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.

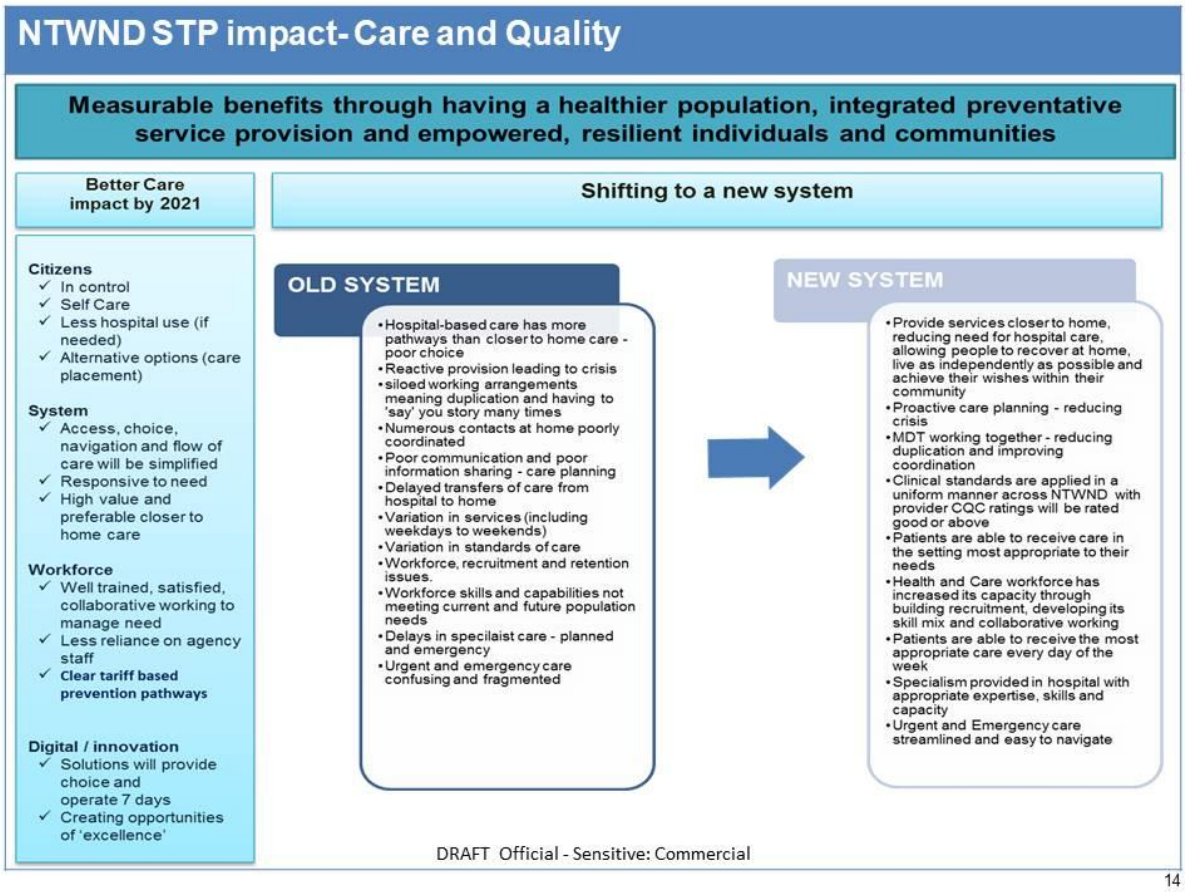
Looking forward to 2021, by doing nothing we will see the current gaps in our Health and Wellbeing and Care and Quality outcomes against the rest of the country widen. Our local NHS financial gap coupled with that of our local authorities’ financial constraints, if left unaddressed, will cause a decline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

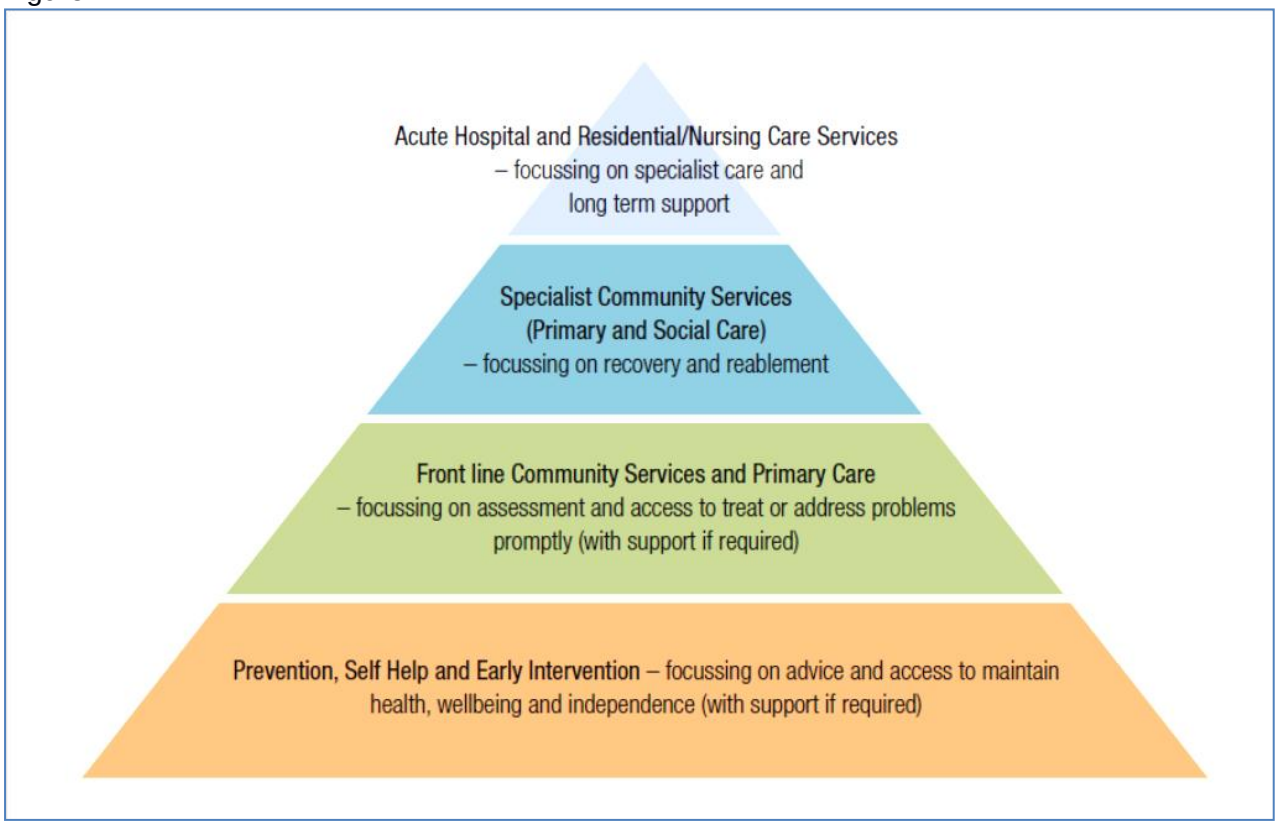


Table 4 shows how the BCF plan is aligned to these four levels:

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.

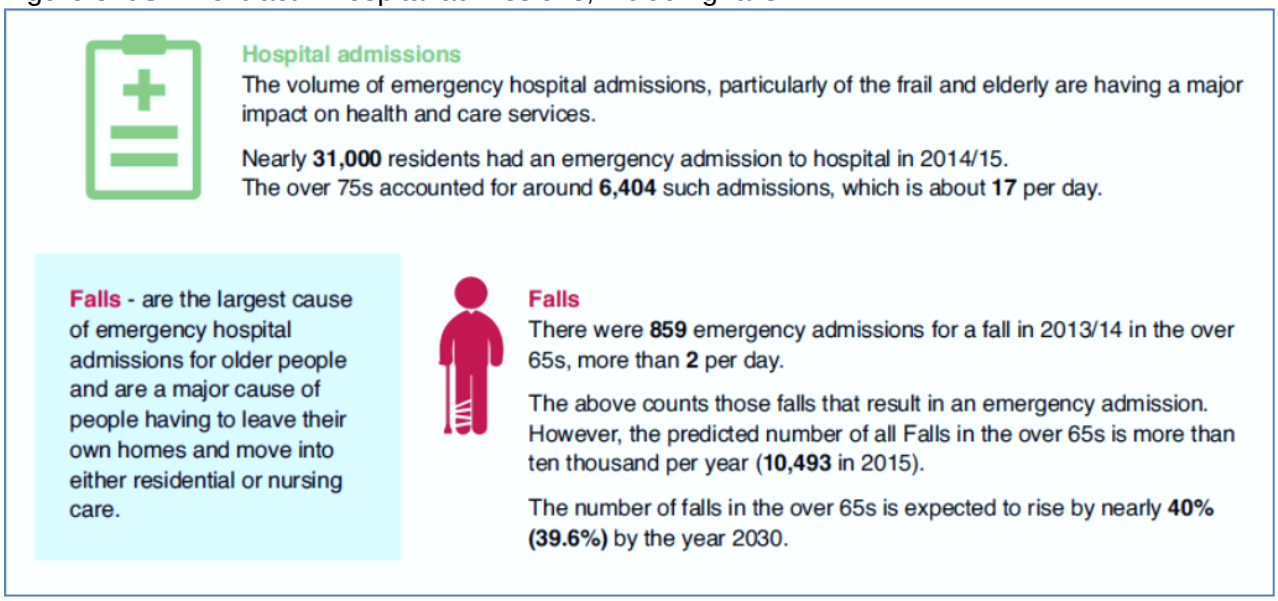
By 2039, the overall population is forecast to increase to 223,000, of which 33,000 will be aged 75+, forming 14.8% of the population. The rising number of older residents is a key driver of increasing demand for health and social care.

[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.

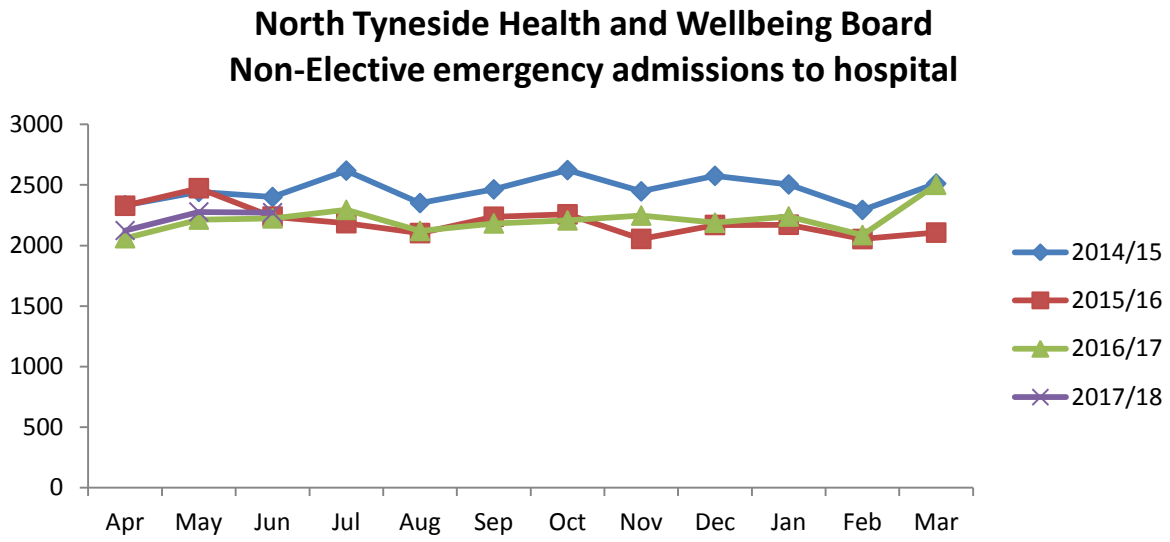
However in 2015/16 there was a substantial reduction in volume of emergency admissions, particularly following the opening of the Northumbria Specialist Emergency Care Hospital, the first UK hospital to specialise in emergency care.

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

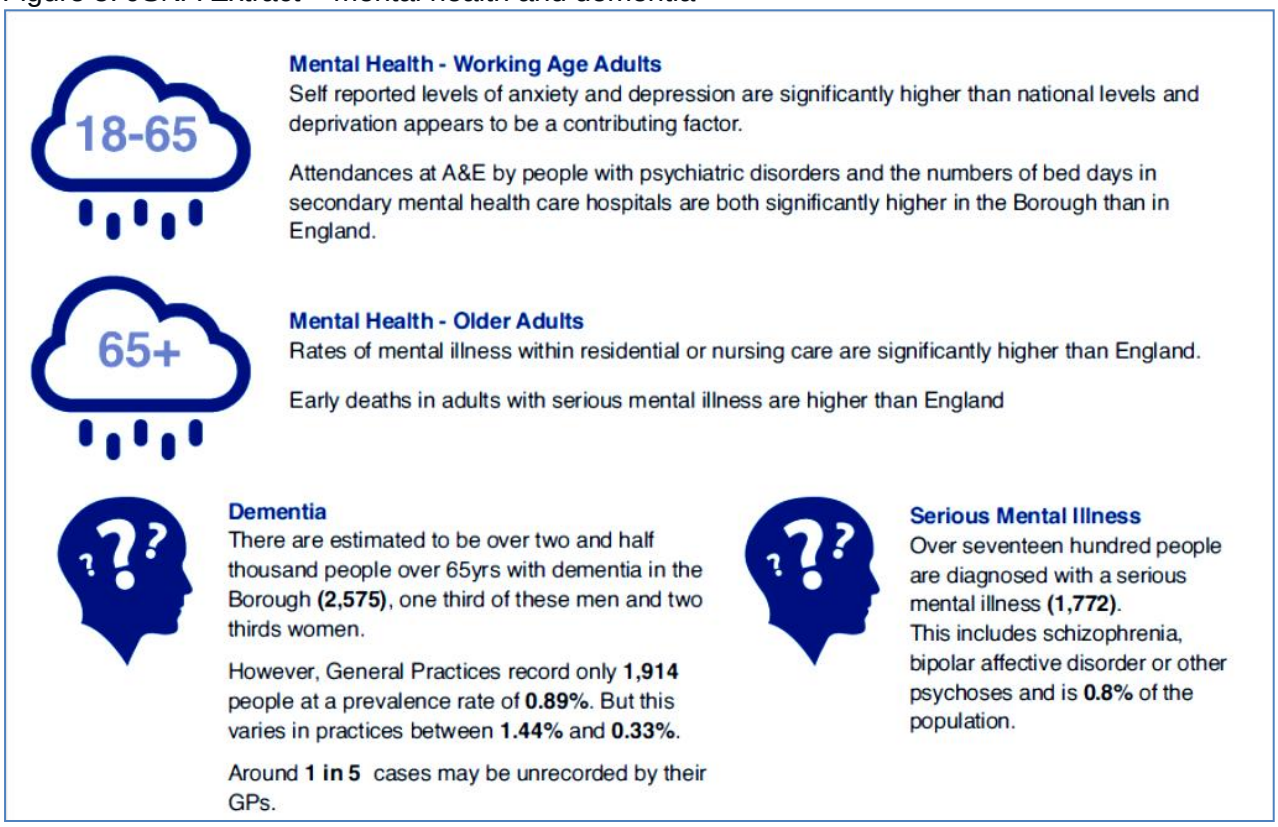


Nevertheless the BCF services will continue to play a role in maintaining the level of emergency admissions at the new lower level, particularly with regard to older people. For example:

- 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:

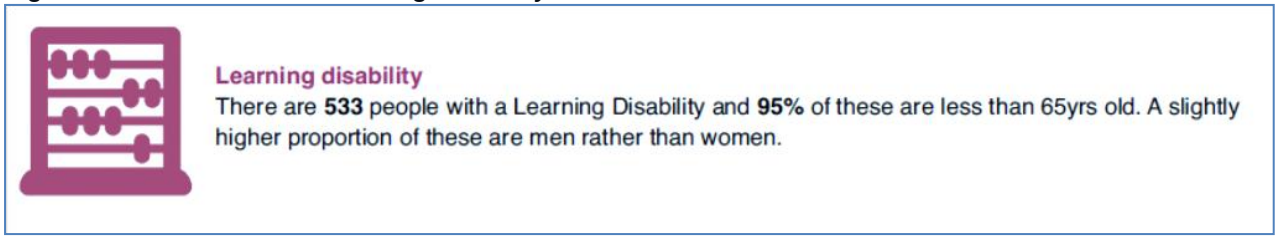
- Continue to exceed the national IAPT Access standard
- Achieve the national IAPT Recovery Rate
- Exceed national IAPT waiting time standards
- Achieve the national standard for Early Intervention in Psychosis
- Improved pathways for people experiencing a first episode of psychosis and reducing hospital 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 83.

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

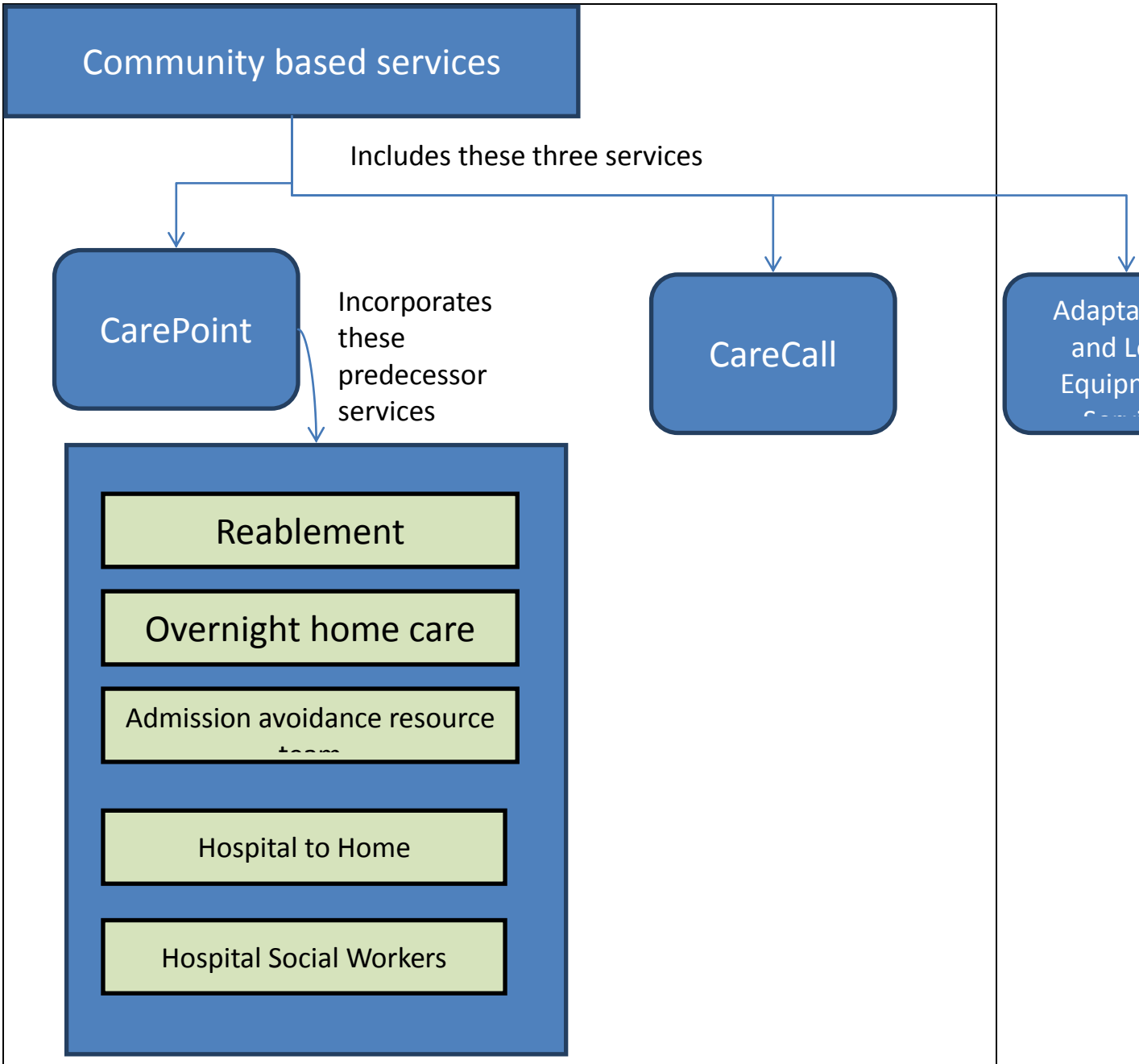
		Sum of 2017/18 Expenditure (£)	Sum of 2018/19 Expenditure (£)
1	Community-based support, including Carepoint; reablement; immediate response and overnight home care; adaptations and loan equipment service; and CareCall / telecare	£ 7,138,533	£ 7,274,165
2	Intermediate Care beds	£ 3,653,432	£ 3,722,847
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 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 76.

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 works 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 73.

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	100,000	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 £4,074,843 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 83

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 Ty	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:

---

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

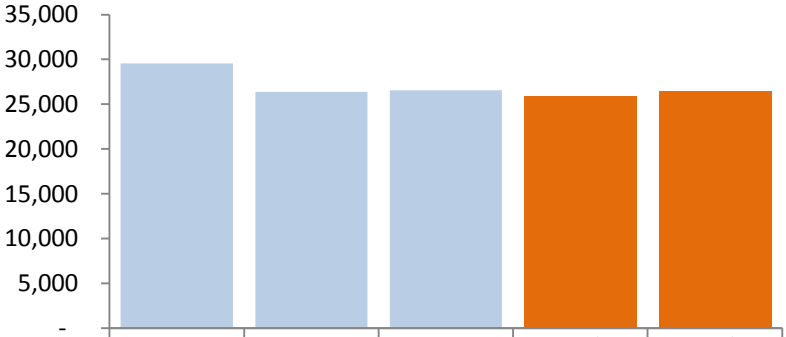
Summarise the metrics you have set for each of the four national metrics.
You should include an explanation for how each target has been reached, including an analysis of previous performance and a realistic assessment of the impact of BCF schemes on performance in 2017-19.

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.

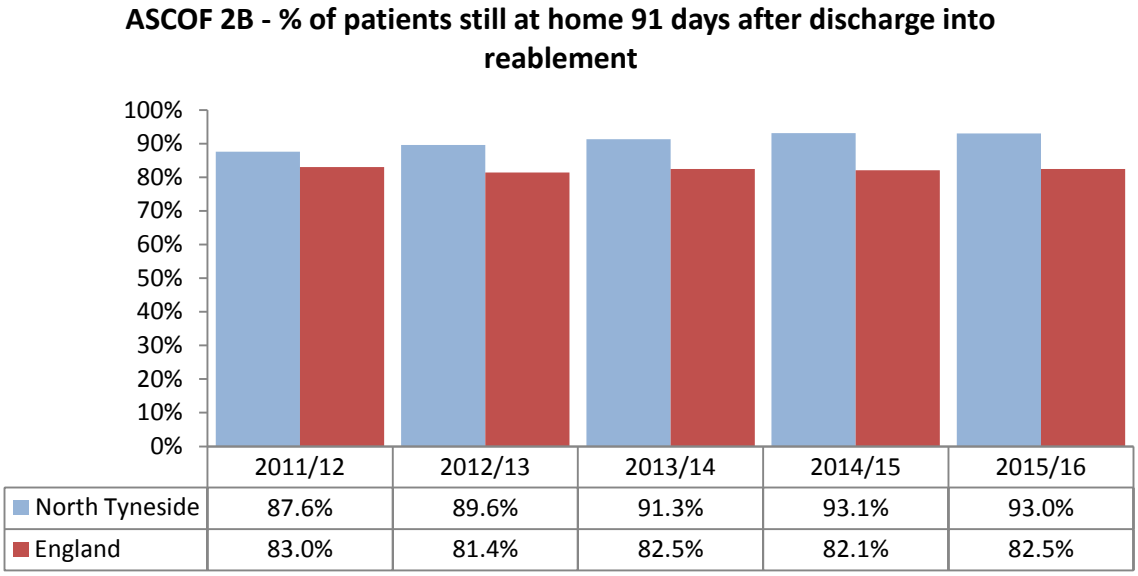
Our progress in implementing the High Impact Change Model will help to constraing growth in permanent admissions to residential care, by ensuring that early planning is carried out by multi-disciplinary teams to ensure that options other than residential care are actively

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.

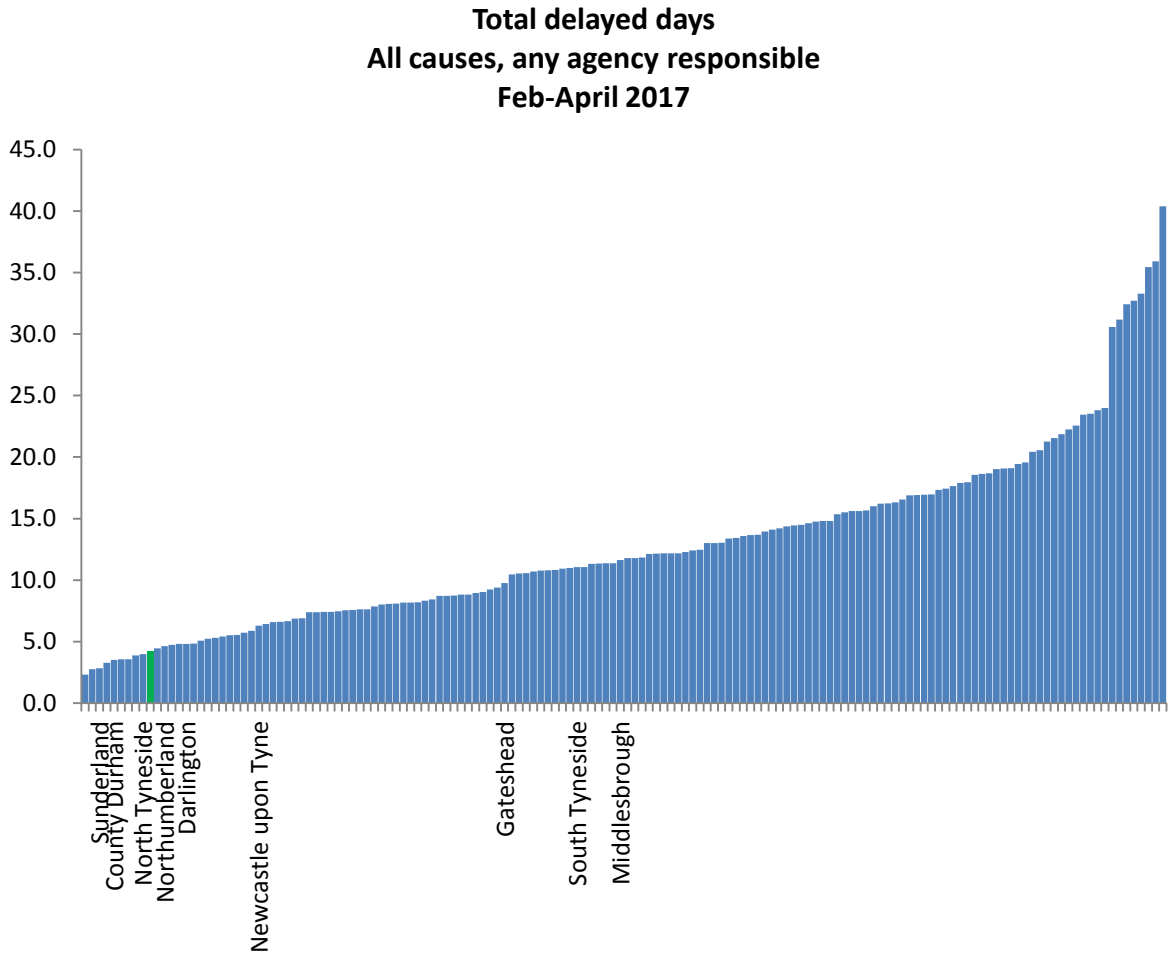
Whilst the level of delays in North Tyneside are relatively low, we are committed to maintaining them at that low level and to seek further reductions. Our plan to do so is inextricably linked with the further implementation of the High Impact Change Model for Managing Transfers of Care.

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.

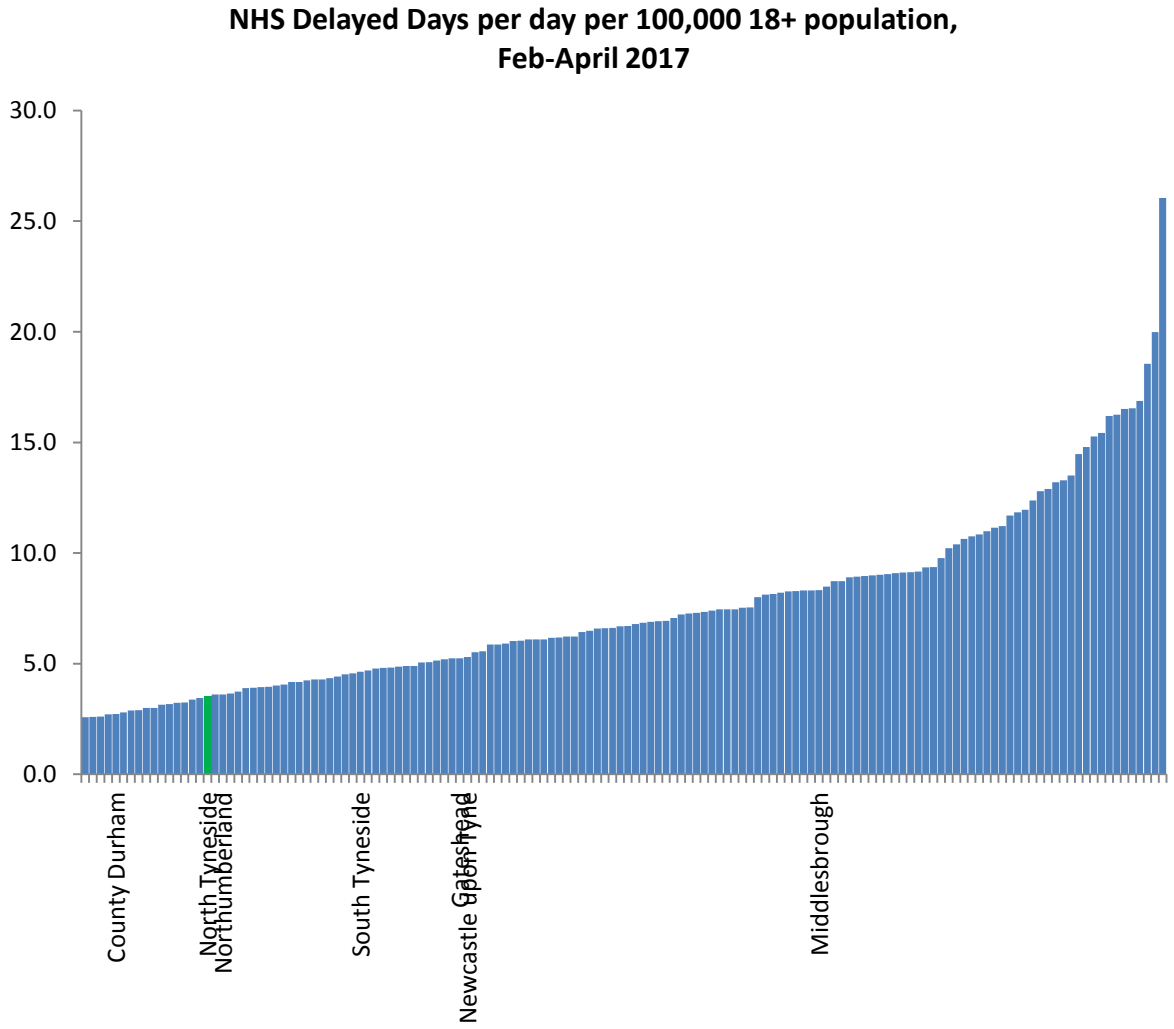
This section assesses the baseline situation, using the time period February-April 2017 which was the period quoted in the NHS-Social Care Interface Dashboard, which informed the national exercise in setting DTOC trajectories in July 2017.

Figure 11



Error! Reference source not found.Figure 11. 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.**Figure 12.** 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

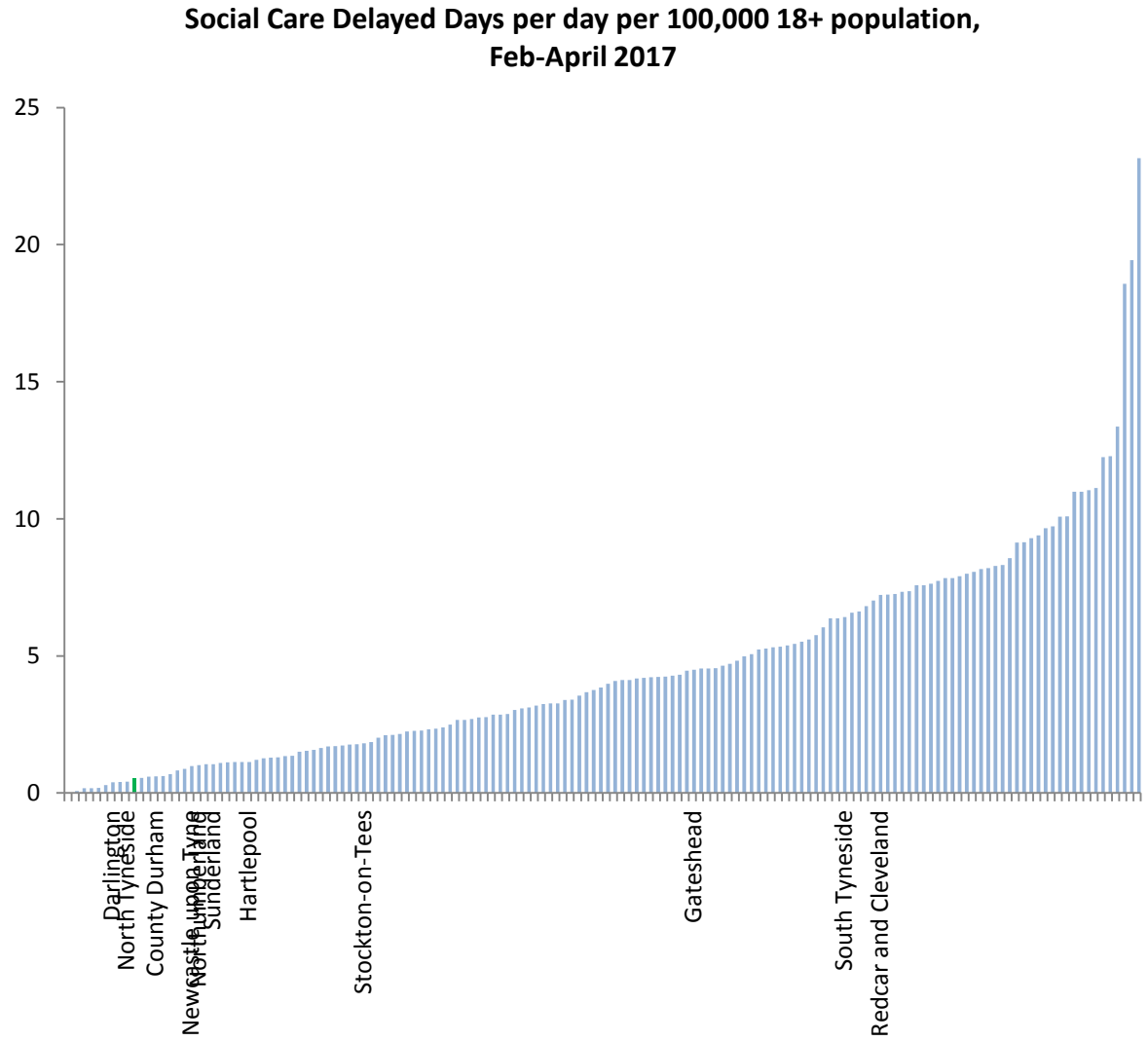
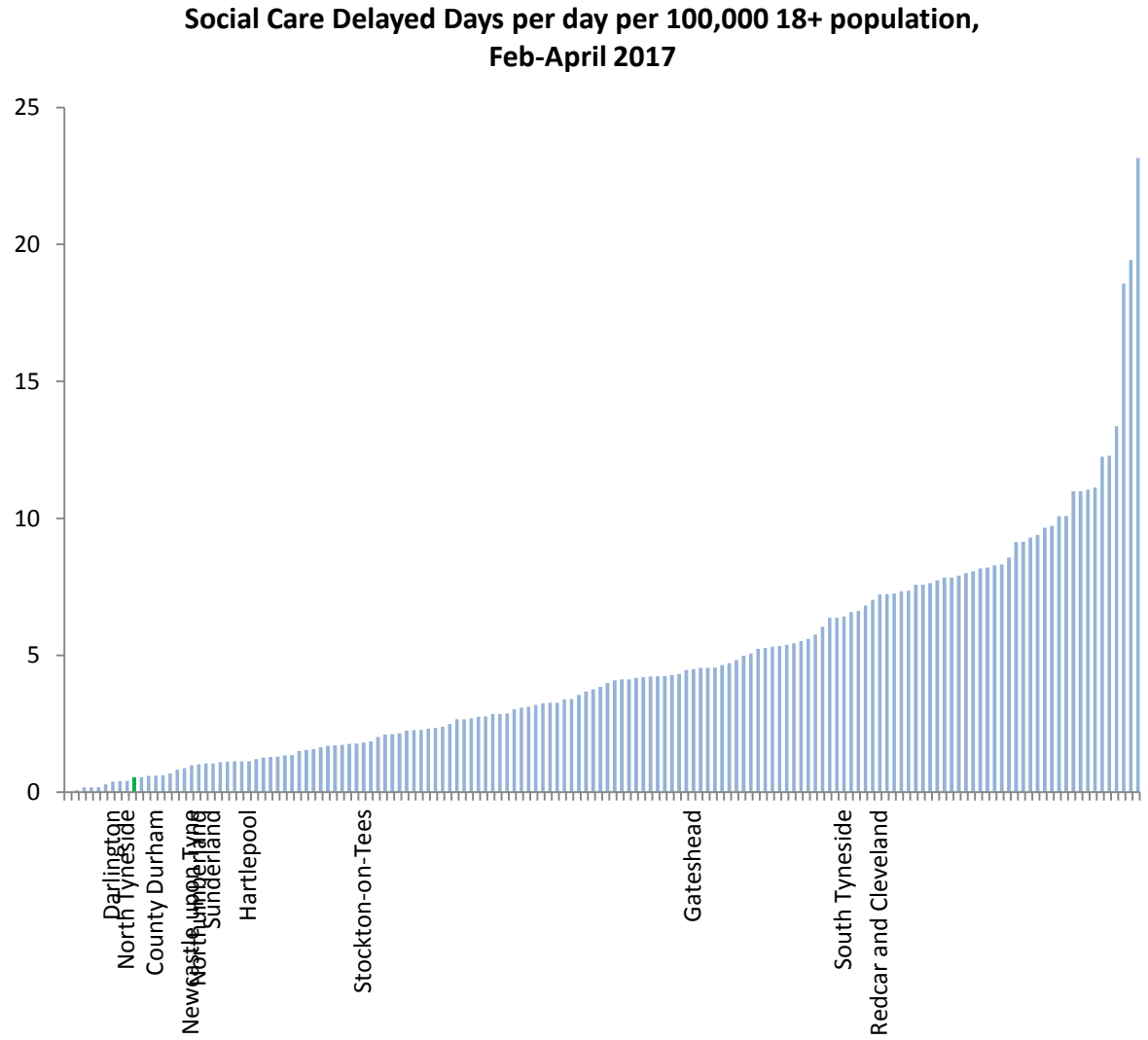

Social Care Delayed Days per day per 100,000 18+ population, Feb-April 2017
25
20
15
10
5
0
Darlington
North Tyneside
County Durham
Newcastle upon Tyne
Northumberland
Sunderland
Hartlepool
Stockton-on-Tees
Gateshead
South Tyneside
Redcar and Cleveland

Figure 13



Fugure 13 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. Table 18 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.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.Error! Reference source not found. Table 20**.** 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.

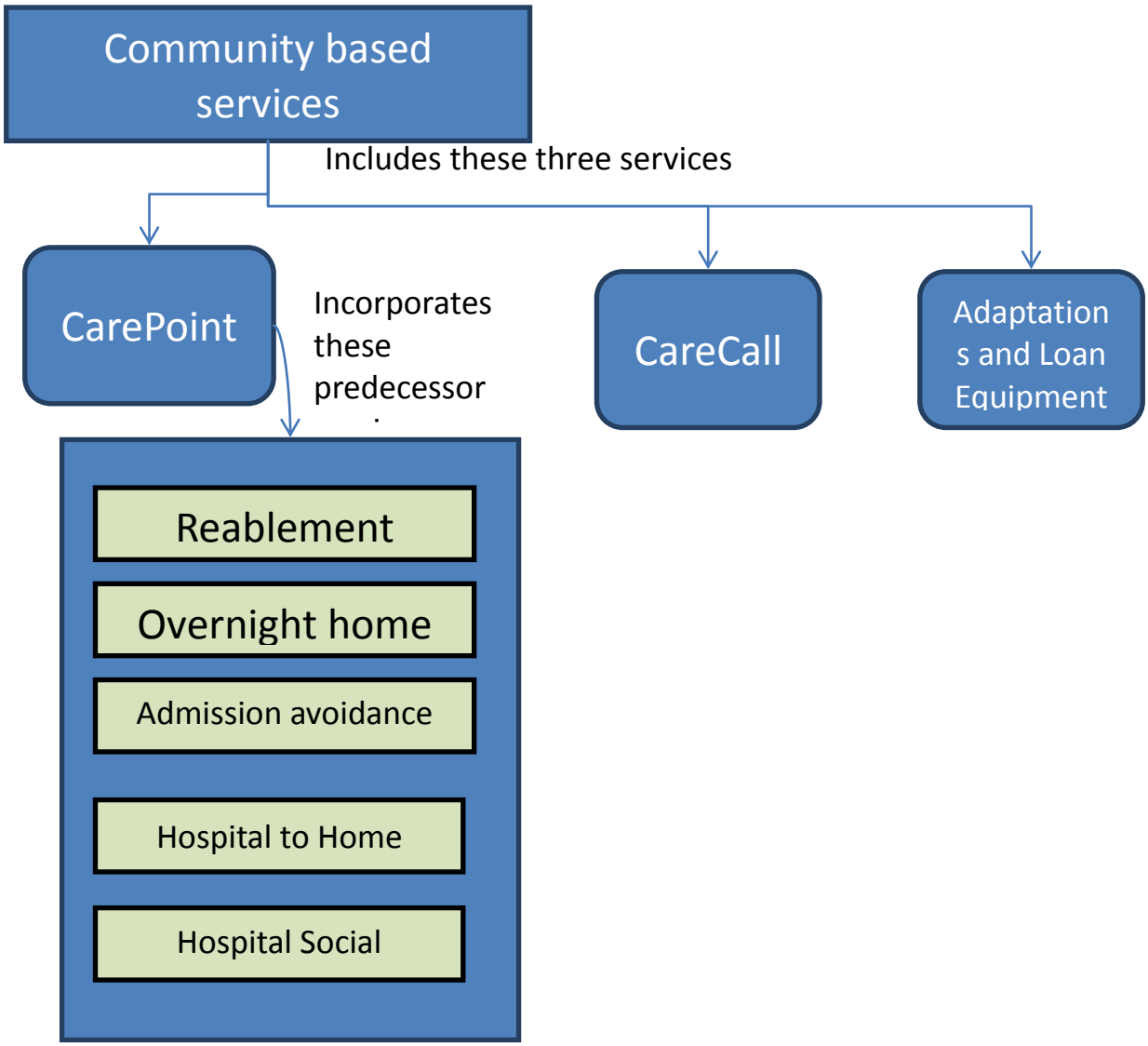
Pharmacist
The Care Plus pharmacist will carry out a personalised medication review. This will include an evaluation of the risks/ benefits of medications, consideration of polypharmacy and drug interactions, an assessment of patient compliance and patient education around medications.

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 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 supports 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 has 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

This service is 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 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:

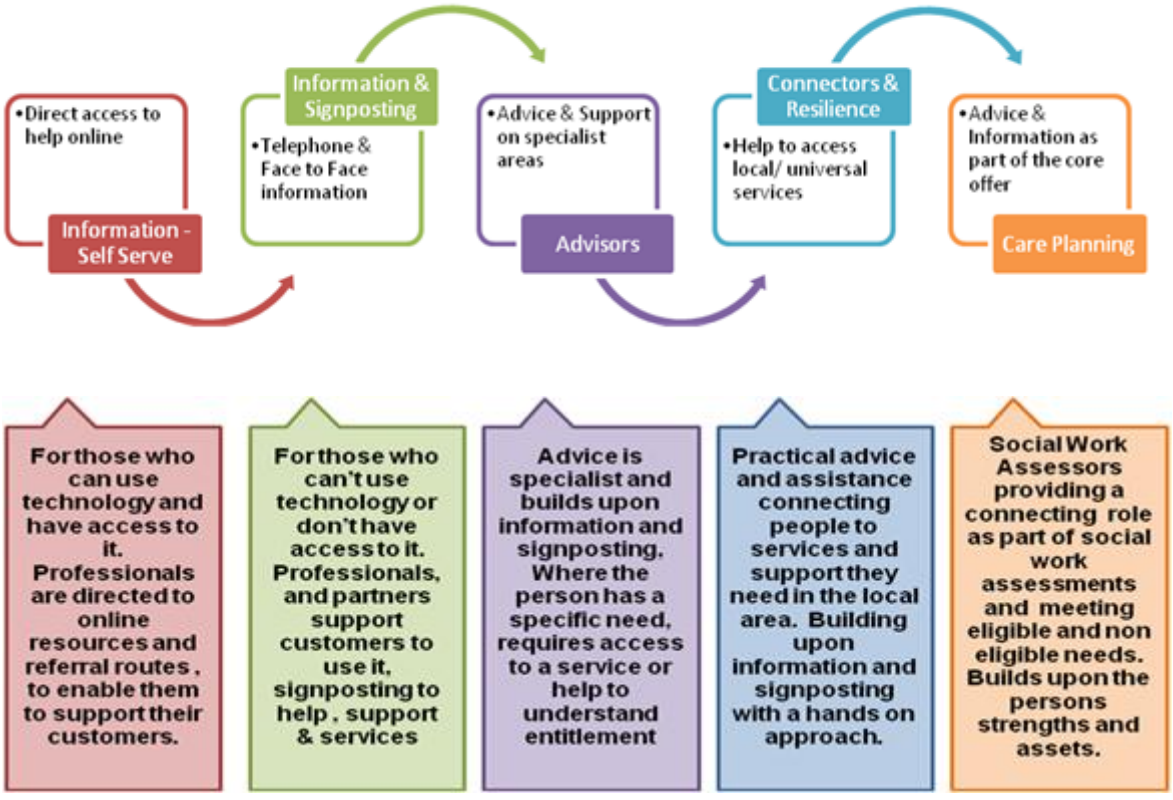
- Young Carer awareness – identification and assessment by all
- Carers and hospital discharge processes
- Collecting carers views of the current system and support – (including Healthwatch NT findings)
- Assistive technology to support carers and the use of the carers Jointly App
- Support for carers 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.