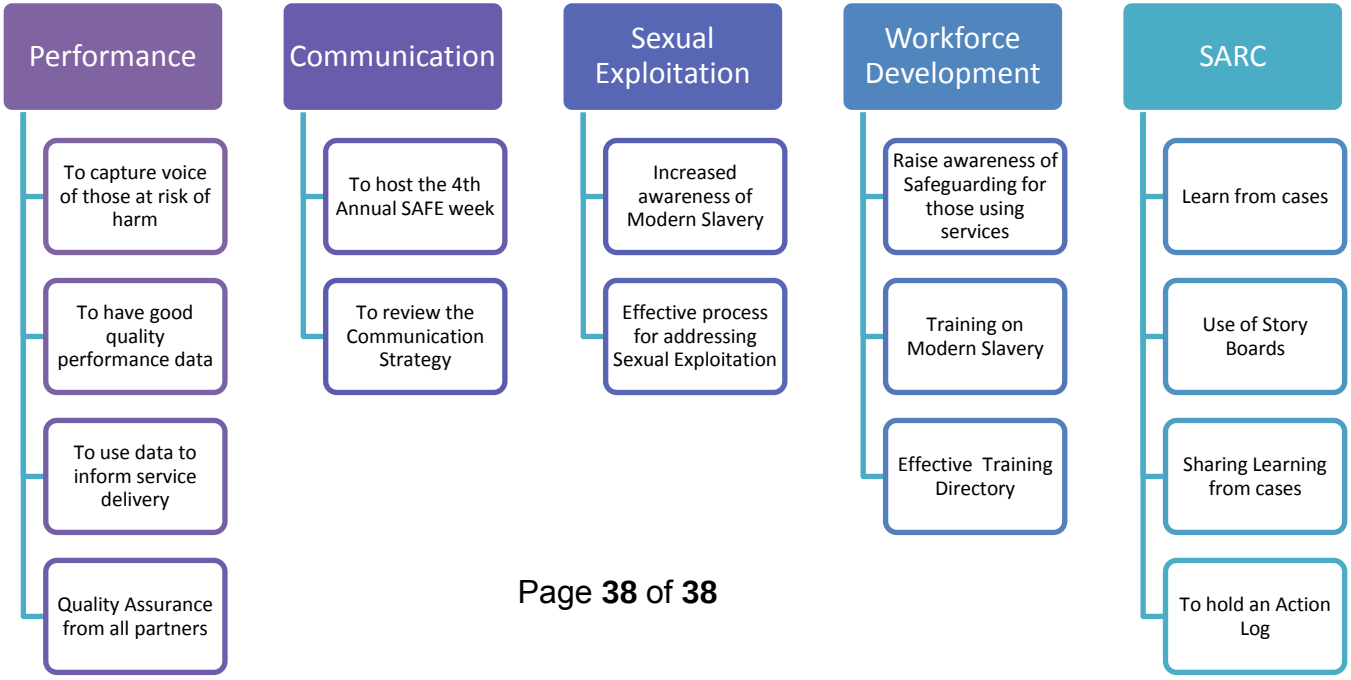
12 SAB Annual Plan 2017-18

Impact



13.1 Sub Groups

For more details and the full Annual Plan see: http://my.northtyneside.gov.uk/sites/default/files/web-page-related-files/SAB%20Annual%20Plan%202017-2018.pdf



Safeguarding Adults Board
North Tyneside and Northumberland

Business Priorities 2016-19

The proposal is that North Tyneside SAB sets it's priorities for the next year years to be aligned to the six key principles which The Care Act 2014 states should underpin all adult safeguarding work. These are:

Empowerment – People being supported and encouraged to make their own decisions and informed consent.

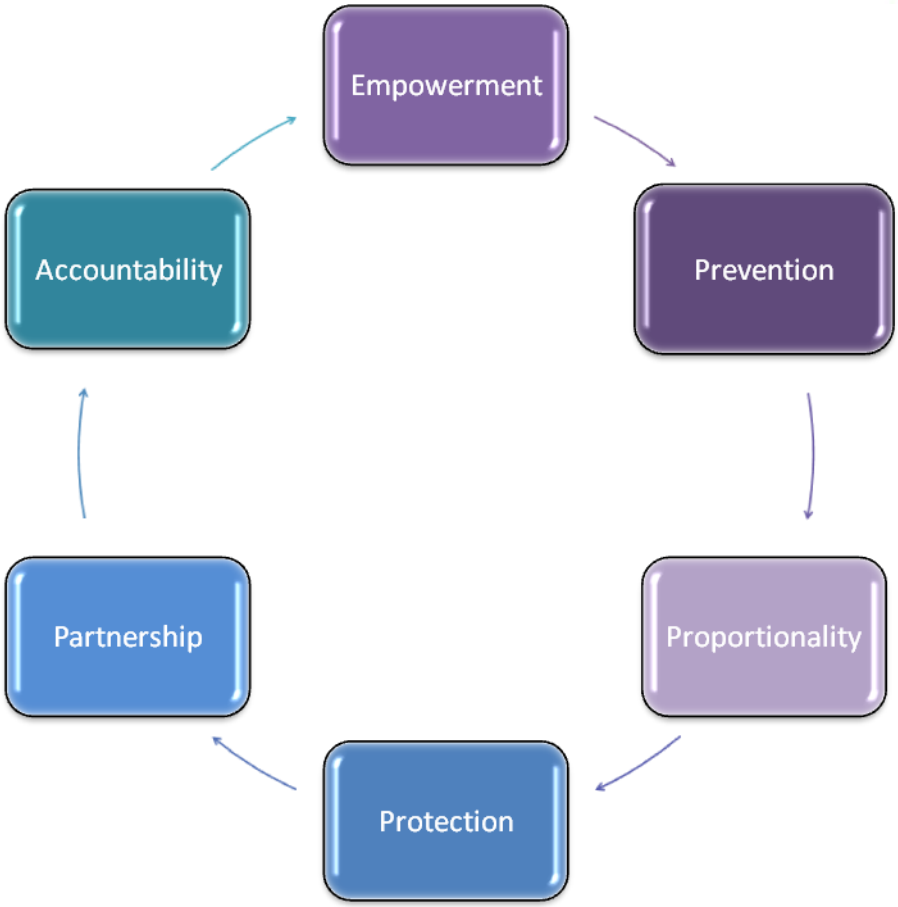
Prevention – It is better to take action before harm occurs.

Proportionality – The least intrusive response appropriate to the risk presented.

Protection – Support and representation for those in greatest need.

Partnership – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

Accountability- Accountability and transparency in delivering Safeguarding


Empowerment
Prevention
Proportionality
Protection
Partnership
Accountability

SAB

Objectives	Outcomes	Actions	Lead	Quarterly update	Rag Rating	Timescale
1. All agencies are able to demonstrate that they are implementing the Making Safeguarding Personal, MSP, Agenda in a consistent way by their frontline services	To ensure that the SAB has lay members to provide a	To recruit to the role of lay member for the SAB	SAB			
2. To ensure that the quality of commissioned services	That the SAB is assured of the arrangements in place to oversee commissioned services	Assurance is provided to the SAB regarding the quality monitoring processes and safety prevention measures in place for commissioned services	LA and CCG Commissioners			
3. Increased understanding of particular topics and vulnerabilities	Effective Prevent process	Prevent agenda process to be embedded in practice. Clear Channel process in place	Police and LA joint working arrangements			

Sub Groups

Performance Sub Group

Objectives	Outcomes	Actions	Principle	Quarterly Update	Rag Rating	Timescale
1. All agencies are able to demonstrate that they are implementing the Making Safeguarding Personal, MSP, Agenda in a consistent way by their frontline services	To ensure that the SAB strategy is informed by the voice of service users and carers.	That the voices of service users and carers are captured. Report to the SAB on an annual basis	Empowerment			
	All agencies to be engaged in MSP	All agencies to have responsibility to support individuals to identify outcome at the start of the safeguarding process. This will be reflected in agencies alerting/referral processes	Empowerment			

2. Raising awareness of Safeguarding across the wider community	For professionals, services users and the families and members of the general public to have an increased awareness of safeguarding adults	For the SAB to advise on the questions set being asked within general household survey e.g. “Would you know what to do if you were worried about someone who was vulnerable?”	Prevention			
3. Proportionate decision making in Safeguarding process	Improved use of notifications and escalation process	Monitor through audit process and performance data	Proportionality			
4. Data is used to inform Board re service delivery and planning	Improved use of performance data	Data dashboard to be used more effectively to understand safeguarding profile in North Tyneside and Northumberland	Accountability			

		Safeguarding data is overlaid with wider information e.g. Community Safety and LSCB to increase the understanding of vulnerability and risk factors	Accountability			
5. Board is assured that frontline practices are effective	Board is assured that agencies safeguarding processes are as effective and streamlined as possible	Quality Assurance Framework to be completed by all agencies SAB to monitor and quality assure	Accountability			

Communication Sub Group

Objectives	Outcomes	Actions	Principle	Quarterly Update	Rag Rating	Timescale
1. Raising awareness of Safeguarding across the wider community	For professionals, services users and the families and members of the general public to have an increased awareness of safeguarding adults	To host the 4th Annual SAFE week	Prevention	Safe week undertaken as planned	Green	Complete
		Agencies to share information with SAB regarding promotions they lead; e.g. hate crime week, fire prevention initiatives and NHS promotions	Prevention	This work has been undertaken and there is an annual diary of events to follow. The next task is to ensure this is taken forward by the SAB partners on the Communications sub-committee	Amber	April 2018
	The SAB to have an effective Communication Strategy in place	For this to be reviewed and updated	Prevention	Unfortunately, this is the first time the chair has known this action plan was in place. This state's review and update the communication strategy. Could this be forwarded to Robin Harper-Coulson?	Red	November 2017

Workforce Development Sub Group

Objectives	Outcomes	Actions	Principle	Quarterly Update	Rag Rating	Timescale
1. All agencies are able to demonstrate that they are implementing the Making Safeguarding Personal, MSP, Agenda in a consistent way by their frontline services	People using services have increased knowledge of safeguarding and are better equipped to keep themselves safe from harm	Training for service users. That their knowledge is measured before and after training to demonstrate the impact of learning	Empowerment	In North Tyneside : A pre and post survey was created last financial year to conduct with service users to demonstrate impact of learning – but access to training was limited and several sessions were cancelled. A PowerPoint has been developed for staff to deliver within provider services. In Northumberland – Jack and Josphine continue to be used to deliver safeguarding sessions and further thoughts need to be given in both areas on how impact of learning is gaged.		November 2017
2. Empower all partners to prevent abuse from occurring	Improved referrals with better clarity of information	Expand training across voluntary sector	Prevention	We have revised the membership of the Sub-group to ensure		March 2018

	including individual's outcome identified			representation from Police and NEAS, to try to ensure that training is suitable and to improve referrals information.		
3. Increased understanding of particular topics and vulnerabilities	Increased awareness of modern slavery	Training plan for Modern Slavery to be implemented	Protection	E-learning module launched and workshops are planned to take place within both North Tyneside and Northumberland aimed at social care staff. Wider training plan to be drafted to incorporate the wider workforce.		February 2018
	Effective Prevent process	Monitoring of Prevent and Wrap training across all agencies		Prevent / Wrap training is part of the Safeguarding Training offer within both North Tyneside and Northumberland. A gap analysis has been undertaken in North Tyneside and all front facing staff who have not completed this training are currently being targeted and		On-going

				requested to attend a face to face session.		
4. To have an effective Board and well trained members who are clear about their roles and responsibilities	That the Board has an effective strategic overview of Safeguarding across North Tyneside and Northumberland	Training Directory to be implemented and monitored	Partnership	Training Directories for both Northumberland and North Tyneside are now available and Board members are able to book on training as appropriate. Board Members Induction Pack has been designed to ensure that members understand their role on the board and the importance of keeping their training up to date and relevant.		On-going

5. Increased understanding of safeguarding across all agencies	Better skills, knowledge and confidence for workers to take ownership in safeguarding	Assurance that training is taking place across all partner agencies and that it is quality assured.	Partnership	In order to offer assurance to the Board that all partner agencies are accessing safeguarding training and this is of a good standard – provider services who do not access local authority training are being contacted in order to provide information on the training that is offered and the opportunity to quality assure the training materials used.		January 2018

Objectives	Outcomes	Actions	Principle	Quarterly update	Rag rating	Timescale
1. All agencies are able to demonstrate that they are implementing the Making Safeguarding Personal, MSP, Agenda in a consistent way by their frontline services	People using services have increased knowledge of safeguarding and are better equipped to keep themselves safe from harm	Training for service users. That their knowledge is measured before and after training to demonstrate the impact of learning	Empowerment			
2. Empower all partners to prevent abuse from occurring	Improved referrals with better clarity of information including individual's outcome identified	Expand training across voluntary sector	Prevention			
3. Increased understanding of particular topics and vulnerabilities	Increased awareness of modern slavery	Training plan for Modern Slavery to be implemented	Protection			

	Effective Prevent process	Monitoring of Prevent and Wrap training across all agencies				
4. To have an effective Board and well trained members who are clear about their roles and responsibilities	That the Board has an effective strategic overview of Safeguarding across North Tyneside and Northumberland	Training Directory to be implemented and monitored	Partnership			
5. Increased understanding of safeguarding across all agencies	Better skills, knowledge and confidence for workers to take ownership in safeguarding	Assurance that training is taking place across all partner agencies and that it is quality assured.	Partnership			

Sexual Exploitation Sub Group

Objectives	Outcomes	Actions	Principle	Quarterly Update	Rag Rating	Timescale
1. Increased understanding of particular topics and vulnerabilities	Increased awareness of modern slavery	Local arrangements for responding to Operational Modern Slavery to be in place	Protection	Attendance at the regional event in Newcastle added practical food for thought. Agreement made about an approach to managing North Tyneside Cases. Operational guidance being written		**December 17**
	Effective processes for tackling sexual exploitation.	Sexual exploitation strategy to be embedded into practice.	Protection	Schools awareness has been tested in relation to healthy and unhealthy relationships Action plan is progressing Use of training material relating to a recent Coronation Street storyline – using this with social workers Taxi policies revised and drivers now must complete SE training before receiving licence		

SARC

Objectives	Outcomes	Actions	Principle	Quarterly Update	Rag Rating	Timescale
1. The Board will learn from previous issues and ensures practice improves for the future	Ongoing use of the SAR policy to make decisions re learning locally and nationally	Use of story board process for sharing learning	Protection			
		Keeping of an Action Log to monitor implementation of actions into practice – link to workforce development	Protection			
		To consider examples of good practice and share learning from these cases	Protection			
		For partner agencies to share findings from internal learning reviews to the SAB	Protection			

FOR INFORMATION ONLY

Meeting: **Adult Social Care, Health and Wellbeing Sub-committee**

Date: **9 November 2017**

Title: Loneliness and Isolation

Author: Pam Mcardle Tel: 0191 643 7200

Service: Adult Social Care

Directorate: HECS

Wards affected: All

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1. Purpose of Report

To provide an update on the work of Adult Social Care and Public Health to target those who may be lonely or isolated.

2. Recommendations

For information only.

3. Details

In the past 12 months Care & Connect has been re organised and one community navigator post has been deleted, however, two of the remaining navigators continue to work in the community and cover the whole of the Borough. The third post has been funded to provide support primarily to those people who have recently been diagnosed with memory loss or dementia. This is an excellent development as we are aware that many people become isolated following such a diagnosis, which will have a significant impact on their life, and usually on their family.

Care & Connect have continued to work with local people and community organisations to bring people together, to connect them to their community and enable them to develop friendships. Research tells us that people maintain a better sense of wellbeing if they are independent and have a good social network.

We have supported in the organisation of Make it Special events across the Borough, working in partnership with others including North Tyneside living; Anchor Housing, Forward Assist ; Salvation Army and St Aidens's partnership, ensuring that each area has an activity that is open to all – Good Friday fish n chips; pie n pea suppers; afternoon teas; The Big Lunch events, all of these events are attended by between 35-40 each time and the feedback is always fantastic, with people highlighting how good it is to connect with others, and many go on to see their new

friends outside of organised events. We also organise Make Christmas Special. Last year 160 people joined in for Christmas dinner at four separate events supported by 60 volunteers. This is targeted at those who may be on their own at Christmas or just want to be with other people, and for those who may not be able to afford to make a Christmas dinner.

In addition, the navigators support other groups to grow and develop, for example supporting the Wallsend Memorial to get more people attending their lunch club and the men's group; the Salvation Army lunch club has tripled in size in the past year and the lunch club at John Willie Sams is bursting!

Other groups currently being developed include Friendship groups; single cuppa and regular lunch clubs at North Tyneside Living schemes.

In July last year, we identified that a number of people were referred to ASC needing support with shopping and they were often quite lonely as they didn't get out of the house very often. We worked closely with VODA to develop a shopping project. This has grown so much and recently won an Award. People are supported, by volunteers, to go to ASDA – who offer assisted shopping, and then they go to the Rising Sun for a cuppa. The feedback from the people involved in this project has been amazing and all report that they used to feel very lonely and now have new friends; they look forward to their shopping trip and have arranged many of their own trips and outings.

The Community Navigator for dementia and memory loss has identified a lack of specific support in the North West part of the Borough and has worked with the local community to identify a suitable venue and activity. This has culminated in two new groups: Friday Coffee Club at Clousden Hill Community Cottage for people with dementia, memory loss and their carers, and Thursday 1-30 till 3pm 'Singing Back the Memories' at Moor Croft Sheltered Accommodation. This is an open group so non-residents can attend too. This navigator attends MDT meetings at Age UK and is working on a 'map' for people recently diagnosed so that they can navigate their own way round support and services available to them.

ASC and Public Health have recently reviewed some of the prevention support that is currently commissioned from the voluntary sector and this has led to a clear focus of who does what and how the services sit together. For example, AGE UK befriending service will now be targeted to work with those people who are isolated and unable to access the community assets. The Good Neighbours scheme delivered by VODA continues to provide practical support and assistance to those who live alone, or have limited access to others for support. Experience has shown us that people who receive some practical help are often quite lonely and enjoy the company of others, sharing a cup of tea. The Good Neighbours volunteers will also signpost people to Care & Connect for advice and information about what is available in the community.

We have also worked closely with Tyne Health this past year who are developing the role of the Primary Care Navigator, and we have helped shape the training programme. This role is carried out by a member of staff at the GP practice and they will signpost people to other organisations within North Tyneside. It is anticipated that GP practices will be able to identify the more lonely/isolated people who attend their buildings and will signpost these to universal/community assets. They all have access to My Care and SIGN and have good links with their local community navigator from Care & Connect.

4. Appendices

None.

5. Background Information

The regular groups and activities are widely advertised and can also be accessed via MyCare and the SIGN directory. The special events are advertised more locally. The Care & Connect office is based at Wallsend Customer First Centre and is open 5 mornings per week 9.00 – 1.00.