North Tyneside Health and Wellbeing Board

Better Care Fund plan 2016-17

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**North Tyneside Council**
Clinical Commissioning Groups	**NHS North Tyneside CCG**
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of BCF pooled budget: 2016/17	**£16,572,000**
Total agreed value of BCF pooled budget: 2016/17	**£16,675,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS North Tyneside CCG
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Council	North Tyneside Council
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Health and Wellbeing Board	North Tyneside Health and Wellbeing Board
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

Contents

Related documentation

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

Document title	Synopsis	Link or embedded document
Our North Tyneside Plan 2015-18	Sets out the Councils' ambition for our people, places, and economy	http://my.northtyneside.gov.uk/category/368/our-north-tyneside-plan
Joint Health and Wellbeing Strategy 2013-23	Outlines the top priorities for improving the health and wellbeing of North Tyneside residents.	http://www.northtyneside.gov.uk/pls/portal/NTC_PSCM.PSCM_Web.download?p_ID=547453
Joint Strategic Needs Assessment	The JSNA shows the health and wellbeing needs of local people which is used to provide and develop health, wellbeing and social care services. The JSNA: • Provides a picture of health and care needs for the local community. • Looks at the health of the population and the behaviours which affect health. • Looks at social issues that have an impact on people's health and wellbeing, such as education, poverty and employment. • Shows health inequalities	http://www.northtyneside.gov.uk/browse-display.shtml?p_ID=564406&p_subjectCategory=387
CCG Operation Plan	Represents the first year of the Sustainability and Transformation Plan	
Adult Social Care Service plan	The plan sets out the drivers, priorities and actions for the Adult Social Care team in 2016 / 2017. The plan is based on the vision set out in the Our North Tyneside Plan 2015 - 2018 and the major transformation projects in the Creating a Brighter Future Programme.	ASC Service Plan 2016 2017.docx
Example BCF performance report	Illustrates the performance information routinely monitored by the BCF Partnership Report in 2015/16, against KPIs set out in the BCF s75 Agreement	BCF Performance Report Feb 2016.pdf
North Tyneside Commitment to Carers		www.healthwatchnorthtyneside.co.uk/sites/default/files/commitmenttocarersfinaldraft_210915_0.pdf

Relationship to the five-year forward view, including health and social care integration

The Five Year Forward View[1] sets out a clear goal that "the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care."

Significant element of the North Tyneside response to the Five Year Forward View, are our Accountable Care Organisation programme, and the CarePlus/New Models of Care service (page 5)

The CCG, Council, Tynehealth (GP federation), Northumbria Healthcare NHS FT, Northumberland, Tyne and Wear NHS FT, and the North East Ambulance Service NHS FT are all partners in programme to establish an Accountable Care Organisation from April 2017.

The parties have formed a programme board with workstreams, which has the specific remit of overseeing a comprehensive system wide integration programme to deliver the objectives of improving individual and population health in North Tyneside, promoting primary and preventative care, lessening the need for expensive services and ensuring patients are receiving the most appropriate services for their needs.

The CCG has a vision for a clinically and financially sustainable health economy and has agreed with the other parties to consider how this might be achieved for patients and the population of North Tyneside through the creation of an ACO. The CCG Governing Body, authorised by the CCG membership, have considered options for the future commissioning of affordable and sustainable quality health care that is fit to meet the needs of its communities. The CCG concluded that it should explore and develop the concept of commissioning services through an ACO, appropriate for North Tyneside

The BCF plan exists in the context of the ACO programme, and seeks to implement specific identifiable steps towards integration of health and social care in 2016/17. The BCF supports the development of the ACO, but is not dependent upon the ACO.

Relationship to the Sustainability and Transformation Plan (STP)

The timescale for submission of this BCF plan is in advance of the timescale for the completion of the STP and therefore at this stage it is not possible to cross-reference the two plans. However the first draft of the STP identifies some emerging priorities which include:

"Development of needs-based out of hospital models, that support individual and community resilience and reduce the need for health and social care support and acute intervention.

The BCF services described below such as CarePlus, CarePoint, and Intermediate Care are clearly aligned to this goal of improved out-of-hospital services.

The key changes to be delivered through the BCF

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

[1] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

- Integrating 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)
- Redesigning 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 to these new services, 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)

Carepoint

The Carepoint service will bring 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 and overnight home care
- 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 become located on the North Tyneside General Hospital site, although there is more work to be done to identify more suitable accommodation.

An operational manager will be appointed in the first quarter of 2016/17 to further develop and manage the integrated service.

The funding for Carepoint is included in the BCF.

Careplus / New Models of Care

"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.

Our 2015/16 BCF plan outlined our intention to introduce such a model. A team is now in place 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

CarePlus 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

Intermediate Care beds

There are currently a variety of intermediate care beds provided in both in-hospital and out-of-hospital settings:

Figure 1: current provision of intermediate care beds

Setting	Service	Number of beds	Average occupancy 2014/15
In-hospital	NTGH Ward 23	24	73%
	NTGH Ward 5	5	96%
Out-of-hospital	The Cedars Intermediate Care Resource Centre	30	83%

	Princes Court	20	70%
	Coble House	4	37%

A review of intermediate care provision highlighted:

- 90% of the current beds can be accessed only by consultants at Northumbria Healthcare NHS FT
- There is inequity in access to intermediate care provision for those people who are admitted to Newcastle Hospitals (as they cannot directly access intermediate care beds in the community without first being transferred and admitted to NTGH or being assessed by the bed bureau at Northumbria).
- Only 5% of beds are available for “step-up” care, the remainder being used for “step-down”
- There is a gap in terms of specialist intermediate care for people with dementia. The Cedars cannot take all patients with dementia due to the layout and nature of the building affecting CQC registration requirements.
- The estate at the Cedars Intermediate Care Resource Centre is not fit for purpose
- There are varying access criteria and and routes across the system.
- There is duplication in the system

The Older Peoples Programme Board identified that a new model of intermediate care is required which:

- Provides an adequate number of “step-up” beds, for people in the community who are at risk of an inappropriate acute hospital admission.
- Provides “discharge to assess” beds, with appropriate therapy input, which would support the timely discharge of patients from an acute ward into an intermediate care facility, enabling a period of rehabilitation whilst CHC assessments are being carried out or decisions are being made about the appropriateness of permanent placements into residential or nursing homes, or designing the optimal package of community-based care which can support the person in their own home.
- Utilises high-quality accommodation
- Defines clinical responsibility for all intermediate care beds whether GP, nurse, or consultant led.

An allocation of £4,639,000 has been made within the BCF to fund the new model of intermediate care.

Liaison Psychiatry

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

In 2015/16, BCF funding assisted the formation of two liaison psychiatry services, aimed at different target populations:

- For working-age adults, a service was provided by Northumberland, Tyne and Wear NHS FT
- For older persons, a service was provided by Northumbria Healthcare NHS FT.

Older People Liaison Psychiatry
The 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**.**

Working Age Adults Liaison Psychiatry
In relation to working age adults (16-64) services, winter resilience monies were allocated to Northumberland, Tyne and Wear NHS Foundation Trust during 2014/15 to provide a liaison psychiatry service; financial support was continued in 2015/16 through the BCF.

This team was initially based at North Tyneside General Hospital and operated 11:00 – 24:00, 7 days per week. When the Northumbria Specialist Emergency Care Hospital (NSECH) opened in June 2015, the service transferred to the new hospital. All patients who present at A&E with an urgent mental health need are seen within 1 hour. Non-urgent referrals will be seen within 24 hours.

In 2106/17, the service will be continued, and in addition there will be a three-month trial of 24-hour, 7-day a week working followed by an evaluation to ascertain whether a 24/7 service is needed and feasible.

Relationship to the Health and Wellbeing Strategy

The North Tyneside Joint Health and Wellbeing Strategy[2] 2013-2013 is built around the vision that “by 2023 we will have improved health and wellbeing outcomes in North Tyneside to match the best in the country”. It sets out the following objectives:

- To continually seek and develop new opportunities to improve the health and wellbeing of the population
- To reduce the difference in life expectancy and healthy life expectancy between the most affluent and most deprived areas of the borough
- To shift investment to focus on evidence based prevention and early intervention wherever possible
- To engage with and listen to local communities on a regular basis to ensure that their needs are considered and wherever possible addressed

[2] http://www.northtyneside.gov.uk/pls/portal/NTC_PSCM.PSCM_Web.download?p_ID=547453

- To build resilience in local communities through focussed interventions and ownership of local initiatives to improve health and wellbeing
- To integrate services where there is an opportunity for better outcomes for the public and better use of public money
- To focus on outcomes for the population in terms of measurable improvements in health and wellbeing

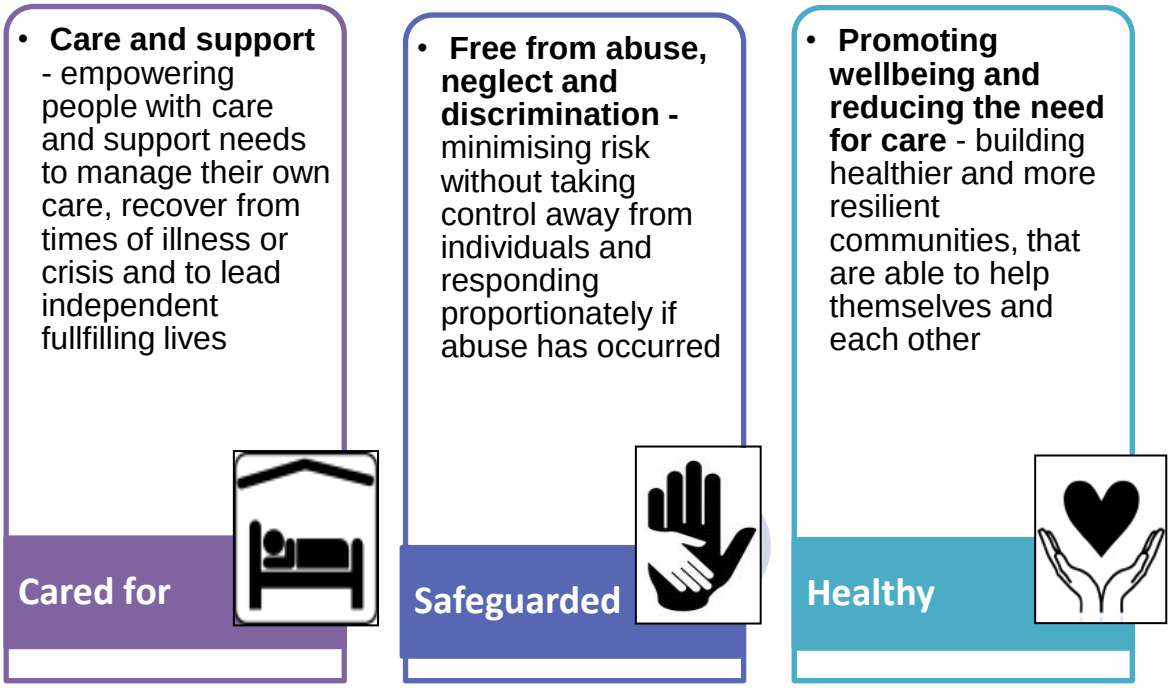
Relationship to CCG Priorities for 2016/17

The BCF plan 2016/17 complements and supports the CCG priorities for 2016/17, which are:

- Commission high quality care for patients, that is safe, value for money and in line with the NHS Constitution
- Deliver the Financial Recovery Plan, leading to the achievement of the CCG's statutory financial duties and future sustainability
- Work collaboratively with partners and stakeholders to develop health and social care fit for the future in North Tyneside
- Continue to develop North Tyneside CCG as a patient focused, clinically led commissioning organisation with a continuous learning culture

Relationship to the Adult Social Care Service Plan 2016/17

Our Vision for the Year Ahead
In 2016 / 2017 our vision for the Service is for as many people as possible to stay healthy, safe and actively involved in their communities in order to delay or avoid the need for care and support services.



Many services funded by the BCF are relevant to the "**Cared For**" element of the vision. This includes the new Carepoint service (see page 5); CarePlus (page 5); intermediate care (page 6); and services to care homes (page 17).

The Self Care and Prevention Programme Board – an element of the North Tyneside Health and Social Care Integration Programme, illustrated on page 44 – has an objective to develop and pilot a shared community wellbeing portal. This a joint health and social care activity; in support of this activity the Council has appointed an Advice and Information Coordinator and a Content Manager. £50k is identified in the BCF investment plan to support the continuation of this work in 2016/17, which is relevant to "manage their own care", "recover from illness", and "building more resilient communities" as outlined above.

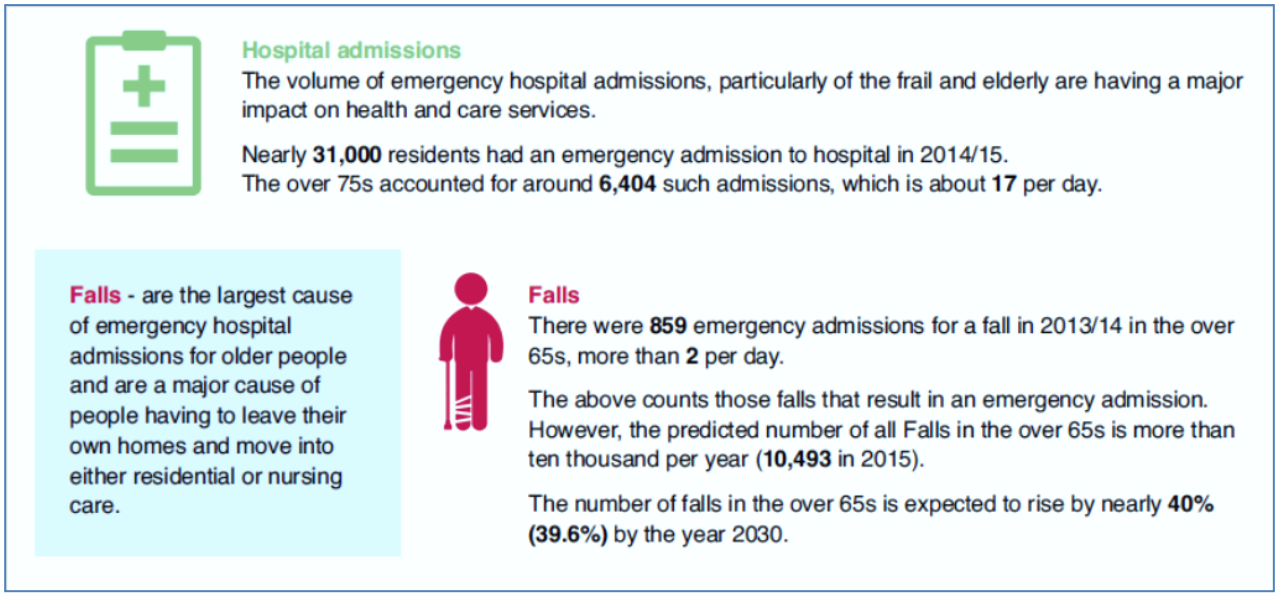
Relationship to the Joint Strategic Needs Assessment

The 2015 Joint Strategic Needs Assessment[3] (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.

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

Emergency hospital admissions

Figure 2: 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 4.3% 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.

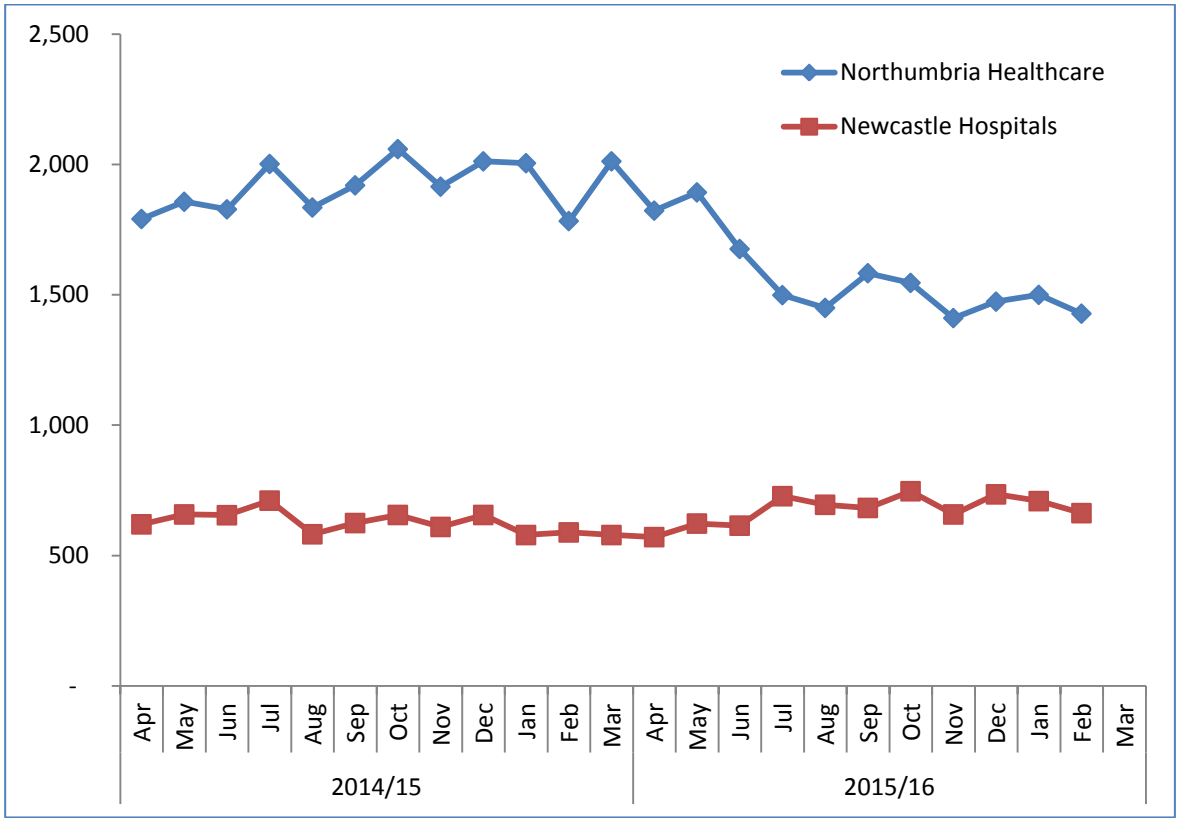
Table 1 below shows that, for the year to date in 2015/16 compared to the same period in 2014/15, there was an overall reduction of 11% in the volume of emergency admissions.

Table 1: Non-elective emergency admissions (Source: RAIDR)

Provider	2014/15 April-Feb	2015/16 April-Feb	% change
Northumbria Healthcare	21017	17297	-18%
Newcastle Hospitals	6939	7430	7%
Others	359	589	64%
TOTAL	28315	25316	-11%

As Figure 3 shows, the reduction in emergency admissions to Northumbria Healthcare was a part-year effect, from June 2015. The CCG trajectories for emergency admissions in 2016/17 take into account the full-year effect of the changed configuration of services following the opening of NSECH, and therefore predict a further downward shift.

Figure 3: monthly trend in non-elective emergency admissions. Source: RAIDR



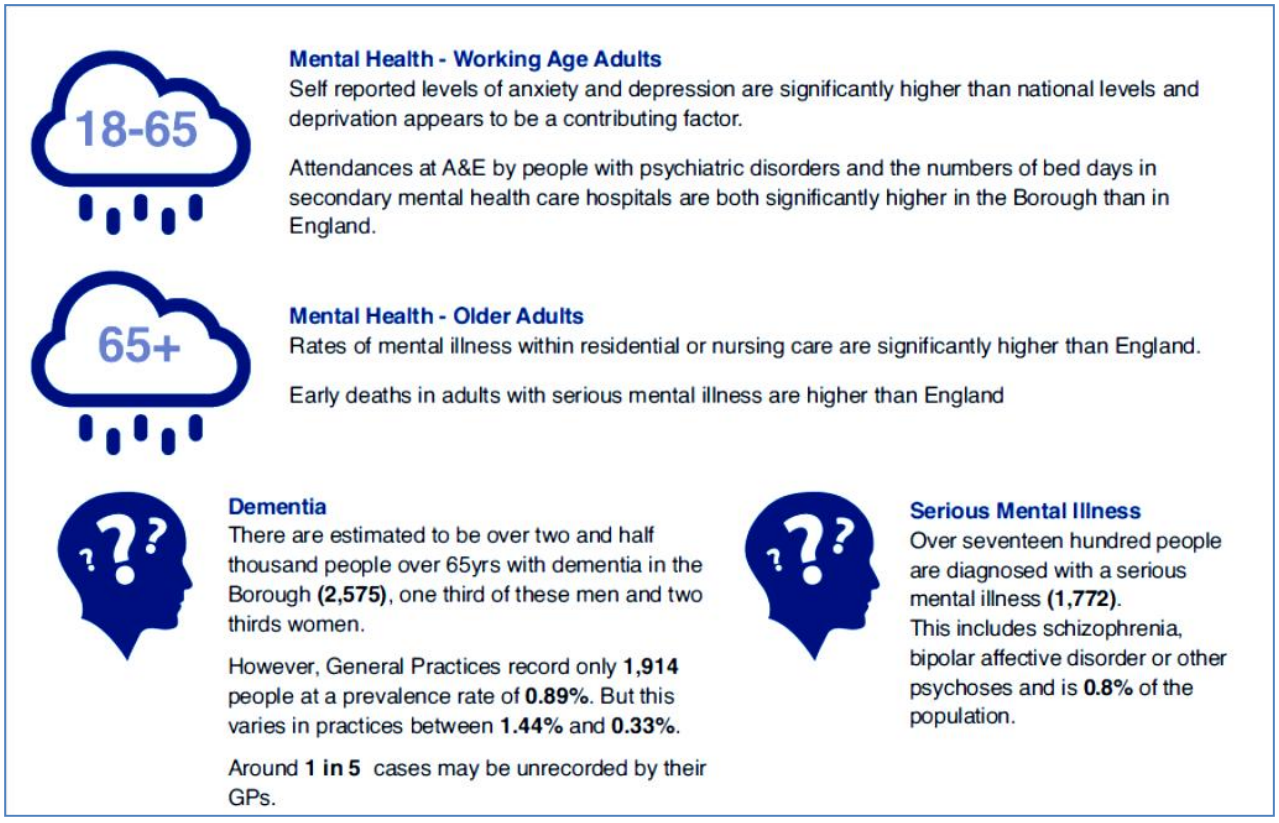
Because of the substantial reductions which have already occurred, the BCF plan does not seek to predict any further reductions over and above those which are already set out in the CCG Operational Plan.

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 4: JSNA Extract – mental health and dementia



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.

As detailed on page 7, the BCF includes funding for Liaison Psychiatry services, which are directly related to the provision of mental health services to those attending A&E.

The 2015/16 BCF included funding for the implementation of new mental health community pathways. The implementation of this work will continue throughout 2016/7.

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

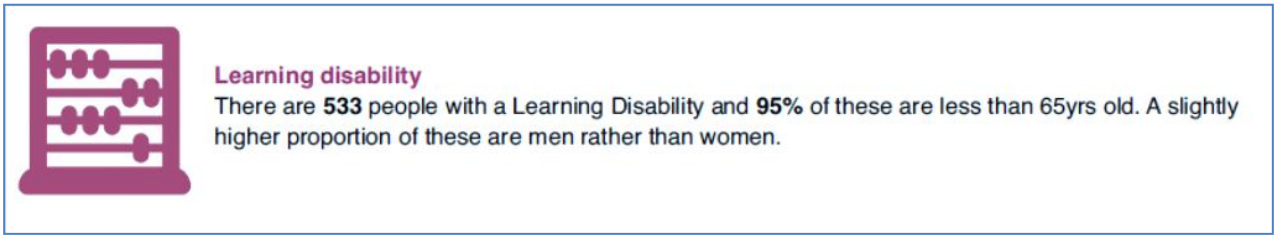
- Continue to exceed the national IAPT Access standard
- Achieve the national IAPT Recovery Rate
- Exceed national IAPT waiting time standards
- Achieve the national standard for Early Intervention in Psychosis
- Improved pathways for people experiencing a first episode of psychosis and reducing hospital 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 5: 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%.

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Carers, Self-help, and prevention

Figure 6: 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.

Developments of carers support services in 2016/17 will include:

1. Re-design of the carers' pathway.
2. A one year pilot to strengthen the advice and information offer and to test out the delegation of carers assessments to the Carers Centre.
3. Pilot a new preventative service. The Service will provide practical support for carers through the provision of a sitting service without the need for a statutory assessment.
4. Review of training in relation to carers.
5. Develop a process for identification and assessment of Young Carers
6. The development of the SIGN smartphone application may also benefit carers.
7. Review the use and purpose of the Carer Emergency Card
8. Continue to work on the remaining actions in the Commitment to Carers[4]

[4] http://www.healthwatchnorthtyneside.co.uk/sites/default/files/commitmenttocarersfinaldraft_210915_0.pdf

Care homes

Figure 7: 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 two 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

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.

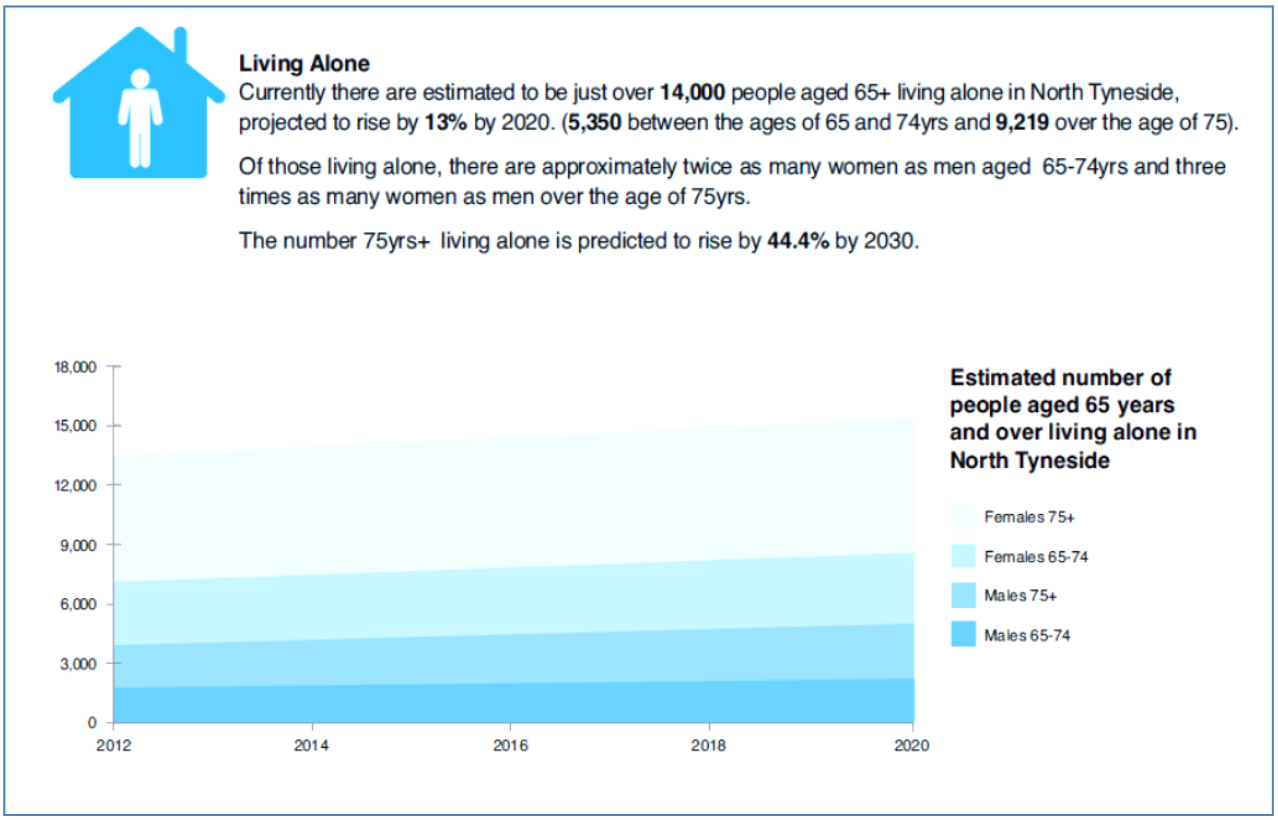
As a result of these services, in 2015, 34.2% of patients died in the place of their choice; an increase from the 2014 average, which was 29.3%

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:

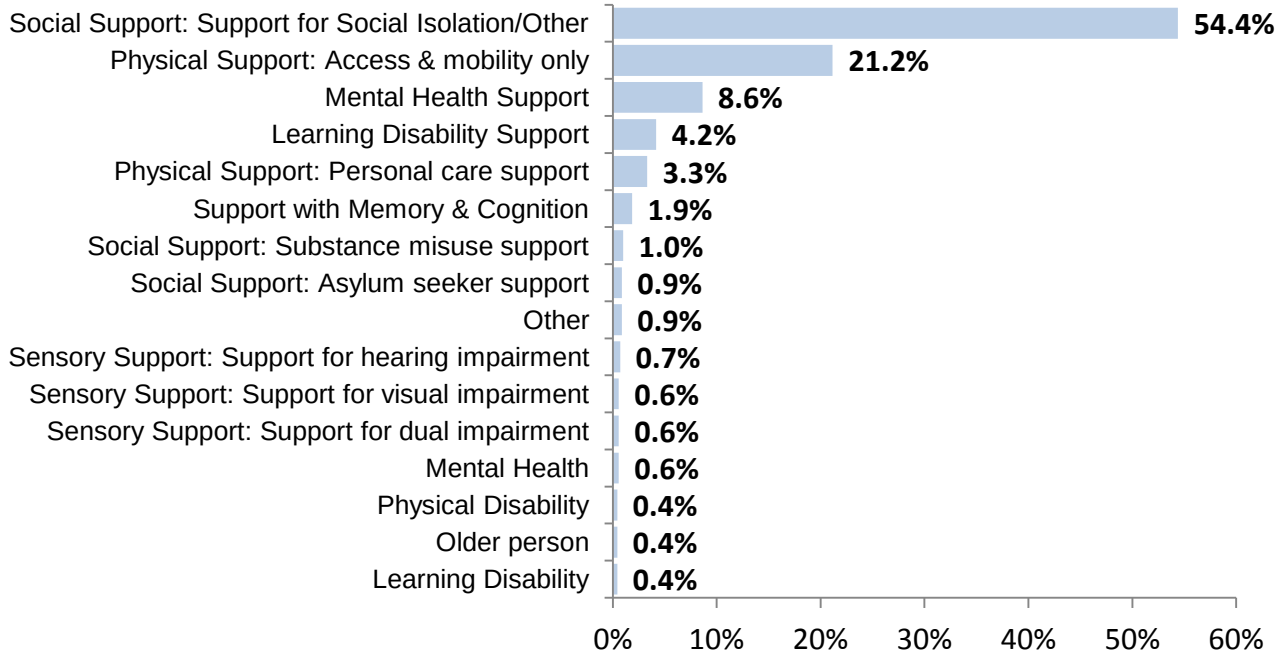
Loneliness and social isolation

Figure 8: JSNA extract – loneliness and social isolation



In 2015 the Council implemented a new service called “Care and Connect”; a small part of the cost (£34k) was funded through the BCF. Care and Connect saw 749 clients in 2015. As Figure 9 below shows, social isolation was the most common reason for accessing the Care and Connect service.

Figure 9: reasons for accessing the Care and Connect service (from 749 clients)



Care and Connect delivered services at the lowest level appropriate for each client, thus only a small proportion received a direct payment following a proportionate assessment

This represents an economical approach to meeting low-level needs.

The Care and Connect service will continue in 2016/17 but will be funded entirely by the Council without utilising BCF funding.

The Health and Wellbeing Strategy states that we will work within the four levels of service delivery, shown in Figure 10 below, to achieve better service integration.

Figure 10

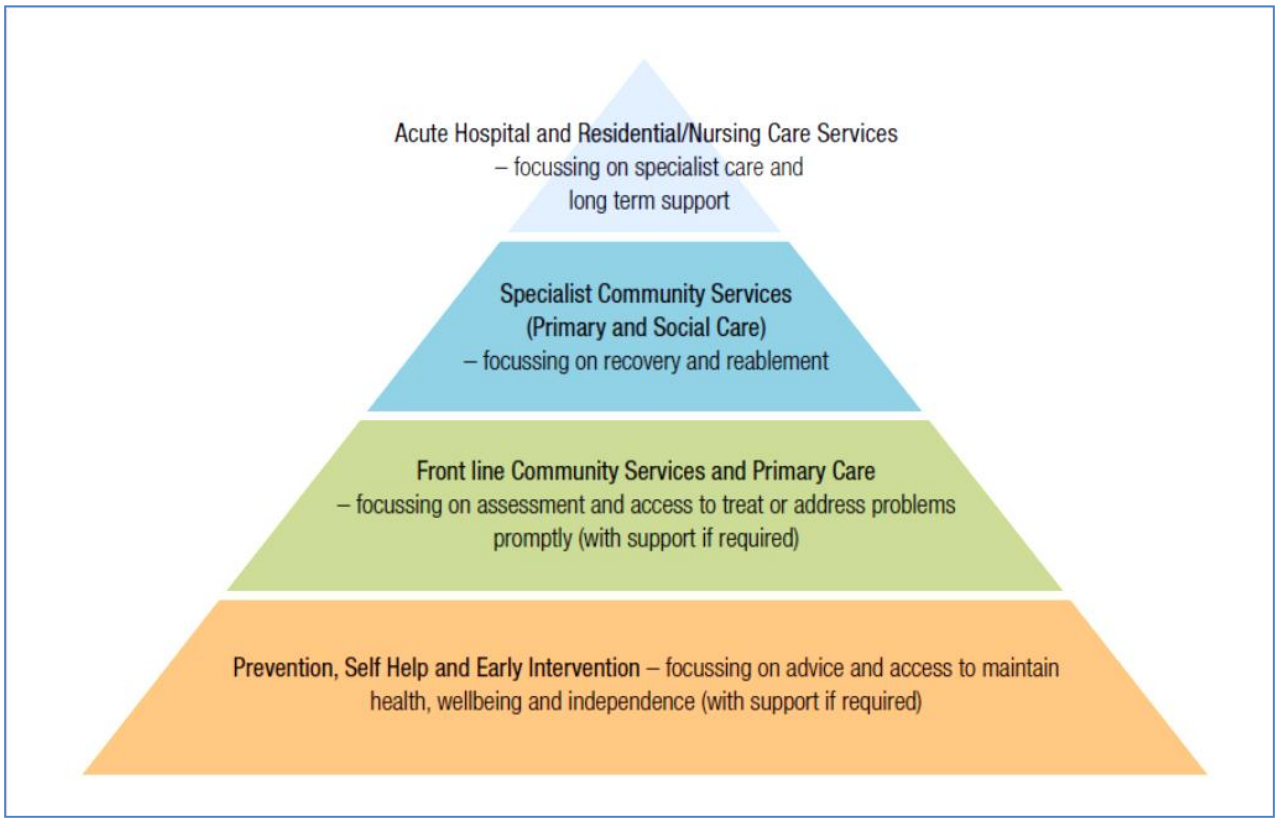


Table 2 shows how the BCF plan is aligned to these four levels:

Table 2

	BCF services	Other relevant initiatives
Acute hospital and residential/nursing care services – focussing on specialist care and long term support	End of life care Liaison psychiatry	GP enhanced service for care homes
Specialist community services (primary and social care) – focussing on recovery and reablement	• Proactive Care and Avoiding Admissions • Carepoint • CareCall / Telecare • Adaptations and Loan Equipment Service • Intermediate Care Beds	• Careplus (New Models of Care) • Mental health community pathways

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
	• Community-based services
	  • older people
	  • dementia
	  • mental health
	  • drug and alcohol
	  • homelessness	

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 • Support for Carers	• NT Sign • Care and Connect

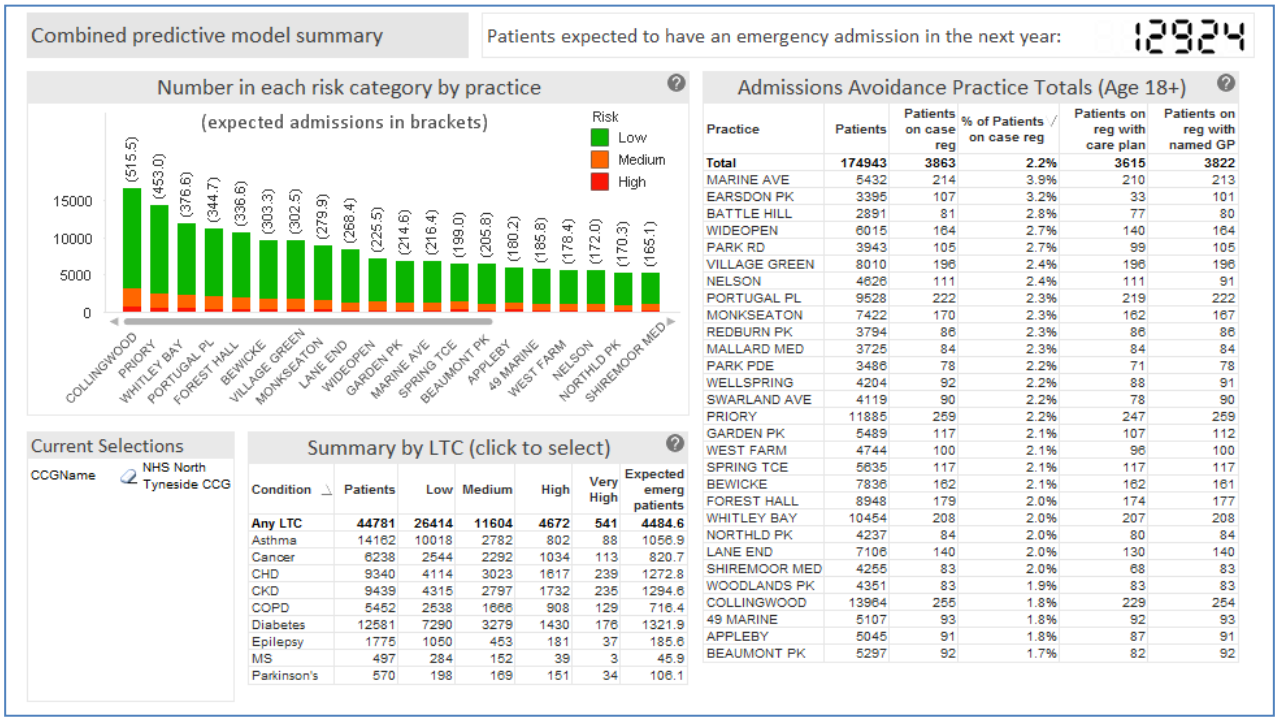
The use of risk stratification

The Combined Predictive Model is already in place as our risk stratification tool. This tool generates a figure of 7,694 persons at “very high” or “high” risk of hospital admission.

The Combined Predictive Model is populated using data drawn from both SUS (secondary care data) and from our 29 general practices, all of whom have consented to provide primary care morbidity data. The results are available to general practices through the “RAIDR” tool and enables practices to generate lists of the relevant patients.

Figure 11 below shows an example of the information available to general practices, which includes the numbers of patients expected to have an emergency admission in the next year for each practice, grouped by condition. General practices have the appropriate system permission to generate a list of the actual patients and can use this list as the basis to plan proactive care for those patients.

Figure 11: Risk stratification information available to primary care



All practices have signed up to the Enhanced Service “avoiding unplanned admissions – proactive case finding and care review for vulnerable people”.

In implementing the Enhanced Service, practices use risk stratification scores, supplemented by expert opinion through MDT meetings, to provide case management of patients with the highest risk of admission.

There are currently (at Feb 2016) 3,836 patients enrolled on the enhanced service, representing 2.3% of the relevant population.

The BCF plan includes funding for additional services provided by Northumbria Healthcare NHS FT which supplement the enhanced service, providing consultant geriatrician, pharmacist, and community matron input.

An additional risk stratification tool, the Electronic Frailty Index[5], is being trialled to assist in the identification of patients for the CarePlus scheme (see page 5).

Joint approach to assessments and care planning

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 through the Combined Predictive Model (see page 22) 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 / New Models of Care service will be rolled out in 2016/17. CarePlus operates 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, also attend 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.

An overview shared care plan document is in development.

[5] http://clahrc-yh.nihr.ac.uk/our-themes/primary-care-based-management-of-frailty-in-older-people/projects/development-of-an-electronic-frailty-index-efi

National Conditions

Plans to be jointly agreed

The BCF Plan will be submitted to the Health and Wellbeing Board on 28th April 2016.

Maintain provision of social care services.

In 2015/16, income to the Council through the BCF totalled £10,660,000. The CCG and the Council have negotiated a change in this position for 2016/17, taking into account the financial difficulties facing both parties, and planned changes to intermediate care provision. As a result, income to the Council through the BCF in 2016/17 will be £9,577,000

.

Implementing the Care Act

This plan includes the full share of the national allocation for implementation of the Care Act. £597,000 is allocated for this purpose.

During 2015 / 2016 Adult Social Care has worked to ensure that it successfully implemented the relevant provisions of the Care Act 2014.

As part of this the Council has:

- Developed a range of services which provide local people with a personalised response to information and advice. Care and Connect was launched, with partial funding from the BCF, offering a more tailored range of information, advice and signposting as well as being able to provide assessments and building community resilience. The 'My Care' web pages were made Care Act compliant and the North Tyneside Signposting and Information Network (SIGN) launched a new user App and website.
- Our social work teams implemented new national eligibility criteria. This has resulted in an increase in the number of carers receiving an assessment of their needs and a focus on wellbeing during assessment.
- We communicated our commissioning intentions through Market Position Statements; making clear the current areas of need, demand and resources available.
- The Gateway team was redesigned to deliver proportionate assessments which seek to get people the support they need as quickly as possible.

Supporting Carers

The North Tyneside Commitment to Carers identifies 6 priorities:

- Early identification of carers and the provision of quality information
- Improved communication
- Improved carer health, wellbeing, and support
- Support that enables carers to go to, or continue with, work or education
- Carers have access to emotional support
- Smooth transition of support from children's to adult services

£560,000 - the full share of the national allocation for support to carers has been allocated to support carers in this BCF plan.

In 2015/16 the BCF funding was used to part-fund a range of services which are shown in Table 3 below.

Table 3

Purpose	Funding
North Tyneside Carers' Centre - to provide information and advice	£ 73,394
Two Carer Support Workers who are employed by the Carers' Centre and work in Adult Social Care	£ 81,308
Young Carers Project Manager (Carers' Centre)	£ 36,093
P.R.O.P.S North East – (Positive Response to Overcoming Problems of Substance misuse) to support carers/family members of all ages who care for drug and/or alcohol users in North Tyneside	£ 104,994
Carers' Assessments	£ 50,600
Carers' Direct Payments	£ 5,680
Respite Care for Carers	£ 600,000
TOTAL	£ 952,069

In addition to the above, £2m was spent in 2015/16 on day care for LD, Mental Health, and Older People clients. A proportion of this care will be providing respite for a carer, but there is not a straightforward way to calculate this proportion.

Developments of carers support services in 2016/17 will include:

- Re-design of the carers' pathway.
- A one year pilot strengthen the advice and information offer and to test out the delegation of carers assessments to the Carers Centre.
- Pilot a new preventative service. The Service will provide practical support for carers through the provision of a sitting service without the need for a statutory assessment.
- Review of training in relation to carers.
- Develop a process for identification and assessment of Young Carers
- The development of the SIGN smartphone application may also benefit carers.
- Review the use and purpose of the Carer Emergency Card
- Continue to work on the remaining actions in the Commitment to Carers[6]

[6] http://www.healthwatchnorthtyneside.co.uk/sites/default/files/commitmenttocarersfinaldraft_210915_0.pdf

7-day services

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.

At Northumbria Healthcare Trust, there is an aspiration that 35% of patients will be discharged by midday and the practicalities of this is being considered. It is intended that the model for managing patients through the acute system going forward in Northumbria is to continually review patients for discharge throughout each day from 8 am onwards, spread across 7 days of the week. There will then be a continual flow of patients being discharged and planned for discharge across the week. Thought is being given as to how this model can be measured and what metrics would be used and it is proposed that this will be done by looking at the numbers of discharges through readmission rates (comparing months / years) and the ability to avoid bed blockages in the system at periods of surge.

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 and will test out 24/7 working for a three month period followed by evaluation.
In relation to primary care, the CCG will work with TyneHealth Federation to identify options for developing 7 day services in GP practices. We will learn from our experiences about access to GP services during the winter periods in 2014/15 and 2015/16 to help inform these options. We will also undertake a needs assessment and an engagement exercise before developing the final plan as we recognise it is important to understand how the public may use such services before implementing any model. We will also ensure regular review and evaluation of a new model of access.

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 Cedars Intermediate Care Resource Centre is open and accepts admissions 7 days per week.

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.

Information sharing

In 2015/16, North Tyneside (and surrounding areas) took a major step forward by implementing the Medical Interoperability Gateway (MIG) across the health community, in collaboration between local NHS FTs and CCGs. This provides access to an enhanced real-time view of the primary care record, to clinicians in acute, mental health, and primary care out-of-hours settings.

Clinicians in accident and emergency (Northumbria Healthcare NHS FT), and out-of-hours primary care (Northern Doctors Urgent Care), are live now with access to the primary care record. Mental health practitioners (NTW NHS FT) are also coming on line and implementation will continue throughout 2016/17. Newcastle upon Tyne hospitals FT are also implementing the MIG.

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.

During 2015/16, the CCG made considerable progress towards improving primary care informatics. For example, phase one of Patient Online was implemented across all twenty nine GP practices which gives citizens access to their online GP records and the availability of online appointments. Also, 97% of GP practices are transmitting prescriptions to the pharmacy electronically and roll out of the Electronic Prescription Service (EPS) will be completed by March 2016.

Electronic discharge summaries are now being used by GP practices across North Tyneside. The CCG are continuing to develop electronic referrals between GP practices and other services to create a fully interoperable digital record.

All NHS organisations are committed to the use of the NHS number. North Tyneside Council currently has NHS numbers for approximately 90% of clients, obtained through the use of a batch-tracing facility. The Council has obtained Information Governance Toolkit compliance and obtained linkage to N3 through a direct connection to the network of Northumbria Healthcare FT.

The Council is currently procuring a replacement Client Management System, to be used for both adults and children's social care, with additional linkage to education systems.

The specification for the system requires that the provider demonstrates:

- The ability to store and retrieve the NHS number

- The ability to find an NHS number in real time
- Their experience in implementing integration between health and social care systems
- That their system provides Open API's to enable integration, at both the basic technical and data structure level.

Information Governance remains a key priority all local stakeholders.

Around 200 Council staff had the opportunity to discuss in detail the importance of managing information properly at a series of Pride in Practice sessions. Training bespoke to social care settings has been developed and delivered. This remains a high priority with the training being mandatory and linked to employee Individual Performance Review. The Central Performance Team has recently been strengthened and policies are reviewed regularly. The Caldicott Guardian sends briefing messages about information management to staff

The Council will explore the opportunities for accessing the MIG in certain high-value circumstances, e.g. in the Carepoint (page 5) and CarePlus (page 5) services, in advance of anticipated fuller integration once the new client management system is implemented.

The CCG supports and leads on the Forward View into Action through the development, delivery and completion of the Digital Maturity Self-Assessment (The Digital Road Map) in collaboration with Northumbria Health Care Trust, Northumberland and Tyne &Wear Trust, North Tyneside Council, Northumberland CCG and Newcastle Hospitals Foundation Trust. The roadmap will have an effective, clear and consistent baseline against which local partners can demonstrate how far they have progressed towards the goal of being paper-free at the point of care. A collaborative working group has been developed which includes all the relevant partners re the delivery of the project.

Impact of changes on providers

There is no impact on hospital admissions which is not already factored into the CCG Operational Plan.

NHS providers are party to many of the BCF services included in this plan; for example Carepoint, Careplus, and the intermediate care review. These services are not new in 2015/16 and providers have been involved in the development of these services through the Older Peoples Programme Board and the Carepoint/ New Models of Care Project Board.

Appendix 1- National Metrics

Non-elective emergency hospital admissions

In 2015 a reduction of 3.8% in the actual volume of non-elective emergency admissions was achieved, which equated to a 4.3% reduction in the rate of admissions, when population growth was taken into account.

The effect of CCG Operating Plans, mapped to the HWB population, is to set out a trajectory for 24,768 emergency admissions, which equates to a reduction in 7.9% from the 2015 level, when further population growth is taken into account.

	2014 actual	2015 actual	2016/17 plan
Number of admissions	28,101	27,045	24,768
HWB Population	203,669	204,882	206,125
Rate per 100,000 population	13,797	13,200	12,160
Percentage change from previous year		-4.3%	-7.9%

As explained on page 12, this takes into account the full-year effect of the reduction in admissions which has been observed since June 2015, following the change in the configuration of urgent care services associated with the opening of the Northumbria Specialist Emergency Care Hospital.

Permanent Admissions to residential and care homes

Figure 12: trajectory for permanent admissions to residential care

	2014/15 actual	2015/16 actual	2016/17 plan
Number of admissions	239	311	296
HWB Population (aged 65+)	38,660	39,423	40,144
Rate per 100,000 population	618	788	737
Percentage change from previous year		27.5%	-6.5%

The national ASCOF definition of permanent admissions to residential care has now changed. The measure used in 2015/16 included only “council-supported” admissions, therefore it excludes self-funders and people who receive NHS Continuing Health Care. The new measure, which will be adopted for BCF monitoring in 2016/17, includes those categories, and therefore data from previous years will not be comparable to the new definition.

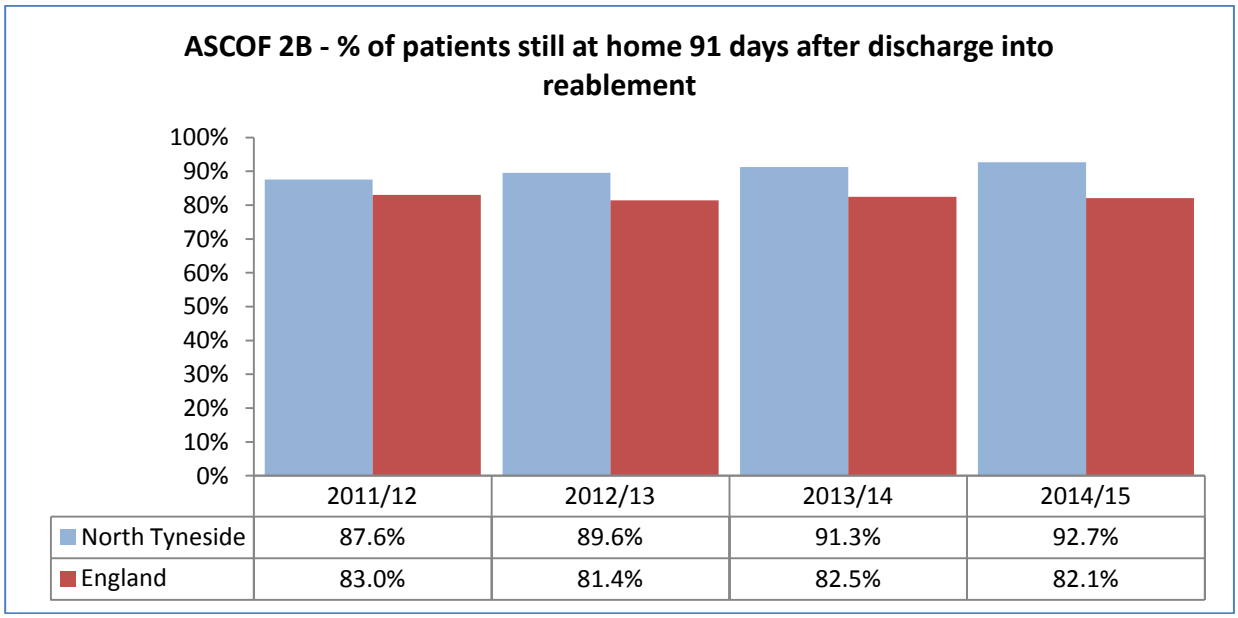
Effectiveness of reablement

Table 4: trajectory for reablement metric

	2014/15	2015/16	2016/17 plan
Value	92.7%	92.1%	Tbc
Percentage change from previous year		-0.6%	Tbc

North Tyneside has achieved a performance for the reablement metric well above the England average since 2011/12 – see Figure 13 below. In 2014/15, our performance was the best in the Northern Region.

Figure 13: benchmarking information for reablement metric



Given the favourable baseline, further marginal improvements are difficult to achieve. In 2016/17 the reablement service will transition into the new CarePoint service (page 5) which will help us to sustain high performance against the context of increasing numbers of elderly residents with complex needs. **Delayed transfers of care**

Table 5: Trajectory for Delayed Transfers of Care

	2014 actual	2015 actual	2016/17 plan
Number of days of delay	2,838	3,042	2,895
HWB Population aged 18+	161,678	163,218	165,423
Rate per 100,000 population aged 18+	1,755	1,863	1,750
Percentage change from previous year		6.2%	-6.1%

The BCF target for 2015/16 called for the numbers of days of delayed transfers to be no more than 3,201 days. The actual level of delays was lower than the target, (i.e. better performance) at 3,042.

However the target for 2015/16 was set before all of the data for the preceding year, 2014/15, was available. The number of delays in 2014/15 turned out to be 2,834.

Despite the increase compared to the previous year, our performance was still in the best 20% of local authority areas in England, as shown on page 42.

For 2016/17, we aim to reduce the rate of delayed days to below the level achieved in 2014. Taking into account population change, that requires an actual number of days of delay no greater than 2,895, equating to a rate of 1,750 days per 100,000 population aged 18+, and a decrease of 6.1% compared to 2014.

Further details are shown in the DTOC plan on page 42.

Appendix 2 – BCF performance management and KPIs

How performance management will operate

The performance management arrangements for 2016/17 will build upon those adopted for 2015/16. In that year, the BCF s75 Agreement stipulated a range of measures, including but going beyond the national BCF metrics. Performance against these indicators were reported regularly to the BCF Partnership Board. An example performance report is embedded in the "related documentation" section on page 2.

In addition to reporting to the BCF Partnership Board, these indicators were included in performance reports to the Older Persons Programme Board and the Systems Resilience Group; these groups take a wider view of service development and transformation, including but not limited to services funded through the BCF.

The tables below are a draft set of indicators for 2016/17 which will be reviewed by the BCF Partnership Board for inclusion in the 2016/17 BCF s75 Agreement.

Table 6: performance measures for BCF services aligned to the Older Persons Programme Board

Service Name	Outcomes	Measures	Frequency
Proactive care and admission avoidance	A reduction in avoidable hospital admissions of patients aged 75+	• Total number of emergency admissions • Number of emergency bed days • Number of avoidable admissions	Monthly
End of Life Care	To reduce the number of hospital admissions of patients on the palliative care register; and to increase the number of people able to die in the place of their choice	• Proportion of people on the palliative care register dying in the place of their choice • Number of non-elective hospital admissions • Number of Accident and Emergency attendances • Number of emergency hospital bed days in the last 100 days of life	Monthly
Falls Pathway	To reduce the number of hospital admissions related to falls.	• Numbers and cost of falls-related admissions	Monthly
Seven-day	To provide an	• Number of	Monthly

Service Name	Outcomes	Measures	Frequency
social work	enhanced social work service in the evenings and weekends with the objective of reducing hospital admissions and facilitating earlier discharge.	emergency admissions for patients aged 75+ • Number of referrals stratified by outcome, per social work team • Average length of stay of hospital admissions	
Immediate response and overnight home care	To prevent unnecessary admissions to hospital and long term care. Effective and responsive emergency support to carers in times of crisis will allow them to continue in their caring role, which is important in terms of preventing carer breakdown and avoiding increased costs to the health and social care system.	• Proportion of service users who are supported to live independently at home (ASC 14) • Number of permanent admissions into residential care per 100,000 of the population (ASCOF 2A) • Number of new service users this period • Number of service users this period • Number of hospital admissions of service users this period	Monthly
Increased use of telecare	To reduce the number of A&E attendances by people aged 75+	• A&E attendances for people aged 75+ • The proportion of calls to the Care Call crisis response service resulting in A&E attendance • The number of people using the Care Call crisis response service	Monthly
Intermediate Care – "The Cedars"	• prevent unnecessary admission and readmission to hospital; • reduce number of	• Number of individuals admitted to intermediate care • Number of admissions to facilitate discharge	Quarterly

Service Name	Outcomes	Measures	Frequency
	attendances at A & E; • provide care closer to home to ensure active recovery and rehabilitation to prevent unnecessary loss of independence; • reduce the average length of stay for older people in hospital; • prevent unnecessary admissions to long term care; • promote independence and reduce dependence upon long term home care packages;	from hospital • Number of admissions to prevent admission to hospital • Length of stay • Average bed occupancy • % of Discharges to home address • % of Discharges to residential care • % of Discharges to Extra Care • % of Discharges with home care packages • % of Discharges with reablement/ongoing therapy • Admissions into hospital from Intermediate Care	
NHS support to social care	Improve services in the community	• Proportion of service users who are in permanent residential care (ASC15)	Quarterly
	Support carers	• Carers receiving a needs assessment or review and a specific carers service or advice and information (ASC28)	Quarterly
	Support people with learning disability	• Proportion of adults with learning disability in paid employment (ASCOF 1E)	Quarterly
		• Proportion of adults with learning disability who live in their own home or with their family	Quarterly
	Prevention/self help/ early intervention	• Number of users of the crisis response service (ASC76)	Monthly
		• Number of calls to	Monthly

Service Name	Outcomes	Measures	Frequency
		the crisis response service (ASC77)	
		• The proportion of calls to the crisis response service resulting in A&E attendance (ASC78)	Monthly
		• The proportion of calls to the crisis response service resulting in a healthcare response other than A&E attendance (ASC79)	Monthly
	Increase access to Telecare & telehealth	• Percentage of items of equipment or minor adaptations delivered within 7 working days	Monthly
		• Median waiting time for delivery of equipment or minor adaptations	Monthly
Reablement	• Reduction in admissions to permanent residential care • Reduction in emergency hospital admissions	• Proportion of Older People (65+) who are still at home 91 days following discharge from hospital into reablement/rehabilitation services (ASCOF 2B pt1) • The proportion of older people aged 65 and over offered reablement services following discharge from hospital (ASCOF 2B part 2) • Emergency hospital admissions of people aged 65+	Monthly
		• Mean average change in EQ-5D score for clients of the reablement service	Quarterly

Table 7: BCF performance measures aligned to the Systems Resilience Group

Service Name	Outcomes	Measures	Frequency
DTOC	A reduction in Delayed Transfers of Care	• Total number of days of delay, grouped by NHS responsible, social care responsible, and both responsible	Monthly
		• Number of days delay per NHS provider	Monthly
		• Number of days delay grouped by cause	Monthly

Table 8: BCF performance measures aligned to the Mental Health Partnership Board

Service Name	Outcomes	Measures	Frequency
Liaison Psychiatry		• Number of bed days for emergency hospital admissions of patients with a mental health diagnosis	Quarterly
		• Length of stay for emergency hospital admissions of patients with a mental health diagnosis	Quarterly
		• Number of referrals to the Liaison Psychiatry Service	Quarterly

The “related documentation” section on page 2 includes an embedded example BCF Performance Report, which illustrates the performance information routinely monitored by the BCF Partnership Report in 2015/16, against KPIs set out in the BCF s75 Agreement. This format will be refined to meet any changed requirements in the 2016/17 BCF plan.

Appendix 3 – Governance Arrangements

The 2015/16 BCF s75 Agreement established a Better Care Fund Partnership Board with the following terms of reference:

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

North Tyneside Clinical Commissioning Group

- Director of Commissioning Development
- 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 Development 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

Role of Partnership Board

The Partnership Board shall:

- provide strategic direction on the individual Service
- 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 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:

POOLED FUND MANAGEMENT

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.

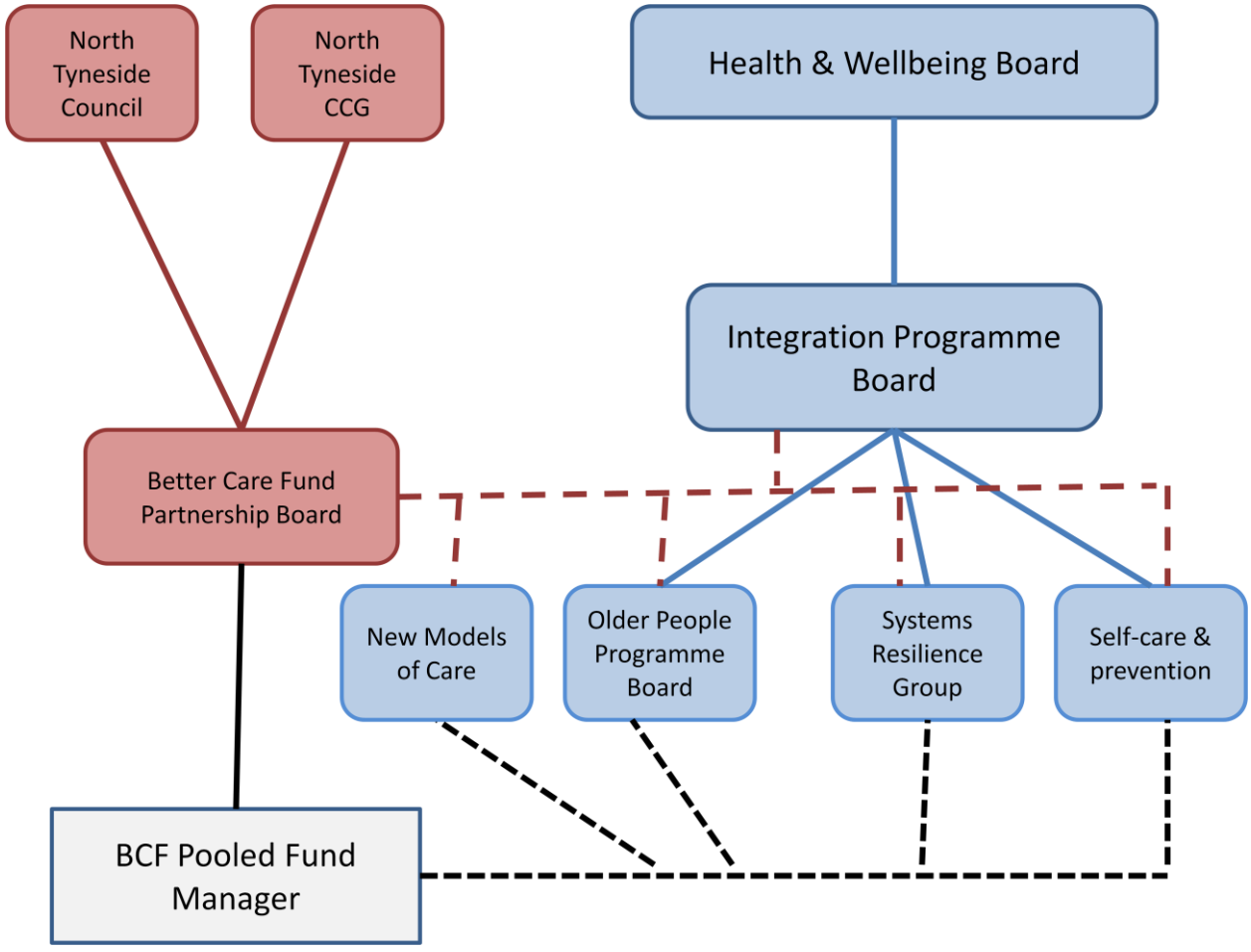
38 In carrying out their responsibilities as provided under Clause 8.2 the Pooled Fund Manager shall have regard to the recommendations of the Partnership Board and shall be accountable to the Partners.

The Council and CCG will review the membership and terms of reference of the Partnership Board, and the duties of the Pooled Fund Manager, to consider whether any changes are required for 2016/17.

The business of planning, implementing, monitoring, and evaluating the Better Care Fund forms a subset of the business of the overall North Tyneside Health and Social Care Integration Programme, led by an Integration Programme Board which is chaired by the Chair of the Health and Wellbeing Board.

The Integration Programme Board reports to the Health and Wellbeing Board. Reporting to the Integration Programme Board, are five partnership boards dealing with specific workstreams: older person's pathway; urgent care / systems resilience group; self care & prevention; and new models of care.

Figure 14



The *Older People Programme Board* will play a particular role in the management of 2016/17 BCF services. It will oversee the implementation of BCF services relating to the categories of seven day services; intermediate care; integrated teams; assistive technology; reablement; and personalised care/support at home.

The *Systems Resilience Group* will own the implementation of the Delayed Transfers of Care action plan, and 7-day working.

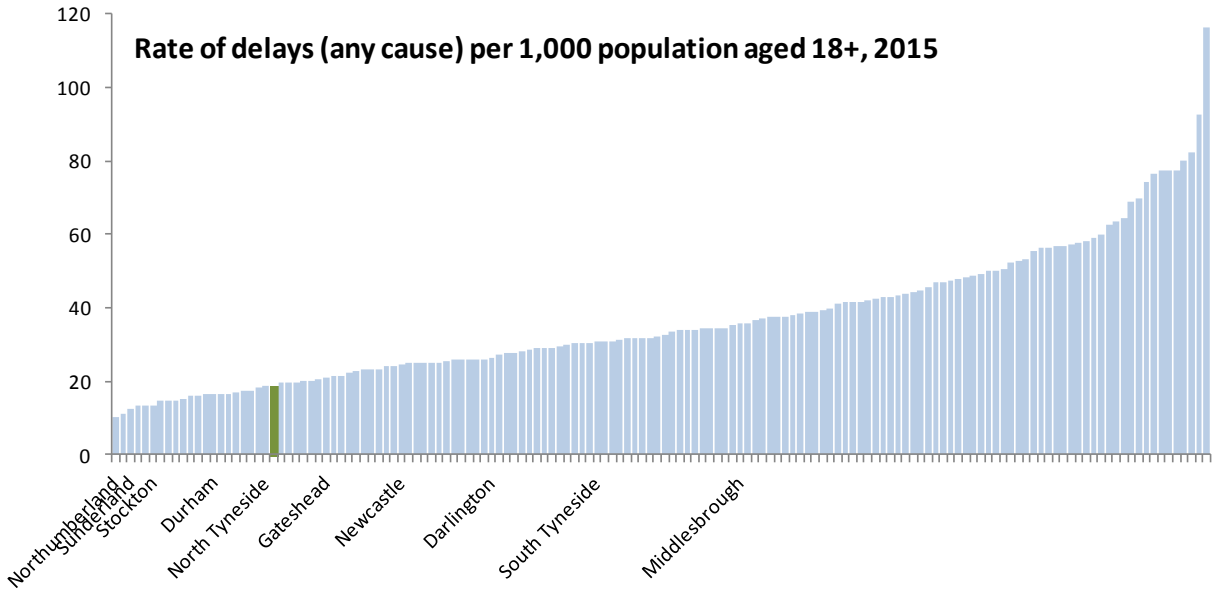
Appendix 4 – Delayed Transfers of Care

The current level of delayed transfers.

In 2015, there were 3,042 bed days lost due to delayed transfers of care of North Tyneside residents.

Figure 15 below shows that the rate of delays in North Tyneside, was well below the average for England. The North Tyneside rate was 18.7 days per 1,000 population aged 18+; the median value was 31.7 days. North Tyneside was in the best-performing 20% of areas.

Figure 15



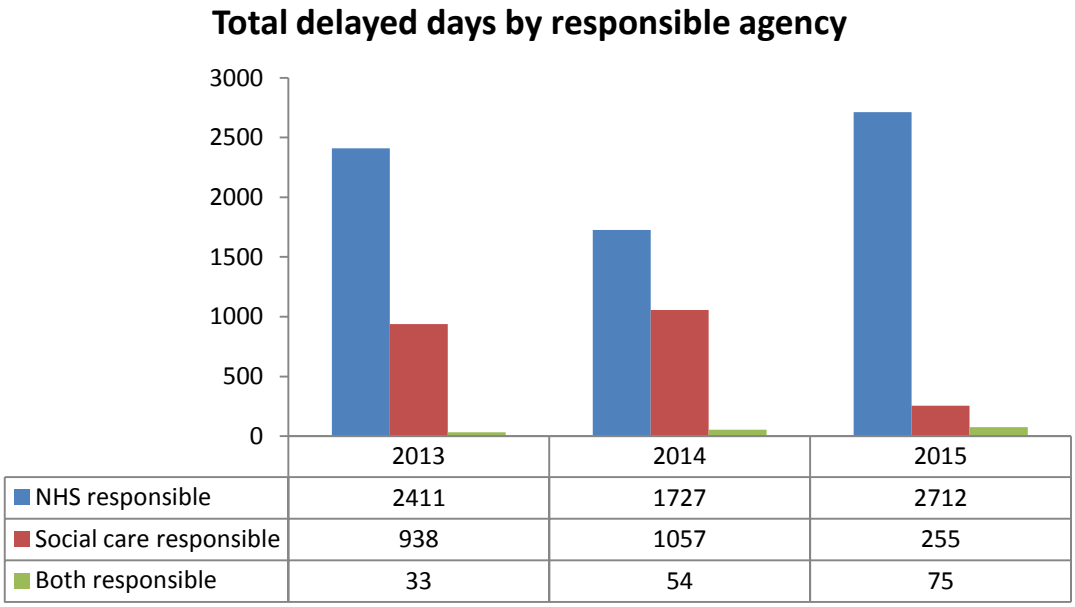
Furthermore, Table 9 below shows that whereas the volume of delayed transfers in England and Wales increased by 23% between 2013 and 2015, there was a 10% reduction in North Tyneside.

Table 9

	Total days of delay	
	North Tyneside	England
2013	3,382	1,398,063
2014	2,838	1,553,204
2015	3,042	1,720,564

The number of delays which were classed as “social care responsible” fell significantly in 2015, whilst the number of “NHS-responsible” delays increased (Figure 16).

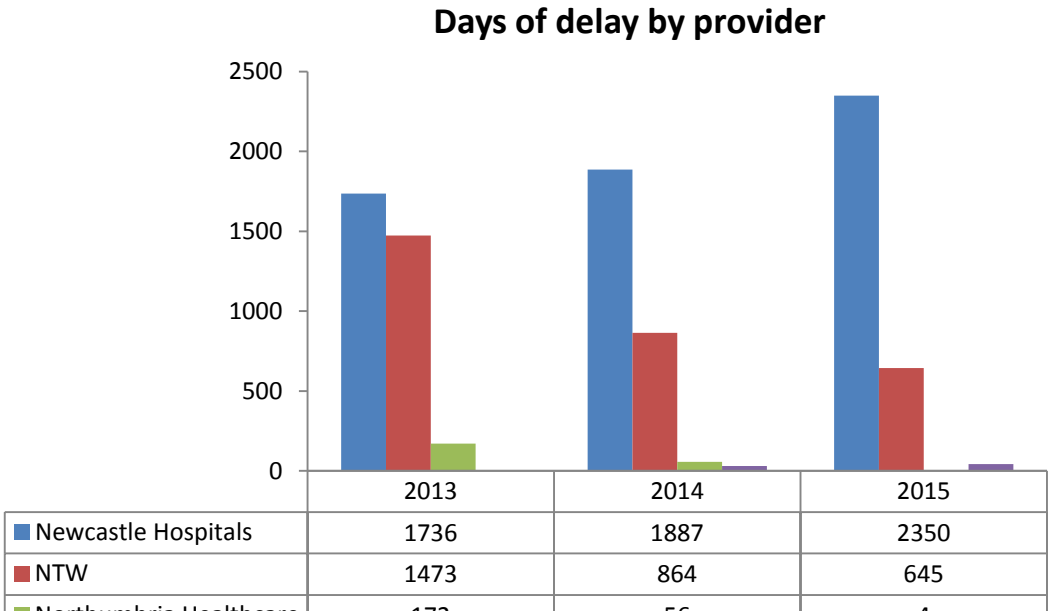
Figure 16



	2013	2014	2015
NHS responsible	2411	1727	2712
Social care responsible	938	1057	255
Both responsible	33	54	75

Figure 17 shows that the number of delays fell over the last three calendar years for North Tyneside residents in Northumbria Healthcare hospitals, as well as at our mental health provider, Northumberland, Tyne and Wear NHS Foundation Trust (NTW).

Figure 17

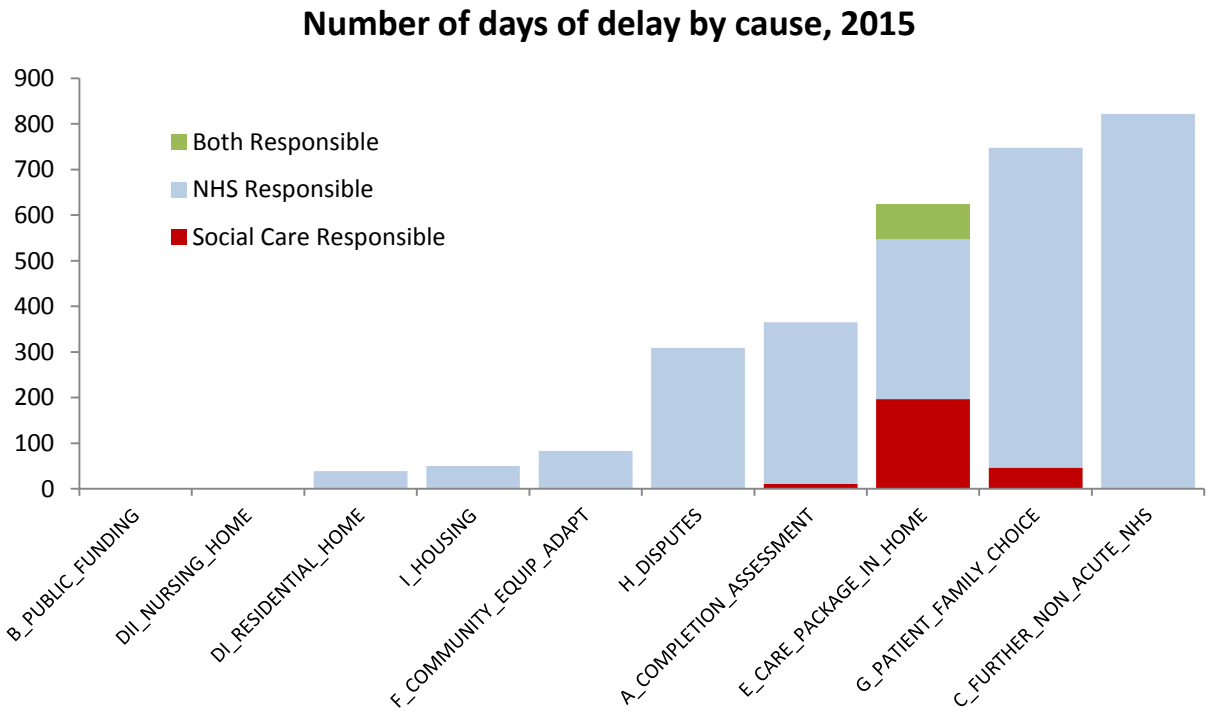


	2013	2014	2015
Newcastle Hospitals	1736	1887	2350
NTW	1473	864	645
Northumbria Healthcare	172	56	4
Other providers	1	31	43

However the number of delays for North Tyneside patients in Newcastle Hospitals increased over the last three years, and accounted for 77% of all delays on 2015.

The number of delays at Newcastle is particularly notable when set in the context that only 31% of emergency bed days for North Tyneside patients were in Newcastle Hospitals – Northumbria Healthcare accounting for most of the rest.

Figure 18



The causes of delay are illustrated in Figure 18 above. The three most common causes accounted for 72% of days of delay:

1. Waiting for further non-acute NHS care (27%)
2. Patient or family choice (25%)
3. Waiting for a home care package (21%)

Appendix 5- Risk sharing

In 2015/16, the North Tyneside BCF plan included a pay-for-performance measure based on the national expectation of a 3.5% reduction in non-elective admissions.

Although non-elective admissions were at a high level in the first half of 2015, there was a dramatic reduction following the opening of the Northumbria Specialist Emergency Care Hospital in June 2015. For Jan-Dec 2015, there was a reduction of 3.8%, and hence the pay-for-performance target was met.

In the second half of 2015 the reduction in admissions was approximately 14% and the CCG trajectory for non-elective admissions reflects the expected full-year effect of the opening of NSECH.

Given the substantial reduction in non-elective admissions which have already occurred, our BCF plan does not anticipate any additional reduction over and above that already reflected in the CCG operational plan. For this reason, there will be no local pay-for-performance scheme linked to the BCF in 2016/17.

Our 2015/16 BCF s75 Agreement set out the arrangements for managing the risk of overspends and underspends. Each BCF service was allocated to a “responsible commissioner” who managed the risk of overspend on that service. For example, the Council managed the risk of overspends on Council-commissioned service and the CCG managed the risk of overspend for CCG-commissioned services. The following extract from Schedule 3 of the 2015/16 BCF s75 Agreement sets out the arrangements:

5 Management of Overspends

5.1 The relevant Responsible Commissioner will manage service expenditure and is responsible for any Overspend unless it can be demonstrated and explicitly agreed by all Partners that additional spend in a particular area is beneficial to the delivery of the Better Care Fund and should be funded from underspends elsewhere with the Pooled Fund or from the dual-running contingency.

5.2 The Partnership Board shall acting reasonably having taken into consideration all relevant factors including, where appropriate the Better Care Fund Plan and any agreed outcomes and any other budgetary constraints agree appropriate action in relation to Overspends, based on the following principles:

The Responsible Commissioner of the Service reporting or predicting an Overspend has responsibility for:

5.2.1 managing expenditure to minimise the risk of an Overspend

5.2.2 taking all reasonable steps to eliminate an Overspend

5.2.3 making a proposal to the Partnership Board to vire funds from other services for which they are the Responsible Commissioner (such proposals are subject to agreement by the Partnership Board)

5.2.4 Absorbing the Overspend from their own funds, outwith the Pooled Budget, if virement from other services is not agreed by the Partnership Board.

5.3 The Partners agree to co-operate fully in order to establish an agreed position in relation to any Overspends.

5.4 Where there is an overspend in a Non Pooled Fund at the end of the Financial Year or at termination of the Agreement such overspend shall be met by the Responsible Commissioner with responsibility for the non-pooled fund to which the overspend relates. Subject to any continuing obligations under any Service Contract entered into by either Partner, either Partner may give notice to terminate a Service Service where the Service Specification provides and where the Service does not form part of the Better Care Fund Plan.

The Partners will review the arrangements set out above to establish whether any changes are appropriate to meet the requirements of the 2016/17 BCF, prior to concluding a new s75 Agreement by the end of June 2016.